AN ETHNOGRAPHIC STUDY
EXAMINING
QUALITY OF WORKLIFE ISSUES
OF OUTPOST NURSES
IN NORTHERN MANITOBA

BY

DONNA E. MARTIN

A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfilment of the Requirements
for the Degree of

MASTER OF NURSING

Faculty of Nursing
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ABSTRACT

An ethnographic study, funded by the Canadian Nurses Foundation and the Manitoba Association of Registered Nurses, was implemented to examine quality of worklife (QWL) issues of outpost nurses in northern Manitoba. QWL issues are factors that affect nurses' perceptions about their practice (Donner, Semogas, & Blythe, 1994). The "Model for Quality of Nursing Worklife" was used to guide the study as it provided a broad framework (O'Brien-Pallas & Baumann, 1992).

Detailed fieldnotes were maintained during a ten day field experience to four outpost stations in northern Manitoba in 1994. One to two hour semi-structured interviews were conducted with 5 Aboriginal and 6 Non-Aboriginal outpost nurses who volunteered to participate. Interviews were audio-taped and transcribed verbatim. The transcripts and fieldnotes underwent content analysis to identify categories and themes.

Findings indicated that outpost nursing was inundated with contradictions and conflicts. Outpost nurses perceived that positive worklife factors outweighed the negative ones. They found personal fulfilment in several aspects of their work. Fulfilment was a major theme comprised of the following worklife categories: (1) attachment to clients; (2) learning on the job; (3) independence; (4) we do everything; (5) being the doctor; (6) a variety of patient needs; and (7) providing quality patient care. Independence was the most significant positive worklife factor.

Worklife issues that outpost nurses perceived to negatively affect QWL reflected a self image of having no power. Powerlessness was a theme that contained the following categories: (1) isolation from family and friends; (2) working and living together; (3) inadequate educational preparation; (4) frustration over clients' dependence on the system; (5) massive responsibility; (6) understaffing; (7) never really off; (8) living in fear; (9) perceived lack of support from Zone Nursing Officers; (10) conflicts with Thompson physicians; and (11) "it's very political up here." "It's very political up here," understaffing, along with working and living together were worklife factors that nurses perceived to strongly affect their worklife in a negative manner.

Aboriginal and Non-Aboriginal outpost nurses shared numerous worklife issues. These groups differed in several aspects. Aboriginal nurses expressed that their knowledge of First Nations language and culture enhanced their practice. Non-Aboriginal outpost nurses were unique in that they demonstrated scepticism over authenticity of clients' health problems. Aboriginal nurses spoke about a long term commitment to outpost nursing; whereas, Non-Aboriginal nurses viewed outpost nursing as a short term experience. Aboriginal nurses participated in group and community activities while their Non-Aboriginal colleagues tended to spend their time off work within the confines of the outpost station. These distinctions appeared to be based upon the groups' age and cultural differences.

Based upon the study's findings, recommendations were developed for future nursing practice, education, research, and administration. A summary of

the findings and recommendations were shared with the participants, and participating First Nations communities. Copies of this thesis were provided to Medical Services Branch, Health Canada and provincial and national nursing associations.

ACKNOWLEDGEMENTS

Dr. Farrell offered me encouragement throughout the research process. The contributions of Dr. John O'Neil, my External Member, are deeply appreciated. Dr. O'Neil, from the Department of Community Health Sciences, Faculty of Medicine, shared his vast knowledge and experiences about northern health care issues. Dr. O'Neil provided me with guidance to access participants, conduct fieldwork and disseminate research findings to First Nations communities.

I would like to express many thanks to Kim Orris, my husband, who endured the gamut of my emotions throughout the entire process. By sharing this process with Kim, I have been gifted with his wonderful insights. Kim's continual support facilitated the completion of this project.

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Abbreviations are presented in alphabetical order.

ANAC   Aboriginal Nurses Association of Canada

BCR   Band Council Resolution

CHR   Community Health Representative

CNA   Canadian Nurses Association

GNWT   Government of the Northwest Territories

MARN   Manitoba Association of Registered Nurses

MSB   Medical Services Branch, Health Canada

NCP   Northern Clinical Program

NIC   Nurse-in-charge

NWT   Northwest Territories

RCMP   Royal Canadian Mounted Police

QWL   Quality of Worklife

ZNOs   Zone Nursing Officers

CHAPTER I

STATEMENT OF THE RESEARCH AIMS AND OBJECTIVES

Introduction

This study explores quality of worklife (QWL) issues of outpost nurses in northern Manitoba. QWL issues are defined as factors that affect outpost nurses' perceptions about their practice of nursing (Donner, Semogas, & Blythe, 1994). QWL is a complex and multivariate phenomenon (O'Brien-Pallas, Baumann, & Villeneuve, 1995). Numerous interrelated factors affect nurses' QWL such as individuals' characteristics, job descriptions, the nature of work environments, management styles and philosophies, clients' demands, and the overall health care system (O'Brien-Pallas & Baumann, 1992).

As described by the Department of Indian Affairs and Northern Development (1993), northern Manitoba is an area of the province that is located north of the 54th parallel (see Appendix A). Northern Manitoba is mainly comprised of remote First National communities similar in size to rural villages (Edmundson & Loughran, 1989). Health care facilities in remote northern communities are referred to as outpost stations. Thirty-six outpost stations are located in northern Manitoba (Kirwan, 1994).

In this chapter, I provide an overview of past and present day health care services to First Nations People because historical and sociopolitical contexts strongly influence outpost nurses' worklife (Canitz, 1989; O'Neil, 1993). Goodwill (1989) succinctly described the necessity of examining outpost nursing in a historical and sociopolitical context:

If nurses working in Native communities go about their duties with side blinders and do not know how to look beyond their daily routine of clinical care or community health, they will never be able to appreciate why the job so quickly becomes frustrating, is filled with misunderstandings, and leads to quick 'burnout' (p. 118).

Prior to discussing background information about worklife issues of outpost nurses, an exploration of the broader context of health care delivery to First Nations People is necessary.

Following the overview of health care services to First Nations People, I present a review of located literature on the topic of outpost nursing in northern Canada. My review of the literature addresses potential worklife issues of outpost nurses and substantiates the necessity for conducting a study that explores QWL issues of both Aboriginal and Non-Aboriginal nurses.

Since a "good statement of the problem will serve as a guide throughout the study" (Polit & Hungler, 1991, p. 85), I clearly delineate the research aims and objectives. I include an accompanying set of definitions of the variables involved in the study.

The conceptual framework used for the study is thoroughly described. The "Model for Quality of Nursing Worklife" is an appropriate conceptual model to base this study upon as it provides a broad framework and can be applied in any nursing workplace. I conclude this chapter by briefly introducing the research design chosen for the study, and provide the rationale for its selection.

Background to the Study

In 1992, I had the opportunity of co-presenting a nursing workshop for the annual conference of the Northern Critical Care Nurses in Thompson, Manitoba. During the workshop, several outpost nurses from northern Manitoba shared stories about their worklife. These stories intrigued me as they illustrated a unique nursing experience and an element of adventure. This brief introduction to outpost nursing motivated me to review the literature on past and present day northern nursing. Although I found numerous anecdotal articles and documents on topics of northern health care and nursing, research on outpost nursing in northern Canada was limited.

To grasp the complexity of outpost nurses' worklife, the history of health care delivery to northern Canada is described. Sociopolitical issues emerge as they are intertwined within the historical background and evolution of health care delivery to First Nations People. Sociopolitical issues have a profound affect on outpost nurses' QWL. For example, outpost nurses in northern Manitoba have voiced frustration over their clients' dependency upon them (Edmundson & Loughran, 1989). Because of historical and sociopolitical circumstances, First Nations People have become socialized to rely on health care personnel for timely and comprehensive delivery of health care (Cheater, 1993). Following a brief overview of the history of health care delivery to First Nations People, I describe crucial sociopolitical issues that continue to have profound affects on outpost nurses' QWL and the delivery of health care.

The History of First Nations' Health Care Services

The history of health care for First Nations People has been organized into four main eras (Young, 1988). The first era occurred before 1670, when Europeans initially arrived and settled in Canada. This period was described as the "pre-contact era". The second historical period, referred to as the "early contact era", included the early fur trade from 1670 - 1763 and competitive trade from 1763 - 1821. The third period was the "contact-traditional era", beginning with a dependency on trading posts (1821 - 1890) and progressing to early government influence from 1890 - 1945. The last historical period is the "modern era", which includes 1945 to the present time.

Pre-Contact Era (prior to 1670)

During this era, Canada was inhabited by Aboriginal people who were a nomadic, tribal society. Prior to contact with Europeans, Canada's Aboriginal population flourished and was estimated at 210,000 (Graham-Cummings, 1967; O'Neil, 1993). These people had accomplished adaptation to a harsh environment by hunting and gathering (Young, 1988). The people's lives revolved around hunting large game such as bison, moose and caribou. During the summer, many social functions occurred along the edges of lakes and rivers as fishing was a major activity. In the fall, people focussed on hunting. When winter came, camp sites followed the movement of game.

Aboriginal societies were not suited to a complex, hierarchical, social and political structure (Young, 1988). This scattered population valued consensus and co-operation that was based upon a matriarchal social

structure. The people lived in a harmonious relationship with different ecological systems (O'Neil & Postl, 1994).

Some community members were capable of assisting others in the maintenance of ecological, social, and spiritual balance (O'Neil & Postl, 1994). "A variety of traditional health care personnel such as medicine men/women, shamans, midwives, bonesetters, and herbalists" provided health care (Canitz, 1989, p. 176). All members of the community shared the responsibility to live balanced lives and obtain some knowledge about traditional medicines (O'Neil & Postl, 1994).

Contrary to European beliefs, illness was believed to occur as a direct result of failing to respect or follow the community's basic moral code (O'Neil & Postl, 1994). The maintenance of social structure and governing systems of each group was rooted in the healing process (O'Neil & Postl, 1994).

Early Contact Era (1670 - 1821)

Contact with Europeans marked the beginning of radical social and cultural change (Canitz, 1989; Young, 1988). By the late eighteenth century, the fur trade had affected the lives of many Aboriginal people. Aboriginal lifestyles drastically changed from hunting and gathering to relying heavily on trapping furs. Their livelihoods depended on external forces such as fur prices within the world market and the business tactics of local Hudson's Bay Company traders (Young, 1988). During this era, massive death and injuries occurred from combat (O'Neil, 1993). The Plains Cree suffered from starvation,

which resulted from the extermination of the bison (O'Neil, 1993; O'Neil & Postl, 1994).

To expedite swift travel for Aboriginal fur trappers, their families either remained behind and/or began to spend more time in and around the trading posts. This change from nomadic to sedentary lifestyles resulted in drastic changes in the pre-existing social, political, and spiritual structures of Aboriginal communities (Canitz, 1989).

As community leaders and healers gradually lost their status, decisions were no longer made through group consensus, and health care changed from traditional healing methods to colonial medicine (Canitz, 1989). Traditional beliefs that illnesses were caused by societal factors were challenged by European beliefs that illnesses were caused by individual factors (Canitz, 1989). Aboriginal people no longer looked to each other for healing. Health care services were offered by business agents at local trading posts. "Traders had basic medical supplies, and treated many minor injuries and ailments" (Canitz, 1989, p. 176).

Contact-Traditional Era (1821 - 1945)

By the late 1800s, game depletion, low fur prices, lower incomes, and the availability of credit for goods created a 'welfare society' among Canada's Aboriginal people (Young, 1988). Although economic conditions were deplorable, the concomitant health status of Aboriginal people was insufferable. "Famine and disease were allowed to virtually decimate Aboriginal communities" (O'Neil & Postl, 1994, p. 71).

Most significantly, high mortality and morbidity rates resulted from the introduction of infectious diseases by Europeans to which the Aboriginal people lacked immunity (O'Neil; 1993; O'Neil & Postl, 1994). The effect of infectious diseases such as smallpox, measles, influenza, diphtheria, poliomyelitis, and tuberculosis was devastating (Graham-Cummings, 1967; O'Neil & Postl, 1994). Mortality rates ranged from 40 to 90%. I was appalled when I discovered that the Aboriginal population dropped from a quarter of a million to approximately 80,000 in 1870 (O'Neil, 1993; O'Neil & Postl, 1994).

As a direct result of infectious diseases, Aboriginal societies experienced another major destruction. Their social network became destroyed as the infected individuals were dislocated from their families and communities (O'Neil & Postl, 1994). Infected individuals were relocated and isolated in southern hospitals for long periods of time (O'Neil, 1988).

Missionaries followed fur traders and in their evangelical enthusiasm, discouraged traditional religious rites and other expressions of the Aboriginal culture (Young, 1988). One example of this oppression occurred with the residential school system. Children were removed from their families and relocated in residential schools operated by churches. Children were subjected to a system that ignored the very existence and worth of the Aboriginal culture (Sarsfield, Andrew & Rawlyk, 1983). This educational system taught a value system that was at odds with the Aboriginal social structure (Sarsfield, Andrew, & Rawlyk, 1983). For example, strict discipline was used to punish children who spoke their own language (Young, 1988).

Treatment of illness became a factor in negotiations between Aboriginal people and White missionaries and traders, with surrounding spiritual and economic orientations (O'Neil, 1988). Health care became a commodity to be exchanged in a capitalistic economy (O'Neil, 1988). Western health care providers assumed that traditional medicine had disappeared. When traditional healing occurred, it was undermined and called "superstition" or "witchcraft" (O'Neil & Postl, 1994). If missionaries discovered traditional healing taking place, they denounced traditional healing as non-Christian. In exchange for health care services, Aboriginal people would agree to convert to Christianity. The treatment of illness continues to be a factor in negotiations between Aboriginal people and the Federal Government surrounding political and economic orientations.

To ensure survival at a time of soaring mortality rates, Aboriginal leaders strived to negotiate agreements with government representatives (O'Neil & Postl, 1994). Aboriginal leaders who were experiencing the decimation of their friends and families, agreed to relocate their people onto reserves. They negotiated that in return for the use of their land and resources, the Crown would provide for their future welfare, including health care (O'Neil & Postl, 1994). By isolating Aboriginal people onto reservations, the Federal Government managed to protect the European settlers from the devastation of the infectious diseases. By relocating Aboriginal people onto reserves, infectious diseases were easier to manage and control and the best interests of Non-Aboriginal Canadians were upheld.

An influx of White settlers occurred as a result of the completion of the railways across the southern portion of Canada (Young, 1988). Aboriginal people from northern reserves were then drawn to White settlements in search of job opportunities. Racial discrimination often characterized the social interactions between the White townspeople and Aboriginal people.

In 1867, Canada became a Confederation. Under the British North America Act and then the Indian Act of 1876, the Federal Minister for Indian Affairs assumed responsibility for Canada's Aboriginal people and their lands (Frideres, 1983; Little Bear, Boldt, & Long, 1984). The Indian Act called for Aboriginal people to politically organize themselves into colonial, hierarchical governments with Band Members, elected Council Members and Chiefs (Little Bear et al., 1984). As previously presented, this form of a hierarchical social structure was absolutely foreign to Aboriginal people as they had always based their decisions upon group consensus.

In a series of treaties signed between the Federal Government and Canada's Aboriginal leaders, only one treaty mentioned health care. The famous "medicine chest clause" appeared in Treaty No. 6, which was signed in 1876 between Canada and the Plains Cree in Saskatchewan. Notable excerpts from Treaty No. 6 included:

- In the event hereafter of the Indians...being overtaken by any pestilence, or by a general famine, the Queen...will grant to the Indians assistance of such character and to such extent as Her Chief Superintendent of Indian

Affairs shall deem necessary and sufficient to relieve [them] from the

calamity that shall have befallen them.

- A medicine chest shall be kept at the house of each Indian agent for the

use and benefit of the Indians at the direction of such Agent (Young,

1988, p. 6).

Although Aboriginal people appealed for provision of health care in future

treaties, all subsequent legal documents lacked mention of health care

services.

From 1880 - 1945, the Federal Government juggled its responsibility to

manage Aboriginal health care by transferring this portfolio from department to

department (Frideres, 1983). Finally in 1945, Indian Health Services

transferred from the Department of Mines and Resources to the Department of

National Health and Welfare (Frideres, 1983).

Although morbidity and mortality rates within the Aboriginal population

were extremely high, the Federal Government only provided a visit by a

physician at treaty time once a year (Young, 1988). Mobile nurse-visitor

services were added in 1922 (Canitz, 1989; Young, 1988). Nurses travelled to

reserves and residential schools, performing health education and public health

duties.

The Modern Era (1945 - present)

First Nations People of northern Manitoba managed to avoid the

restrictions of life on a reserve until the 1940s (York, 1992). Under the terms of

Treaty No. 5, they surrendered all rights to traditional land in exchange for $5

per person, farming equipment, cattle, schools, ammunition, and twine. Farming

equipment and cattle were useless in the bleak northern climate. The

reservation land was equal to 160 acres for every family of five. In northern

Manitoba, First Nations People were gradually drawn into the bureaucratic world

of compulsory education and welfare payments as they were required to settle at

fixed locations.

In response to another crisis in Aboriginal health during the 1940s, the

Federal Government provided more health care facilities in northern

communities (Canitz, 1989; Gregory, 1992). Northern hospitals, outpost

stations, and health centres were established . Since 1945, health care services

to Aboriginal people have steadily increased (Goodwill, 1989). Today, northern

health care services is compiled of a network of 450 health facilities (Gregory,

1992; O'Neil & Postl, 1994). The adoption of universal medical and hospital

insurance programs in the late 1960s further improved health care services as it

facilitated First Nations People's access to health care (Postl & Whitmore, 1988).

Registered nurses continue to function as the primary resource for health

care services in northern communities (Gregory, 1992; Nowgesic, 1995). During

the 1960s and 1970s, many British-trained nurses were hired to work in the

north because of their advanced clinical skills in areas such as midwifery

(O'Neil, 1986). Since then, recruitment into outpost positions has included

Canadian nurses and nurses from around the world (Goodwill, 1992).

A community health representative (CHR) program, initiated by the

Federal Government in 1961, involved local people in the delivery of health care

in their northern community. Aboriginal men and women continue to be recruited into this program where they receive training in health related programs and health promotion techniques. CHRs work under the guidance of nurses to provide a liaison between community members and health care system (Gregory, 1992).

Strained relationships have been noted between nurses and CHRs (Goodwill, 1992). New outpost nurses may incorrectly perceive CHRs' roles as being mere translators or patient chauffeurs, undermining the effectiveness of CHRs (Gregory, 1992). Most CHRs are employed by the Bands or communities while many other health care personnel are employed by the Federal Government, placing CHRs in a double bind when expectations and demands of these groups are in conflict (Gregory, 1992).

In response to a meningitis outbreak in northern Manitoba in 1993, an Aboriginal leader demanded that more nurses be recruited into outpost nursing positions (Cheater, 1993). Poor hygiene, crowded housing, and lack of sewer and water were recognized as possible causative factors in the meningitis cases (Cheater, 1993). At the time of the outbreak, some outpost stations in northern Manitoba were understaffed by 3 to 4 nursing positions (Cheater, 1993). Understaffing and a high demand for acute care health services were identified as factors preventing outpost nurses from providing community health programs.

Health Transfer Initiative. In 1969, the Federal Government developed a policy referred to as the "White Paper." This document created controversy as it announced the government's intent to withdraw its responsibilities to Aboriginal

people. A growing political confidence within Aboriginal organizations brought health and social issues to the attention of the Canadian public as these groups strongly responded to the contentious "White Paper" (Little Bear et al., 1984; O'Neil, 1993).

The first initiative displayed by Aboriginal people to take control over their health care system occurred in 1978, when the Government of Canada attempted to reduce their provision of uninsured services such as ambulances, eye glasses, and certain prescription medications (O'Neil, 1993). Numerous consultations and position papers were undertaken, resulting in a 1979 Federal Government document on health policy. Traditional medicine and community control were important components of this proposed Aboriginal health care system (O'Neil, 1993).

During the 1980s, new health care administration initiatives gained momentum. Widespread dissatisfaction with a paternalistic system, increased interest in traditional medicine, and professional interest in traditional healing created an impetus for change (O'Neil, 1993).

In 1986, the Federal Government developed the Indian Health Transfer Policy as a means to facilitate self-determination in health by Aboriginal people living south of the sixtieth parallel (Gregory, Russell, Hurd, Tyance, & Sloan, 1992; O'Neil, 1993). The Canadian government viewed this document as a formal blueprint to involve First Nations People in the planning and delivery of their health care services. Others viewed the Indian Health Transfer Policy as "seductive in its promises for self-determination in health care", but "impotent in

its abilities to effect actual change in health status at the community level"
(Gregory, 1992, p. 185). In 1993, Thompson identified two questions about
health transfer that remain to be answered: (a) are Band governments ready to
administer health services? and (b) will transfer of health care services improve
the health status of First Nations People?

The Federal Government and First Nations People have different
viewpoints about the process of health transfer (Isaac, 1991; Postl, 1989; Postl &
Whitmore, 1988). The Federal Government sees health transfer as a process
involving an increased involvement of First Nations People in administration and
operation of health care services (Postl & Whitmore, 1988). First Nations People
view health transfer as an integral process to return to complete self-government
(Fontaine, 1991; Postl & Whitmore, 1988).

> Canadians often assume that Indian self-government would entail the
> creation of a sovereign state or a new level of government. But in reality,
> self-government has a much more practical meaning for most Indian
> bands. It begins with the freedom to regain control of individual elements
> of their community: their schools, courts, health system, and child welfare
> system. These are institutions that affect people most directly. By
> asserting their right to make their own decisions in such vital areas,
> Indian bands are liberating themselves from a state of dependence and
> government control (York, 1992, p. 26).

Health transfer plans may be threatened in Manitoba due to these continuing,
differing viewpoints (Lett, 1995; Redekop, 1995; "Treaties and Health", 1995).

The Assembly of Manitoba Chiefs was unable to negotiate a health transfer agreement with the Federal Government (Redekop, 1995). The point of contention was still identified as whether health services should be provided to First Nations People as a matter of treaty right or as a matter of government policy ("Treaties and Health", 1995).

Outpost Nursing Today

Present day outpost nursing will be described. In order to examine outpost nursing thoroughly, I explored current information about northern health care consumers, Non-Aboriginal, and Aboriginal outpost nurses. This depiction of outpost nursing today is followed by a review of research on outpost nursing.

Northern Health Care Consumers

Over one million Aboriginal people currently reside in Canada (Nowgesic, 1995; Thomlinson, 1992). The estimated number of Aboriginal people includes: (1) status Indians registered with an Indian Band; (2) nonstatus Indians who have lost their registered status; (3) Metis, who are descendants of marriages between Aboriginal people and European settlers; and (4) Inuit of the Arctic (Thomlinson, 1992). One third of Aboriginal people live in the northern regions of provinces and territories and constitute the majority of Canada's northern population (Nowgesic, 1995). First Nations People encompass both status and nonstatus Indians (Nowgesic, 1995). First Nations People represent about 4% of the national population - the fourth largest ethnic group in Canada (York, 1992).

A typical northern Manitoba community consists of dwellings that are usually scattered along a river or lake (York, 1992). Typically, the houses are the size of a suburban garage. York (1992) described houses on northern Manitoba reserves as tattered and weather beaten. Few houses have glass windows and many windows are covered with plastic or wooden planks. Packs of dogs roam through reserves, and garbage blows through the scrub between the houses. Public buildings such as the schools, outpost stations and Royal Canadian Mounted Police (RCMP) offices are typically segregated from the rest of the community. These buildings are different because they are tidy and new, being recently built by the Federal Government. Non-Aboriginal residents are housed in their own compounds, isolated from the grim daily reality of their Aboriginal clients.

First Nations People perceive Non-Aboriginal residents as symbols of the authority of outside institutions such as the Federal Government (York, 1992). For decades, First Nations People have resented the dominance of White agencies in their communities. First Nations People acknowledge that outpost nurses are employed the government. Outpost nurses are viewed as crucial decision makers in the community, yet they are controlled ultimately by their employer, the government - not the community (York, 1992).

Unemployment rates on northern reserves exceed 80% (York, 1992). Many Aboriginal people living on the reserve are homeless. They share the overcrowded homes of friends or relatives. Often water is retrieved in buckets from the river or lake, and homes are heated by wood stoves constructed from

old oil drums. To gather wood to heat their homes, Aboriginal people travel as far as 15 kilometres, towing the fuel back by snowmobile or floating it down the river.

Because of the high cost of shipping, food is extremely expensive in northern Manitoba communities (York, 1992). A litre of milk is more than double the price set in Winnipeg. The Northern Store, where the food, tools, and clothing items are purchased, still dominates reserves as the major trading post (York, 1992).

To this day, First Nations People experience an overwhelming poor health status as compared to other Canadians. Although a decline in the incidence of some infectious diseases has occurred, chronic diseases such as diabetes and cardiovascular diseases have escalated. More recently, the principal causes of death in many First Nations communities are accidents, poisonings, violence, and young adult suicides (Gregory, 1992; O'Neil & Postl, 1994; Paul, 1994b;Young, 1983, 1988). Substandard housing, absence of central heating and plumbing, lack of safe drinking water, and inappropriate waste disposal have all contributed to poor health. Social breakdown along with mental illness, substance abuse and domestic violence have been consequences of high unemployment and welfare dependency.

Aboriginal leaders in Manitoba have critiqued the health care services provided in isolated northern reserves (Paul, 1994a). Aboriginal leaders acknowledged that health care was profoundly affected by geographical isolation from tertiary health care centres and physicians. First Nations People

value timely health care, which has been hampered by: (1) high turnover of health care providers; (2) chronic understaffing at outpost stations; and (3) confusion with roles of CHRs and provincial or federal health care personnel (Paul, 1994a). Dedicated health professionals working in northern Manitoba, are often overwhelmed by the high demand for their services (Paul, 1994a).

Non-Aboriginal Outpost Nurses

Since the middle of the twentieth century, northern nursing has been associated with a sense of adventure and described as both challenging and rewarding (Kraiker, DeLuca & Hood, 1983; Nanowski, 1993). I found several references that alluded to worklife issues of outpost nurses. Outpost nurses expressed worklife issues that were similar to their "southern" counterparts, such as a frustration over lack of community health programs in their communities (Canitz, 1989; Clevett & Maltby, 1992; Doucette, 1989; Gregory, 1992; Mardiros, 1987; Morin, 1984; Scott, 1991).

A disproportionately higher nursing turnover rate exists in northern Canada (Canitz, 1989; Clevett & Maltby, 1992; Goodwill, 1984; Government of Northwest Territories, 1990; Morewood-Northrop, 1994; Nowgesic, 1995; Scott, 1991). This rising trend in turnover rate indicates a significant problem in outpost nurse retention. Isolated areas of Canada have estimated length of employment for nurses from 3 to 32 months with turnover rates of 80 - 319% (Canitz, 1990; Nowgesic, 1995). "The high turnover rate in northern nursing has an unfavourable impact on the communities involved and the health care system as a whole" (Nowgesic, 1995, p. 5).

Supporting a continuous cycle of recruitment and orientation has resulted

in staggering costs to the health care organization (Clevett & Maltby, 1992;

Kirwan, 1994). Recruitment and orientation programs have been estimated to

cost between $2,500 to $50,000 in American dollars (Clevett & Maltby, 1992).

Recruitment costs in Canada include pre-employment advertising, interviews,

and relocation visits that may add up to $3,000 and relocation costs are upward

of $5,000 (Clevett & Maltby, 1992). Depending on the nurse's previous

experience, Clevett and Maltby (1992) noted that orientation periods in northern

Manitoba ranged from seven to ten weeks, costing up to $10,000 (Canadian).

Therefore, the total cost for a single employee may be $18,000 (Clevett &

Maltby, 1992). Kirwan (1994) estimated the costs associated with hiring an

outpost nurse to be much higher. Included in Kirwan's calculations were

recruitment, relocation, orientation, and mandatory educational programs

(1994). The total cost of recruiting and hiring a single outpost nurse could be as

high as $43,000 (Kirwan,1994).

Other worklife concerns, unique to northern nurses, were expressed in

the literature. I identified several worklife concerns that emerged as

experienced outpost nurses offered advice to novices who may be

contemplating the adventure of a northern nursing experience. Advice included

the need to prepare for an expanded nursing role, social isolation, and nursing

in a community with a different culture (Aish, 1983; Canitz, 1989, 1991; Goodwill,

1984; Gregory, 1992; Morewood-Northrop, 1994; Nanowski, 1993; Ross, 1989;

Scott, 1991; Smith, 1983).

The historical and sociopolitical context of outpost nursing provides a basis for the complexity of this unique worklife experience (Thorne, 1993). Nurses' relationships with Aboriginal clients have been described as being tainted with power and control and Aboriginal people continue to perceive outpost nurses as government representatives (Canitz, 1989; Edmundson & Loughran, 1989; York, 1992). Nurses who worked in remote northern communities strongly recommended the need for recruits to develop cultural and political sensitivity along with culturally appropriate nursing skills and political leadership (Canitz, 1989; Doucette, 1989; Gregory, 1986, 1992; Morewood-Northrop, 1994; Morin, 1984; Ross, 1989). These recommendations are noteworthy; however, strategies to achieve the development of cultural and political sensitivity were not detailed. Actualization of cultural and political sensitivity may require lifelong learning through formal and informal educational experiences.

Canitz (1989) encouraged northern nurses to escape the limited visions of their education and bureaucratic socialization. To serve as advocates and facilitators of First Nations People's health, northern nurses must "choose to move beyond the limited boundaries of the medical model and our 'western' philosophy" (Canitz, 1989, p. 182). Although this viewpoint of Canitz (1989) was pertinent, I challenged the realistic basis of this recommendation. In contrast to Canitz's belief that shifting nurses' values and worldviews is a personal decision, choice, or process that occurs over a short period of time, my opinion is

that values and philosophies develop over a longer time frame based upon complex factors.

Non-Aboriginal outpost nurses have practiced in expanded roles as the primary health care providers in northern Aboriginal communities since 1922. Experiences have been documented as both challenging and frustrating. In northern Manitoba communities, outpost nurses are the primary providers of comprehensive health care services. Aboriginal clients may perceive nurses as representatives of the government, preventing the development of a mutual relationship between patient and nurse due to the presence of power, control, and resentment.

Aboriginal Outpost Nurses

Until recent times, all providers of health services in First Nations' communities were Non-Aboriginal (O'Neil & Postl, 1994). In 1982, there were approximately two hundred Aboriginal health care professionals in Canada (Thomlinson, 1992). Three hundred and fifty Aboriginal nurses are now included in the total of Canada's 200,000 nurses (Thomlinson, 1992), which accounts for less than 1% of Canadian nurses. Today, Aboriginal nurses are being actively recruited into outpost nursing positions.

In 1974, Aboriginal nurses in Canada formed a special organization. The Registered Nurses of Canadian Indian Ancestry was initiated in 1974, during International Women's Year, despite a lack of government support (Goodwill, 1992). This group was the first Aboriginal professional organization established in Canada (Goodwill, 1989). The group's name changed to the Indian and Inuit

Nurses of Canada and is now the Aboriginal Nurses Association of Canada

(ANAC). In the early 1980s, financial support was acquired from the Federal

Government for special projects and operational costs (Goodwill, 1992). The

ANAC's mandate is to introduce ideas about improved health care for First

Nations People, Metis and Inuit and to encourage Aboriginal students to enter

the nursing profession (Goodwill, 1992).

In an effort to recruit Aboriginal youth into nursing, the ANAC published a

profile booklet (ANAC,1995). In this publication, Aboriginal nurses shared their

individual histories, career goals, and a vision of improved health for Aboriginal

people. Their stories described the trauma of leaving isolated communities to

pursue a nursing education in unfamiliar urban centres, and the joy of

contributing positively to Aboriginal communities.

ANAC has not developed a position statement about health transfer

(A. White, personal communication, April 17, 1995). This professional nursing

association is in a political bind since it is funded by Medical Services Branch

(MSB), Health Canada to provide information to Bands concerning health

transfer (A. White, personal communication, April 17, 1995). ANAC provides

support to Aboriginal and Non-Aboriginal nurses employed by Bands (Goodwill,

1992). ANAC surveyed and provided workshops for nurses employed by Bands

about the health transfer process (Dumont-Smith, 1994).

Potential and actual worklife issues of Aboriginal outpost nurses were

described by Goodwill (1984, 1992) and Thompson (1993). Recruitment of

Aboriginal people into health professions is based upon hope that many

Aboriginals will return to their home communities to provide services (Goodwill, 1992). "In some communities, chiefs are asking whether Indian students in Health Career Programs are developing into an elite group who may not wish to return to their communities after experiencing a different life-style 'outside'" (Goodwill, 1992, p. 606).

Aboriginal nurses, educated in an ethnocentric "White" health care system, could experience inner conflict between their personal and professional beliefs and roles (Thompson, 1993). An example of this conflict was illustrated when an Aboriginal outpost nurse wrote, "I remember the nursing station, which could have been transplanted straight out of a southern, middle class, non-native community" (Goodwill, 1984, p. 6).

Another potential worklife concern was interpersonal conflicts existing between various groups employed at the outpost station. Baccalaureate prepared Non-Aboriginal nurses were noted to exhibit resentment towards diploma prepared Aboriginal nurses who were employed in northern communities because of their knowledge about the culture (Goodwill, 1992).

Aboriginal nurses compile a small percentage of all Canadian nurses. However, Aboriginal nurses are and will continue to be significant health care providers in northern communities. Specific concerns of Aboriginal nurses have been voiced: (a) the trauma of leaving their home communities to acquire a nursing education; (b) being scrutinized as "elitists" by community members because of their experience 'outside' the community; (c) inner conflict occurring due to differing personal and professional values; and (d) interpersonal conflict

with other members of the health care team. Since Aboriginal nurses are being actively recruited into outpost nursing positions, worklife issues specific to this group need to be identified and explored.

Nursing Research on Outpost Nursing

Although I was able to locate numerous anecdotal articles on northern nursing, I discovered a distinct lack of research on this topic. Five nursing research studies were located and reviewed on the topic of outpost nursing in northern Canada. These studies were conducted in the Northwest Territories, Yukon Territories and in northern Manitoba (Canitz, 1990; Edmundson & Loughran, 1989; Government of Northwest Territories, 1990; Gregory, 1986; Kirwan, 1994).

Three studies explored the consequences of outpost nursing or in other words, the after-effects of QWL issues (Canitz, 1990; Government of Northwest Territories, 1990; Kirwan, 1994). Nursing burnout, turnover, and post-traumatic stress disorders were identified as costly consequences of nursing in remote geographical areas (Canitz, 1990; Government of Northwest Territories, 1990; Kirwan, 1994).

Gregory (1986) identified factors affecting collaborative efforts between nursing staff and Indian Elders and explored the interaction between northern nurses and traditional healers. Factors influencing nurses' participation in the collaborative process were identified as past transcultural experiences, knowledge of who/what Elders are, influence of the nurse's own culture, and the attitude of the Elders and the community towards the nurse. Client conditions

that were identified as appropriate for Elder referral were: lack of self worth, family discipline problems, social interaction problems, child neglect, and parent-child conflict.

Edmundson and Loughran (1989) examined the nature and extent of power in the work environment and role of nurses who practiced in northern Manitoba communities. They found that northern nursing was beset with conflicts that existed among the participant groups: Federal and Provincial Governments, nurses-in-charge, subordinate nurses, physicians, community leaders, and the Aboriginal clients.

Retention, burnout, turnover, and post traumatic stress disorders are significant outcomes of outpost nursing. Collaboration with Indian Elders and power conflicts between health care consumers and providers are also noteworthy, as they contribute to outpost nurses' QWL and the overall health care delivery to Aboriginal people. However, the reviewed studies only examined particulars about outpost nursing. I was unable to locate a study that examined outpost nurses' worklife as a whole. A study that systematically examined outpost nurses' worklife in a holistic manner was greatly needed due the complex nature of outpost nursing. Outpost nursing requires an examination within its historical and sociopolitical context.

Many Canadian nurses have addressed the necessity to study nurses' worklife (Attridge & Callahan, 1989; Attridge & Callahan, 1990; Canadian Nurses Association, 1990; Canadian Nurses Association & Canadian Hospital Association, 1990; Irvine & Evans, 1992; Pick, Melchior & Letourneau, 1988).

Factors such as gender bias, pay equity, job design, job layoffs, and worker satisfaction have been receiving closer attention from nurse researchers (Baumann & O'Brien-Pallas, 1993).

The Quality of Nursing Worklife Research Units at the University of Toronto and McMaster University are conducting an array of studies aimed at understanding and improving nurses' worklife in Ontario (O'Brien-Pallas, Baumann, & Villeneuve, 1994). Outpost nurses were not included as participants in these studies (personal communication, M. Villeneuve, December 4, 1993). The rationale for this exclusion was not acquired.

In light of the initiative for health care transfer to First Nations People, a study exploring outpost nurses' worklife was timely. "The systematic evaluation of worklife is an important one when the delivery of health care is in a period of rapid change" (Baumann & O'Brien-Pallas, 1993, p. 40).

Recent advertisements by the Canadian government for outpost nurses included specific requests for Aboriginal nurses to apply. Due to this current initiative to recruit Aboriginal nurses into outpost settings, the perspectives of both Aboriginal and Non-Aboriginal nurses need to be examined. Although Goodwill (1992) described pertinent worklife issues of Aboriginal nurses, no research study has been implemented to specifically study this group's QWL.

Research Aims and Objectives

The subjective meaning of work and the components that contribute to worklife have preoccupied social scientists for the past thirty years (Baumann & O'Brien-Pallas, 1993). However, the "examination of what work is and what

work represents has not been a traditional focus in nursing research" (Baumann & O'Brien-Pallas, 1993, p. 40). Nursing work has increasingly become more complex, with an emphasis on delivery of quality care to the consumer, productivity, and cost effectiveness (Baumann & O'Brien-Pallas, 1993; Lock, 1991).

Contributing factors affecting QWL and consequences of worklife are perceived by individual nurses. Nurses' QWL will influence other aspects of nurses' lives including their own health status, and the quality of health care delivered (Canitz, 1989; Nowgesic, 1995; O'Brien-Pallas & Baumann, 1992).

This study aims to explore the culture of outpost nursing in northern Manitoba. QWL issues of outpost nurses will be identified and examined. The following research objectives were developed:

1. Explore the meaning of QWL as defined by outpost nurses in northern Manitoba.

2. Identify the most significant QWL issues of outpost nurses in northern Manitoba.

3. Compare and contrast the QWL issues of Aboriginal and Non-Aboriginal outpost nurses in northern Manitoba.

4. Identify the QWL issues that outpost nurses perceive to impact on the nursing care delivered to individuals, families and northern communities.

5. Develop and communicate recommendations for future nursing practice, education, research, and administration.

6. Evaluate the applicability of the "Model of Quality of Nursing Worklife" developed by the Quality of Nursing Worklife Research Unit, Faculty of Nursing, University of Toronto and School of Nursing, McMaster University.

Definition of Terms

The problem statement would be incomplete without an accompanying set of definitions of the variables involved (Polit & Hungler, 1991). To clarify the meaning of terms, I have provided definitions. In this study, the following definitions will apply:

1. Nurses' Worklife - the practice of nursing in any setting (Donner, Semogas, & Blythe, 1994).

2. QWL - a term that emerged in the vocabulary of workers, managers, unions, academics, government legislators, and the media during the 1970s. QWL refers to the design of work in a way that recognizes, uses, and develops the multiple capabilities of people. QWL represents a broad array of concerns ranging from the provision of safe work environments to the development of new forms of organization. QWL postulates a set of qualities that would comprise a quality work environment (Attridge & Callahan, 1990).

3. QWL Issues - perceived elements of nurses' worklife that influence their QWL. According to O'Brien-Pallas (personal communication, November 23, 1993), factors that contribute to nurses' worklife fall under four broad categories: (a) homelife/worklife interplay; (b) work design or nature of the work; (c) work context or nature of the work environment; and (d) work world or the health care system.

4. Outpost Nurse - a registered nurse employed by MSB in an outpost station located in a remote northern community.

5. Northern Manitoba - a region of the province of Manitoba that lies north of the 54th parallel as recommended by the Northern Scientific Program, Department of Indian Affairs and Northern Development (see Appendix A).

Methodological Perspective for the Study

Design of the research study included protocols for sample selection, data collection, and data analysis (Wilson, 1987). To achieve the research objectives, it was imperative to choose an appropriate design for the study.

My choice of research design was based upon the level of knowledge about the topic, and the degree of control the study proposed over the situation or variables (Brink & Wood, 1989). Little theory, lack of previous research, along with the least amount of control over the research situation lead me to the choice of an exploratory design (Brink, 1989). The central purpose of an exploratory design study is to develop definitions of a concept such as QWL and contribute to beginning theories such as the "Model for Quality of Nursing Worklife" (Brink, 1989).

Initially, I considered focus group interviews as a method to collect data. Focus groups are special types of groups in terms of purpose, size, composition, and procedure (Krueger, 1988). Focus groups are defined as a carefully planned discussion designed to obtain perceptions on a specific area of interest in a permissive, non-threatening environment (Krueger, 1988). "A focus group is typically composed of seven to ten participants who are unfamiliar with each

other" (Krueger, 1988, p. 18). This method was used in other studies exploring QWL (Attridge & Callahan, 1989; Attridge & Callahan, 1990; Villeneuve, Semogas, Irvine, McGillis, Peereboom, Walsh, O'Brien-Pallas, & Baumann, 1993). Focus groups in outpost stations would be comprised of a small number of participants (two to five) from diverse cultural backgrounds who were familiar with each other. If nurses were participating in a focus group interview and their interprofessional relationships were not positive, their thoughts and feelings may not be fully expressed. Focus group interviews were therefore excluded as a method to elicit detailed descriptions of the true meaning of QWL and worklife factors in an outpost setting.

Mailed questionnaires were used in previous studies exploring outpost nursing (Canitz, 1990; Government of Northwest Territories, 1990; Kirwan, 1994). This format of data collection may be less costly and require less time and energy (Polit & Hungler, 1991). Despite these benefits, the merits of interviews outweighed those of the questionnaires with respect to this study (Polit & Hungler, 1991).

Face-to-face interviews and fieldwork provided numerous advantages. Advantages of interviews and fieldwork included: (a) a higher response rate; (b) the opportunity to offer clarification for questions; and (c) information obtained from interviews tends to be richer and more complex (Polit & Hungler, 1991). Face-to-face interviews and fieldwork produce additional data through observation (Polit & Hungler, 1991).

Ethnography

An ethnographic approach was the most appropriate design for this study. "In ethnography, the goal of inquiry is to achieve a rounded, not segmental understanding" (Hughes, 1992, p. 443). As this study's aim was identified to holistically explore the worklife of outpost nurses in northern Manitoba, ethnography was chosen as the research design.

Ethnography is an "amalgam of fieldwork techniques" that provides structure to enable the discovery of people's experiences and how they interpret them (Bauman & Greenberg, 1991, p. 12). Ethnography was initially a research method used by anthropologists to study different cultures (Chuborn, 1991). The central concept is culture, which can be defined as a learned social behaviour or a way of life of a particular group (Germain, 1993). Every human group that is together for a period of time will evolve into a culture (Germain, 1993).

Recently, this methodology has been used to study groups of people in our own society (Chuborn, 1991). Field (1983) described a "new ethnography" which asks the question, "How do members of a nursing culture actively construct their social world?" The new ethnography examines the surface structure of a nursing society, allowing participants to speak for themselves. The process of probing under the surface elicits rich descriptions. These rich descriptions are examined for social meanings that lie in the base of social actions (Field, 1983). Ethnography facilitated the description of the everyday lives of outpost nurses and focused on their QWL (Fetterman, 1989).

The ethnographer's most important data gathering technique is the interview (Fetterman, 1989). Interviews provide rich insights into attitudes, values, and behaviours (Bauman & Greenberg, 1992). Interviews would enhance the understanding of the phenomenon of QWL of outpost nurses in northern Manitoba.

Fieldnotes were maintained during the fieldwork experience in northern outpost stations in a manner described by Wilson (1987). Fieldnotes added to my understanding of the QWL of outpost nurses, by providing a recording of my observations, thoughts, and feelings during the field visits.

Assumptions

"Assumptions refer to basic principles that are accepted on faith, or assumed to be true, without proof or verification" (Polit & Hungler, 1991, p. 18). In this study, I formulated the following assumptions:

1. All nurses perceive worklife factors as contributing negatively or positively, or not at all, towards their overall QWL.

2. QWL affects nurses and patients in terms of job retention, job-related stress, motivation, commitment, occupational health, and quality of patient care.

3. Nursing practice in remote northern communities in northern Manitoba will manifest unique QWL issues. The QWL issues of northern nurses will differ from the QWL issues of their "southern" counterparts.

4. Nursing practice in remote northern communities must be examined within its historical and sociopolitical context. The historical and sociopolitical context of Aboriginal health care services will affect outpost nurses' QWL.

Limitations

As this study did not include patients as participants, I could not determine whether the QWL of outpost nurses actually affected patients. Patients' perceptions about the quality of health care was not addressed. As the "Model for Quality Nursing Worklife" posits that QWL affects patients, it would be beneficial for further studies to correlate northern residents' perceptions of the quality of health care delivered with outpost nurses' perceptions of their QWL.

Considering the sensitive nature of the subject matter, I realize that a sampling bias may occur. Those who have strong opinions about their QWL may have been more willing to participate, and hence, may be over-represented in this study.

In this study's sample, none of the participants were men. In future research of outpost nursing, inclusion of male nurses may assist in further understanding of the worklife experience of all northern outpost nurses. Male nurses may express similar and/or unique QWL issues.

Another limitation may occur as a disparity has been noted to exist between what people say and what they mean (Schwartz & Jacobs, 1979). In other words, outpost nurses may have said one thing and meant something different. In an attempt to reduce this disparity, I asked for clarification and validation during the interview and during my fieldwork at the outpost stations. Member checks were also performed, asking for participants' feedback, clarification, and validation of the preliminary findings. By conducting member

checks, I received validation of the finding that Aboriginal nurses tended to participate more actively in northern communities than Non-Aboriginal nurses.

As all participants were employed by the Federal Government, any particularities of this health care delivery system may influence perceptions of the work experience. Outpost nurses employed by the Provincial Government or First Nations People may be influenced by other particularities of their specific employing agency.

Organization of the Thesis

In the forthcoming chapters, the events leading to the analysis and discussion of the findings are addressed. In the next chapter, relevant literature related to the study topic and conceptual framework are thoroughly presented. In Chapter III, I provide details of the study's research design. Along with the specifics of data collection and analysis procedures, ethical considerations relating to participants are discussed. Chapters IV and V respectively present and discuss findings synthesized and analyzed from the data. The discussion in Chapter V includes recommendations for future nursing practice, education, research, and administration. These recommendations are based upon the study's findings. Reflection and reflexivity are also described.

Summary

The quality of nursing worklife in northern Canada could be greatly enhanced by understanding the factors that contribute to both Aboriginal and Non-Aboriginal outpost nurses' perceptions of their QWL. The QWL issues of outpost nurses have not been addressed systematically through nursing

research. In this chapter, the study's aims, research objectives, and methodological perspectives were presented.

For a research study to be scientifically sound, that is, for it to accomplish the research objectives, there must exist a proper triangular fit between the study's purpose, conceptual perspective, and methodological perspective. As the aim of this study was to seek an understanding of the culture of outpost nurses, I explain how the "Model for Quality of Nursing Worklife" provides a framework that can be applied to an outpost setting, in Chapter II. By using an ethnographic approach, perspectives of both Aboriginal and Non-Aboriginal outpost nurses will be explored. Observations recorded in fieldnotes and the words transcribed from the participants' interviews will enable an understanding of northern nursing experiences and how outpost nurses interpreted their experiences.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

In this chapter, I present my review of literature on outpost nursing. Five studies were located that addressed some aspect of outpost nursing in northern Canada. Following this review, I describe the conceptual model, "The Model for Quality of Nursing Worklife." This model was developed by O'Brien-Pallas and Baumann of the Quality of Nursing Worklife Research Unit in Ontario in 1992. O'Brien-Pallas and Baumann were attempting to relate worklife factors to nursing outcomes. This model is an appropriate guide for this study as it provides a broad framework and can be applied in an outpost setting. Following the presentation of the model, I provide an overview of the located research studies in terms of the model's worklife factors. This overview will support my position that a study is needed to holistically explore outpost nursing.

How worklife factors impact upon individual nurses or groups of nurses is a complex matter. Although it has been identified that worklife factors affect nurses' (O'Brien-Pallas & Baumann, 1992; Villeneuve et al., 1993), nurses' perspectives of their worklife have not been well established. Perceptions of worklife experiences may be unique to individual nurses, or similar to groups of nurses.

A review of the literature from 1967 to the present suggested that research related to outpost nursing in northern Canada was limited. Although outpost nursing has been the mainstay of health care delivery to northern

Canadians for decades (Canitz, 1990), no research studies about outpost

nursing appear to have been conducted prior to 1986. Since 1986, only five

studies were located, reflecting the paucity of nursing research in the area of

outpost nursing in northern Canada.

The worth of the located studies is critically appraised using an approach

suggested by Polit and Hungler (1991). By reviewing these studies, I will gain

information about ways in which the results may have been compromised, along

with insight into developing a more appropriate research design (Polit &

Hungler, 1991). The review of the five studies is organized according to

location, north or south of the sixtieth parallel. I begin by reviewing two studies

that were conducted north of the sixtieth parallel.

Outpost Nursing North of the Sixtieth Parallel

Two studies were conducted in a region of Canada located north of the

sixtieth parallel. The purpose of both of these projects was to explore the issue

of turnover in outpost nursing (Canitz, 1990; Government of NWT, 1990). The

first study was conducted on outpost nurses in both the Yukon Territory and the

Northwest Territories (NWT). The principal investigator of this study was Canitz,

a nurse with previous outpost nursing experience. The second study was

conducted by the Government of NWT (GNWT) in response to an extremely high

nursing turnover rate.

Study on Nursing in the NWT and Yukon. Canitz (1990) examined job

satisfaction, burnout, and turnover of outpost nurses in the NWT and Yukon

Territory. The study was significant to the nursing profession as it was inspired

by the exorbitant turnover rate of nursing staff from northern remote stations, which became a crisis in this region (Canitz, 1990).

Canitz (1990) recognized the personal, administrative, and financial costs of nursing turnover as astronomical. When nurses left the north, they frequently exited the nursing profession, carrying with them a sense of failure. The morale of health care administrators and remaining personnel plummeted as they were continually orientating new staff and they observed the deterioration of existing programs. Financial costs of turnover were estimated to range from $10,000 to $50,000 for every nurse who resigned. The average length of employment for nurses in some communities was as low as 3 months.

The purpose of Canitz's study (1990) was to explore the occupational, social, structural, and environmental factors that promoted or mitigated stress in nurses who worked in isolated settings. Nurses in outpost stations or health centres compiled the target group of the sample. The comparison group was teachers working in the same regions of the Yukon Territory and the NWT.

