

## CANADIAN RURAL WOMEN'S EXPERIENCES WITH RURAL PRIMARY HEALTH CARE NURSE PRACTITIONERS

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### ABSTRACT

**Background:** In Canada, one in five women lives in a rural area. These rural women often experience different health challenges than urban women, including lower life expectancy, higher rates of disability and cancer, fewer available health care resources and greater distances to access health care services. Nurse practitioners [NPs] provide important primary health care [PHC] services to rural women.

**Research Objective:** The purpose of this research study was to explore rural women's experiences with primary health care nurse practitioners [PHCNPs].

**Method and Sample:** In-depth, face-to-face interviews using interpretive description methodology were conducted with nine rural women, aged 18-80, who used NP services in rural southwest Ontario, Canada.

**Results:** The participants in the study particularly appreciated the nursing knowledge of the NP, the time the NPs spent with them, and the thoroughness of the care provided by NPs. These foundational elements of the participants' experiences with rural NPs created a sense of trust and respect, which lead to a collaborative partnership between the NP and the rural women.

**Conclusions:** Results of this study suggest that these rural women were overwhelmingly satisfied with the care provided by NPs. In particular, they valued the collaborative partnership with the NP. These findings have important implications for rural health care practice, policy, and education.

### BACKGROUND AND SIGNIFICANCE

In Canada, one in five women lives in a rural area (Health Canada, 2002; Sutherns, McPhedran & Haworth-Brockman, 2004). Rural women face unique health challenges, such as a lower than average life expectancy, and higher rates of disability, infant mortality, and deaths from cancer and circulatory diseases compared to their urban counterparts (Romanow, 2002; Sutherns et al.). These health risks are combined with a lack of access to appropriate primary health care [PHC] services, as an estimated 5.5% of

rural dwellers have no access to PHC services compared to 4.5% of urban dwellers (Statistics Canada, 2004). Clearly, rural women's health is an important area for study (Leipert, 2005; Sutherns et al.). Through the provision of high quality accessible care, nurse practitioners [NPs] can play an important role in the delivery of PHC services to rural women (Canadian Nurse Practitioner Initiative [CNPI], 2006; Government of Ontario, 2006).

The Canadian Nurse Practitioner Initiative [CNPI] (2006) recommends that "Canadians... should have the opportunity to have NPs on their health-care teams" (p.12). However, in Canada, despite the proven efficacy of NPs (Way, Jones, Baskerville, & Busing, 2001), the inclusion of the NP on the health care team is in its infancy. Because the health of rural women is often overlooked, and because rural women are often the key health care providers in their families (Leipert, 2005), it is important to understand rural women's experiences with rural primary health care nurse practitioners [PHCNPs]. The purpose of this research study was to explore rural women's experiences with primary health care nurse practitioners [PHCNPs]. The findings of this research provide important information with regards to how rural NPs can best meet the health care needs of rural women, and can help to inform practice decisions and policy development.

## **REVIEW OF THE LITERATURE**

Multiple databases were examined, including the *Cumulative Index to Nursing and Allied Health Research*© (CINAHL); *ProQuest Nursing Journals* ®; *Pub Med*; *PsycINFO*©; *Women's Studies International*; and *Google Scholar*™. Search words included "rural areas," "rural women," "rural health," "farm women," "geographic isolation," "women's health," "primary health care services," "primary health care nurse practitioners," and "advanced practice nurses". Inclusion criteria for the literature review were that articles were: 1) published in the English language; 2) published in the last ten years with the exception of classic articles; 3) research based and focused on rural women, PHC services, and PHCNPs; and 4) reflected research conducted in Canada and other developed countries (including the United States, Australia, and the United Kingdom). Exclusion criteria included articles that were not written in