The study lacked guidance from an established conceptual framework, model, or nursing theory. Canitz (1990) relied on five major themes that emerged from a literature review on nursing and working under isolated conditions. These five major themes were: (1) gender; (2) culture; (3) loneliness and isolation; (4) power and control; and (5) stress and burnout.

Canitz (1990) believed that gender played an important role in the economic and social structure of nursing, health care, and northern communities. Personal attitudes, beliefs, and values were acknowledged to be

formalized and legitimized within social systems and institutions of society. Since people's attitudes, beliefs, and values were processed through behavioral and attitudinal norms, gender role behaviour was identified as one set of these norms. Canitz (1990) believed that the attributes of a 'good nurse' would parallel the attributes of a 'model woman' - passive, affectionate, and self effacing. These professional and cultural stereotypes promoted increased expectations of outpost nurses with a concomitant withdrawal of support and resources. Full and equal participation of women as nurses within the health care system was impeded by these stereotypes.

Canitz (1990) recognized the importance of cross-cultural sensitivity. "Becoming aware and sensitive to cross-cultural differences is a slow and intense learning process" (Canitz, 1990, p. 3). Outpost nurses must consider the complexity of issues affecting Aboriginal people to realize the true meaning of health and well-being.

Loneliness and isolation were identified as consequences of living in a harsh climate, and being geographically isolated. Social isolation was described as a consequence of living in a community with cultural differences, away from social supports (Canitz, 1990). Loneliness was associated with feelings of powerlessness, low work productivity, and poor adjustment to stress. Because of the transient nature of northern professionals, a social support system was difficult to establish.

Power and control were identified as potential influences on outpost nurses' job satisfaction. Control was defined as an individual's perception that

outcomes in life were due to forces either within their control or beyond their control. Outpost nurses who believed that they were masters of their own fate, were labelled as having an internal locus of control. Canitz (1990) hypothesized that nurses with an internal locus of control would report higher job satisfaction than nurses who believed they were helpless pawns.

Stress and burnout were identified as important factors to consider for northern nurses. Stress was defined as a process where stressors challenged an individual's equilibrium usually causing strain. Burnout was described as a syndrome of emotional exhaustion and cynicism caused by excessive stress. Canitz (1990) perceived that outpost nurses were positioned at the centre of a complex web of stressors. These stressors were related to the constant, interpersonal nature of the work, the high acuity level of patients, limited support, limited resources, and harsh environments.

Canitz's rationale for using a correlational survey design was not provided (1990). A correlational survey design with mailed questionnaires and interviews was implemented. Canitz (1990) suspected a strong relationship among the many variables within the themes of gender, culture, loneliness, power/control, and stress/burnout.

Canitz (1990) used several research tools. The UCLA Loneliness Scale was based upon the identified theme of loneliness/isolation while the Maslach Burnout Inventory was based on the theme of stress/burnout. The Norwicki-Strickland Internal/External Control Scale was used to explore relationships between perceptions of control, job satisfaction and turnover (Canitz, 1990). A

twenty-four hour activity time-budget matrix was used to document the activities of outpost nurses every fifteen minutes. The time-budget matrix recorded information on tasks, number of interruptions, persons present, and location of the activity. Canitz (1990) believed that outpost nurses experienced numerous interruptions that impeded their primary role as health care providers.

The study included two phases. Phase one consisted of a self-administered mailed questionnaire. A recognized, problematic feature of this approach was the low response rates (Polit & Hungler, 1991). Questionnaires were sent to 80 outpost nurses and 95 teachers.

The self-administered mailed questionnaire consisted of seven sections. The first three sections dealt with demographic data about the participant and the community. The fourth section consisted of the Maslach Burnout Inventory tool. The fifth section was the Norwicki-Strickland Internal/External Control Scale and the sixth section included a revised UCLA Loneliness Scale. The last section offered one page of open-ended questions with space available for descriptions about worklife experiences and feelings.

The questionnaire response rates of 70% (56/80) for the nurses and 48% (43/95) for the teachers were related to several factors. For both groups, lack of interest, problems with mail delivery, and concern for anonymity were provided as reasons for non-participation.

Of the nurse respondents, 95% were women and 66% were single (Canitz, 1990). One third of the respondents were married or living with a

significant other. Seventy percent of the nurses were diploma prepared, which was consistent with other nursing groups across Canada (GNWT, 1990).

Phase two of this study consisted of 16 on-site interviews in 7 communities and 15 time-budget observations. Sixteen semi-structured audiotaped interviews were conducted with nurses who volunteered to participate. Seven interviews occurred in communities with a population of 900 to 1100, while eight interviews took place in communities with a population of less than 400. One interview occurred in a community with a population of 19,000. This particular interview was a focus group interview of staff nurses with previous experiences as outpost nurses. The number of nurses in the focus group was not provided. Fifteen nurses completed a 24 hour activity time-budget matrix. Nursing supervisors and human resources officers were interviewed for their insights into retention of outpost nurses.

More than half of the outpost nurses scored an 'external' control orientation in the Adult Norwicki-Strickland Internal/External Control Scale (Canitz, 1990). Since an 'external' score represented a sense of little control over one's life, Canitz (1990) stated that outpost nurses perceived limited power and control in the health care system. A linear regression analysis was not used to test the validity of this proposed relationship, as suggested by Wood and Brink (1989).

Time-budget matrixes demonstrated that nurses averaged 4 concurrent activities during each 15 minute period (Canitz, 1990). Canitz's viewpoint that outpost nurses experienced constant interruptions could not be substantiated

without performing a linear regression analysis to test the validity of this proposed relationship.

Since half of the nurse respondents had previously worked in the north, Canitz (1990) used a fixed-answer format to determine why they had left their previous places of employment. The majority of these respondents answered that they left the north to further their education. Canitz (1990) assumed that education was used as outpost nurses' solution for lack of control.

Education was an easy outlet, and may open up more job opportunities outside the hospital setting. For nurses with a diploma education, their only choice was to either leave nursing or advance their education if they did not want to work in hospitals" (Canitz, 1990, p. 30).

"Feeling bushed" was the second most common response, and "frustrated with the system" was the third most common answer.

Despite the ranked order of these responses, Canitz (1990) stated that turnover was most strongly related to loneliness. When nurses were asked why they would eventually leave the north, they all voiced their feelings of social isolation and loneliness. Geographical isolation coupled with worklife demands, produced an alienating experience with limited rewards. Almost half of the nurses rated a high score on the loneliness scale, signifying feeling "very lonely". Compared to teachers and other groups working in the north, outpost nurses were identified as more lonely. Nurses-in-charge, outpost nurses designated to be in charge of the station, scored higher in levels of loneliness than staff nurses. Nurses experiencing loneliness reported perceptions of less

community support, and higher levels of emotional exhaustion in the Maslach Burnout Inventory.

All respondents commented on the negative impact that housing arrangements had on their personal and professional lives (Canitz, 1990). Two thirds of the respondents lived in accommodations that were attached to the nursing station (Canitz, 1990). During interviews, nurses expressed their awareness of the differences in housing arrangements that existed between nurses and other professionals such as teachers and the Royal Canadian Mounted Police (RCMP). All teacher respondents lived in apartments or houses that were not attached to their work environments.

Twenty-seven percent of the outpost nurses reported experiencing verbal or physical abuse from their clients (Canitz, 1990). Most of these situations were associated with alcohol abuse and occurred when the nurse was alone at the outpost station, providing health services to the perpetrator. According to Canitz (1990), outpost nurses were regarded as government representatives. Because of northern residents' experiences of government oppression, they projected anger onto nurses (Canitz, 1990).

A key reason why nurses were initially attracted to the north was the challenge of working as a primary health care practitioner (Canitz, 1990). "Nurses who rated high on the Personal Accomplishment Subscale of the Maslach Burnout Inventory estimated that they would stay longer" (Canitz, 1990, p. 39). Challenge and opportunity were the most influential factors in retention of nurses in outpost stations. Nurses who reported an intention to stay in the

north, enjoyed their contact with a new culture. Seventy-one percent of the nurses who reported an intention to continue in their outpost position, stated that they felt the Hamlet or Band Council was supportive. Many nurses voiced their attraction to the beauty of the north and its outdoor activities (Canitz, 1990).

The size of the community and the number of nursing positions were positively related to nurses' anticipated length of stay. Canitz (1990) found that working in larger communities with a higher number of filled nursing positions created the reassurance of having professional backup and support. Outpost nurses in larger community health centres were provided with a stronger sense of being a member of a health care team (Canitz, 1990).

Turnover was found to be related to loneliness, unrealistic expectations, lack of continuing education, lack of professional support along with cultural and community issues (Canitz, 1990). Nurse retention was found to be positively influenced when individual nurses expressed joy in their practice, participated actively in the community, appreciated the northern lifestyle and experienced sufficient professional support (Canitz, 1990).

Canitz's study was highly significant in its contributions to the knowledge of factors involved in retention and turnover of outpost nurses. The limitations of this study lie in its lack of a conceptual framework, its research design, and the data analysis. Polit and Hungler (1991) recommended that a power analysis be performed to determine sufficient sample size. Sample size may have been insufficient and evidence of a power analysis was not available. The quantitative data analysis was limited in terms of its reliability and validity.

Regression analysis, multiple regression, and factor analysis may have enhanced the reliability of suggested relationships between variables (Wood & Brink, 1989). The qualitative data analysis was limited because the predetermined themes that emerged from the literature were the only themes identified. Although Aboriginal nurses may have been included in the sample of northern nurses, similarities and differences between Aboriginal and Non-Aboriginal nurses were not explored.

Study on Nursing in the NWT. In 1989, health care services were transferred from the Federal Government to the GNWT. At this time, the vacancy rate for nursing positions was greater than 25% and the turnover rate of outpost nurses was approximately 70% (GNWT, 1990; Morewood-Northrop, 1994). The Nursing Services Division of the Department of Health, GNWT, conducted a survey to learn why this turnover rate was so high. The purpose of the survey was to solicit concerns of northern nurses in the areas of recruitment, orientation, leadership, communication, professional development, daily worklife, and living accommodations (GNWT, 1990).

Prior to conducting the survey, a literature review was performed. Lack of job satisfaction in "southern" nursing was found to be related to numerous factors. These factors were grouped into eight major categories (GNWT, 1990). Staffing, education, economics, organizational support, patient care management, communication, nurse/physician relationships, and status/image were identified as influencing the resignation of "southern" nurses (GNWT, 1990). Informal discussions with NWT nurses on these sources of job

satisfaction, revealed that northern nurses viewed job satisfaction and turnover to be related to similar items (GNWT, 1990).

The GNWT (1990) identified that recruitment and retention issues had changed because nurses previously "learned to endure and make the best of their work situation" (p. 24). Assertiveness and a heightened awareness of nursing's role in the health care system have resulted in a lack of tolerance to poor working conditions (GNWT, 1990).

A six page survey was circulated by the NWT Registered Nurses Association to 557 active and associate members on the 1990 membership roster (GNWT, 1990). Through different boards and agencies, the GNWT employed approximately 383 nurses (Government of NWT, 1990). The total response rate was 62.5%. Of the total sample, 270 nurses were employed by the GNWT, which constituted 77.6% of the sample.

Nurses practicing in hospitals and community outpost stations represented approximately 90% of the entire nursing workforce employed by GNWT. Within these two employment settings, respondents represented 60.3% of the nursing positions in outpost stations and 64% of the positions in hospitals (GNWT, 1990).

The survey was organized into eight sections that included: (1) personal data; (2) present employment data; (3) recruiting/hiring/orientation; (4) relationships/leadership/communication; (5) career advancement/present employer; (6) factors affecting daily worklife; (7) housing; and (8) general questions. The general questions were a combination of open and closed-

ended questions that explored attitudes about nursing in the NWT, attractions to northern nursing such as adventure, and factors related to retention. The form appeared relatively easy to fill out, as nurses selected their choices with a check mark. An estimated time frame for filling out the survey form was not provided.

Although expressed levels of satisfaction were significantly low in both hospital and outpost station groups, analysis of the data supported the researchers' perception that nurses in outpost stations were extremely dissatisfied (GNWT, 1990). Issues of immediate concern were inadequate orientation, inadequate vacation leave benefits, lack of access to continuing education, and performance of non-nursing tasks (GNWT, 1990). Only 17.7% of the outpost nurse respondents indicated an adequate orientation program. In regards to vacation leave benefits, 88.6 % of the outpost nurses were dissatisfied. Many outpost nurses expressed that continuing education was more essential in the north due to professional and geographical isolation (GNWT, 1990). Despite this opinion, less than 13% of outpost nurses were presented with regular continuing education opportunities. More than 50% of the nurses working in the outpost stations reported spending more than 2 hours per day performing non-nursing tasks such as janitorial or secretarial tasks.

The top three recommendations included provision of inservice education programs, the development of a job sharing program, and a plan to provide independent living quarters for outpost nurses (Morewood-Northrop, 1994). A recruitment program that addressed the realities of outpost nursing and an improved orientation program were other recommendations (GNWT, 1990). The

study advocated the use of a workload measurement system to provide a tool for staffing levels and staff mix. Immediate discussions between the GNWT and the nursing union regarding vacation time allocations were suggested. With housing accommodations, the GNWT (1990) recommended that dedicated housing units be identified and standardized for outpost nurses.

An explanation of how the data were analyzed was not provided. Frequencies of responses were offered.

The strength of this study is that the GNWT designed and implemented a descriptive survey to obtain information from nurses about factors that influenced retention and turnover. The response rate was adequate to generalize the findings to the outpost nurses employed by this agency. Correlational analysis was not performed to validate inferences about relationships.

Disadvantages of studies conducted north of the sixtieth parallel is that information obtained from surveys could be described as relatively superficial (Polit & Hungler, 1991). Survey methods have little value in the examination of complex social interactions such as QWL (Marshall & Rossman, 1989). Inferring strong cause-and-effect relationships was not permitted with these survey approaches (Polit & Hungler, 1991).

Outpost Nursing South of the Sixtieth Parallel

Three studies have been conducted in northern Manitoba. Gregory (1986) was the first researcher to study outpost nurses in Canada. Gregory (1986) identified factors affecting collaborative efforts between nursing staff and Indian Elders, and explored nurse-healer interactions. In 1989, a study on

outpost nurses' power was conducted (Edmundson & Loughran) and later in 1994, a study on outpost nurses' lack of power was implemented by Kirwan in response to critical incidents.

Collaboration with Indian Elders in Northern Manitoba. Gregory (1986), who had previous experience as an outpost nurse in northern Manitoba, identified that northern nurses faced several challenges in the collaborative process with Indian Elders. These challenges included: (a) overcoming stereotypes of the aged; and (b) treating clients who may benefit from counselling sessions with Indian Elders. The second challenge was based upon premises that some clients were receptive to counselling services provided by Indian Elders, and that nurses recognized and appreciated the alternative health care system.

Three theoretical perspectives were integrated to form the conceptual basis. Theoretical perspectives were used to identify possible factors influencing the perceptions of northern nurses about collaboration with Indian Elders. Possible factors were formulated into two major clusters - internal and external. The internal factors included: (a) influence of culture; (b) influence of personality; (c) professional and personal gratification; (d) maximizing social response; and (e) professional and personal goal attainment. External factors included generalized norms/rules and community/social factors. The conceptual framework provided infrastructure for Gregory's research design.

Gregory (1986) implemented an exploratory-descriptive research design. The first phase consisted of semi-structured, face to face interviews with 10

outpost nurses and 13 Indian Elders in three communities. Information gained

during this phase guided the construction of a questionnaire that was

implemented in the second phase. The second phase consisted of close-

ended, structured, census survey mail questionnaires administered to 64

outpost nurses.

Findings based on the interviews and an 81.2% return rate of the

questionnaires, indicated that nurses who were appreciative of the traditional

health care system collaborated with Indian Elders and traditional healers.

Potential client conditions that were perceived by nurses as appropriate for

Elder and healer referrals were lack of self worth, family discipline problems,

social interaction problems, child neglect, and parent-child conflict. Major

factors influencing nurses' collaboration with Indian Elders and traditional

healers were identified as: (a) confidentiality of patient/client disorders; (b) cross

cultural experiences; (c) knowledge of Indian Elders; (d) attitude of the Elders

towards the nurses; (e) influence of the nurse's own culture; and (f) attitude of

the community towards the nurses.

This study was significant in that its findings had implications for nurses

providing care to First Nations People in northern, rural, and urban settings.

Although nurses were willing to collaborate with Elders, the majority of nurses in

this sample did not actively refer clients to Elders and/or traditional healers. The

most significant implication was the need for nurses to employ the use of

transcultural nursing concepts. Acknowledgment and support of a traditional

health care system could contribute to an improvement in health status for First

Nations People. Almost all (88.5%) of the nurses acknowledged that a more indepth cultural orientation was needed.

Another finding was that a six month time frame enabled outpost nurses and the community to establish the nature and quality of their professional-personal relationships. Gregory (1986) suggested that MSB use this time frame to foster collaborative/interactive efforts between nurses and the traditional health care system.

Although Gregory's study was conducted ten years ago, its findings are pertinent in today's health care system. Gregory (1986) noted that the Federal Government was in favour of and encouraged a close working relationship between traditional healers and physicians. In 1996, the Federal Government limited funding for Aboriginal people to access traditional healers (Mitchell, 1996).

Work Environment, Role and Power. Edmundson and Loughran (1989) conducted this project as a partial requirement of a Business Administration course at the University of Manitoba. Their project examined the nature and extent of power that was inherent in the work environment and role of nurses who practiced in northern outpost stations. Power was defined as an "ability to influence others' attitudes or actions, or the ability to mobilize resources" (Edmundson & Loughran, 1989, p. 9). To provide a focus for their study and to facilitate data collection, the purpose was subdivided into three categories: (a) organizational issues; (b) social, political, and environmental issues; and (c) a personal attribute issue.

Research questions related to organizational issues included how the organizational structure, geographical isolation, nature of the facility, and nature of the role affected nurses' power. Research questions related to social, political, and environmental issues included how the nature of the health care consumer affected the nature and extent of a nurse's power, and how sociopolitical factors in the community affected the nature and extent of a nurse's power (Edmundson & Loughran, 1989). One research question was related to the personal attribute issue. This research question asked how a nurse's education, experience, and personal characteristics affected the nature and extent of a nurse's power.

This study relied upon an integrated conceptual framework. A conceptual framework was established using: (a) Rotter's internal-external dichotomy; (b) French and Raven's six bases of power; (c) Kanter's lines of supply, support, information and opportunity for discretion and recognition; (d) Kotter's power dependency; (e) attributes of bureaucracy and the semi-professional; and (f) Lipsky's street-level bureaucrat.

Published and unpublished literature on nursing, northern nursing, and Aboriginal community conditions was reviewed. This information was coupled with interviews. The reality of northern outpost nursing was then linked to the conceptual framework. Fourteen interviews were conducted with two nurse managers (MSB and Manitoba Health), one occupational health nurse (federal), two faculty members from the University of Manitoba (Nursing and Social Work), two physicians and one nursing research associate from the University of

Manitoba (Northern Medical Unit), four northern outpost nurses (MSB), and two nurses employed by northern Aboriginal organizations. Participants were asked for detailed descriptions of the most and least powerful outpost nurses that they had known.

Northern nursing was found to be inundated with contradictions and conflicts in power among participant groups. Federal and Provincial governments were identified as two groups that held different viewpoints. The operative objectives of the Federal and Provincial Governments were contrasted. The researchers favoured the Federal Government's operational objectives in that they clearly recognized the relationship of socioeconomic, cultural, and spiritual development to the health status of First Nations communities. I questioned the reality of fulfilling this operational objective. I also noted that the researchers' viewpoint that the Federal Government affirmed its relationship with Canada's Aboriginal people was debatable. MSB was described as operating well-equipped and well-staffed outpost stations. MSB was described as an agency that offered 24 hour primary care, community education, and illness prevention services.

Edmundson and Loughran reported that the Provincial Government's health delivery objectives were more focussed and limited in comparison to the Federal Government's operational objectives, which embraced the concept of community development. The Provincial Government's mandate was simply to prevent disease and promote health and ensure early diagnosis, treatment and follow-up of diseases to residents of northern Manitoba.

The bureaucratic organizational structures of both MSB and Manitoba Health enhanced and detracted from nurses' power. Outpost nurses were found to have substantial legitimate power over clients and to a lesser extent, the community. Limited reward power existed due to the nurses' fixed salary and benefit policies. The bureaucratic contribution to power was skewed to be favourable to nurses-in-charge. Supervisory nurses tended to have a more powerful call upon a wider range of resources within the outpost station and community, while using a limited reward system consisting of verbal praise and coercive power. Several participants described some nurses-in-charge as exercising a feudal-like power in a community.

Distance had a contradictory effect on nurses' power. Distance increased nurses-in-charge potential power by providing less service competition, more discretion, and greater recognition. Distance limited nurses-in-charge by constraining their lines of supply, support and information. Subordinate nurses' power may either benefit from accessible lines of a nurse-in-charge (NIC) or may be reduced by close supervision and monopolization by the NIC.

Health facilities were found to have contradictory effects on outpost nurses' power. Having the authority to access outside resources by telephone and having the authority for transporting clients out of the community enhanced nurses' legitimate, reward, and coercive powers. Lack of resources and working/living in the same environment promoted feelings of powerlessness.

Edmundson and Loughran (1989) identified that physicians held the power of monopolized occupational authority over nurses. Because northern

nurses were isolated from senior management and because they were the only source of health care services, they carried more legitimate, expert, and informational power. Outpost nurses experienced scarce resources and worked harder as individuals to fill the greater power demands for a high level of service. Outpost nurses' expanded roles increased their legitimate, expert, reward, and coercive powers, but placed a higher dependency on lines of supply, information, and support. Performing unfamiliar functions gave rise to ambiguity and feelings of powerlessness.

Other groups involved in contradictions and conflicts were community leaders and clients. Contradictions and conflicts resulted from cultural differences. Edmundson and Loughran (1989) acknowledged that northern nurses faced an extremely high demand for a wide variety of services, compounded by a high degree of dependency upon the part of the community. Clients' demands on the health care system had an overall negative effect on nurses' power. The high demand for services affected the power of outpost nurses in that nurses perceived that they had no control over the number and type of clients served. Outpost nurses found it difficult to maintain a balance between participating in their clients' lives, maintaining professional objectivity, and maintaining control over their free time and private lives. At times when nurses' workload was particularly heavy, nurses were unable to fulfil community demands.

An interdependent relationship existed between nurses and their clients. "Nurses are dependent on their communities to meet the demand for health

service" (Edmundson & Loughran, 1989, p. 68). The participants who were interviewed indicated the importance of a positive working relationship with CHRs and Bands. The most powerful northern nurses were identified as nurses who developed positive relationships with the Band Chiefs, and Band Councils, that facilitated the mobilization of resources.

Edmundson and Loughran (1989) identified one of their participants as an Aboriginal nurse. This nurse reported that being successful in a White culture (i.e. completing a nursing educational program) created problems of acceptance in the Aboriginal culture. This respondent perceived that clients tended to have less respect for Aboriginal nurses in comparison to Non-Aboriginal nurses.

The complexity of the historical, political, economic, and social conditions that exists in northern Aboriginal communities was acknowledged. The historical, political, economic, and social conditions contributed to contradictions and conflicts among health care participant groups.

Conflicts were managed by the NIC and community leaders who communicated their concerns with each other. Band Councils used their legitimate power to force the nurse in question out of the community. The NIC referred conflicts upward to the bureaucratic management, and this may in turn be referred to Provincial and/or Federal Ministers of Health.

Nurses' personal characteristics had contradictory effects on nurses' power. Nurses with diploma preparation and a minimal amount of experience were found to be ill-equipped for their expanded roles, resulting in feelings of

inadequacy and powerlessness. Lack of cultural awareness and lack of knowledge of traditional medicine threatened nurses' power; whereas, age and maturity were found to enhance northern nurses' power. Ancestry of Aboriginal nurses both increased and decreased nurses' interpersonal power.

One strength of this study was that it relied upon a conceptual framework to study power in an organizational setting. Using an interview approach, Edmundson and Loughran (1989) gathered rich data to describe the nature and extent of power inherent in outpost nurses' roles and work environment.

Weaknesses of this study included an important oversight. Unfortunately, the method of data analysis was not described. For example, the finding that Aboriginal nurses' ancestry positively or negatively affected nurses' positions of power was not substantiated by text or number of responses. Another weakness of this study was the lack of anonymity for the respondents, whose names were listed in the reference section.

This study focused on the notion of power in an organizational, sociopolitical, and personal sense. Although Edmundson and Loughran (1989) addressed the complexity of outpost nurses' worklife, they have only examined outpost nursing in respect to the nature and extent of its power.

Critical Incident Stress. Violence and social disruption have been identified as common health problems for residents of northern Canada (Young, 1983). Therefore, the probability of outpost nurses witnessing a tragedy resulting from violence and social disruption is high.

In 1990, a nursing union official representing outpost nurses in northern Manitoba, expressed concerns for nurses' safety to the Deputy Minister of Health, Province of Manitoba (Kirwan, 1994). With increasing awareness of the affects of violence and social disruption on its employees, MSB responded by committing its support and services to all employees who experienced critical incidents. Critical incidents and their affects on staff were identified as priorities by MSB.

Critical incidents were defined as events outside the usual human experience causing an unusually strong, emotional reaction (Kirwan, 1994; Manitoba Association of Registered Nurses, 1993). Another characteristic of critical incidents was that they usually occur without significant warning (Manitoba Association of Registered Nurses, 1993). Recognized examples of critical incidents included: (a) death of a child; (b) tragic death of a family unit; (c) death of a family member, friend, or co-worker; (d) patients with gruesome, disfiguring, or dismembering injuries; and (e) result of an error in nursing judgment placing a patient at risk of serious harm or death (Manitoba Association of Registered Nurses, 1993).

Kirwan was the co-ordinator of critical incident stress management services for MSB and the principal investigator of this study. Kirwan (1994) conducted a 2 year pilot project in northern Manitoba to address outpost nurses' concerns about critical incidents. The findings and recommendations of this pilot project would have implications on future critical incident stress prevention and management throughout MSB's jurisdiction in northern Canada.

The purpose of Kirwan's study (1994) was to determine the nature and scope of critical incidents among outpost nurses. An objective of the study was to develop procedures and protocols for timely delivery of critical incident stress prevention and management.

To begin the project, Kirwan (1994) interviewed 20 participants who were outpost nurses, nurse managers, occupational health nurses, and personnel consultants. These interviews were used to determine: (a) what constituted critical incidents occurring between 1988 to 1991; (b) what protocols were effective/ineffective; (c) what preventative measures were required; and (d) how to diminish the effects of critical incidents. These interviews revealed 74 critical incidents. From these critical incidents, effects included 18 resignations, 38 transfers, and several nurses remaining off work for extended periods. Protocols and guidelines to respond to the critical incidents were nonexistent.

During a two year period from 1991 to 1993, records were maintained on all critical incidents reported to MSB, in Manitoba. Of the 81 reported critical incidents, 75 occurred in outpost stations. All outpost stations reported critical incidents. One third of the incidents were results of assaults, attempted assaults, or threats of assaults towards a nurse. One fifth of the critical incidents happened when there was only one nurse in the community. The most common intervention was telephone counselling and support. Ten formal debriefings were conducted. One quarter of the employees who experienced critical incidents, were transferred to an urban centre for short term counselling. Of the

nurses who received some form of intervention, all but one nurse returned to work and completed their terms.

Based on findings of the conducted interviews and previously developed scales, a modified questionnaire was constructed. A questionnaire was developed to collect information on nurses' demographic backgrounds, type of events, reactions to incidents, degrees of trauma, and supports available.

Questionnaires were mailed to 140 nurses employed in northern hospitals, health centres, and outpost stations. Eighty-eight nurses completed the questionnaires for a response rate was 63%. The number of respondents that were outpost nurses was not provided. Nurses' demographic backgrounds were not included in the report. The report lacked detailed descriptions of nurses' reactions to incidents and degrees of trauma. A change had occurred from the three years prior to the pilot project as most nurses involved in critical incidents reported that they received telephone support from their nursing supervisor (n = 19) or were referred to MSB's occupational and environmental health service (n = 21).

Respondents had been involved in at least one critical incident such as the death of a child, attempted assault or threat to a nurse, or a suicide attempt of a patient. Nurses working in outpost stations were more likely to be exposed to violence than nurses working in northern health centres or hospitals.

A prevalence rate of 33% for diagnosable levels of post-traumatic stress disorder among the northern nurses was reported - twice as high as studies of Vietnam veterans. The reliability of the tool used to measure post-traumatic

stress disorder was not addressed. Although Kirwan (1994) included diagnostic criteria for post-traumatic stress disorder in the report, the actual tool used to assess diagnosable levels of post-traumatic stress disorders was not provided. Signs and symptoms of post-traumatic stress disorder and sleep deprivation are similar. When stations are understaffed, outpost nurses work a high number of hours per week causing fatigue. Signs and symptoms of fatigue, rather than post traumatic stress disorders, may have skewed the findings to reveal this high prevalence rate.

National recommendations were provided. They included initiating a northern critical incident stress program, eliminating the practice of placing only one nurse in a community, ensuring that preventative training in security be available to all nurses, and upgrading safety features of all nursing stations. Kirwan's dual roles as occupation head nurse in charge of critical incident management and principal investigator for the study may have skewed results.

Conceptual Perspective of the Study

"Research as a tool of science is a means for advancing substantive scientific knowledge" (Batey, 1977, p. 326). Since a sound body of knowledge about nursing worklife needed to be constructed, an interdependence between worklife theory and worklife research was essential (Walker & Avant, 1988). With an intention to advance the knowledge about outpost nurses' worklife, I acknowledged the phenomenon of nurses' worklife as part of the development of the research proposal (Batey, 1977). According to Batey (1977), the conceptual phase of research contains four elements: (a) the phenomenon to be

addressed; (b) the knowledge state that exists about the segment of the phenomenon that the study is addressing; (c) a logical construction or mapping of the phenomenon; and (d) the specific part of that logical construction that is to be explored in the empirical phase of the study.

The term, model, is used to denote a symbolic representation of conceptualizations of phenomena (Polit & Hungler, 1991). Models are constructed representations of some aspect of our environment, using abstractions as building blocks (Polit & Hungler, 1991). Models attempt to represent reality with a minimal use of wording (Polit & Hungler, 1991).

I located a suitable model to guide a descriptive study about outpost nurses' worklife. As suggested by Polit and Hunger (1991), I carefully evaluated the model in terms of its congruity with the problem to be studied, my philosophy of nursing worklife, and my worldview. The "Model for Quality of Nursing Worklife" (O'Brien-Pallas & Baumann, 1992), developed by the Quality of Nursing Worklife Research Unit in Ontario, Canada, 'fit' both the problem and my philosophy that outpost nursing was affected by numerous factors. The "Model for Quality of Nursing Worklife" offered a framework of propositions for conducting research on outpost nurses' worklife (Wilson, 1987).

Model for Quality of Nursing Worklife

A model identifying the relationships among nursing worklife factors was conceptualized by O'Brien-Pallas and Baumann (1992). This theoretical model was developed in an attempt to explore and establish relationships between the

individual nurse's experience, the institutional context of work, and the features

of the broader health care system.

Based upon a review of the literature, O'Brien-Pallas and Baumann

identified two broad themes of worklife factors: internal and external dimensions

(1992). Internal dimensions includes factors focusing on the nurse and the work

environment. External dimensions encompass factors outside of the nurse and

work environment. Internal and external dimensions will be discussed

separately and related to outpost nursing. Please refer to Figure 1 on page 65

for a depiction of the model.
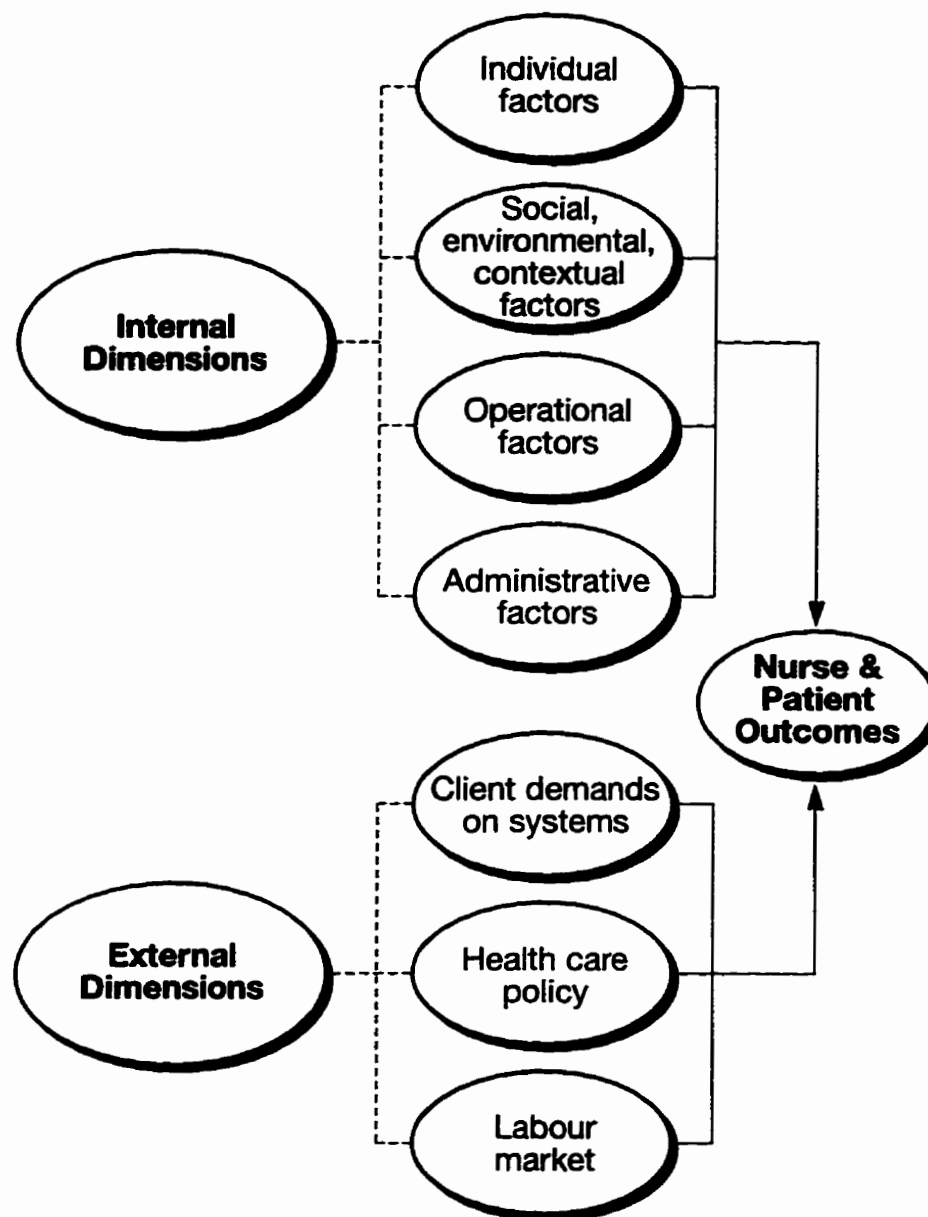
Figure 1. Model of quality of nursing worklife depicting internal and external dimensions that influence QWL.
Note. From "Quality of Nursing Worklife - A Unifying Framework", by L. O'Brien - Pallas and A. Baumann, 1992, Canadian Journal of Nursing Administration,5(2), p. 13.

Internal Dimensions. Internal dimensions are based on studies in the area of women's issues, highlighting the concerns of women in the workplace. As shown in Figure 2 on page 67, internal dimensions include four categories: (a) individual factors; (b) social/environmental/contextual factors; (c) operational factors; and (d) administrative factors.

Under individual factors, O'Brien-Pallas and Baumann (1992) identified the interplay of homelife and worklife. Nurses in outpost settings may work alone or with one to four other nurses (Edmundson & Loughran, 1989). Because of their workload and geographical isolation, outpost nurses may not be provided with flexible schedules, day care, part-time employment, or time for themselves and their families. Usually, outpost nurses rent subsidized apartments that are located within the health care building itself. Outpost nurses working north of the sixtieth parallel expressed concerns about their lack of privacy and merging of home and work due to their living arrangements (Canitz, 1990; GNWT, 1990).

Individual needs of nurses include attitudes, self-image, mass media, career goals, life values, respect, recognition, and autonomy (O'Brien-Pallas & Baumann, 1992). Outpost nurses have been described as adventuresome (Nanowski, 1992). Given the remoteness of the work setting and lack of accessible resources, outpost nurses are the primary sources of health care. Autonomy in decision-making and nursing practice was commonly viewed as a positive component of outpost nursing (GNWT, 1990).

Internal Dimensions: Organization/Agency

Individual Factors	Social/Environmental/ Contextual Factors	Operations	Administration

Individual Factors

Home Work Interplay
Job Sharing
Flexible Schedules
Day Care
Part-Time Work

Individual Needs
Attitudes
Self-Image
Mass Media
Life Values
Goals: Job-Career
Respect
Recognition
Autonomy

Social/Environmental/Contextual Factors

Climate

Status Role

Decision Making/ Management Style

Communication

Work Team Goals

Interprofessional Relations

Advancement (Career Laddering)

Physical Environment, including Geographical Isolation

Organizational

Operations

Care Delivery
Work Design
Work Load
Work Flow
Staffing Mix
Care Delivery Systems

Degree of Role Specificity

Technological Demand and Support

Equipment/Materials

Administration

Institutional Policy

Wage/Salary Benefits

Promotional Career Laddering

Performance Appraisal

Philosophy of Management

Recruitment Program

Budgets/Reports

Figure 2. Internal dimensions affecting nurses' QWL.
Note. From "Quality of Nursing Worklife Issues - A Unifying Framework", by L. O'Brien -
Pallas and A. Baumann, 1992, Canadian Journal of Nursing Administration, 5 (2), p. 14

Within the social/environmental/contextual category are factors such as climate, status and role, decision making, management style, communication, work team goals, inter-professional relationships, career promotions, physical environment, and organizational structure. This category encompasses the social context within which outpost nurses must function. Outpost nurses are members of a small health care team that is lead by the NIC. Based upon personal characteristics, educational preparation, and previous administrative experience, NICs may display various management styles.

Important factors that have been found to affect nurses' QWL are the intraprofessional and interprofessional relations (Attridge & Callahan, 1989). As previously mentioned by Goodwill (1989) and Gregory (1992), intraprofessional and interprofessional relations have been proposed to strongly influence outpost nurses' QWL.

A crucial consideration in the environmental category would be the fact that nurses in outpost stations are geographically, socially, and professionally isolated. Outpost nurses work in remote northern settings. Their only connection to social and professional support is by telephone.

The operations category includes care delivery systems, degree of role specificity, technological demand and support, and available equipment/materials. These factors may have a strong influence on the QWL for nurses in the north. As noted by Scott (1991) and Smith (1983), the demands of care delivery can be exhausting and affect the health of the nurse. Outpost nurses participate in multiple roles: laboratory technician, X-ray technician,

pharmacist, social worker, secretary, and janitor. The nurse must learn to be resourceful with the equipment and technology that is available.

The administration category consists of the agency's policies, wage/salary benefits, promotional career laddering, budgets, performance appraisals, philosophy of management, and recruitment programs. MSB possesses a bureaucratic organizational structure with its central headquarters located in Ottawa. For the purposes of administration, Canada is divided into regions and each region is subdivided into "Zones." Manitoba Region is divided into North and South Zones. The North Zone office is located in Thompson, while the South Zone office is located in Winnipeg. Regional headquarters are also located in Winnipeg.

The hierarchical structure of MSB is composed of outpost nurses who are supervised by a NIC, Zone Nursing Officers (ZNOs), Zone Directors, and Regional Directors. Outpost nurses "as employees of MSB work within the existing health care system and are subject to the system's philosophies and policies" (Gregory, 1986, p. 35). Edmundson and Loughran (1989) identified differences in the Federal and Provincial Governments' mandates of health care delivery to First Nations People.

External Dimensions. Dimensions that are external to nurses are client demand on systems, health care policy and the labour market, as shown in Figure 3 on page 70.
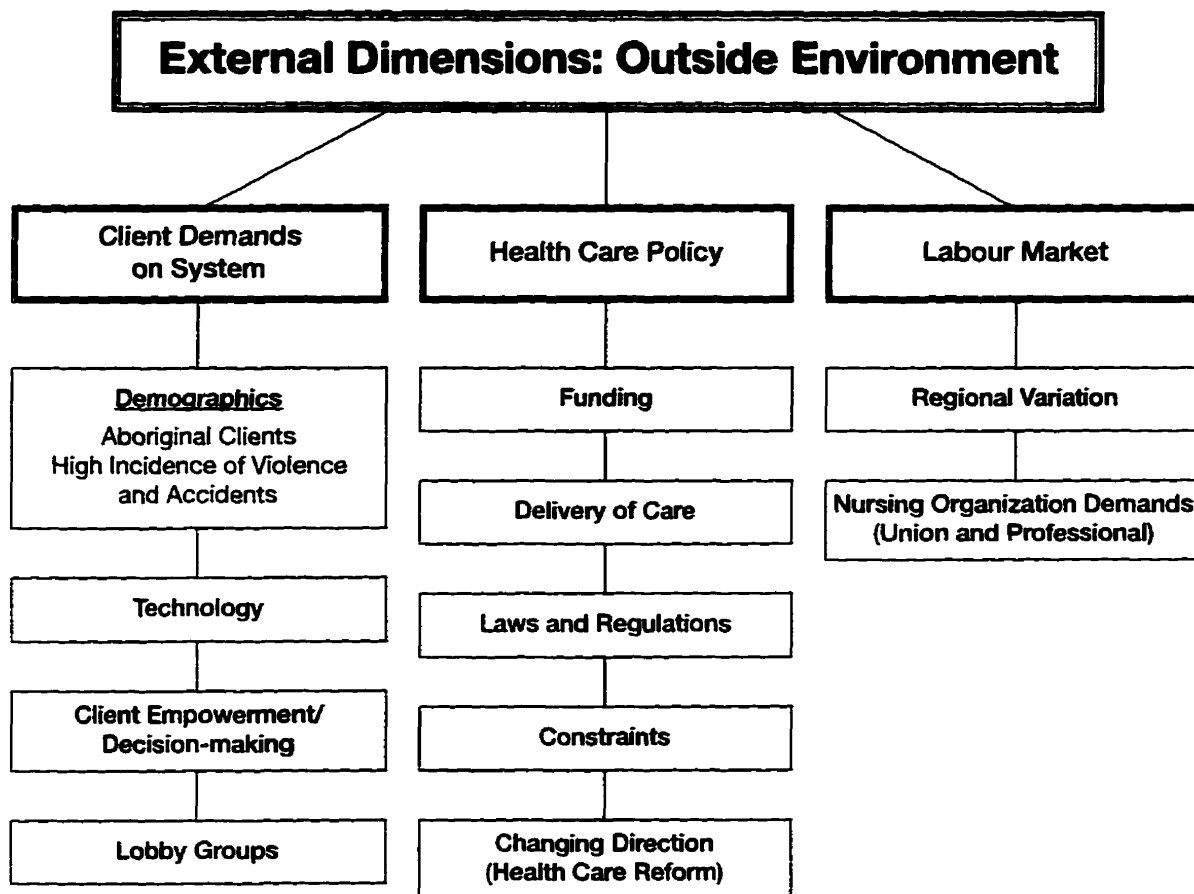
Figure 3. External dimensions affecting nurses' QWL.

Note. From "Quality of Nursing Worklife Issues - A Unifying Framework", by L. O'Brien-Pallas and A. Baumann, 1992, Canadian Journal of Nursing Administration, 5, (2) p. 15.

As consumers of health care at outpost stations are primarily Aboriginal, outpost nurses provide primary health care services within a complex, historical, and sociopolitical context. Aboriginal clients have become socialized into becoming increasingly dependent on outpost nurses to provide comprehensive health care services (Edmundson & Loughran, 1989; Gregory, 1992).

Health care policy includes factors such as funding, delivery of care, laws, regulations, constraints, and changing philosophies such as the impetus for health promotion. Health care policy could greatly affect nursing worklife in outpost stations as the health transfer initiative falls under this category. By transferring health care administration to local Bands, numerous aspects of outpost nurses' worklives will be affected. These affects include and are not limited to payroll, benefits, performance appraisals, and program development.

The category, labour market, includes regional variation of jobs available for nurses, and the affects that nursing organizations may have on the job market. The number of positions available define the conditions of the labour market. Nursing turnover rates in northern Canada have traditionally been higher than in southern Canada (Canitz, 1991; Government of NWT, 1990; Clevett & Maltby, 1992; Nowgesic, 1995). The existing applicant pool for positions available in northern nursing stations is a reflection of interest in this specialization of the profession of nursing.

"Articulation between the professional association bodies is important, yet little is known about how the practicing nurse is affected by activities of these divergent groups with different mandates" (O'Brien-Pallas & Baumann, 1992, p.

15). Although the Manitoba Association of Nurses (1991) specified the roles of registered nurses employed by Aboriginal agencies, this professional nursing association may lack visibility to some nurses in northern Manitoba (Manitoba Association of Registered Nurses, 1992). Outpost nurses who work in Manitoba must be registered as active practicing nurses with the Manitoba Association of Registered Nurses (MARN).

Nurses in outpost stations are not members of the provincial or territorial nursing unions (Canitz, 1989); they are members of a federal employees' union. As noted in Kirwan's study (1994), a union representative informing government officials of outpost nurses exposure to unsafe conditions, stimulated MSB's commitment to create safer work environments.

The ANAC could provide an united voice for Aboriginal and Non-Aboriginal outpost nurses. Since the ANAC is funded by the Federal Government to provide a liaison service between the government and the Bands, this organization's hands may be tied.

While O'Brien-Pallas was a visiting lecturer at the University of Manitoba in 1993, I had the opportunity to discuss the "Model for Quality of Nursing Worklife" with her. As depicted in Figure 4 on page 73, the model recently was reworked and collapsed into four broad categories: (1) homelife/worklife interplay; (2) work design; (3) work context; and (4) work world (Baumann & O'Brien-Pallas, 1993).
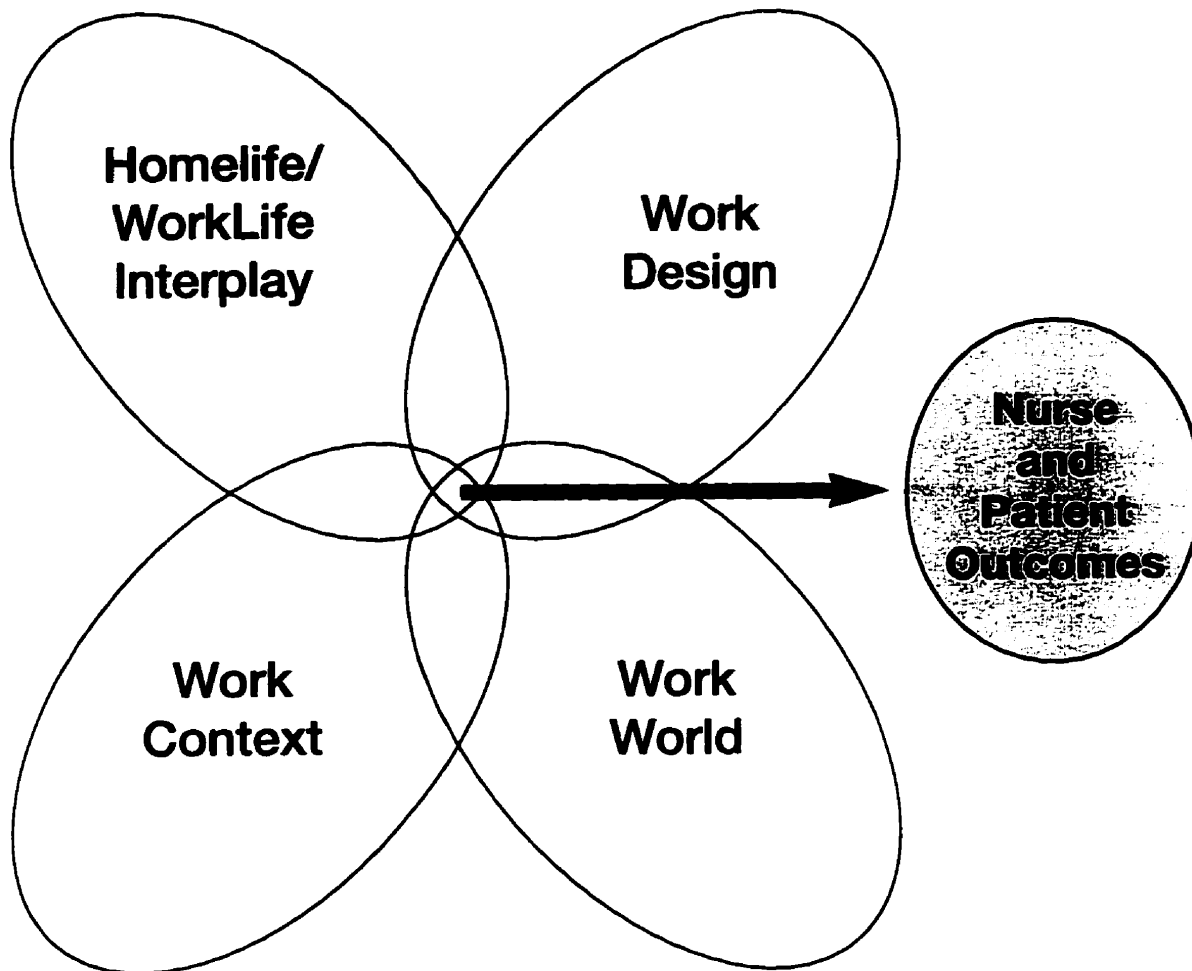
Figure 4. Revised model of quality of nursing worklife, including homelife/worklife interplay, work context, work design and work world.

These categories parallelled the nature of the worker, the nature of the work, nature of the work environment, and the nature of the work world as identified by McClure in a 1979 analysis of the components of nurse executives roles (Strike-Cruickshank, 1988).

Homelife/Worklife Interplay. Homelife/worklife interplay has traditionally received insufficient research attention (Donner, Semogas, & Blythe, 1994; O'Brien-Pallas & Baumann, 1992). Limited attention has been allocated to the issues and problems associated with nurses' homelives (Donner, Semogas, & Blythe, 1994). Employers and nurses themselves have barely acknowledged nurses' "other" lives (Donner, Semogas, & Blythe, 1994).

Most nurses make difficult decisions about how much energy to expend on their careers because they frequently have competing domestic responsibilities (Donner, Semogas, & Blythe, 1994). Caring at work and caring at home represent a significant double burden for nurses (Donner, Semogas, & Blythe, 1994). Homelife commitments have been found to be significant factors in job-oriented attitudes and decision making (Donner, Semogas, & Blythe, 1994). Homelife/worklife interplay applied to both Aboriginal and Non-Aboriginal nurses in terms of their attitudes, values, isolation from family and friends, time off work activities, career goals, self-image, educational preparation, past work, and past life experiences.

Within the category of homelife/worklife interplay, educational preparation is included. The minimal educational requirement for an outpost nursing position is a two year diploma in registered nursing. With MSB's mandate to

fulfil health promotion and illness prevention programs in northern communities, I agree with Gregory (1992) and question if this educational requirement may be adequate. A four year baccalaureate program in nursing, as a minimal educational requirement, may provide outpost nurses with more appropriate educational preparation in the areas of public health.

Work Design. The second category, work design describes the nature of the work. This category includes nursing delivery models such as primary care nursing or team nursing, workplace policies, job descriptions, shiftwork, and technology. Components such as work load, degree of role specificity, and availability of resources are included in this category. "Few technological resources are available, and the presence of other health care professionals and support staff is limited" (Gregory, 1992, p. 185). Since outpost nurses exercise a degree of autonomy as primary care practitioners, work design definitely affects outpost nurses perceptions about their QWL.

Work design had special implications in the worklife of outpost nurses due to their expanded nursing role. In 1991, the Manitoba Association of Registered Nurses (MARN) developed a document to address the role of registered nurses in outpost stations. Because registered nurses working in isolated outpost stations function as primary health care practitioners, they are: (1) direct care providers to individuals, families and communities; (2) health care educators; (3) health care administrators; (4) health care researchers; and (5) health care evaluators (MARN, 1991; Nowgesic, 1995).

Work Context. Work context is a term used to describe the environments in which nurses practice. Work context or the nature of the work environment includes factors such as management techniques. An important foci in work context has been intra- and inter-professional relations (Attridge & Callahan, 1989; O'Brien-Pallas & Baumann, 1992). Another contributing factor in work context is decision making processes within the workplace (O'Brien-Pallas & Baumann, 1992). Traditionally, nurses implemented decisions made by others, rather than making their own decisions (O'Brien-Pallas & Baumann, 1992). As outpost nurses function independently, often without resources such as "on-site" physicians and pharmacists (MARN, 1991), work context will have a profound affect on outpost nurses' QWL. Factors such as pay scales, promotions, performance appraisals, and philosophy of management are also included under work context.

The physical layout of the work setting is included in the work context category. Outpost stations have been described as modern suburban buildings located within bleak northern communities (Goodwill, 1984). Most of outpost nurses' living accommodations are located within the physical setting or building where their work environment exists. Work context may be overshadowed by outpost nurses' homelife/worklife interplay.

Work World. The fourth category, work world, describes the previously mentioned external dimensions. Work world involves the overall health care system, clients' demands on the system, health care policies and nursing job markets.

Client demand on systems would entail demographics of the community that is served and the degree of client involvement in treatment decision making. Client demand on systems would also encompass Chief and Band Council's involvement in the function of the outpost station.

Health care policies would include availability of funding. In the midst of health care reform, availability of funding and changes in health care delivery may affect the QWL of nurses. Other factors included under work world are standards of care developed by professional nursing organizations. Changes in laws and regulations, and the changing direction towards health promotion may affect nurses' worklife.

Labour market for nurses would involve regional variation. Geographically isolated areas have always experienced nursing shortages (Canadian Nurses Association & Canadian Hospital Association, 1990). Nursing organizations such as unions or professional associations may also place demands on nurses with standards of practice, dues and/or fees (O'Brien-Pallas & Baumann, 1992).

Outcomes of Quality of Worklife Factors. Although systematic studies that link QWL issues to patient and nurse outcomes are lacking, O'Brien-Pallas and Baumann (1992) posited that QWL affects both patient and nursing groups (Villeneuve et al, 1993). As shown in Table 1 on page 78, QWL affects patients and nurses in various manners. Patient outcomes consist of consumer satisfaction and quality health care service. A crucial outcome is the improvement in health status of clients due to the enhanced delivery of care.

Table 1

<u>Nurse and Patient Outcomes</u>

Patient Outcomes	Nurse Outcomes
Client satisfaction	Retention
Quality	Job satisfaction
	Stress
	Cohesion (group)
	Commitment
	Motivation

"A generally accepted thesis is that satisfied employees give better quality care as well as maintain a higher quality work environment" (O'Brien-Pallas, Baumann, & Villeneuve, 1995, p. 395). As stated by Canitz (1990), the quality of health services available to First Nations People is influenced by how well nurses adjusted to living and working in isolated outpost stations. Nursing outcomes included job retention, nurse satisfaction, occupational stress, cohesion, commitment, productivity, and motivation (O'Brien-Pallas & Baumann, 1992).

Congruent with Attridge and Callahan's study (1989), O'Brien-Pallas and Baumann (1992) acknowledged the importance of collegial support as a driving force in the retention of satisfied workers. Commitment and cohesion of nurses as professionals occurs at many levels. Nurses are seeking a positive identity through many collectives (O'Brien-Pallas & Baumann, 1992). Nursing outcomes have been studied but the linkage between the model's elements and outcomes need to be further tested through ongoing nursing research.

The "Model for the Quality of Nursing Worklife" was used to guide the study as it provided an appropriate broad framework. The multiple factors within the model's four categories of homelife/worklife interplay, work design, work context; and work world were applied to outpost nursing in northern Manitoba.

Overview of the Located Literature

I revisited the literature using the "Model for Quality of Nursing Worklife" as a guide. I examined previous studies' inclusion of internal dimensions (see Table 2 on page 80) and external dimensions (see Table 3 on page 81) .

Table 2

Review of the Literature's Examination of Internal Dimensions of the Quality of Nursing

Worklife Model.

Cara	Expectations
	Loneliness
	Power/Control
	Gender
	Transcultural
	  nursing knowledge
	Continuing
	  education
	Challenge
	Opportunity
	Autonomy
		Housing
		Beauty of the North
		Outdoor activities
		Interprofessional
		  support
			Tasks
			  performed
			Staffing ratios
				Vacation
				Benefits
				Support from
				  management

GNWT	Continuing
	  education
	Attitudes about job
	  sharing
		Communication
		Housing
		Interprofessional
		  relationships
			Tasks
			  performed
			Staffing levels
			Staff mix
				Recruitment
				Orientation
				Leadership
				Vacation
				  leave
				Benefits

Gregory	Knowledge of
	  transcultural nursing
	Attitudes about
	  traditional/Western
	  medicine
	Educational
	  background
	Length of time in
	  community
		Relationships between
		  nurses and Elders
			Referral
			  activities
				Support from
				  nursing
				  administration
				Orientation to
				  role/function
				Elders/
				  healers

Edmundson
& Loughran
	Personal attributes:
	  education,
	  experience, personal
	  characteristics
	Power/Control
	Limited control over
	  free time/private lives
		Geographical
		  isolation
		Relationships
		  with CHRs
			Roles
			Scope of
			  practice
			Telephone
			  consults
				Organizational
				  structure:
				  Federal &
				  Provincial

Kirwan	Demographics
	Reactions to
	  critical incidents
	Signs of post-
	  traumatic stress
		Safety features
		  of station
			Staffing levels	Counselling

Table 3

Review of the Literature's Examination of External Dimensions of the Quality of Nursing
Worklife Model.

Canitz	Community support Verbal abuse Physical abuse Size of community		
GNWT		Nursing union/ management policy on vacation time	
Gregory	Cultural differences	Policies about referrals to Indian Elders Traditional healing versus colonial medicine	
Edmundson & Loughran	Nature of consumer Demand for wide variety of services Dependency on nurses Relationship/Bands	Fixed policy - wage - benefit Transporting patients out of community Historical sociopolitical context Band Council resolutions	
Kirwan	Critical incidents	Union expressed concern: Nurses safety National northern critical incident stress	

As shown in Table 4 on page 83, I also examined previous research for specific patient and nurse outcomes that were studied.

By placing the literature in the context of the "Model for Quality of Nursing Worklife", I examined previous research in terms of foci and gaps in the study of outpost nurses' worklife. Analysis of the five research studies revealed that no study had: (a) identified Aboriginal nurses' perspectives; (b) included all internal and external dimensions and their effects on nurses and patients; (c) addressed the affects of health care policy on nurses' worklife; and (d) explored Aboriginal clients' perspectives.

Table 4

Review of the Literature's Examination of Nurse and Patient Outcomes.

Canfiz	Job satisfaction Burnout Turnover Job related stress
GNWT	Turnover Job satisfaction
Gregory	Client outcome

Edmundson & Loughran	Power relationships
	Mutual relationships
	Nurse-in-charge
	Power influence
	  communication
	  resources

Kirwan	Post-traumatic
	  stress disorders
	Long term
	  disability

Summary

Although outpost nursing has been practiced since the 1950s, studies on outpost nursing were not conducted prior to 1986. Since 1986, only 5 studies were located that examined specific aspects of outpost nursing. These aspects were significant as they focused on nursing retention, turnover, burnout, post-traumatic stress disorders, collaboration with Indian Elders/traditional healers, and power. A common strength of the studies was their significance to the nursing profession. High nursing turnover rates in Canada's Territorial Regions needed to be addressed.

Two studies were conducted north of the 60th parallel, attempting to establish causal relationships between worklife issues, nursing turnover, and job retention. These studies relied heavily upon quantitative data obtained through mailed questionnaires. Data analysis techniques were basic and limited the reliability of assuming causal relationships between factors.

Three studies were conducted south of the 60th parallel, in northern Manitoba. The first study dealt with collaboration between outpost nurses and Elders/traditional medicine. Gregory (1986) found that outpost nurses lacked an adequate orientation about cultural differences prior to working in First Nations communities.

The second study focused on the extent and nature of power inherent in the roles of outpost nurses. Edmundson and Loughran (1989) used a conceptual framework to guide their study and their qualitative research design.

The method of data analysis was not described, making it unclear how findings were determined. A significant finding was that outpost nursing was beset with numerous contradictions and conflicts that existed between all participatory groups in Aboriginal health care. These conflicts appeared to be due to cultural differences and bureaucratic processes.

The third study dealt with powerlessness in outpost nursing. Kirwan's study focused on critical incidents and post-traumatic stress disorders experienced by northern nurses (1994). This study was significant in that post-traumatic stress disorders are devastating consequences of outpost nursing. The reliability of the tool to measure post-traumatic stress disorders was not addressed and the tool was not described. The findings that outpost nurses demonstrated a prevalence rate of diagnosable levels of post-traumatic stress disorders that was twice as high as Vietnam veterans created scepticism.

Retention, burnout, turnover and post traumatic stress disorders were identified as significant outcomes of outpost nurses' worklives. The extent and nature of power inherent in outpost nurses' role was also an important feature. Collaboration between outpost nurses and Elders/traditional healers was perceived by First Nations People to have a positive affect on their health status. At this time, Canadian nurses need to systematically examine outpost nurses' perceptions of the contributing factors affecting their worklife along with the consequences of outpost nursing.

Although Aboriginal nurses have been practicing nursing in outpost stations, no research study specifically addressed this group's perceptions or

needs. By actively recruiting Aboriginal nurses into remote northern communities, and with the health transfer initiative underway, a study that explored worklife issues of both Aboriginal and Non-Aboriginal nurses was warranted.

By critically appraising the literature, my viewpoint on the necessity of an ethnographic study examining the entire worklife of outpost nurses was firmly supported. A nursing research study exploring QWL issues of Aboriginal and Non-Aboriginal nurses was drastically needed.

CHAPTER III

RESEARCH DESIGN

Introduction

In this chapter, I describe a research design using an ethnographic approach. An ethnographic approach was most appropriate to achieve the aim of this study and its particular objectives. In the description of ethnography, I fully explain the rationale for its selection.

The design of a research study includes protocols for sample selection, data collection, and data analysis (Wilson, 1987). Details about the study's sample selection, setting, data collection techniques, ethical considerations, and data analysis are provided.

This study explores QWL issues of outpost nurses in northern Manitoba. The exploration of nurses' experiences is highly valued by nurse researchers (Artinian, 1988). Given the subjective and complex nature of the study topic, a qualitative approach was deemed to be ideal. In particular, ethnography provided an appropriate research design to focus on the work of nursing as a human practice (Kleinman, 1992).

Choice of a research design is based upon the level of knowledge about the topic, and the degree of control the study proposes over the situation or variables (Brink & Wood, 1989). Little theory, lack of previous research, along with the least amount of control over the research situation, facilitated the choice of an exploratory design (Brink, 1989). As the central purpose of an exploratory study is to develop definitions of a concept such as QWL or contribute to

beginning theories, this particular research design is most suitable in the examination of outpost nurses' QWL (Artinian, 1988; Brink, 1989).

Initially, focus group interviews were considered as a method to collect data. This method was utilized in other studies exploring QWL (Attridge & Callahan, 1989; Attridge & Callahan, 1990; Villeneuve et al, 1993). Focus groups are typically composed of seven to ten participants who are unfamiliar with each other (Krueger, 1988). Focus groups in outpost stations would be compromised as they would consist of a small number of participants (2-5) who were familiar with each other and who may be from diverse cultural backgrounds. According to Edmundson and Loughran (1989), power relationships may exist between NICs and subordinate nurses. Goodwill (1992) described resentment between diploma prepared Aboriginal nurses and baccalaureate prepared Non-Aboriginal nurses. If power relationships and conflicts existed, a focus group would not be conducive to indepth discussions about particular worklife issues. Based on the low number of participants, and the proposed conflicts between nursing groups in outpost stations, focus groups interviews were excluded as a research method. Focus groups may not elicit detailed descriptions of the true meaning of QWL and its contributing factors.

Mailed questionnaires were previously utilized in studies on outpost nursing (Canitz, 1990; GNWT, 1990; Kirwan, 1994). This format of data collection may be less costly and require less time and energy (Polit & Hungler, 1991). Despite these benefits, the merits of face-to-face interviews outweighed those of the questionnaires with respect to this study (Polit & Hungler, 1991).

Advantages of face-to-face interviews included higher response rates and the ability of the researcher to offer clarifications for questions (Polit & Hungler, 1991). Information obtained from interviews tends to be richer and more complex (Polit & Hungler, 1991). Face-to-face interviews and fieldwork produces additional data through observation (Polit & Hungler, 1991). In the systematic analysis of outpost nurses' worklife, I required rich data to achieve the research aim and objectives.

Ethnography

This study's purpose is to holistically explore outpost nurses' worklife. "In ethnography, the goal of inquiry is to achieve a rounded, not segmental understanding" (Hughes, 1992, p. 443). The primary goal of ethnographic fieldwork is the collection of rich data leading to in-depth descriptive analysis of cultural phenomena (Doolittle, 1994). The aim of an ethnographic approach is to learn about and report the perspectives of the people being studied (Chuborn, 1991).

To achieve the study's objectives, it is necessary to explore Aboriginal and Non-Aboriginal nurses' perceptions of their worklife. Observations and interviews occurred in each of the outpost stations located in the participating northern communities. In other words, I collected the data in the natural settings, with no major investigator manipulation. Since this research required no control over behavioral events, the most appropriate method to explore outpost nurses' perceptions about their experiences was the ethnographical approach, including semi-structured interviews and field observations (Wing, 1990).

Ethnography is an "amalgam of fieldwork techniques" that provides structure to enable the discovery of people's experiences and how they interpret them (Bauman & Greenberg, 1991, p. 12). Ethnography was initially a research method used by anthropologists studying different cultures (Atkinson, 1992; Chuborn, 1991; Field, 1983; Hughes, 1992). The central concept is culture, which can be defined as the learned social behaviour or the way of life of a particular group (Germain, 1993). Every human group that is together for a period of time will evolve into a culture (Patton, 1990 as cited in Germain, 1993).

"In recent years this methodology has been used to learn about groups of people in our own society" (Chuborn, 1991, p. 52). Field (1983) described a "new ethnography" which asks the question, "How do members of a nursing culture actively construct their social world?" The new ethnography examines the surface structure of the nursing society, allowing participants to speak for themselves. The process of probing under the surface elicits rich descriptions which are examined for the social meanings that lie in the base of social actions (Field, 1983). Ethnography facilitates the description of the everyday lives of outpost nurses and focuses on their QWL (Fetterman, 1989). Ethnography was the most suitable research method for me to study the culture of outpost nurses. I was asking the question, "How do outpost nurses actively construct their social world?"

Study Population

An estimation of the total number of outpost nurses working in northern Canada was difficult to approximate due to numerous employment agencies.

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Employment agencies included: (a) Federal Government; (b) Provincial

Government; (c)Territorial Government; and (d) the Band or Hamlet Council.

According to Kirwan (1994), MSB provides health care services to most

regions of northern Canada in hospitals, health care centres, and outpost

stations. MSB has jurisdiction over a total of 77 outpost stations, employing 343

outpost nurses (Kirwan, 1994). Health care services in the NWT were

transferred from the Federal Government to the GNWT in 1989, and thus all

outpost stations in the NWT are not included in the Federal Government's

agencies and employees (GNWT, 1990; Morewood-Northrop, 1994). The

GNWT employs approximately 383 nurses, working in a variety of settings that

include hospitals, health centres, and outpost stations (GNWT, 1990).

Therefore, the total number of outpost nurses in Canada is estimated to be 700.

.   In Manitoba, 36 outpost stations are operating to serve approximately

28,500 northern residents (Edmundson & Loughran, 1989). Of the 36 outpost

stations, 21 stations are administered by MSB, 11 are administered by Manitoba

Health, and the remainder are administered by local Bands (Edmundson &

Loughran, 1989; Kirwan, 1994). The separation of Federal versus Provincial

delivery of health care flows from a Memorandum of Agreement struck in 1964

(Edmundson & Loughran, 1989). In this agreement, the Federal Government

was responsible for providing health care to communities with a majority of

registered Status Indians (Edmundson & Loughran, 1989). The Provincial

Government was responsible for communities with a large Metis and/or non-

Status population (Edmundson & Loughran, 1989). Today, several outpost

stations in Manitoba have been transferred to Band Councils for administration under the realm of the health transfer initiative.

To estimate the population of outpost nurses in Manitoba, I considered that outpost stations in Manitoba are administered by the Federal Government, Provincial Government, or First Nations People. The number of outpost nurses employed by MSB and/or First Nations People is approximately 145 (Kirwan, 1994). The number of nurses employed at outpost stations administered by Manitoba Health is approximately 8 (personal communication, J. Gow, June 17, 1994). Within Manitoba, I calculated that over 150 registered nurses are employed in outpost station settings.

Sample Selection

This study used theoretical or purposive sampling. A small sample was chosen through a deliberate process as it represented the desired perspective (Brink, 1989). The objective of theoretical or purposive sampling is not to focus on similarities that can be developed into generalizations, but instead to detail numerous specifics to give the context its unique flavour (Lincoln & Guba, 1985; Strauss & Corbin, 1990). "In qualitative research, events, incidents, and experiences, not people per se, are typically the objects of purposeful sampling" (Sandelowski, 1995, p. 180). Sample size in qualitative research may refer to numbers of participants, but also to number of interviews and observations conducted (Sandelowski, 1995).

Each nursing station in Manitoba employs between 2 to 5 nurses. Initially, I calculated that the number of participants could range from a minimum

of 8 to a maximum of 25. Upon completion of the fieldwork, the sample size of this study included 5 Aboriginal and 6 Non-Aboriginal nurses. I conducted 11 semi-structured interviews that were audiotaped. I documented extensive fieldnotes during the entire fieldwork in the 4 participating communities.

When I decided to seek out participants for the study, I considered outpost nurses who were employed by the Federal and Provincial Governments. I needed to recruit a sample from one particular employer to reduce the variability of two employment agencies. For numerous reasons I viewed outpost nurses employed by MSB as excellent sources of information about outpost nursing (Sandelowski, 1995). The outpost stations under the Federal Government's management are located further north than the outpost stations managed by the Provincial Government. I wanted to be able to capture the essence of QWL particular to outpost nurses who were more geographically isolated. During 1992, MSB presided over 21 outpost stations in Manitoba (Kirwan, 1994). At that time, the total number of outpost nurses employed by MSB in Manitoba was 145 (Kirwan, 1994). Eighty-six nurses were employed in Manitoba North Zone, whereas 59 nurses were stationed in their designated "southern" region.

As Manitoba North Zone contained the greatest number of outpost nurses, outpost stations within this area were considered in the recruitment of participants. The cost of travel in northern Canada is high. Because I was cognizant of the amount of funding that I had received from research grants, it was necessary for me to plan my destinations and travel arrangements in a cost-effective manner. I carefully considered specific communities based upon their

proximity, air access, and ground access to Thompson, Manitoba. Thompson was a main point to access flights and bus transportation.

I approached MSB for permission to access their employees as participants. I wrote a letter to the Regional Director, explaining the purpose of the study and the research method. I asked for permission to access registered nurses working in outpost stations. The Regional Director discussed the study with the North Zone Director. In turn, the North Zone Director consulted the Zone Nursing Officer. Permission was granted by MSB in 1993 (see Appendix B).

As outpost stations are located within and service residents of a reserve, Band Chiefs and Councils were approached for permission to enter their communities. Support of the project by the Band Chiefs and Councils was an important consideration in the overall aim of the study. I approached the North Zone Director, MSB, for suggestions on appropriate northern communities and outpost stations for the study. Due to this collaboration, nine communities were approached. I co-wrote a letter with the North Zone Director, MSB and we mailed it to eight Chiefs and Band Councils and one Mayor (see Appendix C). The letters described the research topic, objectives, and its methodology. We asked for permission to visit the community and conduct the study. Eight Chiefs and Band Councils, along with the one Mayor received letters, facsimiles, and telephone calls, requesting permission to enter their communities to conduct the study. A summary of the findings was offered upon completion of the study. Permission was granted by a total of 8 community leaders. Permission was not

granted by one community due to a problem with research saturation as ten other studies were already underway.

Following approval from the Ethical Review Committee, Faculty of Nursing, University of Manitoba, outpost nurses were recruited to participate in the study. Outpost nurses employed by MSB in the 8 participating communities were approached by a facsimile and asked to volunteer to participate (see Appendix D). This facsimile included the names of the principal investigators, description of the study's purpose, methods of data collections, and methods to maintain participant's anonymity. I strived to make the purpose of the study clear for participants (Sorrell & Redmond, 1995). Explanations about the study that are specific to ethnographies included statements like, "I am interested in learning more about your unique kind of nursing" (Sorrell & Redmond, 1995). Another purpose of this facsimile was to prepare participants for the future interview and fieldwork (Patterson & Bramadat, 1992).

The Sample. Using a sociological perspective, participants in ethnographic studies are referred to as key actors (Sorrell & Redmond, 1995). A key actor is an individual who is a member of a social group under study (Fetterman, 1989). The key actors in this ethnographic study were the individual outpost nurses. The key actors who volunteered to participate in this study were 5 Aboriginal and 6 Non-Aboriginal registered nurses, employed by MSB in northern outpost stations. A full description of the sample is provided in Chapter IV on page 122.

The Setting. In an ethnographic study, participants "are studied in their own natural life setting, because human behaviour can best be understood within the context that it occurs" (Andersson, 1993, p. 810). The setting for ethnography can be wherever there are people and activities related to nursing that need to be addressed in a holistic context (Germain, 1993).

I conducted my fieldwork for a total of 10 days in 1994. I travelled from Winnipeg to Thompson, Manitoba. From Thompson, I travelled to each of the four participating communities. Thompson was the "hub" for travel to and from the northern communities. The length of stay at the outpost stations was dependent upon the number of interviews required, my pre-arranged travel schedule, and the funding available.

Funding, that I graciously received, permitted travel to 4 northern communities. Due to limited funding and grant regulations, I was unable to collect data in the other 4 communities despite the fact that I had received permission and support from their political leaders.

Prior to entering the community, I arranged field visits with the NICs. The NIC facilitated my accommodations at each outpost station and arranged for someone to meet me at the airport or bus station. Usually, one or two nurses met me at the plane or bus. Nurses drove me to the outpost station in a designated MSB truck.

I entered each community as a stranger. Entering the field as a stranger limited bias and allowed for a degree of culture shock (Germain, 1993). I experienced a mild degree of culture shock as I travelled from my familiar

"southern" surroundings to northern Manitoba communities. Culture shock, in moderation, allowed me to "get the feel as well as the facts of the cultural scene" (Germain, 1993, p. 246). For example, I learned some "northern" terminology. When outpost nurses were describing violence and social disruption in their communities, they referred to clients "spending the night in the cells". I asked for the definition of "cells" and received clarification that Band Constables or RCMP officers may retain certain clients in the community jail for a short time period.

When I arrived at each outpost station, I was introduced to the nurse-in-charge (NIC) who arranged for me to receive a tour of the facility. Either the NIC or a delegated nurse would show me the physical layout and material resources of the outpost station. During these informal tours of the stations, I met informally with the nurses. At this time, I provided an additional explanation of the purpose of the ethnographic study as suggested by Sorrell and Redmond (1995).

During these tours, I usually met other health team members such as the physician, the dentist, the CHR, support staff, and RCMP officers. Following the tour of the facility and my accommodations, I often joined the outpost nurses in the lounge area for a meal or coffee break. During this social gathering, I would informally discuss why I was interested in outpost nursing, the research topic, and methodology. I discussed how I would assure participants' anonymity. I reassured the nurses that they could withdraw from participating in the study without any personal or professional recourse.

Exploration of each community was facilitated by either a tour provided by 1 or 2 outpost nurses or I would venture out for a walking tour by myself.

Generally, the outpost nurses would take me on a drive through the community and throughout the tour, they would describe certain aspects of the community to me. I gathered and documented the outpost nurses' accounts of their communities. These descriptions included each community's physical layout, the economic resources and lack thereof, previous social events and locations, the community's strengths, health problems, and current gossip.

> Sherry took me on a tour of the community. She explained that the houses were not much to look at from the outside because the winters were harsh. On many houses, I noted that the paint was wearing off. She said that the houses were wonderful inside...She showed me where the Band Office was located. It has a really nice sign. I liked the artwork...I couldn't believe it when I saw the school. The school is a modern building. Sherry explained later that it was a million dollar building...We drove by the teachers' residences and Sherry had a name for them called teachadences. These houses were modern (FN4994 p. 13, line 25).

The population of each First Nation community ranged from 500 to 2,500. Usually the community was located alongside a river or lake. Our transportation within the community was achieved by using a truck or an all-terrain vehicle along gravel roads that were poorly maintained. The gravel roads contributed to a dusty quality of air. Each community had buildings that were newer and well maintained. These facilities included: (a) the Northern Store; (b) the Band Council Office; (c) an elementary and high school; (d) teachers' residences; and (e) MSB's outpost station. Some communities also had RCMP offices and

residences. The First Nations People's homes varied in appearance from older and poorly maintained to newer and well maintained. Most houses lacked fresh coats of paint and were generally weather-beaten. Many homes are not equipped with telephones and/or running water. "Half the community doesn't have running water" (Sherry, p. 15, line 15). I noticed that northern communities differed from southern communities in that many dogs were visible and ran freely about the community. Another northern community was described in my fieldnotes as:

> The town is laid out in a picturesque way. Along the waterfront is the Band Office and the Band's Development Corporation. These buildings are modern and a flag hangs from both of these. The Northern Store is located across the street and there are several vehicles in front of it...Many people were standing in front of the vehicles outside the store, talking. About 80% of the people that I came upon said hi or hello to me. I walked up the road and saw the school, the arena, and the fire hall. I noticed that criss-crossing many grassy fields were pathways linking 1 area of the community with another (FN6994 p. 8).

My fieldwork was conducted in the fall of 1994. At this time, the leaves of the trees were changing colour. The weather was quite mild and there were numerous black flies. Fieldwork in each community ranged between 24 and 72 hours with a total of 10 days fieldwork in a northern Manitoba setting.

Data Collection Instrument

"Meticulous attention to how data are collected is a prerequisite to accurate, meaningful interpretation of those data" (Rew, Bechtel, & Sapp, 1993, p. 300). In this study, I was most certainly the data collection instrument. From the moment that I arrived in each community and for the entire 10 day field experience, I observed outpost nurses' behaviours, listened and participated during conversations and story-telling, and asked questions about outpost nurses' worklife. When I had the sense that I was saturated with information, I would retire to my accommodations and document the fieldnotes. The use of a lap top computer facilitated the documentation of my observations, thoughts, and feelings. I would maintain my fieldnotes once or twice daily, spending from three to six hours at a time on the computer.

My relationships with participants were crucial to the study of a complex human living experience such as QWL (Rew, Bechtel, & Sapp, 1993). As the major research instrument, I was seeking insider's answers to questions and I was aiming to capture the cultural context in detail (Germain, 1993). I strived to establish a relationship with each outpost nurse, by explaining why I was interested in learning about outpost nursing. I offered information about who I was, by informally providing them with a brief overview of my personal and professional background.

Data Collection Procedure

Data collection will be described. I provide detailed descriptions of ethnographic interviews and ethnographic fieldwork.

Ethnographic Interviews. Prior to conducting interviews, I consulted each NIC. The NIC and I discussed scheduling of interviews. Interviews were scheduled to facilitate safe and adequate coverage of patient care in the clinics. Interviews were scheduled during the day time - not evenings. The NIC and I wanted to ensure that each outpost nurse received the appropriate amount of free time away from the workplace setting and topic. We then discussed scheduling of interviews with participating and non-participating outpost nurses.

During each on-site visit to the outpost stations, I conducted one to two hour interviews with participating nurses. At each outpost station, I interviewed between 2 and 4 registered nurses. Interviews were audiotaped. The shortest interview was 1 hour, while the longest interview was 2 hours. The total number of interviews was 11.

Interviews were conducted in several different locations. At some stations, outpost nurses wanted to interviews conducted in their apartment or in my room. Nurses' apartments and my accommodations were located within the outpost station, but were separated from the patient care areas. At other stations, interviews were conducted in the employees' lounge area or a vacant room that was not being used for patient care or patient education sessions.

Each semi-structured interview began with an outline of the topics that I intended to cover. The outline of the research topic to be covered was easily facilitated by reviewing the consent form with each participant (see Appendix E). At this time, I reviewed the study's topic, the research method, maintenance of anonymity, and withdrawal from the study. I also asked each participant if they

wanted a summary of the findings upon completion of the study. Every participant expressed that they wanted a summary of the study's findings. Participants provided me with their signatures and mailing addresses. I photocopied each signed consent form, and provided each participant with a copy at this time.

During the initial part of the interview, I acquired demographic information from each participant using a form that I had developed (see Appendix F). Based on the Model for Quality of Nursing Worklife (O'Brien-Pallas & Baumann, 1992), a series of open-ended questions were drafted in the form of an interview guide (see Appendix G). I used semi-structured interviews because they offered me more latitude to move from one content area to the next and to follow up on cues suggested by the participants (Wilson, 1987). In one particular interview, the participant told several stories about her worklife. The stories included numerous factors contributing to QWL and I was not required to ask a number of the scheduled questions.

Ethnographic interviews were designed to discover cultural meanings (Sorrell & Redmond, 1995). The interview guide (see Appendix G) was designed to discover the meaning of QWL of outpost nurses, who I viewed as members of a unique subculture. Each outpost nurse who participated in the study helped me understand why they do what they do by expressing their ideas, beliefs, and knowledge (Fetterman, 1989).

"The skilled interviewer, as the research instrument, uses responses of the participant to guide data collection, probing for further information as needed

for depth and clarity" (Sorrell & Redmond, 1995, p. 1118). I quickly developed a proper balance between the structure of the interview guide and flexibility pertaining to the individual participant's responses (Sorrell & Redmond, 1995). Although I maintained some control over the interview, I was required to respond to content responses and non-verbal cues from participants (Sorrell & Redmond, 1995). The semi-structured interviews began with open-ended questions and eventually focused on questions related to clarification and emerging themes (Sorrell & Redmond, 1995). During one of the first interviews, a participant discussed Band Council Resolutions (BCRs). I was unfamiliar with this term and its implications and initially did not include it as part of the interview guide. At each subsequent interview, I asked participants for their viewpoints on BCRs.

The main part of the interview involved the use of ethnographic questions (Sorrell & Redmond, 1995). Careful development of ethnographic questions provided me with data that were essential to the completion of rich data analysis (Sorrell & Redmond, 1995). The three major types of ethnographic questions are descriptive, structural, and contrast questions (Sorrell & Redmond, 1995). Descriptive questions are referred to as 'grand tour' questions and are usually open-ended. An example of a descriptive question was: 'Could you describe a normal day in the life of an outpost nurse?' Structural questions provided more specific cultural information and are frequently asked concurrently with descriptive questions. An example of a structural question was: 'Could you tell me what outpost nurses do?' Answers to structural questions told me how participants organized their cultural knowledge. Frequently, participants

described what they did by using the term, "everything". Contrast questions helped me discover the meanings of words that participants use to describe their culture. An example of a contrast question was: 'How do you view BCRs?'

According to Sorrell and Redmond (1995), ethnographic interviews have a unique characteristic. Ethnographic interviews introduce descriptive, structural, and contrast questions in sequence (Sorrell & Redmond, 1995). Ongoing data analysis was essential so that subsequent interviews could be carefully developed and reconstructed (Sorrell & Redmond, 1995). I analyzed the interview process continuously and carefully reconstructed each up and coming interview.

Ethnographic Fieldwork. Ethnography's goal of inquiry is a rounded - not segmental understanding of a phenomenon (Hughes, 1992). In an application of that holistic conception of ethnography, data gathering has typically been characterized by fieldwork (Hughes, 1992). My fieldwork inquiry included a face-to-face relationship between participants and me (Hughes, 1992). I diligently maintained fieldnotes during each visit to the 4 participating communities. My fieldnotes contained rich descriptions of observable phenomena, methodological concerns, and personal notes. During the data analysis phase of the study, I relied heavily on the records that I had documented in my fieldnotes. Atkinson (1992) described ethnographic fieldnotes as imperative records.

I observed the worklife of outpost nurses and maintained fieldnotes according to Wilson's guidelines (1987). Fieldnotes facilitated my abilities to

recapture and comment on a number of important observable actions (Atkinson, 1992). Fieldnotes included my descriptions of the observed events of the nurses' worklife, which could be referred to as a cultural scene (Morse, 1989). These descriptions were compiled of who, what, where and how situations occurred. For instance, an outpost nurse met me at the bus. While driving back to the outpost station, she was gossiping about a community member who was also travelling on the bus. I documented the event by including who, what, where, and how that situation occurred.

My methodological notes included instructions for myself, critiques of certain tactics, reminders of approaches that might be beneficial in future fieldwork and interviews. For example, while informally socializing with outpost nurses, I initially asked them what questions they would ask if they were researching outpost nursing. These nurses responded by exclaiming, "Don't you have your interview questions organized yet?" I perceived that this process created a problem with my credibility as a researcher. I wrote a fieldnote that critiqued this tactic and deleted it from subsequent data collection techniques.

Personal notes were documented. They included my own reactions, reflections, and experiences. For example, I recorded my reactions to the situation where the outpost nurse was sharing gossip about a community member with me.

As soon as I arrived in each community, I began making mental notes of what I would document in the fieldnotes. When I had the sense that I was saturated with information, thoughts, and feelings, I excused myself from the

group of outpost nurses. I retreated to my room and documented my

observations, thoughts, and feelings. Using a lap top computer, I organized

each fieldnote according to the location, date, and time of my documentation. I

would document fieldnotes for 3 to 6 hours. Fieldnotes were documented at

least once and as many as three times daily. At times, I would exit the

community and return to Thompson, Manitoba where I continued to document

fieldnotes about previous field experiences.

Ethical and Human Rights Considerations

Ethical and human rights are addressed. I describe ethical and human

rights considerations prior to, during, and after data collection.

Prior to Data Collection

Robinson and Thorne (1988) noted that nurses, engaged in qualitative

research, experience dilemmas that have significant bearings on the ethics of

their encounters with participants. Dilemmas include informed consent,

researcher's influence, immersion of the researcher in the data, and

researcher's intervention within the research context .

Permission to access outpost nurses in Manitoba North Zone was granted

by MSB (see Appendix B). Permission was granted for me to enter the 8

participating communities through a letter co-written with the Director of

Manitoba North Zone, MSB. The Director was clearly identified as a liaison

person to guide my access to the participants and the communities (Germain,

1993). Following approval from the University of Manitoba, Faculty of Nursing

Ethical Review Committee, a letter was facsimiled to the 8 participating outpost

stations describing the study and requesting volunteers to participate (see Appendix D). Interested nurses were advised to contact me by a collect telephone call.

Informed Consent. Following notification that an outpost nurse volunteered to participate, a consent form was facsimiled to this nurse (see Appendix E). The consent form included information that ensured the participant had the knowledge and understanding needed to make an informed decision as suggested by the Canadian Nurses Association (1983). Once the consent form was signed by the participant, I photocopied it. Each participant was provided with one copy and I also retained a copy. Signed consent forms included participants' addresses, allowing me to share preliminary findings and a summary of the conclusive findings with the outpost nurses.

Invasion of the participants' privacy was a concern (Ramos, 1989). The consent form included information for the participants, allowing them to discontinue their participation in the study at any time without any consequence to them, personally or professionally. Prior to conducting the interview, I reviewed the consent form with the participants and reminded them that they could withdraw from the study at any time. I assured them that there would be no untoward consequences if they withdrew from the study. No participants withdrew from the study during the interview process.

M was slightly anxious about the interview. She stated that she wished she had the questions ahead of time and she didn't know if she would give the right answer. On our way to the interview room, I explained that if

there was a question that I asked and she did not want to answer, that she

could pass on that question and I wouldn't be mad at her. I furthered this

by explaining that she could decide, during the interview, if she wanted to

discontinue it (FN 2994, p. 2).

Following the review of the consent form, I ensured that subordinate

outpost nurses had not been coerced into participating by the NIC. Outpost

nurses assured me that they did not perceive any coercion by the NIC.

During Data Collection

The issue of influence requires close examination in every qualitative

study (Robinson & Thorne, 1988). By merely attending to outpost nurses

through fieldwork and interviews, I was aware that I may trigger shifts in the

meaning outpost nurses assign to their QWL (Robinson & Thorne, 1988).

Qualitative researchers have an obligation to account for their influence on the

process and outcome of their research (Robinson & Thorne, 1988).

As interviews are powerful communication tools, qualitative researchers

must take responsibility for the ethical implications of the relationships that

develop between researcher and participant (Robinson & Thorne, 1988). I

acknowledged that the process of reflecting upon outpost nursing experiences

could have had a powerful impact on participants (Robinson & Thorne, 1988).

With an awareness of the prevalence of worklife consequences among outpost

nurses, I strived to create an environment where the participant and I would

mutually decide to discontinue the interview as soon as the interview was noted

to cause distress. "The investigator must be vigilant in anticipating such

problems, rendering appropriate support during data collection, and arranging appropriate referrals afterward" (Ramos, 1989, p. 60). During one interview, a participant began to cry.

> When I asked her to tell me a situation where she was left with a feeling of satisfaction, she started to get watery-looking eyes. She was looking away from me. I quickly stopped the tape recorder and asked her if she wanted me to get her some Kleenex. She said that she would like that. She cried a little bit and we decided that we would come back to that question. She was having difficulty with it because she could not recall a situation that caused her to feel satisfied with her work. I... recognized her feelings of sadness. I asked her if I was correct in noting her sadness. She clarified it further and I think she called it - being disturbed. I did talk to her about phoning the occupational health nurse for MSB or the Zone Nursing Officer to have someone to talk to about her feelings. (FN 2994 p. 2).

The participant and I mutually decided to temporarily discontinue the interview. After five to ten minutes, we decided to resume the interview. This participant did not demonstrate further distress.

After Data Collection

Nurses who volunteered to participate were protected by my assurances that their names did not appear on the transcripts. An additional assurance for their protection was the exclusion of the names of the communities from the transcripts and any subsequent documentation of the study as recommended by

Freeman (1993). Future documentation, presentations, and publications about the study do not include names of the participants or names of the participating communities.

Participants were assured that I was the only person who had access to the audiotapes. Access to the transcripts (no nurses' names, no outpost station names) was available to the me and my three thesis committee members. Audiotapes and transcripts are located in a locked filing cabinet in my office, where they will remain for 7 years. At that time, the tapes and transcripts will be shredded and destroyed.

With a small sample size, and a depth of detail in thick descriptions, participants identities may be difficult to disguise (Ramos, 1989). As stories may be easily identifiable to participating nurses and communities, the stories have been slightly altered to protect participants' identities. For example, a story about a nurse's participation in a fishing derby may have been altered to a nurse's participation in a canoeing expedition.

Participating outpost nurses and participating Chiefs and Band Councils were provided with a summary of the findings of the study. As opposed to complex quantitative statistical findings, given the qualitative nature of the study, the outpost nurses and community leaders can readily understand the document. "The results of the study should help the community *return* to health, *regain* control, and *improve* its self-esteem" (Freeman, 1993, p. 193).

Data Analysis Technique

Data analysis requires a fluid, flexible, somewhat intuitive interaction between the researcher and the data (Brink, 1989). Time spent with the outpost nurses in the nursing stations and immersion in the data set the stage for categories and themes to emerge (Aamodt, 1989).

Audiotapes were transcribed verbatim. Transcripts and fieldnotes underwent content analysis. Content analysis is defined as a technique that generates inferences by objectively and systematically identifying specified characteristics of messages (Marshall & Rossman, 1989). "Units of analysis for ethnography are often linguistic expressions or domains of meaning understandable in scholarly communication" (Aamodt, 1989, p. 36).

The primary aim of data analysis was to produce a detailed and systematic recording of open codes, categories, and themes addressed by the participants (Burnard, 1991). In order to achieve this purpose, I followed a step-by-step process as outlined by Burnard in 1991. I read and reread the transcripts and fieldnotes to enable my immersion in the data. As many headings as necessary were documented to describe all points of the transcripts' and fieldnotes' data. This process is referred to as open-coding. Many qualitative studies use code words that are derived directly from the data, which may be noted in the margins of fieldnotes and interview transcripts (Cobb & Hagemaster, 1987). The list of open codes are surveyed and grouped together under higher order headings known as categories. Categories are reviewed for similarities and differences. Recurring themes emerged during an

exhaustive overview of the categories. "Cultural themes are conceptualizations that connect domains, giving a holistic view of the culture under study" (Parse, Coyne & Smith, 1985, p. 77).

Each transcript was treated as a separate document. The codes from the coding schedule were attached to segments of data. Segments of coded data were searched. Multiple code searches identified overlapping data.

All QWL issues were identified and documented. Pertinent QWL issues of Aboriginal and Non-Aboriginal outpost nurses were identified, compared and contrasted. Nurses' perceptions of QWL issues, that affected their ability to provide quality care to their clients, were explored. The findings were also addressed in relation to the Model for Quality of Nursing Worklife to assess its applicability to outpost nursing.

Member Checks

Member checks were performed because the true essence of this study was to represent Aboriginal and Non-Aboriginal nurses' realities in a manner that remained faithful to each member's reality (Sandelowski, 1993). I mailed a cover letter to each of the 11 participants (see Appendix H) and to the Band Chief and Council in each of the participating communities (see Appendix I).

Findings were noted in a document (see Appendix J) and mailed along with a cover letter to all participants and participating Chiefs and Councils. Participants and participating Chiefs and Councils were asked to contact me by collect telephone calls if they noted any discrepancies in the findings. Member checks were needed to affirm the study's credibility. Credibility occurred as

participants and participating Chiefs and Councils were provided with an

opportunity to read descriptions and correct any errors in my interpretations.

Of the 11 participants and 4 First Nations representatives, only 1

participant responded to the member checks. One Non-Aboriginal outpost

nurse telephoned me to state that she supported my interpretation that

Aboriginal nurses tended to participate more in community activities/events than

Non-Aboriginal nurses. In this participant's experience, she had noted that the

Aboriginal nurses spent their time off work enjoying activities within the

community. She told me that reading the findings made her wonder why she did

not venture out more into the community and interact with the Aboriginal people.

Data Analysis Revisited

After I conducted the member checks, I experienced numerous demands

in my homelife and worklife. At this time in my life, I had been married for one

year with a stepdaughter. I was ill-prepared for my new role as a stepmother of

an adolescent. Demands in my homelife and worklife were negatively affecting

me, so I chose to reduce stressors by postponing work on my thesis.

When I returned to my thesis, I reread the transcripts and fieldnotes and

again documented open codes. I regrouped identified codes into categories.

From the categories, I recognized significant themes. By revisiting the data, I

sincerely believe that the identified categories and themes were richer.

Perhaps, I was more refreshed, and more capable to generate the essence of

the culture of outpost nursing. Perhaps, my personal experiences contributed to

data analysis in the identification of the major themes: fulfilment and powerlessness.

Methodological Rigor

Sandelowski (1986) noted that qualitative research can claim rigor and scientific merit. The quality of goodness of the study was addressed using the parallel criteria established by Guba and Lincoln (1989). Trustworthiness and authenticity were evaluated using credibility, transferability, dependability, and confirmability (Guba & Lincoln, 1989; Yonge & Stewin, 1988).

Credibility

Credibility in qualitative research parallels internal validity in quantitative studies. "When the researcher's presentation of self is believed by the research participants, the trust and rapport essential to credibility of the team of researchers are established" (Rew, Bechtel, & Sapp, 1993). By travelling to remote outpost settings, participants may have perceived that I was sincerely and keenly interested in learning about their worklife. My demonstration of caring about participants' experiences reflected my authenticity and positively influenced data collection and analysis (Rew, Bechtel, & Sapp, 1993). Following my arrival at each outpost station, I successfully recruited more participants, because they perceived that I was sincerely interested in learning about their worklife and then agreed to share their thoughts and feelings.

I achieved credibility in this qualitative study through engagement in fieldwork. Although I only visited each outpost station for 24 to 72 hours, I was stationed in northern outposts for ten days. This involvement in the worklife of

outpost nurses helped to overcome any misinformation or distortion of realities that I had arrived with initially. Persistent observation of outpost nurses in their worklife settings added depth and scope to the study. The triangulation of data from both interview transcripts and my fieldnotes contributed to thick descriptions of outpost nurses' worklife. For example, outpost nurses described what they do. I interpreted their descriptions as tasks conducted under the realm of the medical model. These descriptions also emerged in my fieldnotes as I described my observations in the outpost stations. Outpost nurses would meet a client in an examination room and discuss the client's health concern. The outpost nurse would leave while the client undressed. The outpost nurse would return and perform a physical assessment. Frequently, the outpost nurse would conclude their clients' visits by providing them a "filled prescription". Outpost nurses clearly functioned as physicians under the medical model of health care.

Peer debriefing was facilitated by my thesis committee members. Extended and extensive discussions regarding the open codes, categories, and themes generated from the transcripts and field notes contributed to the credibility of the study.

Negative case analysis also contributed to the credibility of the study. The open codes, categories and themes were formatted to account for all cases - those that fit and those that do not fit. One negative case analysis occurred when an Aboriginal nurse discussed at great lengths the merits of spirituality, traditional medicine, and healing for First Nations People. None of the other participants addressed their philosophies of nursing, health care, or traditional

medicine; many participants described their work in terms of being the doctor and demonstrated value for the medical model.

"Intuitiveness is the ability of the researcher to synthesize the experience of the informant through immediate contact and empathy" (Rew, Bechtel, & Sapp, 1993, p. 301). Reflection and reflexivity is involved in intuitiveness, permitting the researcher to discern the meanings in terms of the whole (Rew, Bechtel, & Sapp, 1993). Progressive subjectivity was demonstrated in my fieldnotes. Personal reflection contributed to my own credibility as a nurse researcher. Reflexivity provided creative ideas for future data collection and future research studies related to QWL for outpost nurses. This process was fully documented in Chapter V on page 288.

According to Guba and Lincoln (1989), the single most crucial technique for establishing credibility is member checks. The member check is a process of testing hypothesis, data, preliminary categories, and interpretations with actual participants (Guba & Lincoln, 1989). Credibility occurred when the participants read my descriptions and immediately recognized the lived experiences to be their own, even if the description may be of another participant (Yonge & Stewin, 1988). Member checks functioned to provide participants and participating Chiefs and Councils with the opportunity to offer additional information.

Transferability

Transferability in qualitative research parallels external validity or generalizability in quantitative studies (Guba & Lincoln, 1989). Transferability or "fittingness" occurred when research findings fit other contexts as judged by

readers, or when readers find the written report meaningful in regards to their own experiences (Germain, 1993). Fittingness means that the findings can fit into similar outpost nursing contexts (Yonge & Stewin, 1988). The Non-Aboriginal nurse who responded to the member check, validated the finding that Aboriginal nurses tended to participate more actively in community events in comparison with Non-Aboriginal nurses.

A major technique for establishing a degree of transferability was the provision of thick descriptions and verbatim quotations in the report (Germain, 1993). The interview schedule was formatted so that participants were asked to describe their worklife in great detail. I kept extensive fieldnotes that provided a complete data base for content analysis.

Dependability

Dependability is analogous to reliability (Guba & Lincoln, 1989). Dependability is concerned about the stability of the data over a given period of time (Guba & Lincoln, 1989). Instability may occur under conditions where the researcher is bored, exhausted, or under considerable psychological stress (Guba & Lincoln, 1989). As the researcher, I diligently strived to maintain fieldnotes of my observations, thoughts, and feelings on a daily basis. Since outpost nursing was a new experience for me, I can safely stipulate that I did not suffer from boredom. In the event of considerable psychological stress, I made arrangements to contact my thesis committee members by telephone for consultation. My thesis chair contacted me by telephone during my fieldwork. At this time, we discussed particulars about my fieldwork, data collection, and data

analysis. Since I did not experience undue psychological stress at any time,

further contact with my thesis committee members was not necessary.

For dependability to occur, the "researcher should painstakingly

document the entire research process through the use of memos, diaries, or field

notes, mechanical recordings, minutes of meetings, letters etc." (Yonge &

Stewin, 1988, p. 64). The entire research process was documented in the form

of memos, fieldnotes, transcripts, letters, and facsimiles.

Audiotapes were transcribed verbatim. I carefully provided open coding,

categories and themes, that were reviewed or audited by the thesis committee

members. "The inquiry audit is a procedure based on the metaphor of the fiscal

audit" (Guba & Lincoln, 1989, p. 242). My thesis chair ensured that the process

of my data analysis was established, trackable, and documented appropriately.

Confirmability

Confirmability parallels the term, objectivity (Guba & Lincoln, 1989).

Confirmability is concerned with assuring that the findings of the study are

objectively rooted in the contexts of the participants' words in the transcripts, and

the researcher's words in the fieldnotes (Guba & Lincoln, 1989). The findings of

the study can not simply be figments of the researcher's imagination (Guba &

Lincoln, 1989).

Confirmability was achieved by having my thesis committee members

perform an audit of my data analysis. The 'bottom line' audit ensured that the

entries of the transcripts and fieldnotes were verified. The audit confirmed that

the data analysis and research findings were verified by the participants' words and fieldnotes.

According to Yonge and Stewin (1988), confirmability is the criterion to ensure neutrality. Neutrality was achieved as credibility, transferability, and dependability were established (Yonge & Stewin, 1988).

Summary

In this chapter, I described the research design of this study. The research design was driven by the nature of the research objectives and the lack of knowledge and theory about the study's topic. As it was necessary to explore the perceptions of outpost nurses regarding their QWL and little information exists regarding this broad topic, ethnography was the most appropriate approach to collect and analyze data for this study.

Ethical considerations prior to, during, and following data collection were discussed. Following permission to access participants from MSB, Chiefs and Councils, Ethical Review Committee, a letter recruiting volunteers was facsimiled to participating stations. Once participants were established, an informed consent was facsimiled to them. I acquired research grants to support northern travel to 4 First Nations communities and a 10 day field experience. Data was collected from 11 outpost nurses who volunteered to participate, using both an ethnographic interview and detailed fieldnotes. The sample included 5 Aboriginal nurses and 6 Non-Aboriginal nurses.

Interviews were semi-structured and audiotaped, lasting between one and two hours. Fieldnotes contained detailed observations, thoughts, and feelings experienced during the fieldwork.

Audiotapes were transcribed verbatim. Transcripts and fieldnotes underwent content analysis. Content analysis is a technique that generates inferences by objectively and systematically identifying specified characteristics of messages (Marshall & Rossman, 1989).

I followed a step-by-step process as outlined by Burnard in 1991. I read and reread the transcripts and fieldnotes to enable my immersion in the data. As many headings as necessary were documented to describe all points of the data. Code words, that were derived directly from the data, were noted in the margins of fieldnotes and interview transcripts (Cobb & Hagemaster, 1987). The list of open codes were surveyed and grouped together under higher order headings known as categories. Categories were reviewed for similarities and differences. Recurring themes emerged during an exhaustive overview of the categories.

Findings were documented and shared with the participants and participating Chiefs and Councils. Member checks were used to ensure the credibility of the study.

Following the member checks, I decided to retreat from further data analysis. Work on this study was interfering with demands of my homelife and worklife. Following a lengthy hiatus, I reviewed the transcripts and fieldnotes

again. During these numerous reviews of the transcripts and fieldnotes, I noted and revised codes, categories, and themes.

All QWL issues were identified and documented. Significant QWL issues of Aboriginal and Non-Aboriginal outpost nurses were identified, compared and contrasted. Nurses' perceptions of QWL issues affecting their ability to provide quality care to their clients were explored. The identified worklife issues were also addressed in relation to the Model for Quality of Nursing Worklife to assess its applicability to outpost nursing.

CHAPTER IV

FINDINGS

Introduction

In this chapter, I describe the findings of the study. Initially, the demographics of the sample are discussed and analyzed. Following this analysis, QWL issues of outpost nurses are identified. Upon completion of a comprehensive presentation of QWL issues of outpost nurses, four research objectives are addressed. The meaning of QWL, as defined by outpost nurses in northern Manitoba, is explored. The most significant QWL issues are identified. QWL issues of Aboriginal and Non-Aboriginal nurses are compared and contrasted. Finally, QWL issues that nurses perceive to affect the delivery of nursing care are identified.

When I present the findings of the study, I substantiate them with quotes from participants. Fictional names are used to protect participants' identities. Following each direct quote, I include the page and line number where the quote was located in the transcripts or fieldnotes. Fictional names of patients were created and stories were slightly altered to protect the identities of northern residents. Particular northern communities are not referred to by name.

Analysis of the Sample

All eleven participants were women. Their ages ranged from 30 - 51 years with a mean age of 39.5 years and a median age of 39 years (see Figure 5 on page 123).
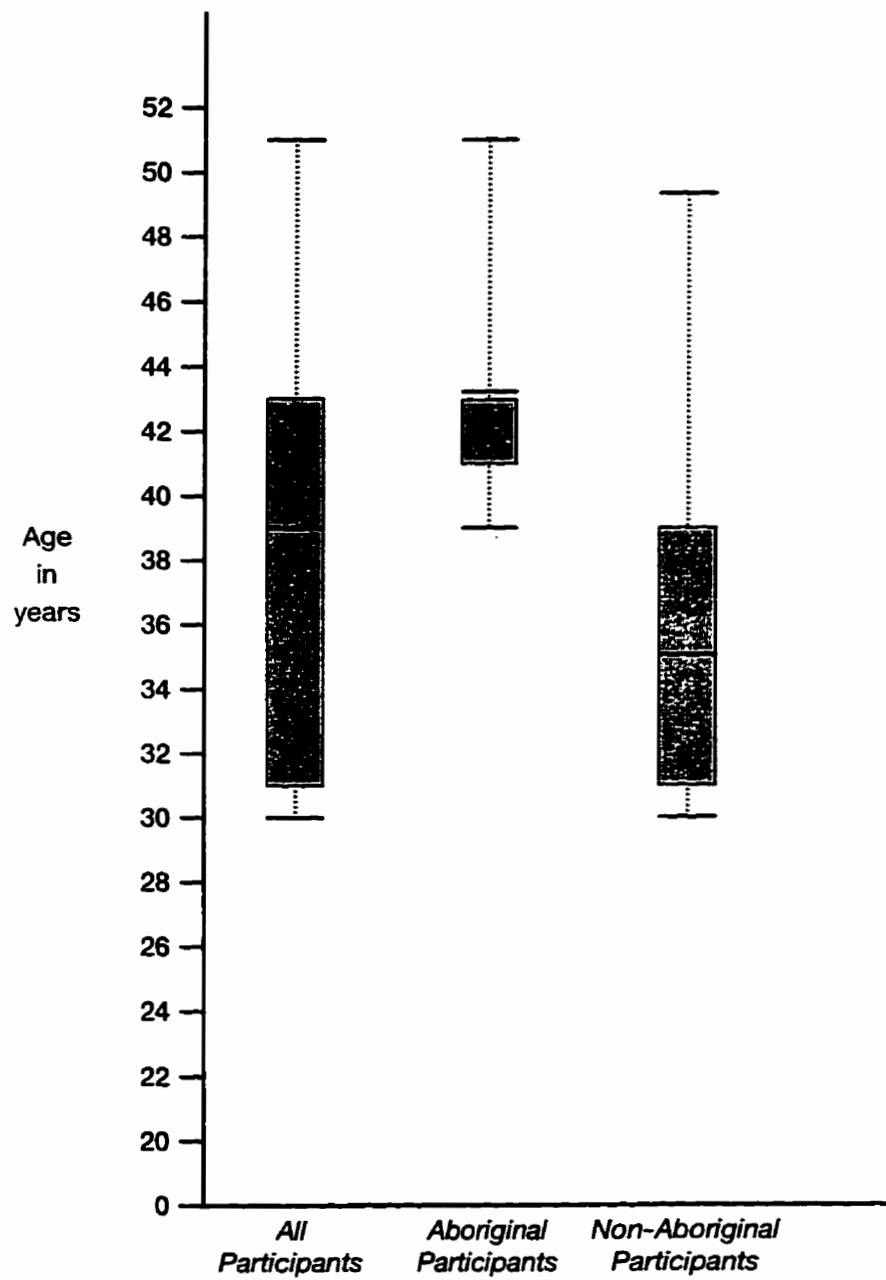
Figure 5. Box plots depicting ages of all participants, Aboriginal participants, and Non-Aboriginal participants.

These particular demographics were in keeping with Canadian nursing statistics

where the majority of nurses are women (97%) and the average age is 40 years.

Upon further analysis of these demographics, I noted that the Aboriginal

nurses were older than the Non-Aboriginal nurses. The ages of the Aboriginal

nurses ranged from 39 to 51 years with a mean of 43.4 and a median of 43. The

ages of the Non-Aboriginal nurses ranged from 30 to 49 with a mean of 36.3 and

a median of 34.5 (see Figure 5 on page 123). This age difference may have

influenced the distinction between the groups' time commitment to outpost

nursing, which is described on page 208 under "Retention of Outpost Nurses."

Most of the Aboriginal nurses viewed themselves as partners within a

couple relationship. They generally described themselves as being married. All

of the Aboriginal nurses talked about their husbands, their children, and/or their

grandchildren.

Four of the six Non-Aboriginal nurses were single. This group expressed

a general perception that they found difficulty in maintaining and nurturing

relationships with family and friends due to their geographical isolation.

Eight of the registered nurses were diploma-prepared and 3 had received

a baccalaureate degree in nursing. This description of the sample was similar to

an overall trend that the majority of nurses in Canada are diploma-prepared.

Many participants acquired certificates in post-basic educational programs.

These certificates were acquired in two to three day courses such as the Basic

Trauma Life Support, Advanced Cardiac Life Support, Neonatal Resuscitation

Program, and/or in educational programs lasting several months such as a

critical care nursing program. Three outpost nurses who were diploma-prepared talked about taking a course to upgrade their knowledge and skills in community health nursing. One baccalaureate-prepared nurse explained that she had successfully challenged this course.

Nine participants were employed by MSB on a full-time basis. Two participants referred to their employment status as part-time. Part-time employment was defined in two ways. One participant defined part-time employment as job sharing. Outpost nurses who were job sharing with other outpost nurses rotated between living in the south for several weeks and then living and working in a northern community for several weeks. Another definition for part-time employment was offered. One outpost nurse who lived in the community explained that she was called in to work on a part-time or casual basis. This type of employment only involved several shifts every two weeks.

Outpost nurses also classified themselves as indeterminate or relief nurses. Eight participants were indeterminate. Indeterminate outpost nurses were established as particular employees within a northern community. I asked outpost nurses to define indeterminate and relief. An outpost nurse in an indeterminate position was described as a full-time nurse who received employment benefits (Fieldnote 30894). Relief or casual nurses may work a term, but they do not receive any benefits (Fieldnote 30894). Three participants classified themselves as relief nurses. Relief nurses were not firmly established as particular employees within a specific community. They were employed by MSB and worked in an outpost nursing position for a brief time period on a

contract basis. Relief nurses were hired under the auspices that they would work on a casual basis or they would remain in one community for a period of time that ranged from 3 - 6 weeks.

> Margie: I just work around here and there. Like now I'm here for 3 1/2 weeks, but then I'm going home for a week, and I was just home for 5 or 6 days before that. So generally, the most I do is 3 weeks - 3 1/2 weeks and that's long enough (p. 10, line 20 - 26).

These nurses were relatively experienced in the area of outpost nursing. Their years of experience as outpost nurses ranged from 1 - 14 years with a mean of 4.8 years and a median of 4 years (see Figure 6 on page 127). This finding differed from the estimated lengths of employment that were reported in the literature, where lengths of stay ranged from 3 to 32 months (Canitz, 1990; Nowgesic, 1995). The Aboriginal and Non-Aboriginal nurses differed in that the Aboriginal nurses had more experience in outpost nursing. Aboriginal nurses' mean length of experience was 6.5 years with a median of 6.5 years. Non-Aboriginal nurses' mean length of experience was 3.3 years with a median of 3.5 years.
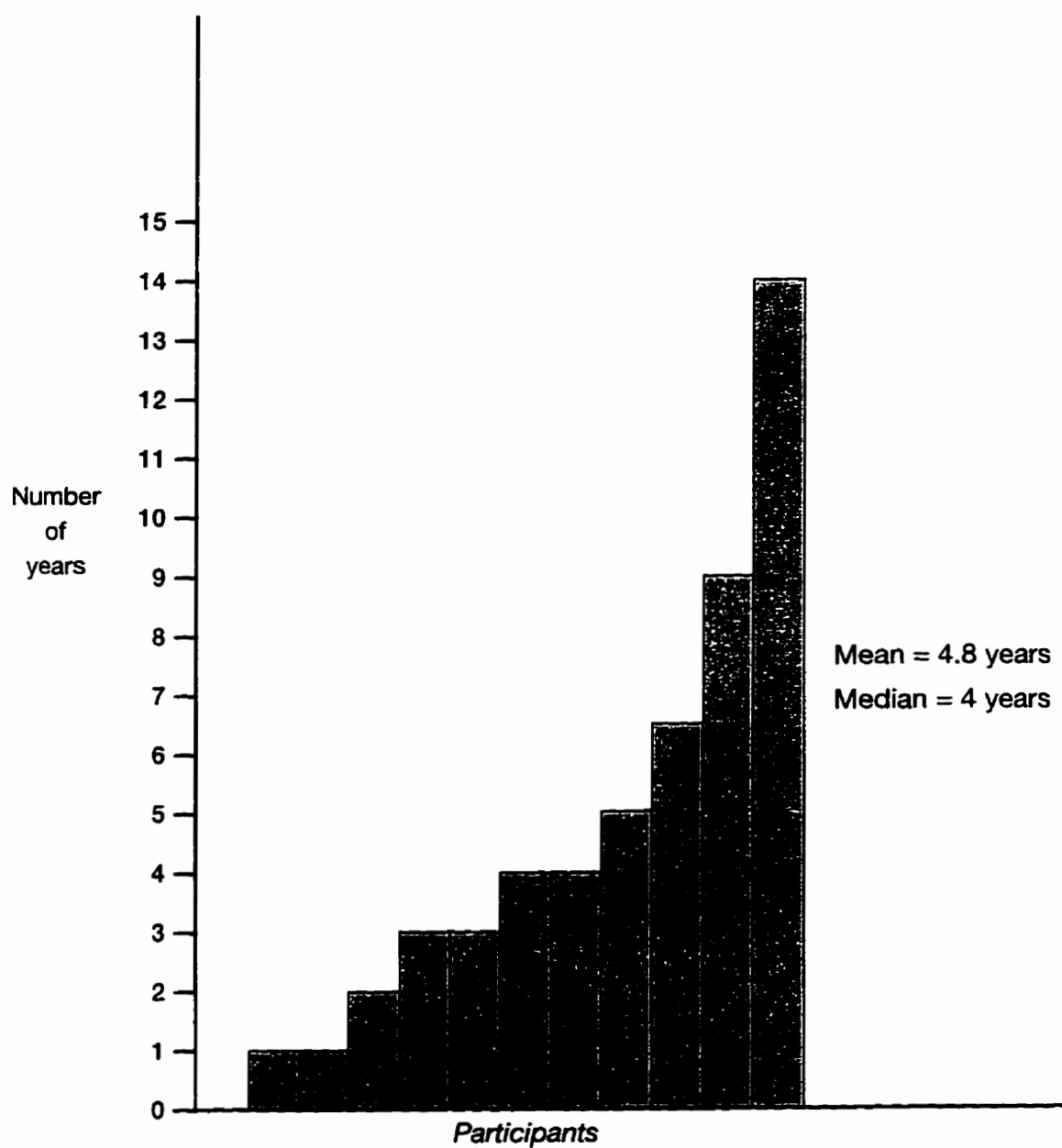
Figure 6. Bar graph depicting participants' (n=11) lengths of experience in years of outpost nursing.

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QWL Issues of Outpost Nurses

The study's findings are presented using the framework of the Model for

Quality of Nursing Worklife. Identified QWL issues are organized according to:

(1) homelife/worklife interplay; (2) work design; (3) work context; and (4) work

world (O'Brien-Pallas & Baumann, 1992). I would like to stress that the findings

of this study are not limited to worklife factors and categories identified within the

model.

Homelife/Worklife Interplay Issues

Homelife/worklife interplay is a category in the Model for Quality of

Nursing Worklife (O'Brien-Pallas & Baumann, 1992) that includes factors such

as nurses' attitudes, values, career goals, self-image, educational preparation,

past work and past life experiences. This category has traditionally received

insufficient research attention (Donner, Semogas, & Blythe, 1994). Under

homelife/worklife interplay, I identified many QWL issues. These QWL issues

included: (1) nurses' attitudes and values; (2) inadequate educational

preparation; (3) previous nursing experience required; (4) nurses' relationships

with Aboriginal clients; and (5) working and living together. Please see Figure 7

on page 129 for a schematic diagram depicting the QWL issues identified under

homelife/worklife interplay.

Homelife/Worklife Interplay

Issues Enhancing QWL

Attitudes about Self (caring)

Acceptance of Health Care System Rule/Regulations

Value for Medical Model

Previous Nursing Experience

Attachment to Individual Clients (caring)

Spending Time with Patients

Knowledge of First Nations Language/Culture

Involvement in Community Activities

Negative QWL Issues

Concern about Educational Preparation

Massive Responsibility

Ethnocentrism

Frustration about Clients' Dependence

Scepticism over Authenticity of Clients' Health Problems

Working and Living Together

Lack of Involvement in Community Activities

All participants

Aboriginal Nurses

Non-Aboriginal Nurses

Figure 7. Schematic diagram depicting identified QWL issues under homelife/worklife interplay

Outpost Nurses' Attitudes and Values

Outpost nurses' attitudes and values emerged from the data. From the data, I identified the following: (1) attitudes about self as a nurse; (2) attitudes about the health care system; (3) value for the medical versus the nursing model. Outpost nurses' attitudes about Aboriginal clients are included under outpost nurses' relationships with clients and are presented on page 137.

Attitudes about Self as a Nurse. Many participants recognized personal qualities that were perceived to enhance practice as an outpost nurse. Outpost nurses focused on caring and interpersonal skills as personal qualities that promoted their nursing practice.

Bonnie: I have a very strong knowledge base...And I care about people (p. 9, line 22).

Elizabeth: I have a good way with people and I also have some humour and I can generally relate to people...I have a good rapport with most of the people here and that makes me feel good knowing that people will come and they think that they can talk to me and that I do some good (p. 11, line 17).

Patrice: I love people. I really do. I feel that I can get along with just about anybody and it doesn't matter whether they're Native, whatever (p. 7, line 45).

Several participants acknowledged that they were strong leaders and could offer direction in emergency situations. Relating well with people, knowledge, assessment skills, leadership qualities and clinical specialty areas such as

pediatrics or obstetrics were identified as personal strengths brought to an outpost nursing position.

Attitudes about Health Care System. Aboriginal and Non-Aboriginal outpost nurses accepted the rules and regulations of the health care system. In the participating communities, I noted that the outpost stations were deemed to be open from 8:30 A.M. to 5:00 P.M. to provide specific and general clinics. I noticed a trend that the outpost stations lacked patients in the early morning hours and the waiting room was filled to capacity in the afternoons. Participants did not discuss the operating hours of the station in terms of the community's needs. Outpost nurses appeared to accept the operating hours of MSB's stations.

Emergency cases were assessed and stabilized immediately, on a twenty-four hour basis. Other clients who attended the clinic were generally assessed by nurses on a first-come, first-served basis. Clients reported to the outpost station clerk, who pulled the clients' chart, and placed the client on a waiting list to be seen by the nurses. A triage system for clinic patients was not discussed and not observed. Participants accepted this system of providing health services to clinic patients.

In one community, a dentist asked the NIC if he could arrange for a woman to attend his clinic after hours. The reason for the late appointment was due to the fact that this woman was ashamed of being wheelchair bound and did not want anyone to see her. The NIC refused to allow the late appointment (FN31894, p. 38, line 6). The NIC ensured that the system functioned according

to its set rules and regulations and would not allow for any flexibility, despite the client's concerns.

Another example of accepting rules and regulations of the health care system occurred when nurses described aspects of women's health. When discussing the protocol for prenatal women and labour and deliveries, nurses did not question why a low-risk delivery was not allowed to take place within the woman's community.

> Margie: At so many weeks, you do this kind of bloodwork, and then you have to make sure they go out for confinement. At 38 weeks, you have to make sure they get out and stay out (p. 15, line 45).

Value for the Medical Model. Ten participants demonstrated a particular value for the medical versus the nursing model of health care. In one community, the NIC asked me if I had ever been an outpost nurse. When I replied, "No," she stated that outpost nurses were mini-doctors. I perceived that her stature and tone of voice demonstrated pride (FN6995, p. 5).

> Connie: We're like rural-living doctors (p. 1, line 33).
>
> Beatrice: They [clients] think, "Well, she's just as good as a doctor."
>
> Meredith: We work like a doctor that works in the doctor's clinic in the city...What outpost nurses should do, well, they should do what the doctor does in the hospital (p. 2, line 26).

Outpost nurses discussed their roles in terms of the medical model.

> Elizabeth: We assess people and we make a diagnosis and we give them medications...(p. 5, line 40).

In this account of outpost nurses' work, Elizabeth demonstrated her value for the medical model - its philosophies and practices. Elizabeth expressed that a person is treated in isolation of their life's contexts and circumstances.

Some nurses had internalized the medical model in that they did not view their patients as whole beings within the context of their families or communities. One nurse compartmentalized her clients according to the presenting problem. This nurse did not describe assessing and treating her clients in a holistic manner.

> Sherry: It's in an outpost station and you're presented with clients who whatever their complaint is, whether it be "I have a sore throat," or "I have sore ears...abdominal pain...whatever." It is up to you to elicit a good...history from them and to be able to look at whatever - ears, throat, abdomen, whatever it is and determine what their problem is and how it would best be treated (p. 1, line 38).

Outpost nurses rarely described their philosophy of nursing. They infrequently referred to beliefs about the importance of nurses' roles in health promotion, illness prevention, and socioeconomic development within the community.

Only one participant broached her nursing care in a holistic manner. This participant discussed her philosophy of nursing and health. This discussion was in stark contrast to the other 10 participants, who embraced the medical model as a way of practicing nursing.

> Lucille: There's quite a few people who deal with herbs and a lot of the medicine lodge people work with the medicine wheel, concentrating on the 4 aspects: body, mind, spirit, and emotional. That's the philosophy we really concentrate on - the spiritual healing of the patient without involving drugs...I guess I learned that it really helps if you can heal yourself, then you can heal others (p. 3, line 28).

Fieldnotes described Lucille's process of developing a philosophy of health and wellness.

> After the interview, she told me that her focus was spirituality in nursing...One day she saw a man that she knew and she had to talk to him about spirituality...She said that she had a burning question for him, "What is spirituality?" The man answered this with another question, "How many holes do you have in your body?" He said not to consider your eyes as holes - they should be considered as windows. He said that your body has 7 holes. You must be careful what you allow into and out of these holes. You must be careful what you hear and what you say. You have to be careful and eat properly and not ingest alcohol. You must treat your body well. You must not be promiscuous and allow infections to enter your body. You must care for your body well as it harbours the soul (FN6994 p. 13, line 1).

This same participant expressed that she wanted outpost nursing to be recognized as a specialty by the Canadian Nurses Association (CNA).

Lucille: ...They [CNA] always wanted to put us with emergency nurses...They're different. And I feel if we're going to have a specialty and we're going to have an exam and be recognized as outpost nurses, then, I don't know, I'd like to see that category - outpost nurse. O-P-N, a specialty, you know (p. 20, line 1).

This participant demonstrated insight into outpost nursing and a proactive strategy to promote this unique kind of nursing. While one nurse articulated her philosophy of nursing and health, the other ten participants expressed and demonstrated their value for the medical model of health care.

In summary, outpost nurses demonstrated and expressed particular attitudes and values. Outpost nurses identified that relating well with clients, a strong knowledge base, assessment skills, and leadership abilities were personal qualities that enhanced their practice. Participants strived to maintain the health care system in which they worked. They demonstrated and expressed a particularly strong value for the health care system and medical model.

Concerns About Inadequate Educational Preparation

Several participants discussed the Northern Clinical Program (NCP) that was offered in Hamilton, Ontario. Two Non-Aboriginal nurses referred to this program as helpful, while one Aboriginal nurse found this experience to be stressful (Connie, p. 11, line 18). This traumatic experience was similar to the those identified by Aboriginal women who left their communities to acquire basic nursing education (ANAC, 1995).

Two participants described perceptions that they were inadequately educated and ill-prepared for an expanded role. These participants expressed concern that they needed more education to care for patients in emergency situations (Connie, p. 15, line 13) and they required more information about the interpretation of X-rays.

> Bonnie: Knowledge, because you can never know everything, and just the, our training. You know, go through the 2 year diploma program, and then no matter how many extra courses you take, you don't. I always feel that I lack (p. 10, line 21).

> Connie: Like I mean, if we're supposed to take the X-rays, like why in tarnations aren't you given, like a...There's a 5 day course offered in Hamilton that should be incorporated in with the NCP [Northern Clinical Program]. We got 1 day and there's just too much for 1 day. To try and to go through 100 X-rays...so little things like that, if they're expecting us nurses to work here, why can't they give us the best education we need (p. 23, line 26)?

In summary, a few participants voiced their concern about inadequate educational preparation for the expanded nursing role. These nurses expressed that they lacked confidence and the ability to perform medical tasks.

Previous Nursing Experience Required

One participant spoke at length about the necessity of having several years acute care nursing experience prior to accepting a position in an outpost station. This nurse recognized that lack of previous nursing experience could

create a difficult situation within an outpost station. In this situation, novice

nurses were noted as being detrimental to the workplace setting. They

contributed to a higher workload by not "pulling their weight."

> Sherry: I think people also need a couple of years of work under their belt,
>
> either in the emergency department, acute medicine, something like that
>
> just to get them some experience before coming up...Last year we had
>
> someone who had less than a year's experience...Well, she was so
>
> green. It's not only hard on her; it's hard on the staff because now you've
>
> got to guide someone through some really basic stuff. And then some not
>
> so basic stuff so it can be very hard, very hard on the person
>
> (p. 24, line 1).

When outpost nurses were employed in a station with a novice nurse, their

worklife might be negatively affected. In this particular workplace setting, novice

nurses were described as liabilities.

Nurses' Relationships with Aboriginal Clients

Although O'Brien-Pallas and Baumann (1992) omitted caring

relationships with clients from homelife/worklife interplay, I included outpost

nurses' relationships with Aboriginal clients in this section. This omission on the

part of the developers of the Model may be due to lack of previous research in

this area.

Under nurses' relationships with Aboriginal clients, several inter-related

QWL issues emerged from the transcripts and fieldnotes. Participants

discussed and/or demonstrated the following QWL issues: (1) massive

responsibility; (2) attachments to clients; (3) caring; (4) spending time with clients; (5) ethnocentrism; (6) frustration over clients' dependence on the health care system; and (7) scepticism about the authenticity of clients' health problems;

Massive Responsibility. Six participants expressed feeling an overwhelming amount of responsibility for providing an efficient and comprehensive health care program for the people in their community. Several participants discussed their feelings of responsibility positively, while other nurses presented responsibility as a burden. Responsibility was described as massive (Elizabeth, p. 7, line 16). Margie stated that outpost nurses were responsible for the whole gamut of health care services (p. 15, line 19). Bonnie expressed ambiguity about her feelings of responsibility:

> Inside the job, we have a lot of responsibility, which is nice. I mean it depends...Sometimes it's scary because you take on responsibility for a lot of things that we're not sure of and some of the sleepless nights are because, "Did I give the right advice? Did I give the right treatments? Are they going to come back if it gets worse?" (p. 2, line 30)

Attachments to Clients. Six participants described their relationships with individual clients as attachments. Codes such as attached, involved, and closeness were merged to form the QWL issue, attachment to clients. Attachments to clients were rarely described in terms of the family, groups, or the community. Most nurses became attached to specific individuals, who would be

treated within the outpost station. One Non-Aboriginal participant described feeling attached to the community.

> Patrice: You get so attached so fast to people...As it's hard to leave the community. It can be attached to you, and the people as well...There's something about the north (p. 4, line 11).

Being connected to people in the community provided this participant with personal fulfilment.

> Several outpost nurses spoke about their attachments to clients as a problem area. They identified that they needed to be aware of boundary issues related to sustaining an effective client-nurse relationship versus a friendship.

> Molly: Other people are saying, "Well, it's time for you to leave. You're just getting a little bit too close." ...There's problems that way developing. I think if you get too close, because you have to maintain a working relationship and then there's a line (p. 19, line 23).

Another participant described the importance of creating a boundary in the nurse-client relationship. She noted that compassion and empathy were crucial to the nurse-client relationship, but nurses also had to detach themselves at times to prevent burnout.

> Elizabeth: I guess in some respects, even now, is that if I let myself get too involved with the patients, like I care too much, and I know that sometimes I just have to say like, "Elizabeth, just back off." Because otherwise, I know I'll get burned. You have to have compassion and you have to have empathy for your patients..(p. 12, line 21).

Caring. Three outpost nurses specifically described caring behaviours towards their clients. As caring has been identified as the essence of nursing, I included caring under nurses' relationships with Aboriginal clients.

> Bonnie: The whole attitude that I really do care what happens to people...I try to treat everybody like they were one of my family members (p. 9, line 38).

> Patrice: I'm hoping that I'm conveying that I care enough about them that I'm saying what I feel. It usually works. And that's in your tone that is usually works. I just generally care (p. 8, line 12).

One participant, in particular, demonstrated that she cared deeply for her clients.

> I really felt that Patrice loved being with First Nations People in the north. Her eyes really were bright and shining when she talked about her feelings about working with Native People. She would hold her arms up to her chest in a folded, hugging kind of manner. Her sincerity really struck me (FN31894 p. 32).

One participant described a perception that nursing care was affected by the personal attributes of the nurse.

> Connie: And if you're not happy, and you're not doing a good job, and you don't feel comfortable with yourself - you're not going to do a good job with your patient. Absolutely not!...You're not going to care (p. 24, line 1).

Spending Time with Patients. Although spending time with patients can also be included under the Model for Quality of Nursing Worklife's category of

work design, I concluded that spending time with patients was crucial in terms of the nurses' relationships with their clients. Four participants talked about the importance of spending enough time with clients to be able to establish and foster a relationship with them.

> Lucille: I think sometimes I could spend a little more time just talking to the patient...People want to talk and if they know that you're rushed and waiting on everybody then they just want to get out of here (p. 12, line 26).

Ethnocentrism. Outpost nurses' ethnocentric attitudes and values emerged from the transcripts and fieldnotes. Ethnocentrism can be defined as having the belief that the values and practices of one's own culture are the best ones and the only ones of any worth (Thiederman, 1986). Thiederman (1986) noted that ethnocentrism can impede nurses' perceptions of their patients and culturally appropriate nursing care. An Aboriginal outpost nurse, described her views about ethnocentrism as demonstrated by Non-Aboriginal colleagues:

> I know that the Non-Aboriginal nurses come with their own values and way of working...Some of the nurses have come from outside - Non-Aboriginal, and they have certain values and they have for themselves and that's when, that negative things started up and they tried to push their values to the Indian (M, p. 7, line 44).

Margie, a Non-Aboriginal nurse, acknowledged that other Non-Aboriginal nurses demonstrated ethnocentrism.

Just because they're so culturally different and I certainly don't think it's because one of the groups are better than the other group. I would hope not. I realize to some people that is (p. 18, line 36).

Other examples of ethnocentrism are offered. Molly was exasperated by the fact that clients in her community did not have telephones (p. 8, line 21). Margie was distressed over her inability to locate an English speaking relative to accompany a pediatric patient to Winnipeg (p. 3, line 9).

Three Aboriginal nurses voiced that knowledge of their clients' language was beneficial to their nursing practice.

Meredith: The Aboriginal nurses work harder for them because we are the same type of people on the reserves. I think sometimes that that is a concern. And if you speak the language of the people that you work with, they tend to approach you first before they approach a Non-Aboriginal nurse. You speak the same language they do, so it's easier to come and speak in your own language than in English. It's easier because in English they could be misunderstood (p. 9, line 10).

Non-Aboriginal nurses rarely discussed the language barrier. Several Non-Aboriginal participants perceived that language was a problem in terms of their clients not being able to speak English.

Only two Non-Aboriginal nurses identified that learning about First Nations Culture enriched their northern nursing experience. Learning about First Nations culture was identified by one participant as an avenue to help nurses assimilate into First Nations' communities. This nurse spoke about

assimilation in terms of nurses demonstrating acceptable behaviours within the First Nations culture rather than First Nations People demonstrating behaviours that were acceptable to Non-Aboriginals.

> Sherry: I think it's important that if you go up to a community, you have to know their values and what is acceptable, and what isn't acceptable behaviour (p. 18, line 39).

Problems in practicing transcultural nursing were not related to the historical and sociopolitical context of Aboriginal health care. Only one participant spoke about the importance of learning First Nations culture to understand the consequences of historical and sociopolitical issues.

> Molly: Learning about their culture. Seeing how they live here. It's basically a third world country. See how rough their lives are. Helps you to understand more why they are the way they are. You know, you get all philosophical. Just a life experience (p. 16, line 39).

Although this nurse acknowledged the importance of learning about First Nations culture within a historical and sociopolitical context, this viewpoint was inconsistent. Molly later expressed frustration over clients' dependence upon the health care system. Clients' dependency was not examined within its broader historical and sociopolitical context. When ethnocentrism and frustration over clients' dependency were expressed and/or demonstrated by Non-Aboriginal nurses, they failed to explore the issue within its complex historical and sociopolitical context. Interestingly, one Aboriginal nurse did not situate suicide within the historical and sociopolitical context of her community.

Beatrice: When I feel dissatisfied is suicide. We have a high suicide rate.

I find the fall, or any time is very, very hard. It could happen after they're

very upset..It's so disturbing to some of them...What do they do? What is it

they're looking for to make them happy and forget their suicide attempt

(p. 7, line 32)?

Frustration about Clients' Dependence. Participants expressed

frustration over Aboriginal clients' dependency upon them. These participants

did not address clients' dependency on health care providers within its historical

and sociopolitical context.

Molly: Like today, we had this woman phone the station. "Well, my

husband went up there for an appointment and he didn't come back yet."

So, what are we supposed to do? Are we supposed to send out some

feelers and magically find him (p. 3, line 40)?

Scepticism Over Authenticity of Health Problems. Several Non-

Aboriginal nurses expressed their lack of trust over the authenticity of clients'

stated health problems. One participant described after-hours clients who were

truly ill as "legitimate" (FN30894, p. 26, line 3). In one community, Non-

Aboriginal nurses explained that outpost nurses quickly learn who is really sick.

The nurses started conversing... One commented to the other that a

young man had been in to the outpost station last Saturday night. They

spoke about the man's drunken state and stated that he was

pretending to be comatose. One nurse asked me if I knew of a

phenomenon where patients could become comatose voluntarily...They

both added that as an outpost nurse, you quickly learn who is really sick and who isn't (FN30894 p. 6, line 22).

In the following fieldnote, several Non-Aboriginal outpost nurses were describing their frustration with their clients' inappropriate use of their services after hours and their lack of trust over accounts of the health status of an Elder.

They were joking with me and said that they have thought of a lot of things that I could study or research. One of their research questions was, "Why do people in this northern community telephone the outpost station at 5:12 P.M. about their suddenly sick Elders? One nurse did a comical routine where she answered the call from a person shortly after closing time. "Has your grandmother gone to the bathroom today? Did this problem only occur in the last 15 minutes? Wow!" (FN30894 p. 18, line 6)

The above fieldnote illustrates other points about outpost nurses' worklife. Not only were these nurses expressing scepticism over the authenticity of clients' health problems, they were voicing their frustration about their clients' dependence upon them. After completing a busy day in the clinic, these nurses were angry because they perceived that their time off work was being impinged upon by clients who ought to know how to care for their Elders.

Although nurses' relationships with their clients was not clearly delineated in the Model for Quality of Nursing Worklife (O'Brien-Pallas & Baumann, 1992), I agreed with Donner, Semogas, and Blythe (1994) and included relationships with clients under homelife/worklife interplay. Nurses' relationships with Aboriginal clients was clearly identified in the data. Outpost

nurses' relationships with their Aboriginal clients was compiled of several QWL issues including: (1) massive responsibility; (2) attachments to clients; (3) caring; (4) spending time with patients; (5) ethnocentrism; (6) frustration about clients' dependence; and (7) scepticism over authenticity of health problems.

In summary, participants expressed and demonstrated attachments to individual clients. These relationships were influenced by the nurses' frustration about clients' dependence upon them. Aboriginal participants addressed that knowledge of First Nations' language and culture enhanced their practice as outpost nurses. Non-Aboriginal participants revealed ethnocentric perspectives, which impedes the delivery of culturally sensitive nursing care. Aboriginal and Non-Aboriginal participants did not examine their relationships with Aboriginal clients in terms of the historical and sociopolitical context.

Working and Living Together

A prominent worklife issue that emerged from the data was working and living together. Outpost nurses' worklife is unique in that they not only have to work with their colleagues - they have to live with them. Under working and living together, I identified several inter-related QWL issues: (1) isolation from family and friends; (2) communal living; (3) inadequate housing; (4) difficulty in balancing worklife and homelife; (5) time off work activities; and (6) northern romances and friendships.

Isolation From Family and Friends. Eight participants identified that they felt isolated from family and friends. Of the 8 participants, 5 were Non-Aboriginal and 3 were Aboriginal nurses. Not only were these nurses geographically

isolated, they found that they were isolated socially and emotionally from family and friends. Many Non-Aboriginal outpost nurses perceived that families and friends lacked an understanding of outpost nurses' northern experience.

> Elizabeth: You go down south and tell our families and friends what it's like up here - they don't understand (p. 14, line 17).

When family members and friends failed to grasp the complexity of their worklives, nurses felt more alienated and isolated from these potential support systems.

> Margie: You talk to people and it's just such an intense job. They have no clue about what you do. It bothers me more than I think it does. I've had people ask me, "Oh well, isn't that interesting. So you fly in for the day and home at night, do you?"...They have such a lack of perception of what happens past Ashern coming north (p. 24, line 7).

Another participant voiced her feelings of detachment from a friend and wondered if it was due to her northern nursing experience.

> Molly: Oh, my friends...I guess I keep in touch with them fairly good. There's a few that I phone fairly regularly. Talk on the phone when they're all right. Every time I'm out in the city, I'll give them a call and we'll get together and do things. There's one specifically that comes to mind that I'm sort of getting more away from. I'm not sure why, and I don't know if it has anything to do with the north at all either. It might have been something that just sort of happened on its own (p. 20, line 13).

Three Aboriginal nurses expressed frustration about being displaced from families and friends. By working in an isolated northern community, they found that they were disconnected from their social circles.

> Connie: Now when I go back to [northern community], it's not going back to..it's almost like I don't belong anymore...Like some people have houses, some people have husbands, some people have but like right now, I don't have (p. 17, line 27).

> Beatrice: Is frustrating. If you don't keep calling. If you don't keep in contact, very soon you lose them. You lose the friends you have. They drift away and you have to find better friends, I guess (p. 13, line 10).

Interestingly, participants rarely described their own feelings of loneliness. Perhaps, this feeling was too painful to discuss. One outpost nurse expressed concern over a colleague's loneliness as her friend was stationed further north.

> Connie: I think you should go that far [north]. [Those outpost nurses] are going to have different views because they're so lonely. My friend is working with someone that is 10 years older than she is, and this person's married. Once this person's finished work, she leaves the clinic. And this one's left alone by herself...to talk to herself, to do anything...(p. 28, line 27).

Communal Living. Six participants expressed concern about the difficulty of living together. Outpost nurses were in a unique situation whereby they work

and live with the same people. If personal relationships were not positive, work and home environments were disrupted.

> Bonnie: When you're not living where you work, you can leave some problems at home. And here you can't (p. 29, line 15).
>
> Molly: You know which is unique - communal living. Working and living with the same people. It's bound to affect your work. If your living conditions after work aren't the best...you know, most of the time what determines that is the people you're living with. Working with someone is one thing - living with them is another. And that can definitely have an impact (p. 1, line 34).

One participant described the nature of her relationships with the other nurses. She recognized that her friendships were forced. If she had a choice, she would not choose these people as her friends in alternate situations.

> Bonnie: The people that you do become friends with, you probably wouldn't dream of socializing with outside of here, just because you don't have common interests, but you have a lot in common just because you're here and you're isolated (p. 12, line 26).

Lack of privacy was a consequence of communal living. During the fieldwork experience, I noted my own loss of privacy as the accommodations were shared and located within the outpost stations (FN26894 p. 8; FN1994 p. 7; FN1994 p. 8; FN2994 p. 1). Two participants talked about their feelings of a lack of privacy with shared accommodations in outpost stations.

Molly: I guess the big thing is privacy...some people are more private than others. I like to have my own space - somewhere I can go to that, you know, you never feel like you're not away from work too though. Like even though I'll be in my apartment, I'll hear the doorbell going off or I'll hear the phone ringing or a kid crying in the clinic (p. 15, line 1).

Beatrice: I lived with all the girls there and I found that I can't just...I was forever walking...Cause they want to be with you, you know, but you just want to go to bed. But then there always is someone cooking for you. It is just that sometimes, your space is so...you need your space (p. 17, line 22).

Inadequate Housing. Most of the participants expressed displeasure in their current accommodations. The majority of outpost nurses were living in apartments located within the outpost station.

Sherry: The thing that I find a concern, and not just me, I think the nurses period, is accommodations. 300 square feet...The accommodations are terrible...They are really small (p. 22, line 30).

Three participants wanted separate living quarters. These nurses described their ideal living quarters as being separate from the health care centre.

Difficulty in Balancing Homelife and Worklife. Two participants expressed difficulty in balancing their homelife and worklife. They articulated that they found balancing homelife and worklife extremely difficult.

> Patrice: Meanwhile, you do have another life and work is not the only thing. I think it is very hard to juggle the two. It's very difficult. It's not easy at all (p. 8, line 32).

Patrice expressed feeling guilty about not being home with her son to fulfil her duties as a mother.

> Patrice: It's very hard on him [son] and it's hard on me too. There's a lot of late night phone calls with him stressed about something. A lot of guilt about not being there. That's the hardest, is choosing and trying to define just how far this affects different people... I have to work and this is a necessity so it's trying to juggle 3 different things at once. It's hard. It's not easy and I wouldn't recommend it to anybody with small children or school-aged children (p. 10, line 10).

Another nurse found that her worklife was all consuming and therefore, no balance existed between homelife and worklife.

> Meredith: I have a problem in having a life outside my work (p. 5, line 16).

Time Off Work Activities. Participants expressed their awareness and identification of work-related tension. Four participants discussed the importance of physical exercise as positive stress management when nurses were not scheduled to work. They suggested that a designated exercise room be available to all staff members.

> Patrice: I feel a lot of pent up energy I've got to get rid of somehow and sometimes, it's very, very frustrating when you can't get out and do some physical activity (p. 9, line 10).

Connie: I'd have an exercise room for all the nurses, and make sure that, I

know some don't like to do it, but you have to do it. You have to, you have

to, to get some stresses out of your life, like from work, and I have found

that that's a good way of doing it (p. 21, line 15).

Many Non-Aboriginal nurses spent their time off work within their

apartments in the outpost station. When Non-Aboriginal nurses exited the

outpost stations, their activities included walking, or driving to the Northern

Store. Many Non-Aboriginal nurses spent their time off work disengaged from

their community and their co-workers. They were involved in tasks or hobbies

that were individual, not group activities. Perhaps, this lack of involvement

furthered their feelings of loneliness within the northern community.

Patrice: I like to cook....I do a lot of reading. I do a lot of research. You

know, something that happened during the day. I make a mental note,

which I look up (p. 9, line 7).

Margie: I read a lot. You go to the Northern Store. That's about all.

Watch TV. Watch movies. Talk on the phone (p. 12, line 22).

Five Non-Aboriginal nurses described a lack of involvement in community

activities and affairs. These participants were reluctant to socialize with

members of the community and to participate in community events and/or

activities.

Molly: They were sure trying to get us involved, and there were some

races going on. We just observed. We didn't really get involved too much

(p. 21, line 44).

Elizabeth: We try and go to winter carnivals or summer carnivals or

whatever. We don't really participate too much...(p. 18, line 29).

One Non-Aboriginal nurse expressed her point of view regarding the

importance of actively participating in something other than work when nurses

were not scheduled to be on call at the station.

Sherry: If I'm not working, I'm not at the station because I don't want to be

around work. And there's several people in the community I know. So

out walking. If there's anything - any function going on at all, I always go.

Whether it's a country music jam, like they have Indian Days summer and

winter. All kinds of things going on there. I just go out to see people or

they come over to my place. I've got, like I bought myself a skidoo and

come winter, we're out all the time. It's just great! I like to just go out and

I'm always out in the community doing something (p. 31, line 25).

In one community, Non-Aboriginal nurses suggested that I ask outpost nurses

how they would integrate into the community (FN30894 p. 24, line 4). As these

participants lacked community involvement , knowledge about other nurses'

strategies would enhance outpost nurses' QWL.

Aboriginal nurses spent their time off work enjoying activities away from

the outpost station. Most Aboriginal nurses grew up on reserves and were

attuned to participate in northern activities such as visiting, berry picking, fishing

camps, and snowmobiling. They spoke about the importance of getting to know

people in the community in an environment away from the outpost station.

Aboriginal nurses expressed feelings of joy and exuberance in their participation in community activities and/or events when they were not scheduled to work. By getting out of the workplace, Aboriginal nurses felt that their QWL was enhanced.

> Connie: I'm happy. You try to, like try to get away from the station as much as you could. You try to socialize (p. 3, line 9).

> Meredith: And that's what I do, or go out into the community and visit, and I just go to what's happening, and stop some places and visit people...It's important to get out. You have to get out because this is where you work and this is where you live and this is where you're stationed. So you have to get out. It's not healthy to be in, I don't think (p. 11, line 2).

Another important feature about active participation in community events and activities was getting to know the people.

> Meredith: And they need to get involved, not just in the health, or not just when they're sick, but also when they're well. And I think outpost nurses should go out and do what the people do...That they live or work with. And they should be able to go out into the community and be able to recognize people outside the sick. I think that's important for the community. The people feel more open to you...outside the nursing stations (p. 2, line 33).

Northern Romances and Friendships. Northern romances and friendships affected outpost nurses' QWL. Only one outpost nurse identified that she was currently involved in a romantic relationship with another person living

and working in the community. Three Non-Aboriginal outpost nurses talked about a lack of romance in their lives up north. Three Non-Aboriginal nurses revealed that they had previously been involved in relationships with RCMP officers who had also been stationed up north (FN31894 p. 28, line 14). One participant described the nature of nurses' relationships with the RCMP.

> Meredith: You go in the north, they're [RCMP and outpost nurses] always kind of together. And they're almost looking out for the nurses. They come around the station (p. 13, line 38).

Most Non-Aboriginal participants expressed that they found it difficult to acquire friends in the community, while one Non-Aboriginal nurse described friendships with Aboriginal people in the community. In two northern communities, I noted that the outpost nurses socialized with RCMP officers, and/or the RCMP officers and their families. Although teachers and Northern Store workers resided in the communities, the nurses preferred to socialize with the RCMP officers. Nurses and RCMP officers may have been more inclined to share a social life as their worklives often intertwined.

In two communities, several participants shared stories about Non-Aboriginal nurses becoming romantically involved with local Aboriginal men. Non-Aboriginal nurses, who were in relationships with local Aboriginal men, were perceived by their colleagues as making bad decisions about their lives due to their abnormal, northern existence.

> Molly: You know I've heard some pretty scary things...like one of the nurses, she met a local Indian guy who slept late, does nothing, not

employed. Met him in September and getting married this month. That,

to me, is scary. Cause you know, I've heard of a few situations like that

where these nurses get themselves into situations and under normal

conditions, you wouldn't even dream of marrying this guy, or getting

yourselves into these normal situations (p. 31, line 6).

Participants also perceived that the community members viewed relationships

between Non-Aboriginal nurses and Aboriginal men in a negative manner

(FN4994 p. 15, line 5). Inter-racial relationships were viewed by Aboriginals and

Non-Aboriginals as unusual.

Summary of Homelife/Worklife Interplay Issues

I identified the following QWL issues under homelife/worklife interplay:

(1) outpost nurses' attitudes and values; (2) concerns about educational

preparation; (3) previous nursing experience required; (4) nurses' relationships

with Aboriginal clients; and (5) working and living together. Nurses'

relationships with Aboriginal clients included: (a) massive responsibility;

(b) attachment to clients; (c) caring; (d) spending time with clients;

(e) ethnocentrism; (f) frustration over clients' dependence; and (g) scepticism

over authenticity of clients' health problems. Working and living together was a

unique issue for outpost nursing that was comprised of: (a) isolation from family

and friends; (b) communal living; (c) inadequate housing; (d) difficulty in

balancing homelife and worklife; (e) time off work activities; and (f) northern

romances and friendships.

Findings suggested that outpost nurses value the medical model of health care. Participants demonstrated and expressed that they valued the traditional, scientific model of medicine in delivering health care to First Nations People in northern Manitoba. Alternative models of health care such as nursing and traditional healing were rarely mentioned.

Two participants described their educational preparation as inadequate. These participants wanted more information to help them function in their expanded nursing roles - in particular, the medical aspect.

Several participants identified that previous nursing experience was an asset in acquiring a position as an outpost nurse. These participants viewed novice nurses as liabilities. Being stationed with a novice nurse affected their QWL negatively.

Nurses' relationships with Aboriginal clients were described in terms of attachments to individual clients. Participants rarely discussed their relationships with families, groups, or the community. Attachments to individual clients were viewed by the participants to enhance their QWL. This connection provided nurses with personal fulfilment.

Participants expressed their frustration over clients' dependence upon the health care system. Clients' dependence upon the nurses was viewed narrowly as participants rarely discussed this problem within its historical and sociopolitical context.

Aboriginal nurses described how their knowledge of First Nations language and culture enhanced their practice. By being able to speak the

language, Aboriginal nurses perceived that their patient assessments were more accurate. Non-Aboriginal outpost nurses demonstrated ethnocentrism in that they expressed and demonstrated superior value for their own cultural beliefs, attitudes, and norms.

Working and living together is a unique feature of outpost nursing. Participants spoke at length about difficulties encountered in working and living together. Working with someone was one thing, but living with them was another. While feeling isolated from family and friends, outpost nurses were forced to socialize with their colleagues in an environment that allowed for limited personal space or privacy.

Aboriginal nurses spent their time off work participating in group activities or events in the community. Non-Aboriginal nurses spent their time off work within the outpost station. Non-Aboriginal nurses rarely engaged in group activities or events within the community.

Work Design Issues

Work design, in the Model for Quality of Nursing Worklife, encompasses the nature of nurses' work. This category includes nursing delivery models such as primary care nursing versus team nursing, workplace policies, job descriptions, shift work, and technology. Also included in this category is work load, degree of role specificity, and availability of resources.

Work design issues were significant to outpost nurses due to the expanded nursing role, and lack of resources. As stated previously under homelife/worklife issues, outpost nurses valued colonial medicine - its

philosophy and practice. This value was again reflected under work design

issues as outpost nurses talked at length about their role as doctor, not as nurse.

Under work design issues, I identified many factors that affected outpost

nurses' QWL (see Figure 8 on page 160). These issues included:

(1) inadequate orientation to outpost nurses' work; (2) learning on the job;

(3) independence; (4) we do everything; (5) being the doctor; (6) too much

paperwork; (7) never really off; (8) lack of resources; and (9) provision of acute

health care versus community health programs.
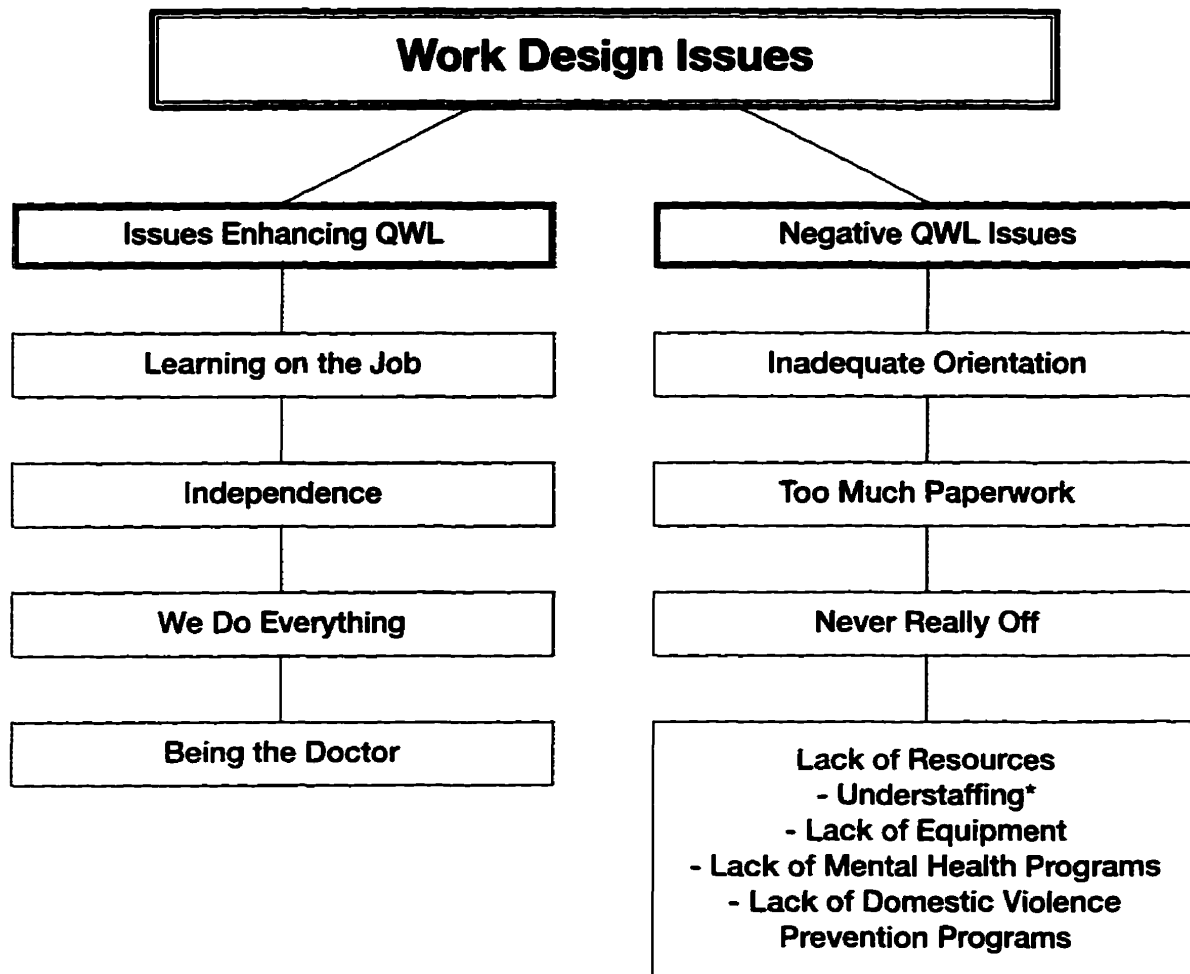
Figure 8. Schematic diagram depicting QWL issues in work design.

Inadequate Orientation

As many participants were relatively experienced in outpost nursing, only 3 outpost nurses discussed their orientation to outpost nursing. They reflected back to this time period and recalled their feelings of terror and uncertainty.

> Sherry: When someone is new to a community, new to a station, period, this kind of nursing. Like it just oh, I hated it. I was just scared. Oh, my God, it was awful (p. 30, line 11).

> Margie's orientation was for 3 weeks in [northern community]. She described this period as "I felt I was on another planet." She thought that the other nurse, who she was paired up with, made her life a living hell (FN2994 p. 3, line 25).

These participants perceived that their orientation period was too short and did not fulfil their needs.

> Connie: When I first started Medical Services, I didn't know what to expect...I went to this one reserve where I was orientated for 1 week and expected to start seeing patients on my own and there was no - there wasn't any structure to it (p. 15, line 11).

> Sherry: I found that when I first came in,...I was thrown into it (p. 15, line 5).

Learning on the Job

Three participants expressed joy in continually learning new things. Their outpost nursing experience offered them intellectual stimulation.

> Lucille: I guess being able to utilize all of your nursing training and it
> makes things more interesting, and to learn a lot more, sometimes right
> on the job that you hadn't learned in nursing (p. 4, line 15).

For many outpost nurses, skills included in their expanded role were acquired by learning them on the job.

> I asked how they learned to take X-rays. Elizabeth said that she asked
> Bonnie to show her. Bonnie said that she learned by reading about it in a
> book when she had to do it. They laughed about the terrible X-rays that
> they had taken with their hands superimposed on skulls. I asked about
> suturing. They said that they learned how here (FN30894 p. 22, line 20).

> When participants described learning on the job, they infrequently

discussed this aspect of their worklife in terms of patient care. Consequences of learning on the job were not discussed. Diminished quality of care and concerns for patient safety were not identified as consequences of learning on the job.

Independence

Participants noted that they especially liked the independent nature of their work. They enjoyed being able to problem solve and perform skills on their own. When I asked participants what they liked about their job, they readily replied, "Independence!"

> Bonnie: Independence...We don't have to rely on anybody and we're
> allowed to do what we want that matters to the community...We're
> independent (p. 2, line 4).

Molly: [I like the] independence...You're allowed to use your brain. You're

given some sort of credit for what you know (p. 9, line 20).

Non-Aboriginal nurses, who expressed that they enjoyed the

independence, were concerned about returning to an urban centre and being

constrained by dependent and interdependent nursing practice. For example,

one participant cited the futility in acquiring a physician's order to administer an

over the counter medication for a patient's fever.

Elizabeth: I like the fact that we have an expanded nursing role up here

and we can do special things that we can't do down south. I think I would

have a really hard time going back onto a ward and having, not having

independence that I have up here (p. 5, line 34).

We Do Everything

Nine participants referred to their expanded nursing role in terms of "we

do everything". Nurses talked enthusiastically about their roles as ambulance

attendants, counsellors, laboratory technicians, X-ray technicians, pharmacists,

telephone triage nurses, weather advisors to airlines, and linkages to the

community.

Lucille: We do our own patient assessment, our own medications. We do

our own X-rays, our own labs. And we do our own medevacs, and we do

extended roles. We do suturing and medications...We go to, if there's an

emergency of accident - we go to the accident scene and bring back the

patients to stabilize. Any emergencies, we stabilize our own people. We

consult with doctors in Thompson. We do all our own assessments for

prenatals and sometimes, we don't usually, but some women will come

back after we send them out for the 8 weeks and we sometimes have to

have emergency deliveries. Sometimes on route, if we can't get them out

fast enough or they don't come here soon enough...And we have to work

with the community, the Chief, and Council (p. 1, line 16).

In terms of their nursing practice, participants expressed the importance of

being a generalist. Outpost nurses stated that some knowledge in all areas of

nursing was required for them to do their job.

Sherry: So you have to know a bit in all areas (p. 13, line 36).

Being the Doctor

Outpost nurses expressed and demonstrated pride in their abilities to

function in a nurse practitioner role, although they did not describe this role in

these terms. The majority of participants described the nature of outpost nurses'

work in terms of "being the doctor".

Meredith: We do treatment - diagnosis and treatment...We work like a

doctor that works in the doctors' clinic in the city. That's how a doctor

works in an emergency in the hospitals (p. 1, line 38; p. 2, line 2).

Lucille: [We work] like a generalized GP (p. 20, line 16).

These nurses demonstrated a strong value for physicians' work and the medical

model of health care. Outpost nurses were proud of their abilities to function in a

physician's role.

Too Much Paperwork

Outpost nurses voiced their frustration over performance of secretarial tasks. They expressed concern about the large amount of paperwork that they were expected to perform along with their other duties.

Margie: Well, I think there's too much paperwork, probably could get rid of that...(p. 21, line 5).

One participant voiced her concern that the paperwork required one nursing position to complete.

Sherry: There's lots of administration work so that pulls one nurse...You've got all, let's say lab results and referral notes, letters, and that come back. You have to go through and sort what can be filed and what the physician needs to see. Going through X-ray reports. During the course of the month, you do a mid-month report. You have to keep your stats of your daily patient stats for how many patients during the day during clinic hours, how many after hours...There's lots of paperwork (p. 5, line 15).

Never Really Off

Outpost nurses expressed that they felt that they were always on duty. Five outpost nurses discussed the notion that they were always looked upon as the nurse, even if they were not scheduled to work.

Molly: Let's say I'm not on call and I want to go out and do something. I still can't go very far...You're just sort of doing as a courtesy to the other nurse. Like let's say some crisis occurs and they're by themselves and

that second nurse in the back-up can't be reached. It's more of a

courtesy...So you're tied to work all the time (p. 6, line 28).

Lack of Resources

Lack of resources affected outpost nurses' worklife. Under lack of

resources, the outpost nurses identified lack of human resources or

understaffing, lack of equipment, lack of mental health programs, and lack of

preventative programs for domestic violence. I will discuss each of these QWL

issues separately.

Understaffing. Understaffing was a significant QWL issue. Outpost

nurses described their interpretation of staffing guidelines for MSB. They

referred to a staffing ratio of 1 nurse for every 500 people in northern

communities. Using this criterion, 3 of the 4 stations that I visited were

understaffed by 1 to 2 nursing positions. In 1 community, there were 2 nurses

stationed in a community of 1800 people (FN4994 p. 6). Nine participants

expressed a concern about the lack of nursing staff.

Understaffing created considerable consequences for the remaining staff

members. When outpost stations were short-staffed, nurses experienced

numerous negative consequences. These consequences included:

(a) sustained heavy workload; (b) high number of hours worked per week;

(c) fatigue; (d) inability to provide a personal touch; (e) inability to provide safe

patient care; (f) lack of community health programs; and (g) occupational stress

and health related problems (see Figure 9 on page 167). Under these

circumstances, nurses voiced dissatisfaction with their work.
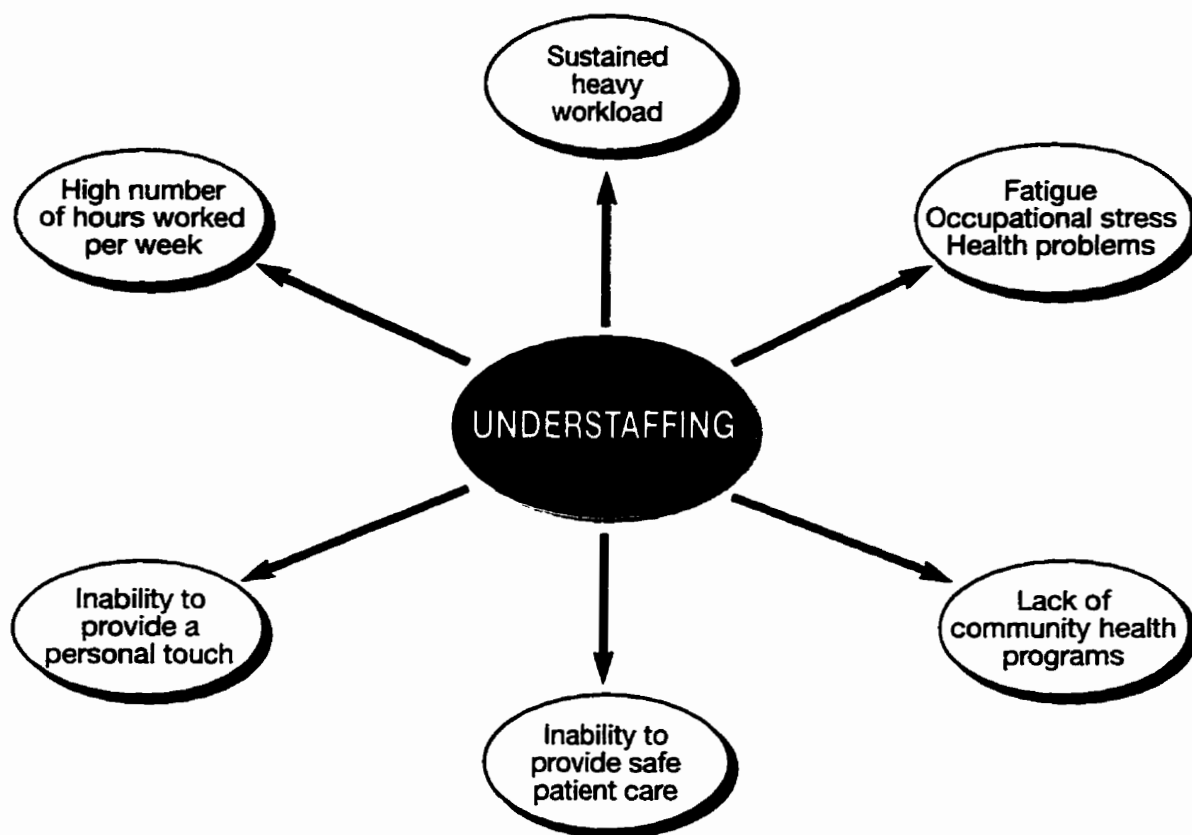
Figure 9. Schematic diagram depicting consequences of lack of human resources or understaffing.

The most common consequence of being understaffed was increased workload for each remaining nurse. Outpost nurses directly related increased workload to understaffing.

> Patrice: One nurse sees 18 - 20 patients during the day in the clinic. If on call, 8 patients over the night (p. 1, line 43).

Outpost nurses worked 37.5 hours/week in a clinic setting at the station. When stations were understaffed, nurses were "on call" every second or third evening/night and every second or third weekend. The average number of hours worked every week was 74, while the median was 75 hours (see Figure 10 on page 169). When asked about hours worked, outpost nurses readily stated, "37.5 hours in the clinic". The hours worked "on call" required more probing from me during the interview. Participants accepted working a 75 hour work week as standard practice of outpost nursing.
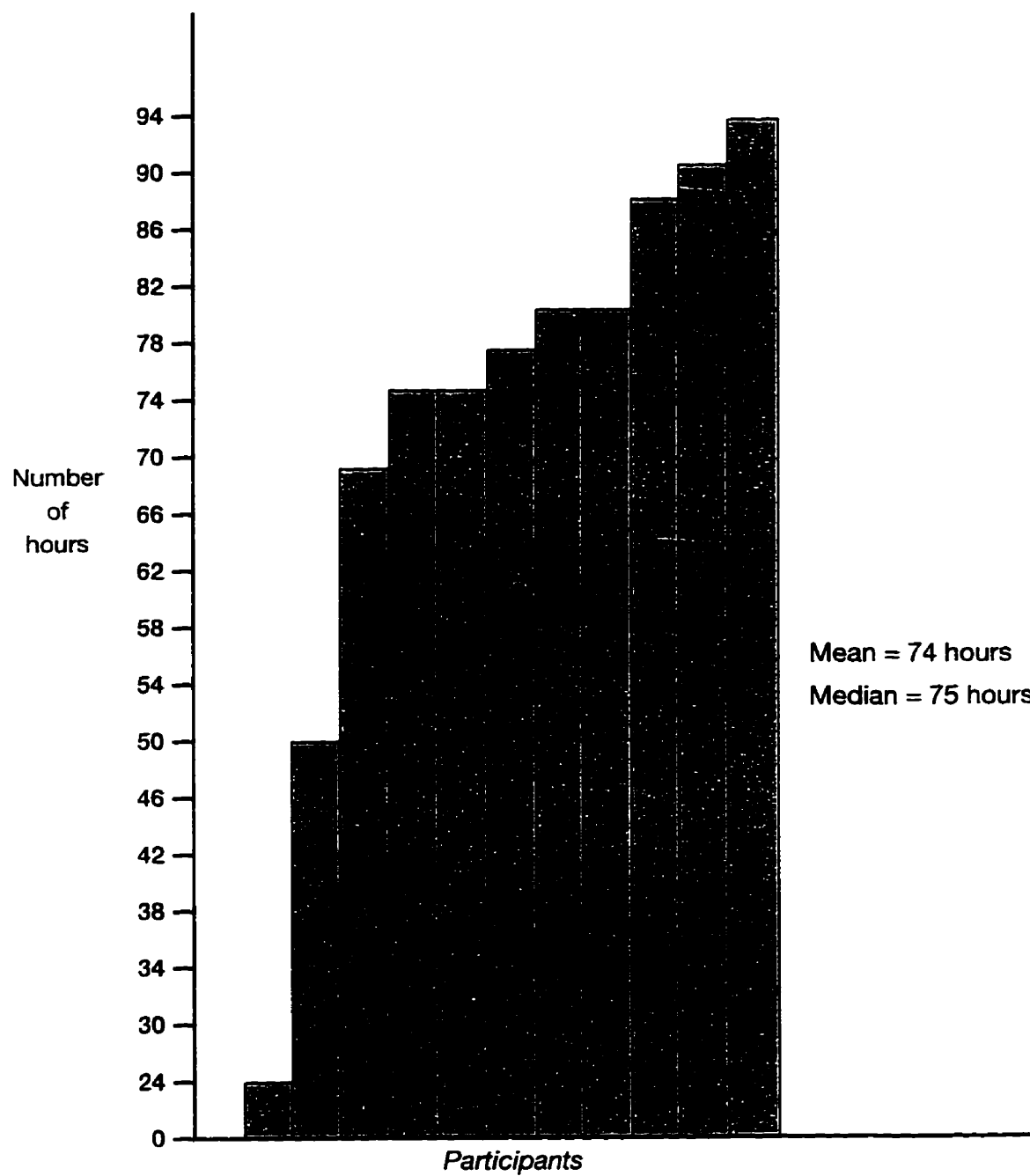
Figure 10. Bar graph depicting number of hours worked/week by participants (n=11).

When nurses were overworked and the station was understaffed, they described dissatisfaction in their job. This dissatisfaction stemmed from the nurses' inability to provide health care with a personal touch.

Sherry: What I find dissatisfying is if we are short-staffed and you have a pile of charts and you're just putting people through, putting people through, and you're seeing them, treating them. "On your way." And there's not really, because of the time element, there's not that time to give that added personal touch and at the end of the day, with something like that, we've just put them through, put them through, put them through. At the end of the day, you've got these charts that you finish and you think, "What a shitty day!" Because you've herded them through like cattle (p. 24, line 41).

Elizabeth: I guess if I was dissatisfied with my job it would be with...the short staff and we know we're not spending as much time as we need to but there's a push from the front desk to get the patients through (p. 10, line 50).

Several participants expressed concern about not being able to provide safe patient care when they were working at stations that were understaffed. One nurse perceived that more staff would have prevented a delay in transferring a patient out of the community (Meredith, p. 6, line 7). Other nurses referred to feeling strained during times when the station was not fully staffed. Fatigue affected their problem-solving skills and they were concerned that they may have been practicing nursing in an unsafe manner.

Lucille: [There were] 2 of us here...We worked 2 weeks. I was here all day, and I'd do call, and nights and work all day and as soon as she left, she said [to Zone Office], "You better get her some help before she cracks up!" And...I wanted to cry, I felt so tired. I felt I was unsafe. I guess that's the only time - when you're really tired. I feel it's not fair because how can they expect me to function. I felt really unsafe. And you're so frustrated that you want to scream. That's the only time that I felt dissatisfied (p. 6, line 39).

Another consequence of understaffing was nurses' inability to provide community health programs. When stations were understaffed, nurses functioned solely as acute care providers. Lack of community health programs is discussed in more detail on page 175.

Six participants identified that understaffing and working a high number of hours every week caused occupational stress, fatigue, and physical health problems.

Margie: You get tired because you're working every second night, and weekends, and just sort of ongoing working (p. 10, line 28).

This finding is discussed in more detail under "Nursing Outcomes" on page 205.

Lack of available human resources created severe consequences in the worklife of outpost nurses. Consequences of understaffing included:

(a) sustained heavy workload; (b) high number of hours worked per week;

(c) inability to provide a personal touch; (d) inability to provide safe patient care;

(e) lack of community health programs; as well as (f) occupational stress, fatigue, and health problems.

Lack of Equipment. Four Aboriginal nurses voiced a concern about lack of appropriate equipment for two particular stations. They related lack of equipment to economics.

> Connie: I would get equipment that worked...A lot of times we're running around and because of budget and that like I mean, how can 4 people share 1 thermometer?...Little things like that really irritate your life (p. 23, line 11).

Although these nurses experienced lack of equipment, they described themselves as being extremely resourceful. Outpost nurses did not perceive lack of technology as a problem.

> Lucille: We don't have the technology that hospitals do. Not as advanced and we have to be more practical. For instance, CPR and first aid. Know the basic skills, and you learn to make sure you know how to get other people involved (p. 4, line 35)...We didn't have those big, long, plastic things that you use to intubate...We didn't have one of those [introducers] so we had to improvise and use a thick, plastic wire kind of thing. The doctor did that. But that's what I mean, you have to be imaginative...You have to use your imagination - that's improvising. And learning to grab what's there (p. 5, line 11).

Lack of Mental Health Programs. Participants noted the lack of mental health resources in northern Manitoba. They expressed feeling inadequate as

providers of mental health services in communities where mental health issues were escalating.

> Bonnie: It gets very difficult for us to get help for a mental health patient because we can send them down when they come in initially suicidal. They'll treat their physical problems but as soon as they don't have them, they'll discharge them and they have no help that there's underlying problems. They take us a month to get a referral to get them out for counselling and then they have to fly back and forth to Winnipeg for counselling...We probably have 20 people going back and forth to Winnipeg for counselling when it would be much cheaper to bring somebody in here a couple of times a month for a couple of days (p. 21, line 16).

> Beatrice: We don't have mental health workers. Provincial government workers aren't there. We don't have any formal help. Yes, I try to check them out. See if they needed drug and alcohol [treatment] (p. 7, line 32).

Two participants explained inadequate support from mental health programs in tertiary health care centres. They expressed frustration in this lack of support.

> Madeleine stated that there had been an increase in the number of teenage suicide attempts lately. Madeleine explained that a boy in this community was very suicidal, so Elizabeth had spent the whole day writing letters and making telephone calls to arrange for him to go to Winnipeg. When he arrived at Children's Hospital, the Adolescent Psyche Unit was full, so this boy was not admitted. He was so fed up

receiving the runaround that he came back home. Elizabeth said, "No wonder he wanted to kill himself ?" (FN30894 p. 10, line 10)

Lack of Domestic Violence Prevention Programs. One participant, in a community without a shelter for women and children, expressed concern for women and children's safety due to the absence of this resource. This nurse expressed frustration that no agency provides transportation or shelter to survivors of domestic violence. This nurse transported a survivor of domestic violence out of the community to ensure the woman's safety. Arrangements were made for this woman to attend an appointment out of the community with the transportation charged to MSB.

> Bonnie: So we have no way of getting them [survivors of domestic violence] out, so we would sort of get around the system by making her go in for a check-up to get them out but that doesn't always work either. Can't afford to go on. So there's no agency or policy and that's such a big thing. If you can get them out maybe it will prevent a long term injury or death, you know (p. 31, line 33).

Her opinion was that the Band should finance and implement a domestic violence prevention program and women's shelter (Bonnie, p. 31, line 22). To illustrate the need for domestic violence prevention programs and shelters, I included this fieldnote:

> I asked the Band Constable if he brought someone in [to the station] who was sick. He got a sad look on his face. He said that he brought in a woman who was beaten up by her old man. He said that they found this

woman running through the community. Later, the nurse explained that the woman was beaten up badly with numerous bruises and her lip was lacerated (5994, p. 1, line 20).

Due to geographic isolation, economic restraints, and the establishment of alternative priorities, outpost nurses functioned in their health care environment with limited equipment, lack of technological advances, limited mental health resources, and lack of domestic violence prevention programs.

Provision of Acute Health Care Services Versus Community Health Programs

Lack of community health programs was a significant finding. Five participants were concerned about the lack of community health programs in their communities. Inadequate community health programs were related to understaffing, the nurses' high workload, and demand for acute care services.

Molly: If you look at our manual, like MSB, what they say - we're supposed to provide the community care work. We're called community health nurses. I find the majority of what we do is not community health, like true public health. Like so much of it is more acute, like I'm in the clinic most of the time. I think we're supposed to be in more homes, as going to the school and teaching and stuff like that, but it's very hard to do that stuff without another nurse here (p. 4, line 20).

Sherry: [When we're understaffed] you really can't do your programs properly because what you would like to see for community health nurses is to get out there and do a lot of teaching on prevention and what not. So

that this is where you'd like to see things go. And that's great if you're full

staffed, but I think it's really important for people to realize and I think it's

often missed when people say, "This is what we'd like you to do - teach

prevention - because that's what you're there for. You're not there to do

acute care." ...In my eyes, they will never get away from the acute care

part of it. A large portion of it being acute care. I don't care what anybody

says (p. 10, line 35).

Although outpost nurses acknowledged that MSB's mandate was to provide

community health services, they identified that community health programs were

not sufficiently provided. One participant recognized the "bandaid" approach of

the current health care services. This participant expressed a need for nurses to

become more involved in illness prevention programs in collaboration with other

resources.

> Lucille: I would want to work a lot more with the Medicine Lodge. Be
>
> more involved in alcohol rehabilitation, detox, drugs, and have us
>
> contribute a lot more to sobering up people rather than just sewing them
>
> up and they're drunk and hurt and coming here to save them and
>
> expecting us to fix them and they'll just be drinking again (p. 14, line 15).

One participant perceived that outpost nurses implemented health

promotion and illness prevention programs.

> Elizabeth: I think we get to do more prevention as promotion. Do a lot of
>
> community health stuff. We get to do a lot of public health stuff. If there's
>
> time and there's been a slack, we get to do home visits. We're supposed

to make a home visit the first 6 weeks after a baby's born and also if

there's enough staff we go out with the doctors when he does his home

visits every week (p. 3, line 23).

This participant later described outpost nurses' expanded role in terms of being

the doctor and providing acute care services.

Elizabeth: Like we are, we assess people, and we make a diagnosis and

we give them medications...I just like that we get to do things like suturing

and X-rays and lab...(p. 5, line 40).

Summary of Work Design Issues

Outpost nurses discussed numerous work design issues that were

perceived to enhance or detract from QWL. Participants identified the following

work design factors as positive elements in their worklife: (1) learning on the job;

(2) independence; and (3) being the doctor. Learning on the job provided

nurses with intellectual stimulation that was perceived as personally fulfilling.

When participants were asked, "What do you like about your work?", they

frequently and without hesitation, answered that they enjoyed the

independence. Independence or autonomous practice provided nurses with

control and power over a limited aspect of their work. Independence fulfilled

nurses' needs for power and control in a worklife setting with limited human and

material resources. Being the doctor was perceived by outpost nurses as a

valuable role. Participants demonstrated and expressed pride in being able to

perform medical tasks.

When outpost nurses described the nature of their work, they exclaimed, "We do everything!" As participants identified their numerous roles, they focused on the medical aspects - not the nursing perspectives.

Outpost nurses identified the following work design factors as contributing negatively to their QWL: (1) inadequate orientation; (2) too much paperwork; (3) never really off; and (4) lack of resources. Of these work design factors, the most significant issue was lack of resources, specifically lack of human resources. Understaffing was identified in 3 of the 4 participating outpost stations. Understaffing created severe consequences in outpost nurses' worklife. These consequences were identified as sustained heavy workload, high number of hours worked per week, inability to provide a personal touch, inability to provide safe patient care, lack of community health programs, along with occupational stress, fatigue, and health-related problems.

Another significant finding under work design issues was the nurses' provision of acute health care services versus community health programs. Participants expressed their concern over their inability to provide community health programs. Community health programs were not being provided because the stations were understaffed, nurses were experiencing a resultant sustained heavy workload, and the community required acute health care services. Acute health care was provided as a priority service.

Work Context Issues

Work context issues encompasses factors within the environments that nurses practice. According to the Model for Quality of Nursing Worklife, work

context issues include factors such as physical layout of the workplace,

management techniques, decision-making processes, intraprofessional, and

interprofessional relationships (O'Brien-Pallas & Baumann, 1992). Work context

issues were identified as: (1) physical layout of the station; (2) employee

benefits; (3) intraprofessional relationships; (4) interprofessional relationships;

(5) living in fear; and (6) nurses' interactions with the community (see Figure 11

on page 180). When participants discussed employee benefits, they perceived

job sharing as positive. Under intraprofessional relationships, I included outpost

nurses' relationships with colleagues, NICs, and ZNOs. Interprofessional

relationships were comprised of nurses' relationships with on-site physicians,

Thompson physicians, CHRs, support staff, and Band Constables. Participants

demonstrated and expressed a keen awareness of maintaining their personal

safety within the station and community.

Physical Layout of the Station

During every field visit, a nurse provided me with a tour of the outpost

station. Most nurses talked about the physical layout of the station in a positive

manner.

Two participants viewed the physical layout of the station as inadequate.

One nurse viewed the waiting room area as too small and the clinic setting was

laid out improperly (Sherry, p. 38, line 23). Another participant stated that the

emergency room was too small (Elizabeth, FN 30894).
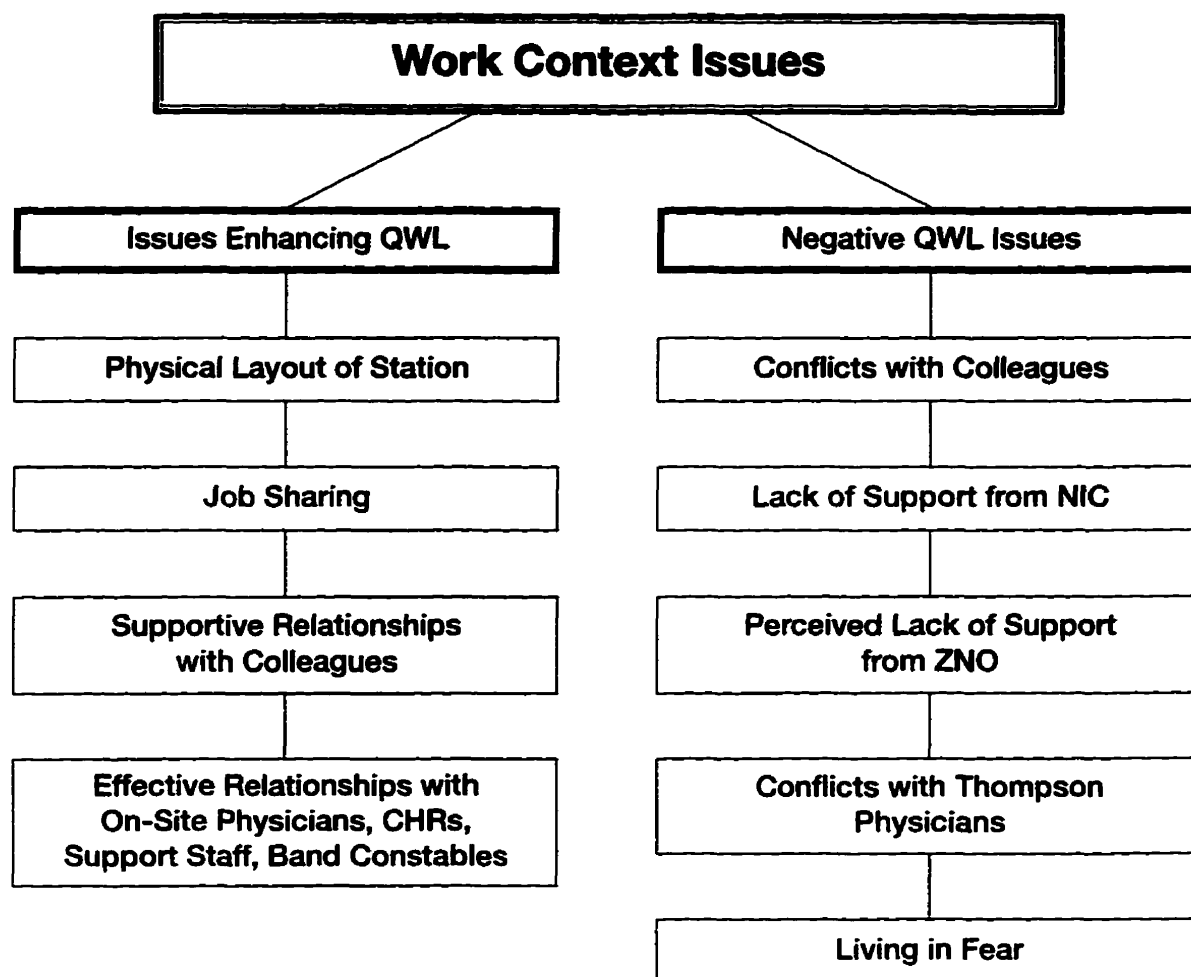
Figure 11. Schematic diagram depicting QWL issues under work context issues.

Employee Benefits

In contrast to the findings of the study by the GNWT (1990), participants talked minimally about employee benefits such as vacation time and pay. Outpost nurses perceived that job sharing was a factor that would enhance their QWL.

Job Sharing. Outpost nurses viewed job sharing positively. Several participants were working in job-sharing positions. One participant identified the benefits of job sharing. She expressed her opinion that job sharing would enhance MSB's retention of outpost nurses.

> Sherry: I think it's a good idea [job sharing]. I'll probably be back. Yep, I will. Because it's the only way they're going to keep nurses in the north...If they could come in for even 5 weeks or 6 weeks and go on leave. And still they know they're going to get out, and they're going to rest, and they're going to come back refreshed. It's one thing they can do to keep you going (p. 27, line 8).

Intraprofessional Relationships

Included under intraprofessional relationships were outpost nurses' relationships with colleagues, NICs, and the ZNOs. Outpost nurses were especially concerned about their relationships with the ZNOs.

Outpost Nurses' Relationships with Colleagues. Five participants talked about their relationships with other outpost nurses. Four of the participants referred to these relationships as supportive and reliable. They talked about the importance of teamwork. One participant shared a negative

experience with me about a colleague and the difficulty that she had in coping with this conflict (Beatrice, p. 10, line 20).

Outpost Nurses' Relationships with the Nurse-in-Charge. In one community, the subordinate outpost nurses expressed their concern about the NIC's lack of communication with them.

> Bonnie: Things I find most frustrating here are - there's a real lack of communication between the nurse-in-charge and the staff. It's like they've got all these big secrets...We don't have staff meetings (p. 25, line 22).

In this particular community, I observed that the NIC rarely socialized with the subordinate nursing staff. This differed from other observations about NICs and nurses. In 3 stations, the outpost nurses described and demonstrated positive and supportive relationships with the NICs. Nurses perceived that NICs were supportive. They readily approached NICs for advice during work and they socialized with them when they were not working. The NIC is crucial to the functioning of the outpost station.

Perceived Lack of Support from Zone Nursing Officers. Five outpost nurses discussed relationships with various ZNOs during their work experience with MSB. Participants expressed having no voice, receiving a lack of support, and not trusting several ZNOs. Outpost nurses viewed their relationships with ZNOs in terms of "them versus us." ZNOs were described in terms of their supervisory position and role, not in terms of actual people within the health care team.

Molly: You know staffing - always short staffed. "You know we're getting tired in here. I want a weekend off." "Oh, there's no relief in sight." Well, maybe it's true to a degree, but it always seems that if something comes up where they really, really need relief - they find it. You know, yet they try to pat you on the back and say, "There, there now. Just hang in there" (p. 28, line 37).

Connie: Ever since I came on - right from day 1, I've learned not to take their [ZNOs] word as gospel because it's not concrete. You become one thing and they turn around, do something else. Like I was told I was going to be in [a northern community] for 12 months. I took all my stuff there in 10 boxes and I was ready to settle down for 12 months. And I was ready to get to know the community and the people and that...And all of a sudden, 3 months later, I wasn't given an option. I was told I had to [leave] because somebody else wanted to come to [that community]...Since I came to work for Medical Services, I tend not to trust people so readily (p. 19, line 8).

One participant talked about being heard by ZNOs, as long as her calls were limited in number.

Sherry: I know I'm listened to by the Zone and I think it's because, now I overheard this, and I don't think I was supposed to, but I overheard it anyways. I heard them talking about, "Oh, this person phoned me again, and they are doing this and they are doing that. And they're phoning again. They phone all the time."...I know that they get several phone calls

from people a day, or I shouldn't say people, I'll say stations a day, and I

know they do...My policy is unless I really need their help on an issue or

whatever, I don't phone (p. 27, line 18).

Two Aboriginal nurses expressed feeling discriminated against by

several ZNOs. Over the course of their outpost nursing experience, they

perceived that Non-Aboriginal and Aboriginal outpost nurses were not treated

equally. In the following quotation, one participant reflected upon her years of

experience as an outpost nurse and shared a story about previous ZNOs.

Lucille: I felt that they weren't listening to me. And I felt a little

discriminated against. And there were other people here who seemed to

get everything they wanted, ask and all. I don't think I got that

support...Non-Aboriginal nurses get better treatment than we do, but I

think it's improving. We're more vocal as Aboriginals (p. 7, line 27).

This participant perceived that relationships between Aboriginal nurses and

ZNOs were improving due to the concerted efforts of Aboriginal nurses who

voiced their worklife concerns.

Interprofessional Relationships

Under the QWL issue of interprofessional relationships, outpost nurses

identified positive and negative working relationships with other members of the

health team. These relationships included physicians, CHRs, and support staff.

On Site Physicians. In one community, all participants referred to the

physician as knowledgeable, accessible, and supportive.

Patrice: Being able to know that we can call and ask things, and talk to

[the doctor]. Just knowing that they're there. Knowing that you can

contact them if you need them and knowing if you need them and

knowing that if you don't agree, or if you're not satisfied, there's just

another phone call (p. 13, line 27).

A participant in another community discussed the benefits of working with a

physician who was willing to share knowledge.

Molly: It's definitely a bonus when good physicians come in...that's a

bonus. He gave us 3 inservices on last Friday afternoon...He just rattles

all this stuff off his head and did this wonderful inservice. And [the other

physician] - the turkey, hasn't given us an inservice for I don't know how

long, and he'll come back here, watch a movie, and eat pretzels instead.

Can't get him to do anything. So it really helps if you have a good

physician, who's really into teaching and helping you as much as

possible (p. 23, line 17).

Conflicts with Thompson Physicians. Four participants expressed a

concern about consulting physicians in Thompson by telephone. MSB's

policies required that they consult the nearest health care centre, which is

located in Thompson. These nurses described situations where they did not

trust the physician's advice, causing them to access alternative medical backup.

Bonnie: But that's a lot of personalities in the medical staff at Thompson

and some of them just can't be bothered to accept patients from us, and

sometimes we'll have major arguments with them and end up sending

them out to Winnipeg at a price cost, but there's nothing we can do and we're not going to keep the patient here (p. 17, line 20).

Margie: I phoned Thompson because that, you know, you phone the closest one, and there's a new doctor there that doesn't speak English at all well. And I don't think he understands at all too well, so when I say redness he asks me what that means. You know what redness means. So, and therefore, and that kid whose been unconscious at least 10 minutes and throwing up. He says give her Tylenol and give her the concussion sheet and send her home. So, you know there, you know you're going to have to go a little further. And the thing is like even our physicians that come out here, now they're, sometimes they give you their home phone number. You can phone them at home sometimes...So I just phoned Children's at Health Sciences - Children's Emergency, because there's always an EMO there and they're really good...Whereas, I waited 15 minutes for the doctor in Thompson to phone me back because they couldn't find him (p. 17, line 5).

In a field note, I described a situation where an outpost nurse was uncomfortable with the advice of the physician in Thompson. The physician's advice was noted to be dangerous to the patient. A confrontation with the physician was avoided. This outpost nurse consulted the NIC and followed the NIC's directions that were contrary to the doctor's order (4994, p. 9, line 23).

A Non-Aboriginal nurse voiced her opinion that some physicians in Thompson demonstrated racism towards Aboriginal people from the northern community in which she worked.

> Molly: I find the physicians in Thompson - this is my humble opinion - are like as soon as they hear someone from [northern community], they almost don't even want to accept the person. Like there's a few that are really bad that give us a hard time and I feel - I really believe this, but if the physician had been seeing the same person in the city and they were a White person, things would have been different. I find that there is definitely bias because it's another one of those Indians from [northern community], you know. I find that does happen (p. 22, line 27).

CHRs. On the most part, outpost nurses perceived that they had an effective working relationship with the CHRs. Outpost nurses from various stations shared stories amongst themselves about their CHRs. Participants noted that CHRs performed a wide variety of functions dependent upon the individual, and their community.

Support Staff. Support staff included the clerks, housekeepers, and drivers. Outpost nurses voiced appreciation for skilled and enthusiastic support staff. One participant referred to the support staff as a key part in the team (Sherry, p. 7, line 16). Three of the four participating Bands arranged for drivers and vans to provide transportation for community members to and from the outpost station.

Meredith: A lot of reserves have drivers. The old people can't drive and maybe the driver can interpret, come into the station and whisper to them...'Cause one community that I went to didn't have drivers and they really missed that. They really felt the loss (p. 19, line 24).

One Aboriginal participant identified a unique problem with support staff. Aboriginal support staff were approaching her about their concerns with her nursing colleagues. Being approached with concerns about colleagues placed this nurse in an uncomfortable position.

Connie: When I was in [northern community], the staff started coming to me, telling me their problems - like telling me about this nurse, or telling me about that nurse...I don't know if it was because I was their colour or they felt comfortable with it, but I didn't want to know that. You know, I didn't want to know this about this person because then I was caught in the middle (p. 18, line 15).

Other Aboriginal participants identified that they had not experienced this problem.

Band Constables. In three communities, outpost nurses spoke positively about Band Constables. Band Constables were found to be extremely helpful and outpost nurses perceived that Band Constables treated them well (Elizabeth, p. 15, line 36; Meredith, p. 13, line 28). One outpost nurse identified how reassured she was by the Constables' knowledge of community activities.

Sherry: The Constables, they know everyone in town, so they get you and interestingly enough, like if I go out for a walk and I'm on call, I put up a

sign. And you know, they always know where you are - always. Doesn't matter. They always know. Someone always knows where you are...One of the Constables said, "Oh, 3 o'clock, someone was out visiting so and so." They knew exactly when we left and they said, "Yeah, you got back at such and such a time." They knew exactly when we got back, and they probably didn't think about it, but that is very reassuring to know that they knew what's going on (p. 32, line 17).

Living in Fear

Eight participants expressed feeling fearful about their personal safety. Participants were especially concerned about their safety when they were left alone. In potentially unsafe encounters, outpost nurses were also aware of the presence or absence of resources such as the physician and/or the RCMP (Patrice, p. 11, line 7).

> Meredith: Especially on weekends because the doctors have gone and somebody has gone on a weekend off and someone would like...Well, somebody's always gone on leave and sometimes you're left here all by yourself because the nurse is in the community, so she's out on call. For us, there's just 2 nurses left here and sometimes there's a lot of drinking and socials and parties. So that's scary when you're by yourself because there's nobody to talk to (p. 12, line 18).

Participants were fearful of patients with mental illnesses, a history of violence, and/or substance abuse problems.

Bonnie: We have a few patients with "psyche" histories who have been a concern, and they are not allowed in the station without the Band Constables. And it doesn't matter if they're bleeding to death on my doorstep, they do not get in if they have a violent history towards everybody...Things have gotten really tense. They would [threaten to] cut me up into little pieces and burn me (p. 15, line 19).

Connie: We were talking about our...schizophrenics. We have a couple, we have, you know the psychotics. Like you never know when you're going to get a mental illness [patient]. That's scary. So you never know how to handle them if they're just going to end up, you know, you've been here awhile...and then bring a gun to your window while you're sitting there and they can see you. You know that is a big concern for me. Because these people have a history of violence in the past (p. 30, line 27).

Beatrice: The hallway was way too long because they [after hours clients] had to come through the residence and knock on your door. I always have to open it. I come alone there. If they're drunk, they're bigger than you. There's a long way to get going if you're worried about yourself (p. 13, line 35).

Participants were keenly aware of unsafe environments. They spoke about potentially unsafe situations that they experienced.

Patrice: The nursing station is detached from the residence and you have to go outside to get across to the nursing station, which is not far. But in

the middle of the night, and 9 times out of 10, the people do not have

phones - they just come and bang on your door. So you don't even know,

and the door to the residence does not have a window in it. It's a solid

door so you cannot even see who's out there or what to expect and so

you do have to open up the door. You can't talk to the door. I was

concerned the whole time I was there about that. Just the safety element

(p. 10, line 40).

Sherry: I think that really has to be addressed is safety. You need, if they

have detached residences, then they need to have some kind of walkway

or whatever so that you don't have to go outside when you're on call

because safety is important and you don't know who's at the door. For us,

you have clients in the community, or people in the community I should

say, who aren't trustworthy, who can be violent...So you need the safety

factor that you don't need to go outside to run into to go to the, to get into

the nursing station to answer the door (p. 23, line 13).

Summary of Work Context Issues

Under the umbrella of work context, I identified several QWL issues.

These issues included: (1) physical layout of the station; (2) employee benefits;

(3) intraprofessional relationships; (4) interprofessional relationships; and (5)

living in fear.

Outpost nurses were keenly interested in describing their relationships

with other people within and outside of the nursing profession. Relationships

within the nursing profession encompassed outpost nurses' relationships with

colleagues, NICs, and ZNOs. Participants recognized that positive working relationships with other outpost nurses enhanced their QWL, while negative relationships with colleagues created more stress in their work and home environment. Participants perceived a lack of support from various ZNOs.

Relationships outside of the nursing profession included outpost nurses' relationships with on-site physicians, Thompson physicians, CHRs, support staff, and Band Constables. Conflicts were described between Thompson physicians and outpost nurses. Participants avoided confrontation with Thompson physicians in the event of a conflict.

Participants identified that they were living in fear and their personal safety was extremely important. Outpost nurses were keenly aware of safe versus unsafe situations. They voiced concern about providing health care services to clients with mental health problems, histories of violence, and substance abuse problems. The presence or absence of human resources such as physicians and RCMP officers were noted. Although outpost nurses wanted to live in separate housing units, they were fearful of their personal safety.

Work World Issues

According to the Model for the Quality of Nursing Worklife, work world involves the overall health care system (O'Brien-Pallas & Baumann, 1992). The overall health care system includes clients' demands on the system, health care policies, and nursing job markets. The Model for the Quality of Nursing Worklife did not include politics under the category of work world. An area that I have

included under work world is the influence that politics had on the worklife of

outpost nurses. Politics permeated the northern nursing environment.

I identified many QWL issues under work world (see Figure 12 on page

194). The first QWL issue was clients' demands on the system. I subdivided

clients' demands on the system into: (a) number of clients per day; (b) variety of

clients' needs; and (c) clients' dependence on the system.

Work World Issues

Issues Enhancing QWL

Negative QWL Issues

Clients Demands on System

Variety of Clients' Needs

Number of Clients/Day

Job Market

Clients' Dependence on System

It's Very Political Up Here
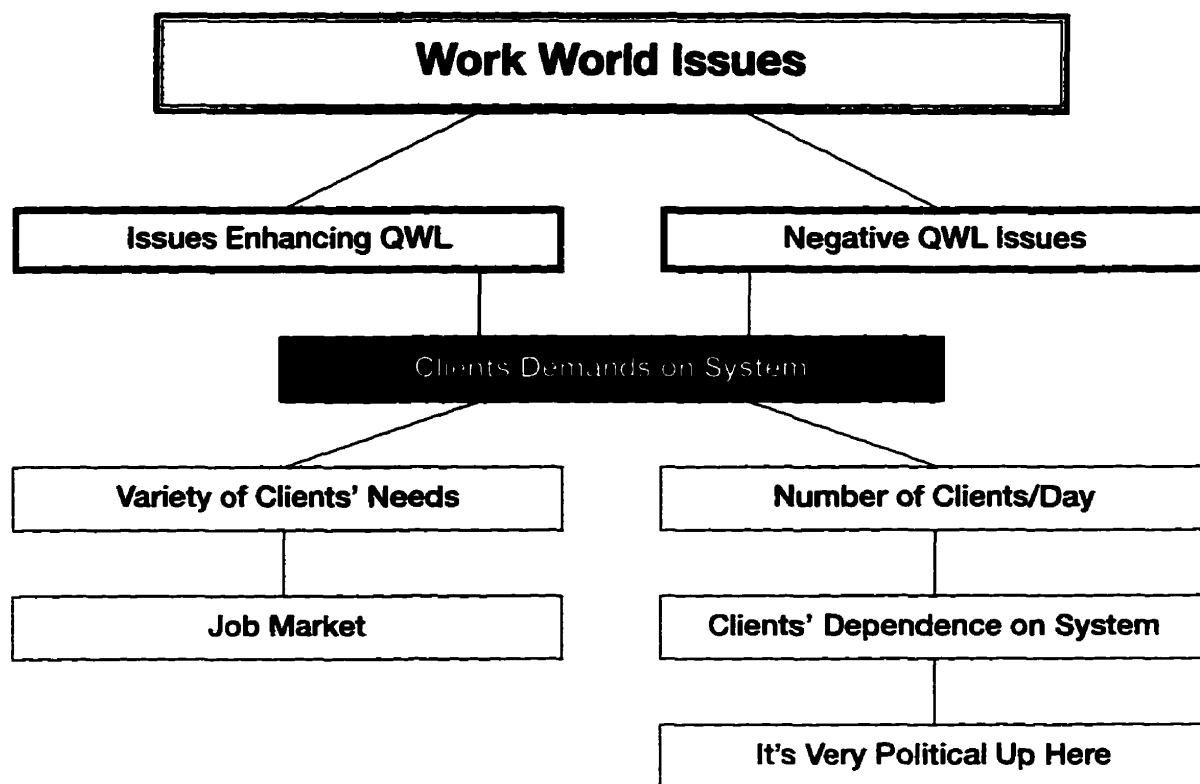
Figure 12. Schematic diagram depicting work world issues.

Politics were perceived to influence every nursing action and interaction. I divided the area of politics into Band Chief and Council's influence and the political nature of nurses' relationships with clients, support staff, the NIC, and ZNOs.

Another QWL issues under work world was the nursing job market. Participants identified that they went where the nursing jobs were located - up north.

Clients' Demands on the System

Outpost nurses described their clients' demand for health care in terms of variety of clients' needs, the number of clients they saw, and clients' dependence on the system. Participants viewed the variety of clients' needs as challenging and stimulating. When outpost nurses talked about the number of clients seen per day, they related this number to being understaffed, having an increased workload, and feeling strained. When they talked about the huge demand that their clients' demonstrated for their services, they did not relate these factors to the historical and sociopolitical context. Participants expressed frustration over their clients' dependence on them.

Variety of Clients' Needs. Participants talked about their feelings related to the various clients' needs. They viewed their clients' various needs to be intellectually stimulating and challenging.

Molly: Everyday there's something different (p. 9, line 33).

Sherry: I like the variety...The fact that it's a wide variety of things that you see. And it's a real challenge (p. 12, line 7).

Beatrice: We get to do, see all types of prenatal and things. We see all

parts of families. You're not just concentrating on surgical, or prenatal

care. We're seeing all of it. All kinds of patients (p. 3, line 20).

Connie: You just see everything, you know. Everything from lacerations

to abdomen pains, to chest pains. So your mind is going all the

time...Thinking, thinking, thinking (p. 2, line 41).

Number of Clients Per Day. Three outpost nurses expressed their

perception of clients' demands on the system in terms of quantity of clients per

day. In 2 northern communities with populations ranging from 1800 - 2400,

employing 4 outpost nurses, 50 - 120 clients were reported as attending the

clinic each day with 8 clients requiring treatment in the station after-hours.

Connie: From 8:30 in the morning until 4 o'clock or 5 o'clock, it's just one

patient after another. You can see up to 25 patients a day. And that's a

little bit, I find, unsafe because you don't do as good assessments, and

you just get them in and out because you have to, you know, otherwise

you're going to be staying in the evening as well (p. 2, line 31).

When outpost nurses' workload increased due to understaffing, and a large

number of clients required acute care services, they expressed concern over the

lack of efficiency in their nursing practice.

Clients' Dependence on the System. Most participants perceived that

their clients were overly dependent on them. They viewed that clients expected

outpost nurses to provide comprehensive services and cure everything.

Molly: We're supposed to cure everybody's problems, no matter what it is.

That's the way the community views us, I think... (p. 3, line 36).

Sherry: I mean we're dealing with the Aboriginal population and their

demands on the system are far greater than Non-Aboriginals would be

because they expect for the most part - everything (p. 40, line 1).

Beatrice: I know they [clients] feel as though you should know everything.

Miracle workers. I think it's kinda scary (p. 9, line 11).

When outpost nurses voiced their frustration about clients' demands and

dependence on the system, they did not express an understanding of the

complex historical and sociopolitical context of Aboriginal health problems. In

complex health problems such as suicides, outpost nurses were overwhelmed

with feelings of responsibility.

Bonnie: People have to accept responsibility for their own health. I just

refuse to be responsible for it any more. It's their problem. Not mine...We

have a lot of suicidal people in the community as there are in all northern

communities and I do what I can. I try to do as much as I can, but the

families have to start accepting responsibility and I refuse to go get

them if somebody does something to themselves anymore because

nobody from the family or the community wants to help this person out.

They're not accepting responsibility in a small community. Hard for them

to understand that. Like they'll blame us if something happens, but we're

not little magic fairies that can wave all their troubles away (p. 23, line 18).

Aboriginal people may experience system-related problems, but this nurse

identified that Aboriginal people are solely responsible for their own health.

In one northern community, the outpost nurses were concerned about

several clients with mental health problems. They found that these clients relied

heavily on them.

> There were 4 people in particular that lived in the community that Connie
>
> described as "capable of sucking your aura." Bradley is a schizophrenic
>
> that has attempted suicide by overdosing on medications approximately
>
> 60 times. Bradley has a seizure disorder. To manage Bradley effectively,
>
> he comes to the outpost station every day at 8:30 A.M. to receive his
>
> medications. Sometimes, he wakes up at 4:00 A.M. and starts
>
> phoning the station to get his medications (FN4994 p. 17, line 11).

It's Very Political Up Here

Participants described their work environment in terms of its intense

political nature. They perceived that their worklives were profoundly influenced

by the Band Chief and Council. Relationships with patients, support staff, NICs,

and ZNOs were also described as being influenced by politics.

Band Chief and Council's Influence. Participants perceived that they

were powerless within their working relationships with the Band Chief and

Council. Outpost nurses also did not view themselves as influential within the

community.

Outpost nurses noted the complex political environment in which they

worked. Participants expressed concern for the political nature of their

relationships the Band Chief and Council. Nine participants expressed feeling powerless about the influence that the Band Chief and Council had upon their lives.

> Molly: I really find that the Band thinks that we're at their beck and call and we should do whatever they say. They tend to forget, like one of the RCMP put it, this place is like under the force of a communist society...It's a dictatorship or whatever you want to call it because the Chief, whatever he says - the people do and I don't know if they don't realize that he has no right. Like a lot of things just over-ride your basic rights and freedoms (p. 24, line 26).

This participant viewed that Aboriginal governments were not democratic and wielded power over outpost nurses and community members.

Many participants perceived that Band Chief and Council involvement impeded their roles as outpost nurses.

> Patrice: I think the political structure impedes our role - the political structure in the community (p. 13, line 42).

> Elizabeth: A process that impedes our roles and our skills is that it is very political up here and in certain situations, we are not allowed to do our job because it would be politically incorrect (p. 19, line 41).

In this instance, this participant was referring to removing a child from an unsafe home environment. A family member was actively involved in the Band Council. Elizabeth perceived that she was not allowed to remove the child from this particular home as her action would be viewed by community members as being

"politically incorrect". To ensure that the child was protected, Elizabeth transported the child out of the community on the basis of an alleged medical problem rather than create a potential conflict with a formal apprehension.

Aboriginal nurses also expressed dissatisfaction and felt pressured by the Chief to perform certain functions. Their perceptions were similar to their Non-Aboriginal colleagues.

> Meredith: And sometimes you are just dissatisfied when you get a lot of political pressure from the local politicians like the Chief and Council...I know there's some pressure from the local politicians that they put pressure on the nurses at the stations. I guess, the nurses who have to, they have to medevac someone because the Chief wants them to (p. 6, line 16).

> Lucille: Sometimes things get a little political. The patients complain, then we have to deal with the Chief and Council (p. 2, line 4).

In one community, several outpost nurses spoke about the Chief's influence on their social activities.

> Elizabeth: People weren't allowed to come visit [the nurses at the outpost station]. Same with the RCMP. Because it doesn't look good to see people outside the nursing station knowing that you're not at work and they're wondering why the RCMP is sitting over there, while all you were doing was playing crib or watching movies or whatever. And the guys were on their own time, but they don't have any other vehicle to use so they had to bring the RCMP truck (p. 13, line 37).

All eleven participants readily talked about Band Council Resolutions (BCRs). Several participants defined this term.

Elizabeth explained that BCR stood for Band Council Resolution. She dreads a BCR. A previous nurse had a BCR which meant that she had to get out of the community in 24 hours. The nurse had been good. She was "riding" a support staff member who was married to a Band Councillor. The Band Councillor took her concerns to the Band and they voted, based on the Band Councillor's story alone, that the nurse had to leave (FN31894 p. 28, line 21).

Sherry: And that stands for Band Council Resolution and they can decide that she is not welcome in the community. Her behaviour is not acceptable, and we [Band Council members] won't put up with it (p. 19, line 17).

All of the Non-Aboriginal and several Aboriginal participants viewed BCRs in a fashion that related specifically to nurses. Ten participants expressed feelings of powerlessness when they talked about BCRs. They related being BCR'd to being shunned and banished from a community. They did not define BCR as a democratic process on the part of the Band Council members to vote and make decisions to benefit the community.

Meredith: When the Chief wants you to leave the community, I guess you have to. If you don't, the guard will come in or not...They [the nurses] are terrified of being BCR'd and they didn't want to be BCR'd because it doesn't look good for anybody to be BCR'd, especially the nurses that got

along with the people in the community, rather than have been there awhile and know the lingo of the people and where they live and what they do, and outside the station (p. 7, line 28).

One Non-Aboriginal nurse did not feel threatened about BCRs. This nurse envisioned herself as an asset to the community.

Sherry: The CHR said, "Oh my God! They want to BCR you. What are you going to do? And I'll tell you exactly what I told the CHR. I said, "Fuck them." [The community] needs me. I don't need the community and I can go to another community (p. 20, line 37).

One Aboriginal nurse described BCRs from the community's and the nurse's perspective.

Lucille: BCRs are usually a community member complains they're being treated unfairly by a nurse or even a teacher, or even their own members. Then if the Council feels it is not professional - usually a BCR. They take you and send you elsewhere anyways...I guess the Band just feels that you can't be professional and go on working if you have a problem and they feel they don't need those kind of people. How else would they deal with them? I guess, they figure rather than keep the person here and have the community reject them - they're better off sometimes for their own safety - they're sent out...I think sometimes BCRs work both ways - to protect the community and the person themselves (p. 9, line 26).

Rather than viewing a BCR as a personal attack, this participant's perspective was that a BCR was implemented in the best interest of the community and the

nurse. In the event that a nurse's behaviour is perceived by community members to be unprofessional, the Band Chief and Council may decide to ban the nurse from the community. This protects community members from further unprofessional behaviours on the part of the nurse. This resolution also serves to protect the nurse from retaliation on the part of angry community members.

Political Nature of Other Relationships. Outpost nurses also discussed the political nature of their relationships with clients, support staff, NICs, and ZNOs. Politics influenced the nature of the nurses' relationships with their clients in many ways.

> Bonnie: This is a concern politically because you'll get blamed (p. 7, line 37).
>
> Patrice: You're careful about who you visit just because you could be walking into something. You have to watch the political aspect of it as well (p. 12, line 47).
>
> Beatrice: Everything you do here. It's presentation. How you present yourself to that patient because it goes back into the community, and everyone says, "I don't want to see that nurse." They'll talk about that nurse and it goes backwards to the Chief and Council (p. 20, line 30).
>
> Bonnie: It's politics from the top down (p. 27, line 1).

In one community, several outpost nurses referred to a communication problem stemming from their NIC. When talking about the NIC, one participant stated that "it's political - that's the way it is and it's not going to change" (FN31894 p. 30, line 22).

Job Market

Four outpost nurses addressed how the job market in nursing affected them. Three outpost nurses described how the job market steered them into considering a northern nursing experience.

Bonnie: You go where the jobs are (p. 32, line 19).

Connie: Well, actually what was happening was that they were giving a lot of layoffs - a lot of layoffs, and I was going to be one of those who graduated after working in hospitals a couple of years...I had some friends that were working in stations telling me it [northern Manitoba] was a really nice place to work...And the money was good (p. 4, line 35).

One participant questioned why outpost stations were under-staffed when many nurses were searching for work.

Molly: I would think that the job situation, being as poor as it is, right?...Staffing shouldn't be a problem. If there's nurses out there that are hungry and wanting to work, and I know the north isn't for everyone, but it is for some people. I can't see why this isn't more in favour to get staff (p. 29, line 11).

Summary of Work World Issues

Under work world, I identified several significant QWL issues of outpost nurses in northern Manitoba. These QWL issues included: (1) clients' demands on the system; (2) "it's very political up here"; and (3) nursing job market.

Clients' dependence upon the system was identified as a QWL issue. Most participants perceived that their clients were overly dependent upon them.

Outpost nurses viewed that their clients expected them to provide comprehensive health care services and cure everything. When participants voiced frustration over clients' demands and dependence, they did not express an understanding of the historical and sociopolitical context of their clients' dependency. Participants' depiction of clients' dependence upon them illustrated a profound lack of understanding of the determinants of health in First Nations communities.

Findings indicated that nurses perceived that they were powerless in an intensely political environment. Outpost nurses perceived that the Band Chief and Council were in total control of their worklives. Outpost nurses also voiced concern that the Band Chief and Council were not working with them - they were working against them. All participants addressed the notion of being shunned and banished from a community due to a BCR. BCRs were viewed as personal attacks.

The political nature of relationships with clients, support staff, the NIC, and ZNOS was described by participants. From the nurses' perspectives, politics undermined effective working relationships that outpost nurses strived to attain with clients, support staff, the NIC, and various ZNOs. Outpost nursing was inundated with contradictions and conflicts in power among participant groups.

Nursing Outcomes

Participants voiced their perceptions of consequences of outpost nursing. Outcomes of nursing in a northern community included: (a) job satisfaction;

(b) physical health problems; and (c) retention of outpost nurses (see Figure 13 on page 207).

Job Satisfaction

Several participants (n=5) used the term, satisfaction, to describe outcomes of their work. One participant appreciated being able to follow a patient through an injury to healing, or through an illness to wellness (Bonnie, p. 4, line 1).

> Beatrice: I'm quite happy with my work. I'm happy everyday since I started. It's so much nicer. I never want to go back to the hospital. Most satisfaction (p. 4, line 9) !

Physical Health Problems

Most participants described how being understaffed and working a high number of hours every week affected them. They complained of fatigue.

> Margie: You get tired because you're working every second night, and weekends, and just sort of ongoing working (p. 10, line 28).

Several participants perceived that worklife affected their physical health. By working long hours and becoming over-tired, they stated that they were more susceptible to upper respiratory tract infections (Bonnie, p. 16; Connie p. 11; Elizabeth, p. 16). Other participants believed that their worklife affected their blood pressure.

> Bonnie: Especially when it's very stressful. You'll see us some nights and we've had a really bad week - checking each other's blood pressure (p. 15, line 32).

Nursing Outcomes

Job
Satisfaction

Physical
Health
Problems
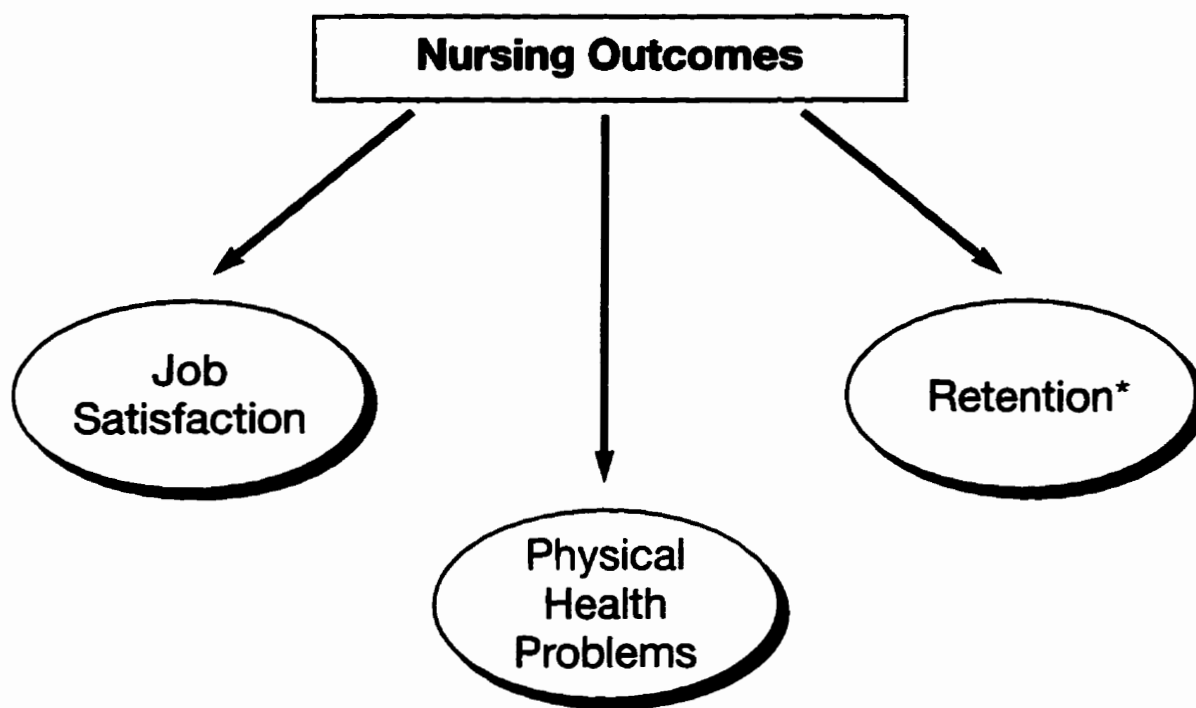
Retention*

*Aboriginal Nurses' Long Term Commitment.
*Non-Aboriginal Nurses Short Term Commitment.

Figure 13. Nursing outcomes identified by outpost nurses.

Retention of Outpost Nurses

A high turnover rate was identified as a chronic problem in northern nursing, but participants in this study had relatively lengthy experiences as outpost nurses. Aboriginal outpost nurses differed from their Non-Aboriginal colleagues in that they expressed a long term commitment, while Non-Aboriginal participants viewed outpost nursing as a short term experience.

Aboriginal Nurses' Long Term Commitment. Aboriginal outpost nurses spoke about their career in terms of a long term commitment. The Aboriginal group of nurses was older than the Non-Aboriginal group. Aboriginal nurses achieved their goals of having a family and were now focused on their nursing career.

> Meredith: I grew up in the reserves and I guess my whole life's goal is nursing...So when I come back to the reserve, I feel right at home (p. 14, line 35).

Non-Aboriginal Nurses' Short Term Commitment. Most Non-Aboriginal nurses expressed that outpost nursing was a short term commitment. Outpost nursing was viewed as a short term plan because these nurses wanted to fulfil other personal goals.

> Bonnie: I don't have a significant other right now, but I want to. There's nobody to meet here to develop a relationship with. You look at the clock and you're getting older as time goes by. There's not lots of time. I want to have children someday (p. 12, line 13).

Molly: But you know the possibility of there ever being [a significant other]

-    it's so very low being here. You know, I think that's maybe one reason too

why I think I should leave (p. 26, line 19)...I think I still would like some day

to have a family and you can't reach that goal staying up north (p. 31, line

3).

One Non-Aboriginal participant described a long term commitment to

outpost nursing. This nurse perceived that a job-sharing arrangement

enhanced her QWL and positively contributed to nurse retention. By working in

a job sharing situation, outpost nurses worked a designated number of weeks in

the community followed by time off work spent out of the community.

Re-Integration Into "The South"

Non-Aboriginal nurses expressed concern over future re-integration into

urban situations. When they spoke about returning to the south, they voiced a

perception of a problem in their adaptability. Because of their experience in the

north, these nurses identified that they had problems re-integrating into southern

society. These participants suggested that new outpost nurses should be

forewarned about strange feelings prior to their first return to the south.

Returning to an urban setting created feelings of being overwhelmed, being

different, and being socially isolated.

Patrice: To be surrounded by White people again is really strange. And

not that I notice colour that much, but you do notice people are okay, the

same, or whatever. You notice that, I mean you can't fight noticing. Just

to be synonymous I had, being the same, seemed strange. Seems out of

place. Like you feel out of place because you're dressed differently...So when you go back out, I would definitely tell them to be prepared for, just the feeling of strangeness. The feeling of being isolated while being surrounded by people (p. 17, line 1).

Molly: I just remember coming out [of the north] and just being overwhelmed by the city a lot of times. People would say we were even bushed...We were bushed. You know, you get off the plane and there's people everywhere and there's traffic and noise and confusion and all that (p. 25, line 38).

Summary of Nursing Outcomes

Outpost nurses perceived that outcomes of a quality work environment included job satisfaction and nurse retention. Consequences of worklife, that was perceived to be lacking in quality, were: (1) physical health problems; and (2) leaving the north. Aboriginal nurses differed from their Non-Aboriginal colleagues in that they expressed a longer commitment to outpost nursing. Non-Aboriginal outpost nurses viewed outpost nursing as a short-term commitment, and therefore, were concerned about problems adapting and re-integrating down "south."

Nurses' Perceptions of Clients' Outcomes

Three participants expressed a perception that their QWL affected their clients. These nurses believed that QWL affected the quality of care that their clients received.

Bonnie: Everything that happens in our lives affects the patients (p. 30, line 15).

Quality of Care

Participants were proud of the quality of care that they delivered. Being able to deliver quality care was a positive outcome of their work that enhanced outpost nurses' QWL.

Bonnie: I guess the one on the positive side is quality of care (p. 2, line 2). Outpost nurses believed that if their QWL was satisfactory, then the quality of care that their clients received would be satisfactory. In contrast, if their QWL was unsatisfactory, the quality of care that their clients received would deteriorate. Several participants noted that the quality of care diminished when the outpost stations were under-staffed and the nurses were fatigued.

Molly: Like when you're tired and you've got a short fuse and someone comes in for something really stupid and you blow up. I tend to do that. Like it takes a lot to get me mad, but if I get mad, sometimes it can just be a stupid, if I'm tired. And I'll admit that I've had some screaming matches out there with some people (p. 17, line 12).

Connie: Sometimes I think they expect you to do too much - the Medical Services...If you're looking at a community where there's 1800 people and there's 3 nurses all the time, you know. That's just too much. Like you can get busy...And then you just don't have time to rest, and then it's work again. So if you're tired then the patients don't get good quality care (p. 12, line 27).

Summary of Findings

I began this chapter by presenting identified QWL issues of outpost

nurses in northern Manitoba. QWL issues were organized according to the

Model of Quality of Nursing Worklife (Baumann & O'Brien-Pallas, 1992).

Findings were presented and discussed under four main headings:

(1) homelife/worklife interplay; (2) work design; (3) work context; and (4) work

world.

Homelife/worklife Interplay

Numerous QWL issues were identified under the heading of

homelife/worklife interplay. The first QWL issue identified under

homelife/worklife interplay was outpost nurses' attitudes and values.

Participants voiced particular attitudes and values about their work. Outpost

nurses, practicing in an expanded nursing role, expressed and demonstrated a

strong value for the medical model of health care. Participants rarely described

a philosophy of health care from the perspective of a nursing model or an

alternative model such as traditional healing.

Educational and experiential preparation were paramount in the

provision of independently functioning outpost nurses. Several participants

identified that educational preparation for the expanded nursing role was

inadequate. Outpost nurses also expressed that working with novice nurses in

an isolated northern setting was extremely stressful.

Participants described the complexity of their relationships with individual

Aboriginal clients. Relationships with families, groups, and the community were

rarely discussed. Factors perceived to contribute negatively to outpost nurses'
QWL included: (a) a massive responsibility; and (b) clients' dependence on the
system. Data revealed that Non-Aboriginal nurses' ethnocentrism and
scepticism over authenticity of clients' health problems detracted from the
provision of quality health care to First Nations communities.

Aboriginal nurses differed from their Non-Aboriginal colleagues in several
aspects. Aboriginal nurses identified that knowledge of First Nations language
and culture enhanced their practice. Being able to converse with clients in their
own language provided Aboriginal nurses with the ability to conduct a more
accurate patient assessment and provide more culturally sensitive care. Non-
Aboriginal nurses rarely discussed language unless they were describing the
frustration of language barriers in that their clients did not speak English.

Outpost nurses experienced a unique homelife/worklife environment in
comparison with other nurses working in different settings. Outpost nurses were
not only required to work with their colleagues, they were required to live with
them in a communal shared housing unit. Working and living together created
an intense work and home environment. If working relationships were negative,
work and home environments were perceived as extremely stressful.

Most participants discussed isolation from family and friends. Although
Aboriginal nurses experienced feelings of isolation from their family and friends,
they spent their time off work with other people in the community. Non-
Aboriginal nurses spent their time off work alone in the nursing station. Non-

Aboriginal nurses rarely engaged in group activities with members of the community.

Work Design

Participants recognized that several work design issues enhanced their QWL. These issues were learning on the job, independence, and being the doctor.

Under work design, I identified worklife issues that negatively affected outpost nurses' QWL. These QWL issues were: (1) inadequate orientation; (2) we do everything; (3) too much paperwork; (4) never really off; (5) lack of resources; and (6) provision of acute health care services versus community health programs.

Lack of human resources had a strong affect on outpost nurses' worklives. Understaffing created profound consequences for outpost nurses. These consequences were sustained heavy workload, high number of hours worked per week, inability to provide safe patient care, lack of community health programs, along with occupational stress, fatigue, and health related problems.

Work Context

Within the realm of the work environment, outpost nurses described intraprofessional and interprofessional relationships, along with their concerns for personal safety. Intraprofessional relationships included outpost nurses' relationships with colleagues, NICs, and ZNOs. Participants perceived a lack of support from various ZNOs. Interprofessional relationships involved outpost nurses' relationships with on-site physicians, Thompson physicians, CHRs,

support staff, and Band Constables. Participants described conflicts with Thompson physicians. These conflicts created an increased workload for the outpost nurses.

Work World

Under the umbrella of work world, I included clients' demands on the system, "it's very political up here", and the nursing job market. Outpost nurses voiced their concern about clients being overly dependent upon them. The most significant finding under work world was that outpost nurses perceived that they were powerless. Powerlessness was an underlying theme when nurses talked about the Band Chief and Council's influences over their worklives and homelives. Participants described a BCR in terms of the Band Chief and Council's power to evict them from the community. Powerlessness emerged when outpost nurses described the political nature of their relationships with clients, support staff, the NIC, ZNOs, and Thompson physicians.

Findings that Address the Research Objectives

In light of the preceding presentation of identified QWL issues, four research objectives are addressed. The first research objective was to explore the meaning of QWL, as defined by the participants. The second research objective was to identify the most significant QWL issues of outpost nurses. To compare and contrast QWL issues of Aboriginal and Non-Aboriginal outpost nurses was the third research objective of the study. The fourth research objective was to identify QWL issues that nurses perceived to affect the quality of patient care delivered.

An Exploration of the Meaning of QWL

The first research objective was to explore the meaning of QWL as defined by outpost nurses in northern Manitoba. Attridge and Callahan (1990) noted that QWL emerged in the vocabulary during the 1970s and focused on the relationship between workers and their work environment. As I used Attridge and Callahan's definition in my study, it was important for me to analyze if the outpost nurses' definition coincided with the study's definition of QWL.

Many outpost nurses defined QWL in terms of consequences of outpost nursing, while several outpost nurses defined QWL in terms of factors that affected nurses' worklife. QWL as a consequence of outpost nursing was defined using nursing and patient outcomes. Five nurses referred to QWL in terms of nurses' outcomes while 3 nurses expressed that QWL was defined in terms of patients' outcomes. Several outpost nurses defined QWL by using worklife factors that affected them. One participant was puzzled by the definition of QWL.

> Beatrice: We thought QWL didn't make much sense. You should differentiate quality of what - quality of our life? Social life? Work life?...We even looked in a dictionary and couldn't find it (p. 1, line 9).

QWL Using Nurses' Outcomes. Most definitions of QWL used nurses' outcomes, which were generally described in a positive manner. These participants used definitions that referred to concepts such as job satisfaction, lack of job stress, positive collegial relationships, and self actualization.

> Elizabeth: Getting satisfaction in my job (p. 1, line 10).

Patrice: It would mean what you are yourself getting out of work ... It's a

job where you feel that your work is important (p. 1, line 11).

Meredith: ...Being able to make opinions and participate in the activities

that are going on or that being able to say what you want to say and make

suggestions to make the workplace more efficient and...that's what I think

QWL is to me...The place that I work has to be good and rewarding for the

individual (p. 1, line 19).

Beatrice: Peace of mind and the enjoyment that you're getting out of your

job (p. 1, line 9).

Lucille: Very little stress (p. 1, line 7).

Two nurses defined QWL in a negative manner. These nurses appeared

fatigued and referred to their worklife negatively.

Margie: What worklife (p. 1, line 19)?

Molly: It doesn't seem like much of a life out here, I would say. Like it is

certainly abnormal. You know, I mean it's an abnormal way to live (p. 1,

line 22).

QWL Using Patients' Outcomes. Three participants defined QWL in

terms of patient outcomes. I found the following definitions interesting as these

particular nurses had obviously concluded from their experiences that QWL

directly affected their patients' lives.

Bonnie: It's quality of care (p. 2, line 2).

Elizabeth: Knowing that even if they're small - the differences, I'm making

a difference in the people's lives out here (p. I, line 22).

Patrice: Seeing results and consistency...What you're giving to people is important and that you enjoy doing because if you don't, they're not going to benefit from it... (p. 1, line 10 - 11).

QWL Defined According to Worklife Factors. Five participants defined QWL using factors affecting worklife. These factors can be categorized according to work design, work environment, and work context. For example, QWL to Bonnie meant independence (p. 2, line 2), which can be related to work design, work environment, and work context.

Molly: Is your worklife nicely laid out? Is it neat? Is it organized? That definitely helps me because I like things organized. Some people can work in disorganization, but I don't, so that would really contribute to QWL (p. 2, line 9).

Patrice: What are your surroundings like (p. 1, line 11)?

Meredith: A safe place. Getting along with your colleagues...(p. 1, line 19).

Lucille: Enough nurses on shift, not overloaded with patients so we can spend time and being treated like a professional by your peers, your patients, and your supervisors. And having enough supplies (p. 1, line 7).

None of the participants related QWL to work world or the overall health care system.

The study's definition of QWL was congruent with the outpost nurses' definitions. Ten participants offered a definition for QWL. They viewed QWL in terms of relationships between nurses and patients, other health care

professionals, work design, and/or the work environment. Most of the outpost nurses defined QWL in terms of nurse outcomes such as job satisfaction, rewards, and lack of stress. Three participants defined QWL in terms of patient outcomes, identifying that nurses' worklife directly affected quality of care. Several nurses defined QWL in terms of its contributing factors, stating that elements within work design, work context, and work environment affected their QWL. QWL was never defined in terms of the overall health care system.

Significant QWL Issues of Outpost Nurses

The second research objective of this study was to identify the most significant QWL issues of outpost nurses in Northern Manitoba. To determine significance of QWL issues, I reviewed all QWL issues. I designated worklife issues as significant in two ways. Initially, I reviewed the identified issues and flagged issues that were identified by more than 50% of the participants. I then rank ordered them according to the number of participants that identified these worklife issues. For example, if all eleven participants or 100% of the sample discussed a particular worklife factor, I classified this factor as the most significant.

QWL issues were then reviewed and classified according to their meanings. For example, I classified outpost nurses' relationships with the ZNOs as a significant QWL issue. Although this issue was only described by 5 participants, the participants spoke at length about having no voice, lacking support, and not trusting the ZNOs. Due to the significant meaning and

consequences of outpost nurses' relationships with the ZNOs, I identified this worklife issue as an important one.

The presentation of significant QWL issues is organized according to worklife issues that enhanced outpost nurses' QWL, followed by worklife issues that diminished QWL. QWL issues that were perceived as positive were combined to form the theme, fulfilment. The theme, powerlessness, emerged from the data on worklife issues that diminished QWL.

Issues That Enhanced QWL: Fulfilment

Outpost nurses found enjoyment in many aspects of their work. When participants spoke about worklife issues that enhanced their QWL, they described a sense of accomplishment and satisfaction. Outpost nurses expressed that factors of their worklife created a sense of personal fulfilment. I identified the theme, fulfilment, to depict positive QWL issues. Fulfilment is defined as a perception of harmony that results when an individual has found meaning and leads a purposeful life (Mosby's Medical and Nursing Dictionary, 1986). Fulfilment is comprised of the following QWL issues: (a) attachment to clients; (b) learning on the job; (c) independence; (d) being the doctor; (e) we do everything; (f) variety of patient needs; and (g) providing quality patient care (see Figure 14 on page 221).
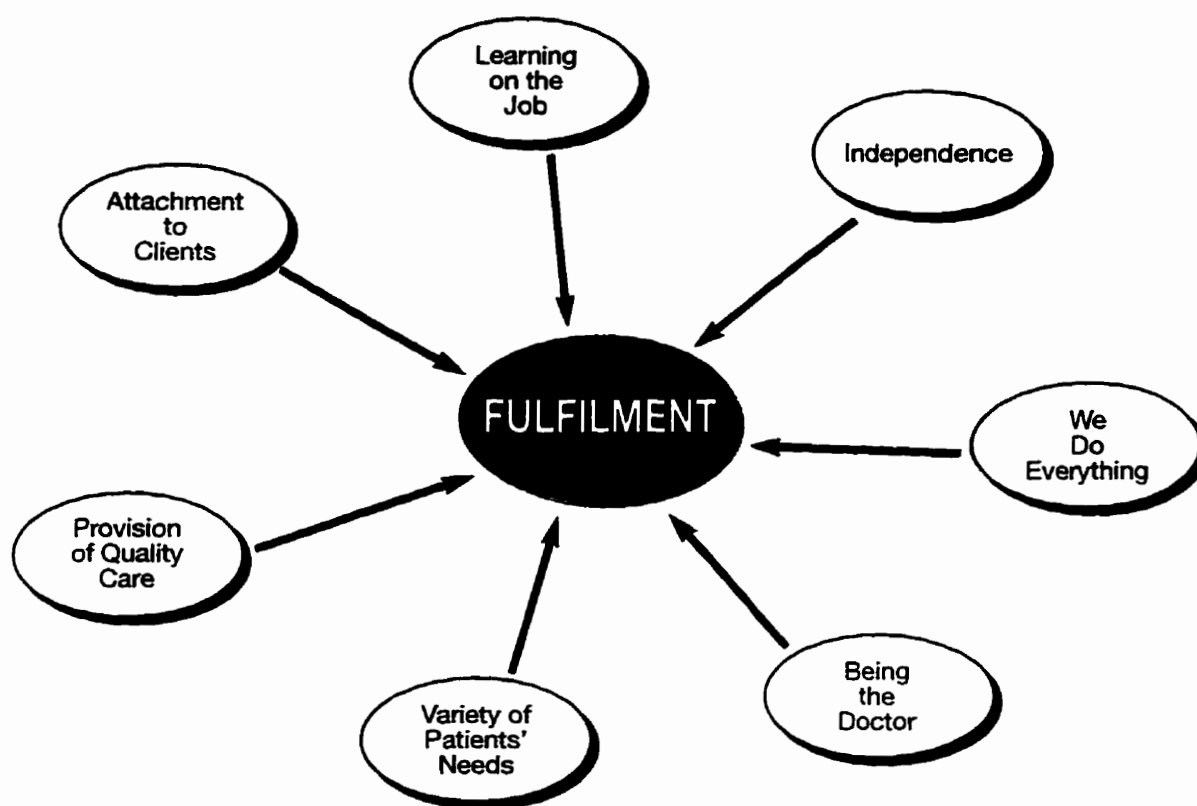
Figure 14. Schematic diagram depicting QWL issues creating the theme, fulfilment.

Attachment to Clients

Attachment to clients was identified as a positive factor in outpost nurses' worklife. Connection to individuals in the community added meaning to outpost nurses' worklives. Attachment to clients fulfilled the nurses' needs to feel connected to others. While Aboriginal nurses expressed a connection to the northern communities, Non-Aboriginal nurses were disengaged from the communities. Non-Aboriginal nurses did not invest in a relationship with their community; however, they invested in relationships with specific individuals.

Learning on the Job

Participants described the intellectual stimulation provided by learning on the job. Intellectual stimulation created a sense of personal fulfilment for the outpost nurses.

Independence

Participants enjoyed the independent nature of their roles as outpost nurses. Outpost nurses were proud that they did not have to rely on other resources to fulfil the needs of others. Problem solving and performing skills on their own were perceived as positive worklife factors.

Independence or autonomy provided outpost nurses with a sense of control over a limited aspect of their worklives, their immediate work environment. While working in the station, outpost nurses relished their independence as they provided health care services to individuals.

Outpost nurses voiced a sense of pride in being able to independently accomplish the task of fulfilling the health needs of their patients. By assuming

many roles in an independent manner, participants expressed feelings of satisfaction from their worklife.

Being the Doctor

Many participants described their work in terms of "being the doctor." They expressed feelings of pride and accomplishment in assuming this role. This positive worklife factor appeared to be directly related to outpost nurses' value of the medical model of health care as 10 nurses demonstrated a particular value for the medical model.

We Do Everything

Outpost nurses thoroughly enjoyed their expanded role and referred to this role as "we do everything." They performed many duties and described the variety of their job functions as stimulating and challenging.

Variety of Patient Needs

Outpost nurses were intellectually stimulated by the variety of patient needs that they experienced during their nursing practice in the north. When exposed to new and varied health problems, outpost nurses were exhilarated. They enjoyed caring for people in all different age groups with a variety of health care problems. A variety of patient needs fulfilled the intellectual needs of outpost nurses. Participants described this aspect of their worklife as challenging.

Providing Quality Patient Care

Many participants were proud of the quality of care that they delivered. Being able to deliver quality care was a positive outcome of their work that

participants identified to enhance outpost nurses' QWL. Nurses perceived that they were providing quality patient care and fulfilling the needs of their patients.

Issues that Negatively Affected QWL: Powerlessness

Participants identified a number of worklife factors that negatively affected their QWL. I identified the theme, powerlessness, from the data on negative QWL issues. Powerlessness was comprised of worklife issues that outpost nurses perceived to negatively affect their QWL (see Figure 15 on page 225). These issues included: (1) isolation from family and friends; (2) working and living together; (3) inadequate educational preparation; (4) frustration over clients' dependence on the system; (5) massive responsibility; (6) understaffing; (7) never really off; (8) living in fear; (9) perceived lack of support from ZNOs; (10) conflicts with Thompson physicians; and (11) "it's very political up here."

Isolation From Family and Friends

Eight participants voiced feelings of isolation from family and friends. Not only were they geographically isolated - they were socially and emotionally isolated. Family and friends were perceived to lack empathy for outpost nurses and lacked an understanding of outpost nurses' roles. Outpost nurses described difficulty in maintaining relationships with family and friends when they were geographically, socially, and emotionally distanced from these important social circles. Being isolated and alone may have compounded outpost nurses' sense of powerlessness.
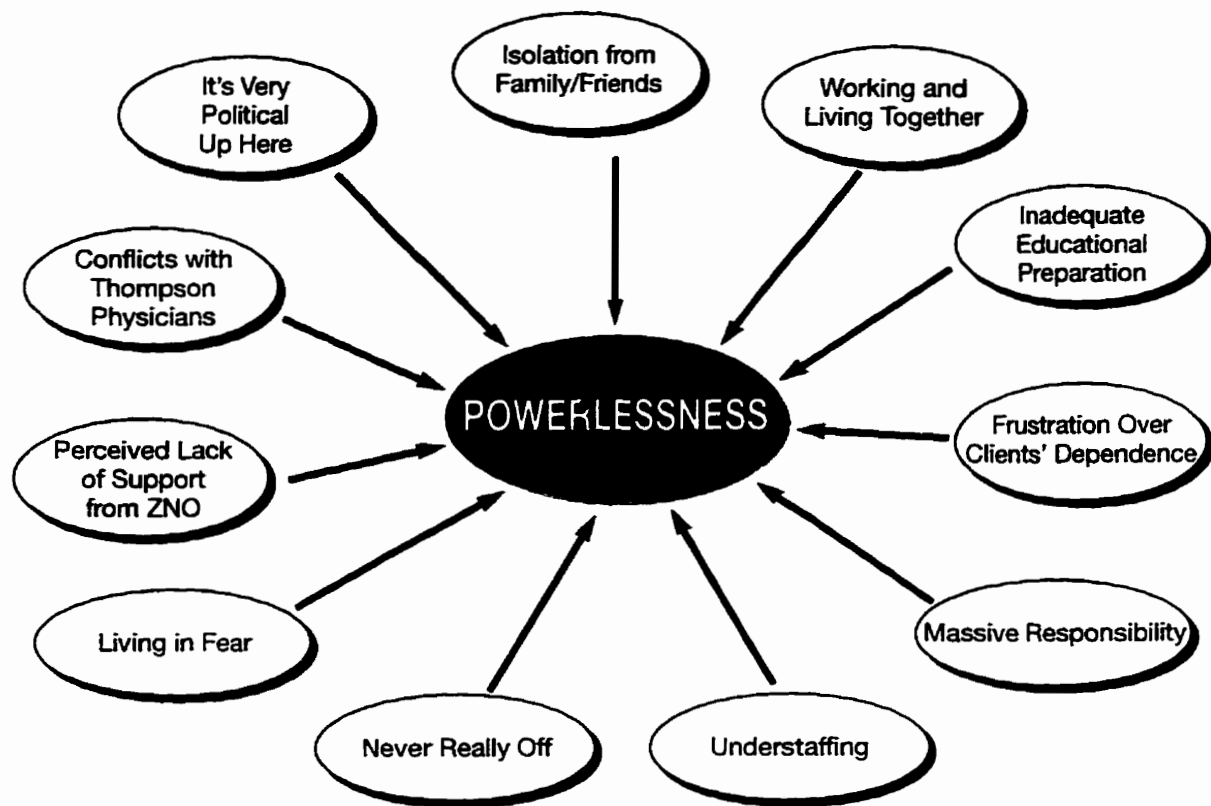
Figure 15. Schematic diagram depicting QWL issues that created the theme, powerlessness.

Working and Living Together

Working and living together was a unique feature of outpost nursing. Nurses were required to work and live with the same people. Working and living together created a sense of powerlessness among outpost nurses. Outpost nurses were not provided with an opportunity to wield power in their own homes, as these accommodations were shared with other nurses, physicians, dentists, and community visitors such as myself. For example, simple activities of daily living such as meal planning and preparation were influenced by factors such as availability of resources and the degree of influence of other health care personnel. Participants perceived that they were powerlessness in their own home environment, within this communal living arrangement. Participants described their homelife/worklife interplay when conflicts arose between outpost nurses.

Elizabeth: I can see it being difficult if personalities clash and people don't get along really well because we are with each other 24 hours a day basically (p. 6, line 32).

Patrice: I see nurses have to breakdown to a point where they would be if you don't get along, we're going to have you removed. You see people destroyed and that is really sad (p. 20, line 15).

Several participants discussed the possibility of having living accommodations that were separate from the outpost station. They perceived that having a homelife that was separate from their worklife would enhance their QWL. Although they thought that separate residences may remedy lack of

privacy and their constant nursing role, they were cognizant of the disadvantages that separate living accommodations would have upon their personal safety.

Inadequate Educational Preparation

Two participants described their educational preparation as inadequate. These participants wanted more information to help them function in an expanded nursing role - in particular, the medical aspect of their work. Further exploration of participants' concern about inadequate educational preparation validated the theme of outpost nurses' sense of powerlessness. Edmundson and Loughran (1989) related inadequate educational preparation to outpost nurses' powerlessness. When outpost nurses performed functions for which they were not prepared, Edmundson and Loughran (1989) noted that nurses failed to meet their obligation and anxiety resulted for both nurses and community members. This anxiety gave rise to self-doubt and feelings of powerlessness (Edmundson & Loughran, 1989).

Frustration Over Clients' Dependence

Seven participants expressed frustration over clients being overly dependent upon them. They were concerned that clients were not becoming more responsible for their own health. When outpost nurses discussed their clients being overly dependent upon the health care system, they did not refer to historical and sociopolitical contexts. Outpost nurses perceived that they had no power over clients' demands on them, and no influence within the community.

Massive Responsibility

Fulfilment in providing efficiency and comprehensive health care
programs for First Nations communities was tempered by feelings of massive
responsibility. Six participants expressed feeling an overwhelming amount of
responsibility for providing an efficient and comprehensive health care program
for the people in their community. Outpost nurses described a sense of
powerlessness when faced with an overwhelming sense of responsibility.

Understaffing

Nine participants voiced their concern over the lack of nursing staff in the
stations. Three of the four stations that participated in the study were short-
staffed by one to two nursing positions. Understaffing created considerable
consequences for the remaining staff members. When outpost stations were
short-staffed, nurses experienced the following severe consequences:
(a) sustained heavy workload; (b) high number of hours worked per week;
(c) fatigue; (d) inability to provide a personal touch; (e) inability to provide safe
patient care; (f) lack of community health programs; and (g) occupational stress
and health related problems. Under these circumstances, nurses voiced
dissatisfaction with their work. When they notified ZNOs with their concerns
about being understaffed, they expressed having no voice, a lack of trust, and
lack of support. Outpost nurses perceived that they were powerless in the event
of working in a station that was under-staffed by MSB.

Never Really Off

Outpost nurses expressed that they felt that they were always on duty when they were located in the community. Five outpost nurses discussed their perception that they were always looked upon as the nurse, even if they were not scheduled to work. The notion of constantly being viewed as the nurse created a sense of powerlessness for participants. They perceived that they wielded no power over their personal time off work in that community members expected that nurses were always receptive to their consultations.

Living in Fear

Fear for personal safety was identified as a worklife issue that negatively affected QWL. Outpost nurses were concerned about unsafe work environments. Participants identified that they were fearful of patients with mental illnesses, histories of violence, and substance abuse problems. In anticipation of unsafe situations, outpost nurses were aware of the absence or presence of other nurses, physicians, or the RCMP as support.

> Patrice: I felt very safe in the nursing station itself, but we were told numerous times by the local RCMP and other people who have been there is that you don't go outside after 5 in the community for a walk, so you're basically shut in the station. It's like, you know, you're triple locking the door, so that says something (p. 11, line 14).

Outpost nurses' perceived that they had no power when their personal safety was threatened.

Perceived Lack of Support from the ZNOs

Five participants perceived that they had no voice, received little support and could not trust various ZNOs. When participants reflected on their worklife experience in the north, they described their relationships with ZNOs in terms of "them versus us." Although outpost nurses notified ZNOs regarding worklife problems, they perceived that ZNOs did not act upon their concerns. Participants sensed that they were powerless in effecting change in their worklives.

> Molly: I find a lot of times the nurses' concerns in the field get almost belittled or, I don't know if it's because of the isolation from the ZNO that we're sort of inaccessible and we're sort of like out there and away. Like we're not in nursing. You know we'll phone [the ZNO]. Like that's how we make our connections is by phone and talking to your ZNO and saying, "Well, look, this is happening and I'm not happy"...You know staffing - always short staffed. "You know we're getting tired in here. I want a weekend off." [ZNO stated], "Oh, there's no relief in sight." Well, maybe it's true to a degree but it always seems that if something comes up when they really, really need relief - they find it. You know, yet they try to pat you on the back and say, "There, there now. Just hang in there" (p. 27, line 40).

This participant described a ZNO in terms of a supervisor who did not act upon a reported concern. This participant also perceived that in the above situation, a ZNO demonstrated a patronizing attitude towards her.

Conflicts with Thompson Physicians

Participants expressed concern about problems with consulting

physicians in Thompson by telephone. Participants described situations where

they could not rely upon the physician's advice, causing them to access

alternative medical backup that was more costly and time-consuming. In a

fieldnote, I described a situation where an outpost nurse was uncomfortable with

the advice of the physician in Thompson. The physician's advice was noted to

be dangerous to the patient. A Non-Aboriginal nurse voiced her opinion that

some physicians in Thompson demonstrated racism towards Aboriginal people

from the northern community in which she worked. Outpost nurses perceived

that Thompson physicians were "giving them a hard time." They had developed

side-stepping strategies to ensure that their patients received proper medical

care. However, these nurses were not directly facing and addressing the source

of the problem. Hence, I concluded that outpost nurses perceived that they

lacked power over conflicts with Thompson physicians.

It's Very Political Up Here

Outpost nurses expressed their concern about politics being integral to

every aspect of their nursing practice. Politics was noted as a key factor

influencing nurses' relationships with clients, NICs, ZNOs, and particularly the

Band Chief and Council. Many nurses felt powerless, given the Band Chief and

Council's perceived influence over their work. Several participants identified

that political structures and processes impeded their roles as nurses. One

Aboriginal participant addressed that outpost nurses were intimidated by Band Council members.

> Beatrice: I didn't know he was a Councillor...Like when the Councillor spoke to me last week and I was laughing...No one told me who he was. He said, "This is a little unusual." Usually nurses don't laugh because they're supposed to be scared...Why should I be so scared? (p. 22, line 29).

Outpost nurses perceived that the Band Chief and Council were powerful and influenced their lives greatly. Participants defined a BCR only in terms of the Chief and Council's ability to banish them from the community. Outpost nurses perceived that they had no power and no voice when a BCR was underway. Terror, shame, and humiliation were associated in the notion of being BCR'd. The only support that outpost nurses received when they were BCR'd from one community was that MSB would continue to employ them, and they would be transferred to another northern outpost.

Comparing and Contrasting QWL Issues
of Aboriginal and Non-Aboriginal Nurses

The third research objective was to compare and contrast QWL issues of Aboriginal and Non-Aboriginal outpost nurses in northern Manitoba. I reviewed identified worklife issues and noted that Aboriginal and Non-Aboriginal outpost nurses shared numerous worklife issues (see Table 5 on page 233).

Table 5

Shared QWL Issues/Outcomes of Aboriginal and Non-Aboriginal Participants

Homelife/Worklife Interplay

1. Attitudes about self as nurses
    - Caring
    - Effective interpersonal communications skills
2. Acceptance of rules/regulations of health care system
3. Value for medical model
4. Concern for educational preparation
5. Previous nursing experience required
6. Massive responsibility
7. Spending time with patients
8. Frustration over clients' dependence
9. Isolation from family/friends
10. Concern for inadequate housing

Work Design Issues

1. Inadequate orientation
2. Learning on the job
3. Independence
4. We do everything
5. Being the doctor
6. Lack of resources
7. Provision of acute health care services versus community health programs

Work Context Issues

1. Job sharing
2. Relationships with colleagues and NIC
3. Perceived lack of support from ZNO
4. Effective working relationship with on-site physicians/CHRs/support staff
5. Conflicts with Thompson physicians
6. Living in fear

Work World Issues

1. Variety of patients' needs
2. Number of clients' day
3. Clients' dependence in system
4. It's very political up here
5. Job market

Nursing Outcomes

1. Job satisfaction
2. You get tired
3. Occupational health problems

Aboriginal and Non-Aboriginal outpost nurses were similar in their expressed and demonstrated value for the medical model. Other shared worklife issues that were perceived to enhance QWL included: (1) spending time with patients; (2) learning on the job; (3) independence; (4) we do everything; (5) being the doctor; (6) job sharing; (7) variety of patients' needs; and (8) provision of quality patient care. The basis of these similarities may lie in a complex socialization process whereby Aboriginal women were integrated into a Non-Aboriginal health care educational system. The Aboriginal and Non-Aboriginal participants appeared to have internalized the belief system of colonial medicine. They were proud of being the doctor and their philosophy of health, patient, environment, and nurse followed the viewpoint of colonial medicine.

The groups differed in the following areas: (1) scepticism over authenticity of health problems; (2) knowledge of First Nations culture and language; (3) participation in community activities; (4) length of time commitment to a northern nursing position; and (5) concerns about re-integration into the south. These differences appear to be based upon the groups' age and cultural differences (see Table 6 on page 236).

Table 6

Differences in QWL Issues of Aboriginal and Non-Aboriginal Participants

QWL issues of Aboriginal nurses	QWL issues of Non-Aboriginal nurses
Knowledge of First Nations language/culture	Skepticism over authenticity of clients' health problems
	Ethnocentrism
Engaged in community activities	Disengaged from community
Long-term commitment to outpost nursing	Short-term commitment to outpost nursing
	Concern for reintegration into the "South"

Scepticism Over Authenticity of Health Problems

Non-Aboriginal outpost nurses were identified as the only group that displayed scepticism over the authenticity of clients' health problems. After-hours clients, who were assessed to be truly ill, were referred to as "legitimate" patients (FN30894, p. 26, line 3). In one community, Non-Aboriginal participants explained that outpost nurses quickly learn who is really sick and who is "faking" their illness or injury.

Knowledge of First Nations Culture and Language

Aboriginal nurses identified that firsthand knowledge of the First Nations culture and language enhanced their QWL and the quality of care provided to their Aboriginal clients. Two of the 6 Non-Aboriginal participants recognized that knowledge of the First Nations culture enriched their northern nursing experience, but no one from this group discussed learning their clients' language.

Participation in Community Activities

The Aboriginal group differed from the Non-Aboriginal nurses in that they spent their time off work outside of the station. Generally, Aboriginal nurses grew up on northern reserves. When Aboriginal nurses were stationed in a northern community, they spent their time off work venturing out into the community to meet the people. Aboriginal nurses participated in group activities such as berry picking, fish camps, and snowmobiling. The Aboriginal nurses enjoyed participating in recreational activities in the community.

On the other hand, Non-Aboriginal nurses spent time off work within the station. They were minimally involved in community activities. When Non-Aboriginal participants socialized, they tended to interact with RCMP officers.

Length of Time Commitment to An Outpost Nursing Position

Aboriginal nurses differed from their Non-Aboriginal colleagues in terms of time commitment to a northern nursing position. The Aboriginal group tended to be older than the Non-Aboriginal nurses. The Aboriginal women had already experienced family life and were interested in pursuing their careers. They spoke about their careers in outpost nursing as a long term commitment.

Most Non-Aboriginal nurses expressed that outpost nursing was a short term experience. These nurses wanted to fulfil other goals that they perceived would not occur if they remained up north. These women wanted relationships and families. They perceived that relationships and family lives would only be possible if they left the north.

Re-integration into "The South"

Non-Aboriginal nurses were unique in their concern about re-integrating into "the south." They spoke about their previous experiences of returning to "the south." During these instances, they detected problems in adapting to a lifestyle and culture that was different from their northern experience. They were concerned about their feelings and adaptation during re-integration. Non-Aboriginal nurses suggested that new outpost nurses be offered a debriefing prior to their first return to "the south" to prepare them for the culture shock.

QWL Issues Affecting Provision of Nursing Care

The fourth research objective was to identify QWL issues that outpost

nurses perceived to impact on the nursing care delivered to individuals, families,

and northern communities. I reviewed the QWL issues identified by the outpost

nurses for factors that were perceived to affect the provision of nursing

care (see Table 7 on page 240). When outpost nurses discussed QWL issues

affecting the provision of nursing care, they referred to the provision of care to

individuals - not families, and communities. Worklife factors, perceived by

outpost nurses to positively affect patient care, were: (1) spending time with

patients; (2) knowledge of First Nations culture and language; (3) nurses staying

in the community longer than the six month probation period; and (4) support

staff. Understaffing and "it's very political up here" were the most significant

worklife factors that nurses perceived to negatively affect their ability to provide

quality patient care. Other worklife factors, perceived by outpost nurses to

negatively affect patient care, were: (1) nurses' fatigue; (2) lack of mental health

resources; (3) lack of domestic violence prevention programs and women's

shelters; and (4) conflicts with Thompson physicians. In previous discussions

about these identified worklife factors, I provided an account of how patient care

was perceived to be affected.

Table 7

QWL Issues Perceived to Affect Patient Care

QWL issues affecting patient care	
QWL issues enhancing patient care	QWL issues negatively affecting patient care
Spending time with patients	Understaffing
Knowledge of First Nations language and culture	It's very political up here
Nurses staying in community longer than 6 months	Nurses' fatigue
Support staff	Lack of mental health resources
	Lack of domestic violence prevention programs
	Conflicts with Thompson physicians

As I did not interview patients about their perceptions of the quality of nursing care, a limitation of the study would be in identifying whether or not QWL issues affected the quality of nursing care provided. Patients' perceptions of the quality of health care provided by outpost nurses requires further study.

Summary

In this chapter, I presented findings of the study. QWL issues were identified and organized according to the Model of Quality of Nursing Worklife (Baumann & O'Brien-Pallas, 1992). Findings were presented and discussed under four main headings: (1) homelife/worklife interplay; (2) work design; (3) work context; and (4) work world. Following a comprehensive review of positive and negative worklife factors, I addressed four research objectives.

The first research objective was to explore the meaning of QWL as defined by outpost nurses in northern Manitoba. Most of the nurses' definitions of QWL used nursing outcomes, which were described in a positive manner. Participants used definitions that referred to job satisfaction, independence, positive collegial relationships, and self actualization.

The second research objective of this study was to identify the most significant QWL issues of outpost nurses in Northern Manitoba. Participants stressed that the positive worklife factors outweighed negative ones, which accounted for their commitment to remain in an outpost nursing position. Outpost nursing was found to be inundated with conflicts and contradictions, supporting the results of Edmundson and Loughran's study (1989).

Participants expressed that they found enjoyment in many aspects of their worklives. I identified the theme, "fulfilment", to exemplify positive worklife factors. Fulfilment included: (1) attachment to clients; (2) learning on the job; (3) we do everything; (4) being the doctor; (5) independence; (6) variety of patients' needs; and (7) providing quality patient care.

Outpost nurses expressed concern over a number of worklife factors that they perceived to negatively affect their QWL. I identified the theme, "powerlessness", to depict negative worklife factors. "Powerlessness" encompassed the following worklife issues that outpost nurses perceived to negatively affect their QWL: (1) isolation from family and friends; (2) working and living together; (3) frustration over clients' dependence on the system; (4) lack of educational preparation; (5) massive responsibility; (6) understaffing; (7) never really off; (8 living in fear; (9 perceived lack of support from the ZNOs; (10) conflicts with Thompson physicians; and (11) it's very political up here.

The third research objective was addressed as I compared and contrasted the QWL issues of Aboriginal and Non-Aboriginal outpost nurses. Aboriginal and Non-Aboriginal outpost nurses shared numerous similar worklife issues. Similarities appeared to be based about a complex socialization process whereby the Aboriginal participants became integrated into the biomedical health care system. The groups differed in the following areas: (1) scepticism over authenticity of clients' health problems; (2) knowledge of First Nations culture and language; (3) participation in community activities; (4) length of time commitment to a northern nursing position; and (5) concerns about re-

integration into the south. These dissimilarities appeared to be based upon age and cultural differences.

Finally, I presented the QWL issues that outpost nurses perceived to positively and negatively affect the provision of quality patient care. Worklife factors that positively affected patient care were: (1) spending time with patients; (2) knowledge of First Nations culture and language; (3) staying in the community longer than the six month "probation period"; and (4) support staff. Understaffing and "it's very political up here" were the most significant worklife factors that nurses perceived to impede the provision of quality patient care. Other worklife factors, perceived by outpost nurses to negatively affect patient care, were: (1) nurses' fatigue; (2) lack of mental health resources; (3) lack of domestic violence prevention programs and women's shelters; (4) conflicts with Thompson physicians.

These findings exemplified that QWL is perceived by outpost nurses. QWL is contingent on numerous worklife factors, including elements of homelife/worklife interplay, work design, work context, and work world. Consequences of QWL were described most frequently in terms of nursing outcomes. The theme, fulfilment, emerged from the data pertaining to positive worklife factors. The theme, powerlessness, emerged from the data about negative worklife factors. The most significant negative QWL issues were understaffing, and "it's very political up here."

Findings suggested that consequences of outpost nursing were comprised of nursing and patient outcomes. Nursing outcomes included

fulfilment, job satisfaction, retention, fatigue, occupational stress and health-related problems. Patient outcomes were described by outpost nurses in terms of quality of care. Patient outcomes were rarely described in terms of improved health status.

CHAPTER V

DISCUSSION OF THE FINDINGS

Introduction

In the concluding chapter, I discuss the findings of the study. Discussion of the findings is organized under the following headings: (1) homelife/worklife interplay; (2) work design; (3) work context; and (4) work world. QWL issues of outpost nurses are examined and related to the literature. The themes, "fulfilment" and "powerlessness" are explored throughout these discussions by linking them to the literature on QWL. Consequences of not understanding outpost nursing within its historical and sociopolitical context are also presented.

Following discussion of QWL issues of outpost nurses in northern Manitoba, the remaining research objectives are addressed. The study's fifth research objective was to develop and communicate recommendations for future nursing practice, education, research, and administration. Recommendations for nursing practice, education, research, and administration are thus provided. The last research objective was to evaluate the applicability of the Model for Quality of Nursing Worklife (Baumann & O'Brien-Pallas, 1992). I identify the strengths and weaknesses of the model in relationship to this study.

As the researcher involved in this ethnographic study, I describe the processes of reflection and reflexivity in the concluding portion of this chapter. Reflection and reflexivity offered me the opportunity to capture the experience of qualitative research. By articulating and analyzing my thoughts and feelings, my

experience as a qualitative researcher was facilitated and enriched. Personal

growth and self actualization are described.

Discussion of QWL Issues Within Homelife/Worklife Interplay

QWL issues within the realm of homelife/worklife interplay are discussed

in relation to located literature. The following worklife factors are examined:

(1) outpost nurses' attitudes and values; (2) inadequate educational preparation;

(3) previous nursing experience required; (4) nurses' relationships with

individual Aboriginal patients; and (5) working and living together.

Outpost Nurses' Attitudes and Values

A finding of this study revealed that outpost nurses viewed themselves as

caring individuals. Caring refers to those assistive, supportive, and facilitative

behaviours for or towards individuals or groups to help them maintain or retain

their health, or cope with disabilities in diverse environmental human conditions

(Leininger, 1988). Nurses also described themselves as caring individuals in a

bibliometric analysis of the nursing literature from 1966 - 1990 (Johnson,1990).

> No matter what skills or tasks are performed by the nurse, the salient
>
> dimension is the underlying beliefs and values that are brought to bear on
>
> how the skills are used and tasks accomplished. Self-awareness,
>
> centeredness, and caring suggest an internal set of principles underlying
>
> this philosophy (Johnson, 1990, p. 137).

This finding also supported Benner and Wrubel's conclusion that the centrality to

nursing was caring (1989). Nurses who value, know, and practice caring

comprehend how meaningful a caring mode of functioning is in assisting people in a variety of human conditions (Leininger, 1995).

Another finding suggested that outpost nurses accepted the rules and regulations of the health care system without question. When I examined participants' acceptances of the rules and regulations of the health care system, I observed that their acceptance was based upon their perception of being powerless. When I reviewed the nursing literature on power and powerlessness, I noted that in contrast to powerless nurses, powerful nurses were described as being capable of improving the quality of nursing care (Raatikainen, 1994). Powerful nurses were highly motivated and implemented policy changes more often than powerless nurses (Raatikainen,1994). Since powerlessness was a prominent theme in this study, I concluded that participants may have lacked an awareness that they could implement change within the system to meet the needs of their clients. The biomedical model of health care served as the basis of health services in First Nations communities in northern Manitoba. As participants were enmeshed in the biomedical model, they may not consider the possibilities of other philosophies and systems of health care delivery.

I also related the finding that outpost nurses valued the health care delivery system to Farrell and Nuttall's (1995) values phenomenon. These researchers described a phenomenon peculiar only to nurses. Farrell and Nuttall (1995) discovered that no matter how cumbersome or inappropriate the health care delivery systems are, nurses will attempt to make them work. Nurses

will treat the health care delivery system as "sick" and in need of "care" (Farrell & Nuttall, 1995). Outpost nurses may have strived to ensure that the existing organizational structure of MSB actually functioned as a health care delivery system to First Nations communities.

A defining characteristic of a profession is the perspective its members bring to the problems they confront (Johnson, 1990). Paradigms are worldviews that contain a set of guidelines that identify appropriate work for the profession, and the ways that knowledge can be applied to scholarly and practical problems (Johnson, 1990). "The traditional scientific medical model, in which the primary focus is on the diagnosis and treatment of symptoms and disease, has been the ruling paradigm for many generations" (Johnson, 1990, p. 129). In recent years, a new paradigm has emerged with a holistic viewpoint (Johnson, 1990). The holistic paradigm of health within nursing contains the philosophy that facilities the integration, harmony, and balance of body, mind, and spirit. Illness is viewed as an opportunity for growth and expanded consciousness. Johnson (1990) found that nursing had been directly influenced by the emergence of this new paradigm.

Participants demonstrated and expressed that they particularly valued the scientific model of medicine in delivering health care to First Nations People in northern Manitoba. Alternative models of health care such as nursing and traditional healing were rarely mentioned. This finding was similar to Farrell and Nuttall's observation that nurses aged 30 years and older hold an ideological value that physicians make decisions in the medical world and nurses care by

implementing these decisions (1995). Roberts (1994) noted that nurses have internalized the values of physicians to such an extent that nurses can be described as marginal. Roberts (1994) proposed that nurses have so internalized the values of the mechanistic model of health that attempts to return to a holistic model of nursing fills them with anxiety. Outpost nurses' value of the scientific model of medicine was particularly disconcerting as the literature expounds on evidence that nursing is moving away from the medical model as a basis of nursing practice (Johnson, 1990; Mitchell & Santopinto, 1988).

The finding that outpost nurses valued the scientific model of medicine supported concerns of several sources (Mitchell & Santopinto, 1988; Orlando, 1987). Orlando (1987) voiced concerns about nursing travelling a dependent pathway to fulfil the aims of medicine and institutional bureaucracies. The expanded nursing role, in which outpost nurses function, was specifically viewed as a retreat to physician-dominated, medical model practice and countered the goal of theory-based nursing practice (Mitchell & Santopinto, 1988).

> Some nurses view the adoption of medical tasks as a way of enhancing nurses' image. This dubious gain may be costly for nursing, since it implicity values medical model practice to detriment nursing science. Even if the scope of added medical tasks appears superficially attractive to some, the cost may be a return to the subservient role (Mitchell & Santopinto, 1988, p. 9).

MSB provides a thirteen week Northern Clinical Program (NCP) to newly hired outpost nurses. This educational program is designed to teach nurses the skills required for the expanded nursing role. In the NCP, nurses learn to assess and treat clients who require acute, emergency, or chronic care (Government of Canada, 1996). This underlying philosophy of the medical model was articulated by the Government of Canada (1996) in recent advertisements for nursing positions in First Nations communities.

Several authors challenged the appropriateness of providing health care to Aboriginal people based upon the medical model (Canitz; 1989; Doucette, 1989; Gregory, Russell, Hurd, Tyance, & Sloan, 1992; O'Neil, 1986, 1989; Young, 1988). Canada's health care system, including MSB, has been a hierarchical, authoritarian, sickness/treatment-oriented organization (Doucette, 1989). This approach is not conducive to community development that requires facilitation from health professionals rather than dominance (Doucette, 1989). O'Neil "argued that the politics of health in northern Canada can be characterized as internal colonialism, in which low-level socialist health ideology struggles for expression within the dominant national capitalist framework" (1989, p. 328). Community development for First Nations People may not be facilitated when health care professionals uphold and believe in the domination of colonial medicine.

Farrell and Nuttall (1995) developed recommendations for bridging a gap between two conflicting value sets. Acknowledgment of caring as the field for examination of values overlap can be used by First Nations People, health care

administrators, and health care providers as a strategy to create an evolving

health care delivery system to northern Manitoba communities.

Inadequate Educational Preparation

Several participants described their educational preparation as

inadequate. These participants wanted more information to help them function

in an expanded nursing role - in particular, the medical aspect of their work.

This finding was similar to previous viewpoints that existing educational

structures for outpost nurses were deficient in meeting the needs for northern

communities (Canitz, 1990; Edmundson & Loughran, 1989; Gregory,1992).

> Nurses in northern and rural settings come from various educational
>
> backgrounds, including diploma, baccalaureate, master's, and doctoral
>
> programs. However, many of these nurses have not received appropriate
>
> education considering the kinds of care they must deliver. Consequently,
>
> nurses may be placed in positions in which they are required to provide
>
> interventions they have not been educated to perform (Gregory, 1992,
>
> p. 191).

Gregory (1992) advocated specialty nursing education in primary health care

through collaborative efforts between universities and MSB's regions. Chalmers

and Kristjanson (1992) suggested that preparation of nurses for future roles in

community health requires a mixture of baccalaureate, master's level, and

doctoral prepared nurses. Baccalaureate community health nurses would be

prepared as generalists. The advanced community practitioner would be

prepared at a graduate level and provide client-focused practice for specific

client groups or community-focused practice (Chalmers & Kristjanson, 1992).

This finding supported the results of the study conducted by the GNWT

(1990). Outpost nurses in the NWT reported inadequate continuing education

programs. In response to the results of this study, the GNWT developed and

implemented inservice programs for outpost nurses (Morewood-Northrop,

1994).

Further exploration of participants' concern about inadequate educational

preparation validated the theme of outpost nurses' sense of powerlessness.

Power has been defined as the ability to influence individuals or groups in their

decisions and actions in order to achieve certain goals and purposes (Leininger,

1995). Powerless would therefore be defined as the inability to influence.

Powerlessness refers to the perception that one is unable to influence others.

Edmundson and Loughran (1989) related inadequate educational preparation

to nurses' powerlessness. When outpost nurses performed functions for which

they were not prepared, Edmundson and Loughran (1989) noted that nurses

failed to meet their obligation and anxiety resulted for both nurses and

community members. This anxiety gave rise to self-doubt and feelings of

powerlessness (Edmundson & Loughran, 1989).

Attridge and Callahan (1989) examined workplace issues that affected

women in typically female occupations. These researchers noted that nurses

who were recognized as being powerful held two forms of power: (1) information

power; and (2) expert power. Information power was defined as the ability to

control others through possession and use of crucial information. Expert power was described as power over others by virtue of having superior knowledge and skill. In Attridge and Callahan's study (1989), powerful nurses were described as being knowledgable. In this study, inadequate educational preparation may have compounded outpost nurses' sense of powerlessness as these participants may have perceived that they were lacking informational and expert power.

Previous Nursing Experience Required

Several participants identified that previous nursing experience was an asset in outpost nursing. These participants viewed novice nurses as liabilities. Being stationed with a novice nurse affected outpost nurses' QWL in a negative manner. This finding supported Scott's observations (1991) that "a new nurse who has had only hospital experience finds the normal responsibilities of a station nurse unusually difficult and the nurse-in-charge has to give extra supervision" (p. 18).

This finding has implications on MSB's recruitment of nurses into outpost positions. In a recent advertisement for nurses in First Nations communities, MSB documented its hiring criteria.

If you are a registered nurse with strong clinical skills and hold a Bachelor of Nursing degree, or a Diploma in community health nursing, why not consider a change? A minimum of at least one year of current acute care experience is essential (Government of Canada, 1996).

MSB's current hiring criteria may curtail experienced outpost nurses' stress related to being partnered with a novice.

Nurses' Relationships With Aboriginal Patients

"Nurse-patient interaction is the heart of the caring relationship and has been extensively investigated from a nursing perspective" (Hewison, 1995, p. 75). Nurses' relationships with Aboriginal clients were described in terms of the nurses' feeling a sense of attachment with individuals. Attached, involved, and closeness were codes that were merged to form attachment with Aboriginal clients.

Outpost nurses identified that attachment to individual patients enhanced their QWL. Attachment to patients as a positive worklife factor was congruent with the findings of Ross, Rideout, and Carson's study (1994). These researchers identified that nurses valued spending time with their patients, listening to them, and talking to them. Wade (1993) also noted that amount of time spent with patients was positively related to the extent of personal rewards. Outpost nurses perceived that spending time with clients created an environment where an effective nurse-client relationship could be established and fostered.

Although participants clearly valued the biomedical model, they experienced fulfilment in the art of nursing or being able to add the personal touch to their practice. When outpost nurses established an effective nurse-client relationship, the connection that they experienced with individual clients fulfilled their needs. This finding was similar to reports from other studies on

nurses' job satisfaction (Baldwin & Price, 1994; Wade, 1993). Baldwin and Price's study identified the exciting nature of work for 176 registered nurses employed in urban and rural home health agencies (1994). They found that nurses selected home health care because of personal fulfilment. The amount of patient contact was a major factor in nurses' decision to practice in home care settings.

Non-Aboriginal participants did not appear to become involved with families, groups, or the community as a whole. Non-Aboriginal nurses spent their time off work in their apartments within the outpost station. Spending time alone, in accommodations that were not enjoyed, may have compounded Non-Aboriginal nurses' feelings of isolation. Non-Aboriginal nurses shied away from any community or group activity. This group socialized with one other group of "outsiders" - the RCMP officers. Outpost nurses and RCMP officers' worklife intertwined creating a venue for further social interaction. This finding was similar to observations of several authors (Canitz, 1989; Ross, 1989; Thomlinson, 1992).

> By the end of their scheduled work hours, southern-trained nurses want to leave their "nurse" role behind. Unfortunately, many native friends do not understand why the nurse is reluctant to check out a health problem during a social visit. The result: many nurses socialize mostly with other non-native members of the community who have similar culture, language, and interests (Ross, 1989, p. 22).

Canitz (1989) reported that many nurses remained within the protective shield of their professional status by staying inside the nursing station. This detachment alienated nurses from the community and decreased nurses' ability to develop an open and accepting cultural awareness.

Attachments to individuals were viewed by participants to enhance their QWL. This connection provided outpost nurses with personal fulfilment in a worklife situation where nurses experienced isolation from family and friends and failed to embrace the concept of community development. Ross, Rideout, and Carson (1994) found that nurses spoke about learning from their patients' experiences, finding self-fulfilment, and developing a broader perspective. Perhaps, the outpost nurses in this study learned from their patients' experiences, which provided them with fulfilment of their social needs, in the absence of other social support systems.

Participants expressed their frustration over clients' dependence upon the health care system. Clients' dependence upon nurses was viewed in terms of adding to nurses' workload. This perspective was narrow as participants rarely discussed clients' dependence within its historical and sociopolitical context. Non-Aboriginal outpost nurses also expressed scepticism over the authenticity of clients' health problems.

Although I did not conduct observations of nurse-patient interactions, the frustration and scepticism voiced by outpost nurses may be a reflection of other aspects of the nurse-patient relationship. O'Neil (1989) observed the interaction of health care professionals and their Inuit patients. O'Neil (1989) reported that

health professionals perpetuated the colonial nature of federal health care by perceiving their culturally different clients as "children." This clinical relationship was viewed as actually supporting clients' dependence upon providers of health care services (O'Neil, 1989).

Another limitation of not observing nurse-patient interaction was that I was unable to discern the nature of the power relationship that may have existed between outpost nurses and their patients. The findings of an observational study conducted by Hewison (1995) confirmed previous research in that the majority of nurse-patient interactions were superficial, routinized, and related to tasks. Hewison (1995) found that nurses exerted control over nurse-patient interactions. As the outpost nurses in this study perceived that they were powerless in many aspects of their work, these nurses may have exerted power within their nurse-patient interactions. A future nursing research study examining the nurse-patient interactions between outpost nurses and First Nations People is warranted.

Aboriginal nurses described how their knowledge of First Nations language and culture enhanced their practice. This finding contradicted a report in Edmundson and Loughran's study (1989), which indicated that Aboriginal clients would rather consult Non-Aboriginal nurses than Aboriginal nurses for health related problems. By being able to speak the language, the Aboriginal nurses in this study perceived that their patient assessments were more accurate and their nursing care was more culturally sensitive. Literature regarding the benefits of Aboriginal nurses' use of clients' language was limited.

More research on the benefits of Aboriginal health care providers in northern

communities is warranted.

Non-Aboriginal outpost nurses demonstrated ethnocentrism. They

expressed and demonstrated a superior value for their own cultural beliefs,

attitudes, and norms. This finding supported Canitz's observations that nurses

find their knowledge of Native cultural and community issues lacking when they

initially enter the north (1990). Researchers have previously supported outpost

nurses acquisition of culturally sensitive and supportive care through ongoing

educational programs (Canitz, 1989; Canitz, 1990; Gregory, 1986). In light of

the findings, I suggest that Non-Aboriginal outpost nurses are provided with

more educational programs on culturally sensitive and supportive nursing care.

Acquisition of culturally sensitive and supportive care may be dependent upon

nurses' individual characteristics, educational preparation, previous life

experience, and previous work experience. Development of cultural sensitivity

and transcultural nursing may require long term planning and intervention on

the part of MSB.

Working and Living Together

Working and living together was a unique feature of outpost nursing.

Participants spoke at length about the difficulties encountered in working and

living together. Working with someone was one thing, but living with them was

another. While feeling isolated from family and friends, outpost nurses were

forced to socialize with their colleagues in an environment that did not allow for

personal space or privacy.

Working and living together created a sense of powerlessness among outpost nurses. Outpost nurses were not provided with an opportunity to wield power or control in their own homes, as accommodations were shared with other nurses, physicians, dentists, and community visitors.

Many participants expressed concern about living with colleagues. Outpost nurses were in a unique situation, whereby they work and live with the same people. If personal relationships were not positive, work and home environments were disrupted. Friendships with colleagues were described as forced friendships. In the study conducted by the GNWT (1990), recruitment and retention difficulties were found to be caused by lack of peer support.

Participants expressed displeasure in their current accommodations. The majority of outpost nurses were living in apartments located within the outpost station. Lack of privacy was a consequence of communal living. This finding was congruent with concerns of outpost nurses working in locations north of the sixtieth parallel (Canitz, 1990; GNWT, 1990). Nurses reported living conditions that were claustrophobic (Canitz, 1990). Virtually all participants in these two studies commented on inadequacies in accommodations provided for nurses. Availability and quality of living accommodations were noted as a determinants in retention of outpost nurses.

An interesting difference in this study was the finding that nurses did not question why teachers, Northern Store employees, RCMP officers and their families were provided with alternative accommodations. Nurses in the NWT and Yukon Territory questioned why they were treated differently from other

"outsiders" in terms of their residences (Canitz, 1990). One participant in this study acknowledged the difference in accommodations and referred to teachers' residences as "teachadences." However, the reason for the difference was never questioned. Perhaps, the participants' overwhelming sense of powerlessness and their concern for their personal safety deterred a tendency to question why they were provided with inadequate housing. Interestingly, following the GNWT study, an arrangement was made for improved living accommodations for nurses (Morewood-Northrop, 1994).

Isolation From Family and Friends. When outpost nurses accepted employment in northern communities, they were aware of the geographical distance that existed between the workplace setting and their family and friends. Working in the north created more than geographical isolation from the nurses' social circles; participants spoke about their feelings of social and emotional isolation from family and friends. Many participants perceived that family members and friends failed to comprehend and appreciate the complexity of their worklife. When participants spoke about family and friends who lacked empathy for their northern experience, they expressed feelings of social and emotional isolation. Social isolation and loneliness were recognized as factors contributing to leaving outpost nursing (Canitz, 1990). The GNWT (1990) found that recruitment and retention difficulties were a result of the remote location.

Aboriginal and Non-Aboriginal outpost nurses shared their sense of isolation from family and friends. However, these groups differed in the ways that they coped with this worklife issue. Aboriginal nurses spent their time off

work away from the outpost station. These nurses had grown up in northern reserves and had learned how to occupy their leisure time. Aboriginal nurses actively participated in community or group activities and events, and were involved in recreational sports such as fishing camps and snowmobiling. Non-Aboriginal nurses spent their time off work within the outpost station. This group was generally disengaged from the community. This finding was significant as community development interventions require that nurses engage with members of the community (Drevdahl, 1995). Perhaps, this lack of involvement furthered their feelings of loneliness within the northern community and compounded their sense of powerlessness. This finding created a different picture than the results of Canitz's study (1990). Canitz (1990) found that 54% of the nurses grew to feel a part of their communities. Community support was related to factors that presented alternative roles for nurses other than the workplace. Canitz (1990) reported that nurses who were married, had family with them, or lived away from the nursing station described an active involvement with the community.

Outpost nurses' sense of isolation may have added to their sense of powerlessness. Attridge (1996) used a critical incident research technique and asked nurses to describe situations in which they felt powerless in the course of their nursing work. Attridge (1996) found that in most powerless incidents, nurses described feeling alone, and sometimes abandoned. Support from others was not evident as in nurses' descriptions of difficult situations (Attridge, 1996).

Lack of romance and friendships affected outpost nurses' QWL

negatively. Most Non-Aboriginal participants expressed that they found it

difficult to acquire friends in the community. In two northern communities, I noted

that the outpost nurses socialized with RCMP officers, and/or the RCMP officers

and their families. Although teachers and Northern Store workers resided in the

communities, the nurses preferred to socialize with the RCMP officers. Nurses

and RCMP officers may have been more inclined to share a social life as their

worklives often intertwined.

Difficulty in Balancing Homelife and Worklife. Several outpost nurses

expressed difficulty in balancing their homelives and worklives. Many nurses

have voiced that they find balancing homelives and worklives difficult. In three

studies (Bergman, 1994; Donner, Semogas, & Blythe, 1994; Ross, Rideout, &

Carson, 1994), nurses reported experiencing a high level of stress associated

with caregiving in both their professional and private lives. Further study in

balancing homelife and worklife amongst outpost nurses is warranted due to

their geographical isolation from social support systems.

Discussion of QWL Issues in Work Design

Outpost nurses discussed numerous work design issues that were

perceived to enhance or detract from their QWL. Participants identified the

following work design factors as positive elements in their worklife: (1) learning

on the job; (2) independence; (3) being the doctor; and (4) we do everything.

Significant negative worklife issues were related to lack of resources.

Learning On the Job

Learning on the job provided nurses with intellectual stimulation that was perceived as personally fulfilling. This finding was similar to the findings of two studies where nurses spoke of learning from the experiences of patients, which provided self-fulfilment (Baldwin & Price, 1994; Ross, Rideout, & Carson, 1994). Baldwin and Price (1994) identified that learning opportunities within community health nursing created "work excitement" which in turn, provided nurses with personal fulfilment. In Attridge and Callahan's study of nurses' QWL (1989), participants identified that QWL was enhanced when intellectually challenging work was experienced. Participants in this study did not relate learning on the job to quality of patient care.

Independence

When participants were asked, "What do you like about your work?", they frequently and without hesitation, answered that they enjoyed their independence. Independence or autonomous practice provided outpost nurses with control and power over a limited aspect of their work. Autonomy has been defined as control over work activities (McCloskey, 1990). Independence fulfilled outpost nurses' needs for power and control in a worklife setting with limited human and material resources. The finding that outpost nurses enjoyed their autonomous practice supported reports of other studies in a variety of nursing specialties (Attridge, 1996; Attridge & Callahan, 1989; Blanchfield & Biordi, 1996; Blegen, 1993; Canitz, 1990; GNWT, 1990; Goodell & Van Ess Coeling, 1994; Irvine & Evans, 1995; McCloskey, 1990; Wade, 1993). Findings

of this study supported that autonomy is an important feature that enhances

nurses' QWL. "This whole notion of *control over work* - control over the content

of work, the place of work, the hours of work, appeared to be a critical

component of the nurses' definition of power (Attridge, 1996, p. 50).

Being the Doctor

Being the doctor was perceived by outpost nurses as a valuable role.

Participants demonstrated and expressed pride in being able to perform medical

tasks. Ross, Rideout, and Carson (1994) reported that nurses identified feelings

of recognition and self-esteem that stemmed from a realization that they were

making a valuable contribution to society. Perhaps, the outpost nurses

perceived that by "being the doctor", they were contributing positively to the

northern community. This contribution may have enhanced their self-esteem.

We Do Everything

When outpost nurses described the nature of their work, they exclaimed,

"We do everything!" This finding supported the findings of other studies and

anecdotes about outpost nursing (Canitz, 1990; Edmundson & Loughran, 1989;

GNWT, 1990; Gregory, 1992). By locating "we do everything" within the

phenomenon of fulfilment, I concurred with Canitz's viewpoint (1990, p. 28).

The attraction of northern nursing has been enveloped by the mystique of

'the expanded role.' Nurses are attracted to a work place where they are

freed from the confines of the institutional patriarchy inherent in the health

care system. This 'expanded' power comes by default. Nurses in the

north are awarded additional power as there are no other health care

professionals that would tolerate this work situation. The limited resources of the central administration are unable to provide other services or control the day-to-day activities of nurses in remote posts. Historically, nurses were legislated to provide comprehensive health care services to specific population groups when medical coverage was inadequate. As the number of physicians working in rural and northern Manitoba is limited, outpost nurses are responsible for fulfilling the roles of all health team members. Outpost nurses were especially proud of performing tasks that were deemed to be doctors' skills. They described their work in terms of being the doctor, not being the nurse. Perhaps, their pride and feelings of accomplishment were based upon society's value of physicians and the medical model of health care. By interviewing First Nations People about their perceptions of health care services, their value set may also be identified.

Outpost nurses also described several QWL issues that negatively affected their QWL. Under work design, significant negative worklife issues were related to lack of resources. Lack of resources has been identified as a negative worklife factor in previous studies (Canitz, 1990; Edmundson & Loughran, 1989; GNWT, 1990). In this study, the most significant resource that was lacking was human resources. Therefore, I discuss understaffing noted in this study and relate it to the literature. I also examine a significant consequence to understaffing - lack of community health programs.

Lack of Resources - Understaffing

Of all the work design factors that outpost nurses perceived to negatively affect their QWL, the most significant issue was lack of resources, specifically lack of human resources. Understaffing was identified in 3 of the 4 participating outpost stations. Understaffing created severe consequences in outpost nurses' worklife. These consequences were identified as sustained heavy workload, high number of hours worked per week, inability to provide a personal touch, inability to provide safe patient care, lack of community health programs, along with occupational stress, fatigue, and health-related problems.

In previous studies on outpost nursing, a high turnover rate was identified as a chronic problem (Canitz, 1990; GNWT, 1990; Morewood-Northrop, 1994; Nowgesic, 1995). Participants in this study were generally experienced as outpost nurses and had been employed in their current position for a length of time. One participant actually wondered why understaffing continued to be a problem when many nurses were unemployed or being laid off "down south." Understaffing may have been due to two alternative factors: (1) an exodus of outpost nurses from northern Manitoba; or (2) MSB not filling available positions. In the study conducted by the GNWT (1990), lack of staffing for positions to cover for vacation, sickness, and educational leaves created a constant recruitment situation. The GNWT found that resources to fill to the appropriate staffing levels were lacking (1990). The GNWT (1990) proposed that planning for these staffing situations would reduce or eliminate the need for short term contracts with nurses.

The third most highly ranked QWL item for nurses in British Columbia was identified as adequate staffing for patient acuity/number (Attridge & Callahan, 1989). In another study conducted by Attridge (1996), a common thread in all identified powerless situations (n=64) as described by nurses, was a lack of resources. Specifically, lack of human resources created situations for nurses and patients that were unsafe or potentially unsafe. As powerlessness was a strong theme in the findings of this study, I propose that understaffing was strongly linked to this perception.

Lack of Community Health Programs

Another significant finding under work design issues was the nurses' provision of acute health care services versus community health programs. Participants expressed their concern over their inability to provide community health programs. Community health programs were not provided because the stations were understaffed. Nurses were experiencing a resultant sustained heavy workload, as the community required acute health care services. Acute health care was provided as a priority service. Lack of community health programs has been a common concern voiced by nurses in a variety of geographical locations (Canitz, 1989; Clevett & Maltby, 1992; Doucette, 1989; Gregory, 1992; Mardiros, 1987; Morin, 1984; Scott, 1991). Cheater (1993) expressed concern about limited community health programs in northern Manitoba communities. "Nursing stations on many Manitoba reserves are severely understaffed and more nurses are urgently needed...Teaching people

the importance of good hygiene is one of the tasks of nurses but it's a job many overworked nurses rarely have time for" (Cheater, 1993, p. A14).

Discussion of QWL Issues In Work Context

Pertinent QWL issues in work context were acknowledged. Identified worklife issues under work context were outpost nurses' relationships with colleagues, nursing administration, physicians, and their perceived lack of personal safety.

Relationships with Colleagues

Participants recognized that positive working relationships with other outpost nurses enhanced their QWL, while negative relationships with colleagues created more stress in their work and home environment. The importance of positive working relationships with colleagues was similar to a QWL item identified by nurses participating in Attridge and Callahan's study (1989). The most highly ranked QWL item was supportive, amiable, enthusiastic, competent, and committed colleagues (Attridge & Callahan, 1989). In Blegen's meta-analysis of related variables affecting nurses' job satisfaction, communication with peers was noted as a moderate indicator (1993). The findings of this study supported McCloskey's reports that nurses valued autonomy, but with autonomy, nurses wanted connectedness with peers (1990). In light of their geographical isolation and perceived isolation from family and friends, positive working relationships with peers provided outpost nurses with necessary social support.

Perceived Lack of Support From ZNOs

Participants perceived a lack of support from various ZNOs. This finding supported reports of other studies on outpost nursing (Canitz,1990; Edmundson & Loughran, 1989). Canitz (1990) found that only 12% of nurses working north of the sixtieth parallel turned to their supervisors when they had a professional concern. This finding was also congruent with reports from other researchers where nurses tend to express their beliefs about managers as an "us-them" opposition (Farrell & Nuttall, 1995; Traynor, 1994). In other studies, nurses rated emotional support and resource support from superiors as important QWL items (Attridge & Callahan, 1989; Blegen, 1993; Coward, Hogan, Duncan, Horne, Hilker, & Felsen, 1995; Hood & Smith,1994; Irvine & Evans, 1995).

In particular, Aboriginal nurses perceived that they had no voice, could not trust, and were not supported by various ZNOs. One participant described feeling discriminated against by various ZNOs during her lengthy worklife experience as an outpost nurse. Aboriginal nurses are and will continue to be significant health care providers in northern communities. Since Aboriginal nurses are being actively recruited into outpost nursing positions, worklife issues specific to this group need to be identified, explored, and improved.

Specific concerns of Aboriginal nurses were previously described in the literature: (a) the trauma of leaving their home communities to acquire a nursing education; (b) being scrutinized as "elitists" by community members because of their experience 'outside' the community; (c) inner conflict occurring due to differing personal and professional values; and (d) interpersonal conflict with

other members of the health care team. The only worklife concern that emerged from the data of this study was interpersonal conflicts with several ZNOs.

Interprofessional Relationships

Relationships outside of the nursing profession included outpost nurses' relationships with on-site physicians, Thompson physicians, CHRs, support staff, and Band Constables. Outpost nurses described positive interprofessional relationships with many on-site physicians and other health care team members. Conflicts were described between Thompson physicians and outpost nurses. Participants avoided confrontation with Thompson physicians in the event of a conflict. This finding was similar to Roberts' observation that although nurses complain about physicians within the nursing group, they rarely generate an explicit complaint to the physician (1994). In this depiction, Roberts (1994) was comparing the behaviour of nurses to the behaviour of oppressed groups and termed it the submissive-aggressive syndrome. "Nurses have criticized themselves for this passive-aggressive behaviour, but it is only symptomatic of their situation" (Roberts, 1994, p. 33). Like other oppressed groups, nurses are forced to be dependent and submissive in order to deal with the domination of the powerful group (Roberts, 1994).

Living in Fear

Participants identified that they were living in fear for their personal safety. Outpost nurses were keenly aware of safe versus unsafe situations. They voiced their concern about providing health care services to clients with mental health problems, a history of violence, and substance abuse problems. The

presence or absence of human resources such as physicians and RCMP officers were noted. This finding was significant in that outpost nurses in northern Manitoba have previously identified a high prevalence rate of post-traumatic stress disorders (Kirwan, 1994). During Kirwan's study (1994), MSB implemented a program to enhance outpost nurses' safety. Perhaps, the information from these programs had sensitized the nurses' awareness of safe and unsafe work environments. I propose that the reality of the situation was that these northern communities were experiencing severe socioeconomic consequences that created potentially and actual unsafe work environments for nurses.

Canitz (1990) found that all participants in her study spoke about the difficulties of providing support services and health care to an Aboriginal community that was under siege. The psychological turmoil of Aboriginal people, along with their economic and political uncertainty created a sense of alienation for northern nurses (Canitz, 1990). The findings in this study expanded on this sense of alienation. Outpost nurses in northern Manitoba were keenly aware of maintaining their personal safety in a potentially unsafe environment due to complex historical, and sociopolitical factors.

Discussion of QWL Issues in Work World

Under work world, I identified the following QWL issues of outpost nurses in northern Manitoba: (1) clients' demands on the system; (2) "it's very political up here"; and (3) nursing job market. These QWL issues will be discussed and related to the literature.

Clients' Demands on the System

Participants enjoyed the suspenseful aspect of their work and the variety of patient needs. This finding supported job satisfaction theory that described feedback together with variety in patients, task identity, and autonomy as inter-related variables affecting job satisfaction (Wade, 1993).

Although outpost nurses identified the variety of patient needs as a positive worklife factor, this factor was tempered by feeling massive responsibility. The overwhelming responsibility inherent in their work was a negative factor for some participants. Several nurses described feeling an overwhelming amount of responsibility in the provision of comprehensive health care services to First Nations clients, families, and communities. This finding reflected Gregory's depiction of nursing practice in Aboriginal communities (1992).

Outpost nurses identified that clients' dependence upon the system caused them to feel frustrated and increased their workload. Again, participants voiced their sense of powerlessness when clients' were perceived to be overly dependent upon them. As patients were not interviewed and nurse-patient interactions were not observed, a limitation of this study was not being able to assess patients' perceptions as consumers in a health care system.

The finding that nurses were frustrated with clients' dependence supported previous research on outpost nursing (Canitz, 1990; Edmundson & Loughran, 1989). I noted that participants in this study voiced a limited understanding of the historical and sociopolitical context that created the

dependence of First Nations People upon the health care system. This particular lack of acknowledgment was also identified in Edmundson and Loughran's study (1989). Canitz (1990) described the historical and sociopolitical context of clients' dependence:

> For decades and even centuries in some regions, native people have been forced to obtain most goods of daily living through non-native people and the government and commercial agencies they represent. Past policies and practises have created a dependency and it is difficult to reverse this trend. Even though native people and nurses despise this dependency, they have been socialized to accept and often perpetuate this situation (p. 24).

It's Very Political Up Here

Findings indicated that nurses perceived that they were powerless in an intensely political environment. Outpost nurses perceived that the Band Chief and Council were in total control of their worklives. Outpost nurses voiced their concern that the Band Chief and Council were not working with them - they were working against them. All participants addressed the notion of being shunned and banished from a community due to a BCR.

This finding was significant and supported the reports of Edmundson and Loughran (1989). These researchers indicated that health care to northern Manitoba's Aboriginal population was inundated with conflicts that existed among the stakeholder groups.

Participants' sense of powerlessness and their struggle with the political nature of their relationships with the Band Chief and Council differed greatly from the results of Canitz's study (1990). In the study of nurses working north of the sixtieth parallel, Canitz reported that 71% of respondents identified that they perceived the Hamlet or Band Council were supportive (1990). Although Canitz (1990) noted a sense of optimism and cooperation developing from the combined strengths and cohesiveness of small towns, she also stated, "Native populations are themselves disempowered, and unable to instigate changes within the nursing station or the health care system which they feel are necessary" (p. 28). Outpost nurses in northern Manitoba perceived that the First Nations People were powerful, and able to instigate changes within the outpost station. This difference in perception may be due to the different populations served or to a trend for First Nations People in Manitoba to wield more power and control in their own communities.

Outpost nurses in northern Manitoba perceived that the Band Chief and Council were working against them - not with them. This perception was embedded in an environment (the outpost station) where nurses functioned as acute health care providers. Participants rarely functioned as community health nurses and rarely expressed involvement in community development.

The political nature of relationships with clients, support staff, the NIC, and ZNOs was described by participants. Politics were perceived to undermine effective working relationships that outpost nurses strived to attain with clients, support staff, the NIC, and ZNOs. By relating this finding to Roberts (1994), I

noted that this finding reflected the outpost nurses' sense of powerlessness. By blaming the lack of effective working relationships on politics, outpost nurses were demonstrating a common characteristic of oppressed groups. This finding supported Edmundson and Loughran's report that northern nursing was inundated with contradictions and conflicts in power among participant groups (1989).

Nursing Job Market

Several participants addressed how the job market in nursing affected them. Some outpost nurses described how the bleak job market in southern Canada steered them into considering a northern nursing experience. One participant questioned why outpost stations were under-staffed when many nurses were searching for work. The finding that several nurses were motivated to consider a northern nursing experience due to the shortage of nursing positions in southern Canada was unique. The finding may be related to health care reform.

Discussion of Nurses' Perceptions of Patient Outcomes

Many participants identified that the quality of care in the community was good. Nurses' self esteem and job satisfaction were enhanced when they acknowledged that the care that they provided was "good." This particular finding was congruent with a finding noted by Attridge (1996). Attridge's research revealed that power for nurses was the ability to have control over the work situation such that nurses could successfully bring about more effective patient care. This definition of power, specifically the need to be successful, had

major implications. Attridge (1996) noted that many participants in her study acted very powerfully in difficult situations. Despite their powerful behaviour, they were not successful in reaching their goal. Therefore, these nurses experienced powerlessness. Additionally, participants expressed feeling guilty and accepted blame as individuals rather than sharing the problem with other levels of the organization. Attridge (1996) declared that these responses did not serve nurses well in that they were destructive and failed to define and solve problems. Moreover, these responses may be seen to serve others within the health care system such as physicians and administrators.

As stated previously, a limitation of this study was that patients were not asked for their perceptions about the quality of care received. Patients' perceptions would have added strength to the study. Future nursing research could attempt to identify a relationship between outpost nurses' QWL and patient outcomes.

Consequences of Not Examining Outpost Nursing
Within Its Historical and Sociopolitical Context

Effects of historical and sociopolitical contexts of nursing need increased attention from nursing scholars (Donner, Blythe, & Semogas, 1994). Nurses' worklives may be understood more fully by relating present day homelife and worklife conditions, history, along with feminist theory and discourse (Donner, Blythe, & Semogas, 1994). Outpost nurses have advised newcomers to examine this unique kind of nursing within its broader historical and sociopolitical context (Canitz, 1990; Goodwill, 1992; Gregory, 1992).

Participants in this study voiced feelings of personal fulfilment related to a variety of worklife factors. Outpost nurses in northern Manitoba also expressed a profound sense of powerlessness in their descriptions of worklife scenarios. By not examining outpost nursing within the broader historical, and sociopolitical context, these participants were limiting their perspectives on health care issues of First Nations communities. This limited perspective may be a symptom of an oppressed group (Roberts, 1994).

A significant consequence of not examining outpost nursing within a broader context, was that problems were not directly confronted. Significant problems may have been identified, but outpost nurses failed to attempt to problem solve. For example, outpost nurses identified conflicts with physicians in Thompson. Physicians were rarely confronted with the nurses' honest viewpoints. Due to a perceived lack of support from various ZNOs, nurses did not approach nursing administration with concerns. In respect to frustration over clients' demands on the system, nurses failed to acknowledge the historical and sociopolitical factors affecting dependency. Outpost nurses voiced their frustration, and rarely spoke about strategies to reduce clients' dependency.

By examining outpost nursing in a broader context, outpost nurses in northern Manitoba may consider the necessity for community development. Due to difficult worklife situations such as understaffing, acute care health services, and a high number of hours worked per week, nurses were fatigued. In this state, they were unable to broaden their perspective of the importance of community involvement and development.

Evaluation of Quality of Nursing Worklife Model

A research objective was to evaluate the applicability of the Quality of Nursing Worklife Model developed by the Quality of Nursing Worklife Research Unit, Faculty of Nursing, University of Toronto and School of Nursing, McMaster University. The model was a useful guide for the study as it provided a broad framework that could be applied to any nursing setting, including outpost nursing. A variety of internal and external factors in the model affected outpost nurses' QWL.

The model was limited in that it failed to adequately include several important features of outpost nurses' worklives. QWL issues that were not articulated by the model included fulfilment, power/powerlessness, and nurses' interactions with their clients. When outpost nurses experienced a personal connection with their clients, they perceived that their work was meaningful. These positive experiences provided personal fulfilment and added to their job satisfaction. Many worklife factors that outpost nurses perceived to negatively affect their QWL were related to the nurses' perceptions of having no power.

Outpost nurses' worklife differed from other nurses' worklife. Outpost nurses' homelife and worklife occurred in the same environment, the outpost station. Other nurses' homelife and worklife occurred in different environments, their homes and their workplaces. Working and living together was a significant worklife factor that affected outpost nurses' QWL. The difference in outpost nurses' worklife is depicted in Figure 16 on page 279.
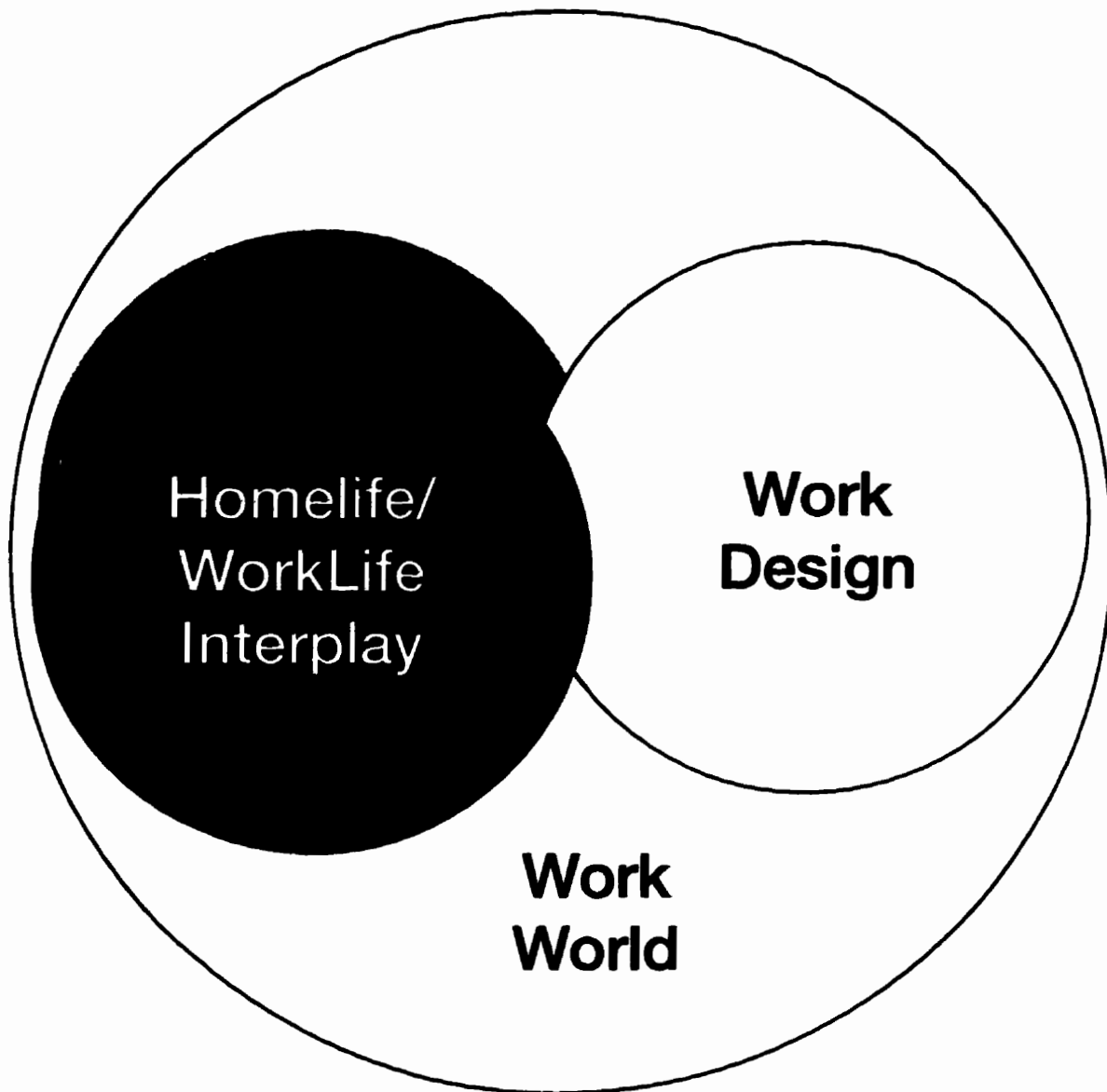
Figure 16. Schematic diagram depicting outpost nurses' QWL.

As shown in Figure 16 on page 279, working and living together strengthened the major QWL category of homelife/worklife interplay. Working and living together affected other aspects of outpost nurses' worklives as illustrated in the overlap of homelife/worklife interplay on other worklife categories. Working and living together was such as significant QWL issue that homelife/worklife interplay actually smothered the category of work context.

In the Quality of Nursing Worklife Model, the category of work world encompassed the health care system. This category included clients' demands on the system, health care policies, and nursing job markets. O'Brien-Pallas and Baumann (1992) failed to acknowledge the profound effect that politics has upon nurses' worklives. Under the category of work world, I added the significant worklife issue, "it's political up here." Outpost nurses recognized that politics affected their worklives negatively. They also perceived that politics impeded their roles as outpost nurses and created problems in their abilities to provide quality health care. I have depicted the significance of "it's political up here" on outpost nurses' worklife in Figure 16 on page 279. Because politics was perceived to influence all aspects of outpost nurses' worklife, I illustrated work world in a manner that surrounds their worklife.

The Quality of Nursing Worklife Model was applicable to the outpost nursing setting. Because this model included a wide range of worklife factors, it provided a broad framework to guide the study. The model was limited in that it did not address significant worklife issues and outcomes: fulfilment, power/powerlessness, and nurses' interactions with clients. A worklife issue that

outpost nurses identified to be important to them was their interactions with their clients. Outpost nursing was unique in that working and living together greatly affected their worklives. Another worklife issue that the category of work world failed to address was the political arena. Politics was identified as an issue that profoundly affected nurses' worklives. Politics was perceived by nurses to negatively affect their abilities to provide quality patient care.

Recommendations

Based upon the findings of the study, I developed recommendations. Recommendations for nursing practice, education, research, and administration are provided.

Nursing Practice

Uniting Voices. Attridge and Callahan (1989) suggested creating and achieving solidarity among members in the nursing group. I strongly recommend that outpost nurses' unite their voices, by becoming active members within various nursing organizations. Organizations that could promote outpost nursing and outpost nurses' viewpoints include the union, provincial nursing association, and the Aboriginal Nurses Association of Canada (ANAC). As members of an organization, outpost nurses could share their concerns and strategies. They could acquire and provide support to their nursing colleagues and the public. Nursing organizations could communicate outpost nurses' concern about understaffing, fear for personal safety, inadequate housing, lack of community health programs, and the need for mental health resources in the north.

Adjusting Hours of Operation of Clinic. Perhaps, one way to initially include the community in the delivery of health care, is to conduct a needs assessment. Nurses could inquire what the needs of the community entail regarding the hours of operation of the clinic. The hours of operation of the clinic may be adjusted accordingly.

Recreational Activities. Many participants voiced that they would appreciate an exercise room. If nurses combined their resources, they may be able to construct an exercise facility within the station. Non-Aboriginal nurses could be encouraged to spend their time off work away from the workplace setting. The development of positive recreational activities could include Non-Aboriginal nurses' participation in group and/or community activities. Aboriginal nurses could mentor Non-Aboriginal nurses in regards to how to spend their time off work. Nurses who ventured out into the community to meet the people could encourage their colleagues to follow suit.

Nursing Education

Value for Nursing and Traditional Healing. Outpost nurses demonstrated and expressed their value for the biomedical model of health care. Other models of health care such as a nursing theory, or traditional healing were rarely described. Nursing education could address students', nurses', administrators' and consumers' values and attitudes about health and health care. Personal philosophies of nursing, environment, client, and health may be explored.

I initially supported Canitz (1989) and considered encouraging northern nurses to escape the limited visions of their education and bureaucratic

socialization. To serve as advocates and facilitators of First Nations People's health, northern nurses must "choose to move beyond the limited boundaries of the medical model and our 'western' philosophy" (Canitz, 1989, p. 182). Farrell and Nuttall (1995) have studied the values of various groups. These researchers advocate using a common value such as caring to bridge the gap between groups that hold differing values and worldviews (Farrell & Nuttall, 1995). As the internalization of values is a long term process, it may be beneficial to openly acknowledge outpost nurses' value for the medical model of health care and link it to traditional healing or a nursing model through the common value of caring.

Political Know How. "It's very political up here" was identified as a significant QWL issue. Participants recognized that politics influenced their relationships with clients, support staff, NICs, ZNOs, and the Band Chief and Council. Outpost nurses expressed feeling powerless when political issues influenced their homelives and worklives. Problem-solving strategies were not addressed and methods to become empowered and involved in politics were not identified by the participants. Roberts (1994) noted that oppressed groups must initially acknowledge their oppression.

Knowledge about politics and nurses' roles in politics may benefit outpost nurses. Information about Band politics and nurses' roles in politics could be provided to outpost nurses in the form of a workshop or correspondence course. The ANAC may be an appropriate agency to provide this information.

In recent advances of health care reform in the Province of Manitoba, the Manitoba Association of Registered Nurses (1994) has advocated that regional boards consist of a member of the nursing profession. In order to ensure that nurses' voices are heard, an outpost nurse's involvement in the northern regional board would be beneficial to health care reform.

Knowledge About Community Development. Orientation of new staff members and inservice sessions to current outpost nurses may include information about the importance of community involvement in health care. MSB, the ANAC, nurses experienced in community development, and representatives from each community may provide educational programs on how nurses and community members could work together. Educational sessions may provide information on how to conduct a needs assessment, develop and implement community health programs, and evaluate these programs.

Nurses perceived that the Band Chief and Council impeded their roles as health care providers. Participants voiced frustration over client's dependence on the system. By empowering community members and working together with the Band Chief and Council on health care issues, effective working relationships may be fostered.

Knowledge About Cultural Differences. Although MSB includes information on cultural differences in its orientation program, Non-Aboriginal nurses require regular inservice sessions to facilitate a process of cultural

sensitivity. MSB and the ANAC could develop, implement, and evaluate the effectiveness of these sessions.

Nursing Research

QWL Issues of Outpost Nurses Employed By Other Agencies. I

recommend that a study be implemented on QWL issues of outpost nurses employed by other agencies. By comparing and contrasting the QWL issues of outpost nurses employed by MSB, Manitoba Health, and First Nations communities, knowledge about outpost nursing would be expanded.

QWL Issues of Male Outpost Nurses. All participants in this study were

women. QWL issues of male and female outpost nurses may be similar or different. For example, feelings of powerlessness may be gender specific. A study on the QWL issues of male outpost nurses would be beneficial.

Effects of Nurses' QWL on Clients. As the research design of this study

failed to include patients' perspectives, a limitation was its inability to evaluate if nurses' QWL actually affected patient care. Future research about the affects of nurses' QWL on clients is warranted. The findings of a study that included an observation of nurse-patient interaction could be compared and contrasted with O'Neil's findings (1989). Hewison (1995) used participant observation to determine nurses' power in interactions with patients.

Action Research. Each community demonstrated similar and different

health care needs. Action research may assist communities and nurses in identifying actual health care needs and effective short and long term strategies

to provide comprehensive health care services to First Nations communities. The benefits of action research include empowerment of community members.

Historical Research. Nurse researchers have recommended that historical research may improve the notion of respect and value for the nurse, the importance of nurses' work, and the quality of nurses' clinical judgment in the performance of work (Attridge, 1996; Attridge & Callahan, 1989). A historical research study on outpost nursing in northern Manitoba may provide nurses with valuable information to improve morale.

Nursing Administration

Improving Staffing. I recommend that MSB evaluate their current recruitment strategies and staffing ratios in northern Manitoba. Although recruitment of outpost nurses has been described as costly, the cost of understaffing may indeed be greater. Since the GNWT developed and implemented recruitment and retention strategies that included a job-sharing program (Morewood-Northrop, 1994), MSB could consult this agency. A recruitment and retention committee comprised of a human resources expert, a Regional Director, a ZNO, a NIC, a member of the ANAC, and several outpost nurses may contribute to further acquisition and retention of nurses.

Findings of this study indicated that job sharing enhanced the QWL of outpost nurses. More job sharing positions could be devised.

Based upon the finding that Aboriginal nurses expression of a long term commitment to outpost nursing, recruitment of Aboriginal nurses into outpost nursing positions would tend to provide MSB with long term employees.

Developing, Implementing, and Valuing Community Health Programs.
Lack of community health programs in First Nations communities could be
addressed by MSB. MSB could support and encourage action research in each
community to facilitate the conduction of a needs assessment Short and long
term strategies may then be developed to provide a comprehensive health care
program along with community development.

Improving Mental Health Resources. I recommend that MSB revise its
current practice of transporting patients out of the community to access mental
health care. By transporting mental health workers into the communities at
scheduled times, patients and nurses would be provided with access to these
resources in a cost-effective manner.

Providing Adequate Housing. I suggest that MSB contact the GNWT
about policies on outpost nurses' housing (Canitz, 1990; GNWT, 1990;
Morewood-Northrop, 1994). I recommend that MSB work together with outpost
nurses to examine communal living versus separate residences. An
assessment of safety related to the housing arrangements of teachers, Northern
Store employees, and RCMP officers could be conducted. MSB and its
employees may identify adequate and safe living accommodations. As
demonstrated in the study in the NWT (GNWT, 1990), outpost nurses' QWL may
be enhanced with the provision of adequate housing.

Promoting and Assuring Nurses' Safety. Living in fear for personal
safety was identified by the participants as a worklife issue that negatively
affected QWL. Environmental safety, adequate staffing, and human resources

must be ensured to improve the nurses' perception of safety. I would strongly suggest that MSB, First Nations communities, the nursing union, and the professional nursing association work together to create and maintain environments that provide for an improved sense of nurses' safety.

Support from the ZNOs. Findings of the study suggested that various ZNOs were perceived as ineffective in their management of outpost nurses. Qualifications and continuing education of ZNOs may require further examination and revision on the part of the Zone Director. QWL of outpost nurses may be enhanced if ZNOs acquire education and skills related to management theory and strategies. As suggested by Chalmers and Kristjanson (1992), managers of community health programs may require preparation at a master's or doctoral level.

Based upon the finding of nurses' perception of powerlessness, I recommend that nursing administration explore management techniques that empower employees. In future communications between ZNOs and outpost nurses, ZNOs may choose to validate that outpost nurses indeed perceive that they are heard. Accurate information may be provided to nurses in a direct manner. When ZNOs actively listen to outpost nurses' concerns, outpost nurses may perceive support from administration. The Zone Director may choose to acquire information about the outpost nurses' perceptions of support from the ZNOs.

Resolving Conflicts with Thompson Physicians. Based upon the findings of this study, I recommend that MSB explore conflicts between outpost

nurses and Thompson physicians with their employees. Following this examination, MSB, nurses, and physicians could work together to address conflicts and develop strategies to resolve them. Perhaps, outpost nurses may benefit with the provision of assertiveness training.

Preparing Non-Aboriginal Nurses for Re-integration into the South.

Many Non-Aboriginal nurses suggested that debriefing and preparation for re-integration into the "south" would be beneficial. I recommend that MSB develop a debriefing and preparatory program. Prior to returning to the "south" for a holiday, inservice, or upon completion of a contract, Non-Aboriginal nurses could be provided with a telephone call from MSB's occupational health nurse or a ZNO. At this time, the outpost nurse could be provided with information about nurses' experiences returning to the "south." Problem-solving strategies could then be mutually explored.

Reflection and Reflexivity

Reflection

According to Rubinstein (1991), reflection is defined as a process whereby the ethnographer looks back upon the fieldwork to form specific self-images. Reflection also involves the management of self-images.

During this study's fieldwork, I documented my thoughts and feelings. When I looked back upon my fieldwork experience and reread my fieldnotes, I was able to construct several self-images. These self-images portrayed an ethnographer, who initially was filled with self-doubt and as time progressed,

self-confidence emerged. Elements of culture shock and ethnocentrism were also reflected.

Lacking previous experience as a principal investigator instilled a lack of confidence in my abilities to collect sufficient data for the study. In my first fieldnote, I documented how these feelings of self-doubt surfaced.

> I was up at 5:30 A.M. to catch my flight to Thompson...I was feeling very tired and kind of numb...I have been so anxious these past 4 days...This worry culminated on Sunday night with a dream that I had been fired from my job...due to my irresponsible behaviour of losing a travel authorization form for my research study. In my dream, I pleaded with my boss, who fired me in front of everyone in the coffee lounge following a meeting. I shouted, "This should have nothing to do with my job; I have only screwed up at the University!" It was a horrible dream (FN30894 p. 2, line 1).

As the fieldwork experience progressed, I documented an improvement in my self-confidence as a researcher. My self-image reflected an ethnographer who was a becoming a skilled interviewer and keen observer. Other qualities that were reflected were self-sufficiency, dedication, commitment, and resourcefulness.

Prior to embarking on the flight from Winnipeg to Thompson, I was processing fears about experiencing a different culture - the culture of outpost nurses. I was wondering how well I would be accepted as an ethnographer by the outpost nurses.

I am anxious about travelling into unknown territories. I keep experiencing an image of being an actress in an old western style movie. My character comes from the eastern part of the United States. My character is travelling by stage coach to the frontier land. My character is unaware of frontier land people, their culture, their beliefs, and their practices (FN 26894 p. 1).

Each culture has certain words, language, or jargon that it uses to depict the realities of their world. Outpost nurses used jargon to depict their world. As a stranger to this world, it was acceptable for me to ask the nurses questions about their language. For example, several nurses were referring to clients who had spent time in "the cells." I explained to the nurses that I did not understand this jargon. They provided me with their definition - "the cells" meant the local jail. Being a stranger to the world facilitated acquisition of data.

Initially, I was concerned about being not blending in with the culture of outpost nurses. During the fieldwork experience, I perceived that outpost nurses welcomed me as they were enthusiastic about this study.

Bonnie: I was really pleased that you were doing this study (p. 32, line 2). By participating in the study, nurses were provided with the opportunity to voice their pleasures and concerns.

Elizabeth: This is long overdue and it's very, very important and I hope they send a copy to Medical Services and give us a copy because this is good because I mean, it's nice to be asked what our feelings are about being here (p. 24, line 20).

I experienced culture shock in ways that I had not anticipated. During the course of my fieldwork, I experienced being a member of a cultural minority on numerous occasions. In these instances, I noted that I was the only White person amongst First Nations People.

> Somewhere along the line, it struck me that all the people here are
> Aboriginal. I'm not sure when, where, and how it struck me, but I know I
> clued in sometime (FN6994 p. 6).

I documented several instances that reflected an element of ethnocentrism. My cultural values, attitudes, and beliefs were revealed. At these times, I lacked insight into another culture's values and beliefs.

> My perception of the residences are that some could fit into suburbia very
> nicely, while other houses are small and not painted. This observation
> made me surmise that the people in this community have a range of
> economic resources. I question if this is an assumption that stems from
> my cultural background and past life experiences (FN30894 p. 5).

Being aware of my ethnocentric values, attitudes, and beliefs facilitated observations and interpretation of ethnocentrism in others.

Reflexivity

"Reflexivity, or the position of the researcher as both participant and investigator, provides nurses with the opportunity to explore cultures within the paradigm of nursing that values the affective and subjective nature of human beings" (Streubert & Carpenter, 1995, p. 92). Reflexivity is a process that

requires the researcher to actively analyze and apply the fieldwork experience to improve data collection techniques and data interpretation (Rubinstein, 1991).

During my fieldwork, I actively analyzed and applied the research experiences to improve data collection and interpretation. In one community, I asked outpost nurses what questions they would ask if they were conducting this study. Due to the nurses responses, I became engaged in a reflexive process and revised future data collection techniques.

I got a chance to ask the nurses if they were doing this research study, "what would they ask outpost nurses?" One nurse responded with, "Don't you have the questions ready yet?" I laughed and said yes, but I wanted to know if I was on the right track. I'm uneasy about the way this went. As it turned out, my interview guide is on the right track (FN30894, p. 23).

Reflexivity affected my interpretation of the data. I documented a dream that I had experienced during the initial course of the fieldwork. The dream illustrated the political conflicts and powerlessness that I had been observing and hearing from the nurses' interviews.

I was in the middle of a dream about a boxing match, where it was really political. The contender was trying to switch from heavy-weight to middle-weight to have a better chance of winning. The only reason why I think I dreamt this was because of the political realm that I have found myself in...It was not violent or upsetting (FN2994, p. 1).

Although I had not formally identified "it's political up here" as a worklife issue at this point in the fieldwork, this fieldnote illustrated how I processed what I was seeing, hearing, and feeling.

Appendix J depicts my initial analysis of the data. During the process of data analysis, I experienced conflicting demands in my homelife and worklife. I was newly married. With this marriage, I was introduced to four new family members: my husband, and three teenagers. With my new role as a wife and stepmother, I experienced numerous rewards and many new stressors. To cope effectively with the demands of these new roles, I chose to reduce my stressors by taking a break from the data analysis.

When I revisited the data, I found that I was able to examine outpost nursing from a broader perspective. The themes, fulfilment and powerlessness, emerged when I revisited the data. Perhaps my recent life experiences provided me with a deeper insight into homelife/worklife interplay. As I had experienced fulfilment and powerlessness in my new situation, I could relate fulfilment and powerlessness to the culture of outpost nursing.

Reflexivity added meaning and depth to the research findings. As a researcher, reflection and reflexivity optimized my experience.

Summary

An ethnographic study, funded by the Canadian Nurses Foundation and the Manitoba Association of Registered Nurses, was implemented to examine quality of worklife (QWL) issues of outpost nurses in northern Manitoba. QWL issues are factors that affect nurses' perceptions about their practice (Donner,

Semogas, & Blythe, 1994). The "Model for Quality of Nursing Worklife" was used to guide the study (O'Brien-Pallas & Baumann, 1992).

Detailed fieldnotes were maintained during a 10 day field experience to four First Nations communities in northern Manitoba in 1994. One to two hour semi-structured interviews were conducted with 5 Aboriginal and 6 Non-Aboriginal outpost nurses who volunteered to participate. Interviews were audio-taped and transcribed verbatim. Transcripts and fieldnotes underwent content analysis to identify open codes, categories and themes.

Outpost nursing was found to be inundated with contradictions and conflicts, similar to results of Edmundson and Loughran's study (1989). They voiced that positive worklife factors outweighed the negative ones.

When participants spoke about worklife issues that enhanced their QWL, they spoke about a sense of accomplishment and satisfaction. I identified the theme, fulfilment, to depict positive QWL issues. Fulfilment was comprised of the following categories: (1) attachment to clients; (2) learning on the job; (3) independence; (4) being the doctor; (5) we do everything; (6) a variety of patient needs; and (7) providing quality patient care.

Participants expressed concern over a number of worklife factors that they perceived to negatively affect their QWL. I identified the theme, powerlessness, to exemplify these perceptions of outpost nurses. Categories within the theme, powerlessness, were: (1) isolation from family and friends; (2) working and living together; (3) inadequate educational preparation; (4) frustration over clients' dependence on the system; (5) massive responsibility; (6) understaffing;

(7) never really off; (8) living in fear; (9) perceived lack of support from the ZNOs; (10) conflicts with Thompson physicians; and (11) it's very political up here. Worklife factors were discussed in relation to the historical and sociopolitical context of Aboriginal health care and outpost nursing. Findings were compared and contrasted with previous research.

Recommendations for nursing practice, education, research, and administration were provided. These recommendations were based upon the findings of the study.

Processes of reflection and reflexivity were addressed. By reflecting and being reflexive, I was provided with the opportunity to examine and analyze data collection techniques, interpretation of data, and my skills as a nurse researcher.

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Appendix A
Map of Northern Canada
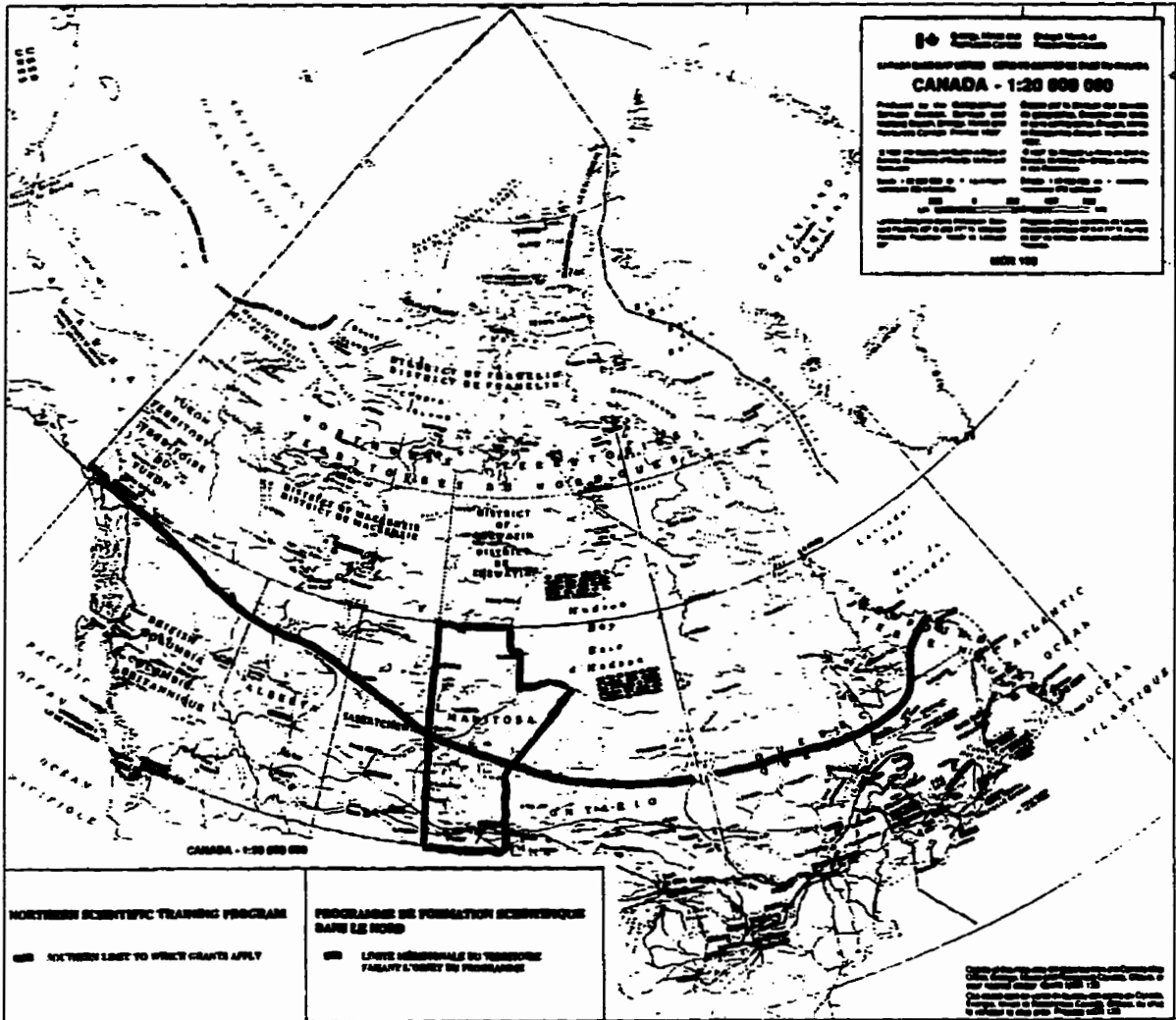
Note. From Northern Scientific Training Program Student's Manual, by Department of Indian Affairs and Northern Development, Circumpolar and Scientific Affairs Directorate, Ottawa, 1993, p. ii.

Appendix B
Letter of Permission from Medical Services Branch

Winnipeg, Manitoba

Dear   ,

This is in response to our conversation of this morning and your letter of October 18, 1993 addressed to Brenda Roos, the Acting Regional Nursing Officer of Manitoba Region.

In your letter you had requested access to nurses working in remote communities in order to interview them about their coping strategies secondary to social isolation and their constant nursing role in a community with a different culture. You listed eight communities of specific interest to you and further wanted feed back regarding their view of the necessity to inform Chief and Councils regarding your study.

Brenda Roos forwarded your request to Bill Rutherford, the Regional Nursing Officer who has subsequently asked me to canvas nurses in each of the communities you listed. I approached all Nurses in Charge; they were all keenly interested and all projected that their staff nurses would be eager to participate. They all advised that Chief and Councils should be appraised of your study prior to your interviews.

Jim Mair, the Zone Director in Manitoba North Zone, is aware of your proposed research as are the two other Zone Nursing Officers with whom I work, Denise Wedmeyer and Berni Decender. Jim Mair has offered to write to the Chiefs in Manitoba North if this would be of help to you.

I hope the above information is of help to you and I wish you all the best with your research and thesis. I look forward to a copy of the out come.

Sincerely yours

Dagmar Philbrook
North Zone, A/ZNO

cc Bill Rutherford. RNO
   Jim Mair, North Zone, ZD

Canada

Appendix C
Letter to Band Chiefs and Council

April 4, 1994

Chief and Council
Address

Dear (Name).

We are writing to request permission from you regarding the participation of your community's nurses in a proposed research study. Ms. Donna Martin, RN. BN , a graduate nursing student from the University of Manitoba, is planning to study quality of worklife issues for outpost nurses in northern Manitoba as a thesis topic. The objectives of the research are:

1. explore quality of worklife issues of outpost nurses in northern Manitoba.
2. identify positive and negative quality of worklife issues.
3. discuss the quality of worklife issues that impact on nursing care of individuals, families and northern communities.
4. develop and communicate recommendations for future nursing practice, education, research and administration.

The communities that have been approached to participate in this study are South Indian Lake, God's River, God's Lake, Island Lake, Split Lake, Shamattawa, Oxford House, Nelson House, and Cross Lake. At this time, all nurses-in-charge have responded positively regarding the willingness of nurses to participate.

Data collection will tentatively occur during August or September, 1994. The data collection will involve Ms. Martin travelling to your nursing station and visiting the nurses for a time period between 24 - 48 hours, dependent upon travel arrangements. Accommodation for Ms. Martin will be arranged with the nurse-in-charge.

Nurses volunteering to participate, will be provided with a consent form assuring them of their anonymity and describing the process prior to data collection. During data analysis and reporting, the locations of the nursing stations will not be identified as an adjunct measure to ensure the anonymity of the nurses.

The nurses will take part in one interview that will be audiotape recorded. Each participating nurse will be interviewed for one to two hours. The interview will be scheduled at an appropriate time when the nurse is not directly involved with patient care. The tape recording of the interview will be transcribed. The content of the transcripts will be analyzed for quality of worklife issues.

In order to provide quality health care to northern communities, nurses must be in prime physical and mental health. As the clients of nurses in outpost stations are predominantly First Nations People, First Nations People will ultimately benefit if deliberate measures are taken to improve the worklife and overall health status of the nurses. To adequately prepare and effectively support nurses who have embarked on this northern experience, nursing research must explore their worklife.

The future of health care for First Nations People will undoubtedly involve transfer from government administration to First Nations People. The findings of this study could provide many insights into the future plan for recruitment and retention of qualified nurses who are sensitive to the health care needs of northern residents. We are hopeful that you will grant us permission to conduct the study. Once the study is completed, a copy of the findings will be supplied to you.

If you have any questions or concerns, please contact us. Would it be possible to inform us about your decision by telephone or fax prior to April 29, 1994? Thank you for your consideration.

Respectfully,

Mr. Jim Mair, Zone Director.
Medical Services Branch
Health Canada
Fax 677-7007

Ms. Donna Martin, RN. BN. Graduate Nursing Program
Faculty of Nursing
University of Manitoba
Fax. 275-5464

Appendix D
Facsimile Requesting Volunteers

July, 1994

Dear Outpost Nurses,

    I am a graduate nursing student in the Faculty of Nursing,University of Manitoba. I am conducting a research study entitled, "An ethnographic study examining the quality of worklife issues of outpost nurses in northern Manitoba."

    I will be travelling to your outpost station in the near future. I would like to observe your worklife during my 1 - 3 day visit and interview nurses who have volunteered to participate. If you choose to participate, I will interview you about your worklife for one to two hours. The interview will be audiotaped so that I can transcribe the interview word for word. I am the only person who will have access to these tapes. Your name will not appear on the transcripts, in subsequent documentation of the study or in future publications. Similarly, the names of the outpost stations will not appear on the transcripts, in subsequent documentation of the study or in future publications. Access to the transcripts will be available only to me and my thesis committee members. My committee members are Professor David Gregory, Associate Professor Pat Farrell and Dr. John O'Neil. Professor Gregory may be reached at (telephone number).

    If you are a registered nurse, employed by Medical Services Branch at an outpost station and are willing to participate, please contact me by calling collect at (telephone number). Following this telephone contact, a consent form will be faxed to you for you to read, sign and copy. One copy will be returned to me during my visit.

                         Sincerely,

                         Donna Martin, RN, BN
                         Faculty of Nursing
                         University of Manitoba
                         Room 246 Bison Building
                         Winnipeg, Manitoba
                         R3T 2N2

Appendix E
Consent Form

Dear Outpost Nurse,

Thank you for expressing an interest in participating in the study entitled,
**"An exploratory study examining the quality of worklife issues of outpost
nurses in northern Manitoba"**. I am interested in learning about your worklife.
You are being invited to participate in the study because you are a registered
nurse employed by Medical Services Branch, Health Canada at an outpost
station in northern Manitoba.

This study has received approval from the Ethical Review Committee,
Faculty of Nursing, University of Manitoba. I have acquired permission from
Medical Services Branch and the Band Chief and/or Councillor. This study has
been funded by the Manitoba Association of Registered Nurses, and the
Canadian Nurses Association.

If you agree to participate, this study will involve me travelling to your
outpost station in August or September, 1994, to observe your worklife. During
my 1 to 4 day visit to your outpost station, I will be maintaining fieldnotes about
my observations of your worklife. We will schedule a 1 to 2 hour interview that
will be audiotaped. During the interview, I will ask you questions about your
worklife. At a later date, I will be transcribing the tapes word for word and
referring to my fieldnotes for data analysis.

Your participation will be confidential and known only to me. Your name and the name of your outpost station will not be used in the transcripts, fieldnotes, write-ups or presentations about the study. In order to ensure your confidentiality, references about your outpost station will be stated as "an outpost station in northern Manitoba". I alone will know your identify. Your anonymity will further be protected as my thesis committee members (Professor David Gregory who can be reached @ 1 - 474-9317, Associate Professor Pat Farrell, Dr. John O'Neil) will not be aware of the data's relationship to individual outpost nurses or outpost stations. The consent forms, audiotapes and transcripts will be stored in a locked filing cabinet for 7 years and then they will be destroyed.

You are under no obligation to participate. You may change your mind and refuse to participate without any personal or professional consequences to you. If you agree to participate, you may withdraw from the study or refuse to answer any questions at any time without any consequence. If you have questions regarding this study, please do not hesitate to ask me in person or by telephone. **Call collect @** (telephone number). All participants will receive a preliminary summary of the findings which will be mailed to you. All participants will be asked to review the preliminary summary and telephone me collect with their thoughts about the results of the study.

I greatly appreciate your interest in helping me learn about your unique kind of nursing. While your participating in this study may have minimal benefit

to you personally, it is anticipated that the shared experiences of nurses like you will provide a better understanding of the worklife factors that affect outpost nurses' quality of worklife.

Sincerely,

Donna Martin, RN, BN,

Graduate Nursing Student

Faculty of Nursing

University of Manitoba

Room 246 Bison Building

Winnipeg, Manitoba

R3T 2N2

Date_____I agree to participate (please sign here) _____

Print Name Here: _____

After you have signed this form, please photocopy it and return one copy for me prior to the interview.

Appendix F

Demographic Data Collection Tool

The researcher will complete this form for each participant prior to the interview.

Code:

A   __

B   __

Site   __

Participant __

1. Gender: Male   Female

2. Highest earned diploma or degree?

RN Diploma   Master's Degree in Nursing

Basic Bachelor Degree in Nursing   Other Master's Degree

Post-RN Bachelor Degree in Nursing   Other

Other Bachelor Degree

3. How many years have you worked as an outpost nurse? _____years

4. Approximately how many hours per week do you work ? _____hours

5. Approximately what proportion of your work time is spent working shifts other than the Monday-to-Friday day shift?

_____%

6. What is your age?   _____years

Note: Adapted from Worklife Concerns of Ontario Nurses in 1993 by M. Villeneuve et al, Quality of Nursing Worklife Research Unit, p. 18.

Appendix G

Interview Guide

1. When I say "quality of worklife", what comes to your mind? In other words, what does "quality of worklife" mean to you?

2. Could you please tell me what outpost nurses do?

3. I would like you to describe a normal day in your life as an outpost nurse.

4. What do you like about your job?

5. In your own words, tell me a story about your worklife where you felt satisfied with your work.

6A. Tell me about the elements of your worklife that are a concern to you. (after interview #1, I added question 6B.

6B. Other nurses have talked about BCRs. What do BCRs mean to you?

7. What do you remember about your worklife that exemplifies a situation where you felt dissatisfied with your work?

8. Do you feel that Aboriginal and Non-Aboriginal nurses have similar or different factors affecting their worklife? What are these similarities/differences?

9. What strengths do you feel you bring to your position as an outpost nurse?

10. What weaknesses do you feel you bring to your position as an outpost nurse?

11. Please describe what you do when you are not working.

12. Tell me what northern nursing has done to your family life, relationships with friends and significant others.

13. Do you have any concerns about your safety? If so, what are your concerns?

14. Do you feel that your worklife affects your health? If so, how?

15. How do you view the quality of patient care in this community?

16. Please tell me about your involvement with the community.

17. What structures and processes are in place that facilitate your role as a nurse?

18. What structures and processes are in place that impede your role as a nurse?

19. If you could change any aspect of your worklife, what would you change? How would you change it? Why would you change it?

20. What do you recall about re-integrating into the "south"? How do you prepare yourself for this? (This question was added while in the field)

21. Here is a schematic diagram depicting a Model for Quality of Nursing Worklife developed by the Quality of Nursing Worklife Research Unit in Ontario. As you can see, the Model describes factors that affect worklife, nurses and patients. I'd like you to tell me your thoughts and feelings about each of these factors. Does this model apply to your worklife?

22. Is there anything else that you would like to tell me about your worklife? Please take this opportunity to voice what you came here to say.

Appendix H

Cover Letter to Participants for Member Checks

May 8, 1995

Dear (Name of Outpost Nurse),

Enclosed please find Findings of "An ethnographic study examining quality of worklife issues of outpost nurses in northern Manitoba". Please review the enclosed package that outlines the preliminary findings of the study. If you have any questions or suggestions about any aspect of the preliminary findings, I would greatly appreciate your input. You can contact me by collect telephone call @ (telephone number) **from June 5th to June 19th, 1995.**

Thank you for participating in the study. I greatly appreciated the interest you displayed in helping me learn about your unique kind of nursing. While your participation in the study may have minimal benefit to you personally, it is anticipated that the shared experiences of nurses like you will provide a better understanding of the worklife factors that affect outpost nurses' worklife.

I plan to complete my study by the beginning of September, 1995. In the fall, I will forward you a summary of the findings of the study. Have a great summer !

Yours truly, (signed)

Donna Martin, RN, BN

Graduate Student, Faculty of Nursing
246 Bison Building, University of Manitoba, R3T 2N2

Appendix I

Cover Letter to Band Chiefs and Councils for Member Checks

May 8, 1995
Chief (Name)
Address, Manitoba
Postal Code

Dear Chief (Name) and Council,

Re: Research study entitled, "An ethnographic study examining quality of worklife issues of outpost nurses in northern Manitoba"

Thank you for your support of this study. Permission to visit your community to collect the data for the study was greatly appreciated. It is anticipated that the shared experiences of outpost nurses will provide a better understanding of the worklife factors that affect outpost nurses in northern communities.

Enclosed please find **Findings** of the above study. Please review the enclosed package. If you have any questions about the preliminary findings, I would greatly appreciate hearing from you. Please contact me by collect telephone call @ (telephone number) from June 5th to June 19th, 1995.

Upon completion of the study this fall, I will forward you a final summary of the findings.

Yours truly,

DONNA MARTIN, RN, BN
Graduate Student
Faculty of Nursing
Room 246 Bison Building
University of Manitoba
Winnipeg, Manitoba
R3T 2N2

Appendix J

Document Used for Member Checks

An Ethnographic Study

Exploring Quality of Worklife Issues

of Outpost Nurses in Northern Manitoba

Findings

by Donna Martin, RN, BN

Faculty of Nursing

University of Manitoba

Winnipeg, Manitoba

Abstract: An ethnographic study, funded by the Canadian Nurses Foundation and the Manitoba Association of Registered Nurses, was implemented to identify quality of worklife issues of outpost nurses in northern Manitoba. The "Model for Quality of Nursing Worklife" was used to guide the study as it provided a broad framework (O'Brien-Pallas & Baumann, 1992). A nurse researcher travelled to four outpost stations in northern Manitoba where semi-structured interviews were conducted with 5 aboriginal and 6 non-aboriginal outpost nurses. The interviews were audiotaped and transcribed verbatim. Detailed field notes were maintained. The transcripts and field notes underwent content analysis. Preliminary findings demonstrated that aboriginal and non-aboriginal outpost nurses voiced similar quality of worklife issues such as: (a) working and living together in the same environment, (b) high number of hours worked per week, (c) sustained, increased workload, (d) lack of community health programming, (e) lack of mental health resources, and (f) local political issues. Differences between aboriginal and non-aboriginal outpost nurses occurred in the areas of incorporating traditional healing methods, participating in community activities and reintegrating into urban life.

Background to the Study

Several articles describe outpost nursing in northern Canada as challenging and rewarding (Kraiker, DeLuca & Hood, 1983; Morewood-Northrop, 1994; Nanowski, 1993). To function as an outpost nurse, recruits are advised to prepare to nurse in an expanded role, to live in a community with a different culture, and to experience social isolation (Gregory, 1992; Morin, 1984; Scott, 1991; Smith, 1983).

Three studies on northern nursing were located in which consequences of nursing in remote areas were explored (Canitz, 1990; Government of Northwest Territories, 1990; Kirwan, 1994). These researchers identified burnout, turnover and post traumatic stress disorders as effects of northern nursing.

Canitz (1990) used questionnaires (n=54) and interviews (n=16) to examine job satisfaction and burnout of outpost nurses in the Northwest Territories (NWT). Turnover was found to be related to loneliness, unrealistic job expectations, lack of continuing education, lack of professional support and cultural and community issues. Job retention was found to be positively influenced when nurses participated in the community, enjoyed the northern lifestyle, and experienced professional support.

In 1989, a survey was circulated to 557 members of the NWT Registered Nurses Association to find out why the nursing turnover rate was 70% (Morewood-Northrop, 1994). The survey's response rate was 62.5%. Of the respondents, 77.6% were outpost nurses (Government of NWT, 1990).

Continuing education, job-sharing programs, and independent living quarters were suggested as measures to improve nursing retention (Government of NWT, 1990).

Kirwan (1994) conducted a 2 year pilot project in northern Manitoba to address northern nurses' concerns about critical incidents or traumatic events. Kirwan (1994) interviewed 20 participants: nurses, nurse managers, occupational health nurses, and personnel consultants. Based on the findings of these interviews, questionnaires were constructed and mailed to 140 nurses employed in northern hospitals, health centres, and outpost stations. Eighty-eight nurses completed the questionnaires for a response rate of 63%. All respondents had been involved in at least one critical incident such as the death of a child, attempted assault or threat to a nurse, or a suicide attempt of a patient (Kirwan, 1994). Nurses working in outpost stations were more likely to be exposed to violence than nurses working in northern health centres or hospitals (Kirwan, 1994). A prevalence rate of 33% for diagnosable levels of post traumatic stress disorder among the northern nurses was reported (Kirwan, 1994). This study was limited in that its questionnaire lacked reliability. Signs and symptoms of post traumatic stress disorder and sleep deprivation are similar. Outpost nurses often work a high number of hours per week causing fatigue. Similar signs and symptoms may have skewed the findings to reveal a high prevalence rate of post traumatic stress disorders. National recommendations such as initiating a northern critical incident stress program, eliminating the practice of placing only one nurse in a community, ensuring that

preventative training in security be available to all nurses, and upgrading safety

features of all nursing stations were made (Kirwan, 1994).

Study's Purpose and Objectives

The purpose of this study was to explore quality of worklife (QWL) issues

of outpost nurses in northern Manitoba. Three research objectives were

developed:

1. Identify QWL issues of outpost nurses in northern Manitoba;

2. Compare and contrast aboriginal and non-aboriginal outpost nurses'

perspectives of QWL.

3. Develop recommendations for future nursing practice, education,

administration, and research.

Definition of Variables

1. nurses' worklife - the practice of nursing in any setting. Factors that contribute

to nurses' worklife fall under four broad categories: (a) homelife/worklife

interplay,

 (b) work design or nature of the work, (c) work context or nature of the work

environment, and (d) work world or the health care system (O'Brien-Pallas &

Baumann, 1992);

2. QWL issues - perceived elements of nurses' worklife that influence QWL;

3. outpost nurse - registered nurse employed by Medical Services Branch

(MSB), Health Canada in an outpost nursing station;

4. northern Manitoba - a region of the province of Manitoba that lies north of the 54th parallel as recommended by the Northern Scientific Program, Canadian Association of Northern Universities.

Theoretical Framework

A model identifying the relationships between nursing worklife factors was developed by O'Brien-Pallas and Baumann (1992). Worklife factors were collapsed into four broad categories: (1) homelife/worklife interplay; (2) work design or the nature of the work; (3) work context or the nature of the work environment; and (4) work world or the entire health care system. Homelife/worklife interplay depicts the relationship between nurses' homelife and worklife. For example, availability of childcare would fall under this category. The second category, work design, includes nursing delivery models such as primary care nursing or team nursing, workplace policies, shiftwork, and technology. Work context is a term used to describe the environments in which nurses practice, including management techniques, communications systems, and physical layout of the workplace. The fourth category, work world, involves the overall health care system, and includes health care policies and nursing job markets. The model posits that worklife factors affect nurses and their patients (Villeneuve, Semogas, Irvine, McGillis, Peereboom, Walsh, O'Brien-Pallas, & Baumann, 1993). Nursing worklife factors affect nurses in regards to job retention, satisfaction with employment, occupational health status, job-related stress, commitment, motivation, and quality care delivery (O'Brien-Pallas & Baumann, 1992). Nursing worklife factors affect patients with respect to

satisfaction with care delivery and improvement in health status (O'Brien-Pallas & Baumann, 1992).

Ethnography

Since the aim of ethnographic research is to describe and understand the people being studied (Chuborn, 1991), we decided that this approach would be appropriate in an exploration of outpost nurses' worklife. Ethnography was initially used by anthropologists studying different cultures (Chuborn, 1991). In recent years, ethnography has been used to learn about groups within our own society (Chuborn, 1991). Field (1983) described a "new ethnography" which asks, "How do members of a nursing culture actively construct their social world?" Rich descriptions are elicited through the use of probing questions or statements in face-to-face interviews (Field, 1983). Additionally, detailed field notes supplement the interview data. Ethnography facilitates a description of the everyday lives of outpost nurses (Fetterman, 1989).

Population

Nursing stations in Manitoba are administered by the provincial government, federal government, or First Nations People. The number of nurses employed at outpost stations administered by Manitoba Health is approximately 8 (personal communication, J. Gow, June 17, 1994). The number of outpost nurses employed by MSB and/or First Nations People is approximately 145 (Kirwan, 1994). Within Manitoba, just over 150 registered nurses are employed in outpost station settings.

Sample, Setting, Ethical Considerations and Data Collection

Chiefs and Councils were approached for permission to conduct the study in nine communities. Eight Chiefs and Councils supported the project.

Following approval from the Ethical Review Committee, University of Manitoba, Faculty of Nursing, outpost stations in the eight communities were sent faxes, inviting registered nurses to participate in the study. The nurses were asked to contact me by collect telephone call if they were interested in the study. Following their contact, I faxed a consent form, which described the methodology of the study and measures to be taken to ensure participants' anonymity. As recommended by Freeman (1993), names or the participants and identifying features of communities do not appear on any documents or presentations about the study.

Research grants for the study were provided by the Manitoba Association of Registered Nurses and the Canadian Nurses Foundation. Given the cost of transportation, funding secured for the study limited travel to four northern communities, but facilitated a ten day field experience. During the researcher's experience in the four communities, detailed field notes were maintained regarding outpost nurses' worklife.

Five aboriginal and six non-aboriginal nurses volunteered to participate. The interviews lasted from one to two hours and were tape-recorded. A semi-structured interview guide based on the "Model for Quality of Nursing Worklife" was used. The tapes of the interviews were transcribed verbatim.

Of the eleven participants, eight were employed as indeterminate or full-time nurses, two were relief nurses, and one nurse was employed in a part-time/job-sharing position. All participants were women. Their ages ranged from thirty to fifty-one years, with a mean age of 39.5 years. Eight nurses held a diploma in nursing, while three nurses were baccalaureate prepared. The length of outpost nursing experience ranged from one to fourteen years with a mean length of experience of 4.8 years.

Data Analysis

The interview transcripts and field notes were reviewed many times to facilitate content analysis. When reading the words, significant phrases were documented in the format of open codes. Open codes, describing similar concepts were grouped together to form categories and themes. Data were explored for similarities as well as differences.

QWL of Aboriginal and Non-Aboriginal Outpost Nurses

Expanded Nursing Role, Variety in Patients' Needs and Independence

Certain aspects of outpost nursing were viewed favourably by aboriginal and non-aboriginal outpost nurses. Outpost nurses enjoyed an expanded nursing role, variety in patients' needs, and independent practice. Outpost nurses' scope of practice has been expanded to include conducting diagnostic tests such as X-rays, formulating medical diagnoses, prescribing and dispensing medications, and performing other physicians' functions such as suturing.

Outpost nurses expressed a sense of excitement and a enjoyed challenges of being presented with a variety of patient needs. Northern

residents were described as having a variety of needs, ranging from nutritional counselling for pregnant women to emergency management, stabilization, and transportation of trauma patients.

Independence was perceived as a positive element of outpost nurses' worklife. All outpost nurses voiced that they enjoyed independent decision-making and practice.

Working and Living Together in the Same Environment

Outpost nurses discussed their relationships with other nurses working at the station. In contrast to other settings, working and living with other people in the same environment strongly affected their QWL.

If a relationship with another outpost nurse was positive, homelife/worklife was enjoyable and QWL was satisfactory. If a relationship with another outpost nurse was negative, homelife/worklife was not enjoyable and QWL was viewed negatively. Although one nurse acknowledged the establishment of close friendships, she noted that ordinarily and under southern conditions, she would not have chosen to socialize with her work colleagues. She expressed a sense of forced interaction and a need to socialize as a consequence of isolation.

Outpost nurses voiced that their privacy and living space were valued parts of their lives. When asked what aspects of their worklife they would change, the nurses talked about having living quarters that were separate from the workplace. Many non-aboriginal nurses did not participate or engage in community activities and therefore, wanted a place "to get away from it all". Within a context of isolation these nurses wanted to be alone.

High Number of Hours Worked Per Week

Outpost nurses worked 37.5 hours/week in a clinic setting at the station. In addition to this mandatory schedule, they were "on call" every second or third evening/night and every second or third weekend. "On call" work was similar to work in an urban or rural hospital's emergency or outpatient department. Nurses performed telephone triage and managed patients in acute phases of illnesses or injuries. The hours worked per week ranged from 24 (one part-time nurse) to 93.5 hours. The mean hours worked every week was 74, while the median was 75 hours. When asked about hours worked, outpost nurses readily stated, "37.5 hours in the clinic". The hours worked "on call" required more probing from the researcher. The participants accepted working an 80 hour week as standard practice for outpost nursing.

Sustained, Increased Workload

Outpost nurses expressed feelings of job dissatisfaction and fatigue in times of a sustained, increased workload. According to the participants, the number of nurses employed in each station should be based on a ratio of one nurse for every five hundred people in the community. Using this criterion, three of the four stations were short-staffed by one to two nursing positions. When stations were not appropriately staffed, nurses were required to increase the number of patients examined in the clinic during the day and had to work more evenings/nights "on call".

Lack of Community Health Programming

Outpost nurses were concerned about not fulfilling their employer's mandate of providing health promotion and illness prevention programs to the people in northern communities. They described the necessity to institute and maintain health education programs in northern communities. Unfortunately, the outpost nurses were often unable to initiate and continue community health programs because their time was spent providing acute health care services.

Lack of Mental Health Resources

Concerns were voiced about personal safety and lack of expertise in caring for people with mental health problems. The nurses were distressed about lack of mental health resources in northern Manitoba. Some nurses talked about feeling uncomfortable working in the area of mental health. They identified inadequate knowledge and lack of clinical skills to care for people with mental health problems. A few nurses revealed a limited understanding about the people who were suicidal in their communities. In these instances, the complex environmental, contextual, and historical factors that contribute to the alarming suicide rates were not acknowledged.

Local Political Issues

Outpost nurses expressed concern over local political issues. For example, Band Councils pass resolutions about various local issues. However, outpost nurses only referred to band council resolutions that expelled health care professionals from the community.

QWL of Aboriginal Outpost Nurses

Group and Community Activities

In this sample, many of the aboriginal nurses grew up in northern communities. They were inclined to spend their time off work away from the workplace, participating in group and/or community activities. The aboriginal nurses voiced a keen interest in learning about the northern community in which they worked. These nurses actively explored the northern community and interacted with the people in their homes and at community events.

Knowledge of Language and Culture

Aboriginal nurses perceived that their firsthand knowledge about the culture and language assisted them in performing thorough assessments and determining appropriate care for their patients. Among the aboriginal nurses, there was a wide range of knowledge of traditional healing methods. Aboriginal outpost nurses spoke about the importance of patients' spirituality and the necessity of incorporating traditional healing into their nursing care plans.

QWL of Non-aboriginal Outpost Nurses

Lack of Group and Community Activities

Non-aboriginal outpost nurses spent more of their time off work within the nursing station setting. They participated less in group/community activities. Due to the high number of hours worked per week, non-aboriginal nurses tended to spend their time off work alone in their living quarters.

Re-Integrating To Urban Life

Non-aboriginal nurses talked about feelings they had experienced on return to urban settings. The northern experience, although greatly valued, was also viewed as temporary by many non-aboriginal outpost nurses.

Conclusion

The findings of this study indicated that aboriginal and non-aboriginal outpost nurses voiced positive worklife factors such as satisfaction with an expanded nursing practice role, variety of patients' needs, and independent practice. They shared similar QWL concerns such as: (a) living/working in the same environment; (b) high number of work hours; (c) sustained, increased workload; (d) lack of community health programming; (e) lack of mental health resources in the north; and (f) local political issues. Aboriginal nurses spent more time off work participating in group or community activities. They attempted to connect and invest in their communities, more so than their non-aboriginal colleagues. Aboriginal nurses perceived that their firsthand knowledge of language and culture enhanced their ability to care for First Nations People. Non-aboriginal nurses spent their time off work in their living quarters located within the outpost station setting. This practice, instead of providing an opportunity to "get away from it all" may contribute to a further sense of isolation for these nurses and negatively impact on their QWL.

A summary of the findings of the study will be shared with participants, Chiefs and Councils from the four northern communities, Medical Services

Branch, the Manitoba Association of Registered Nurses, and the Canadian

Nurses Foundation.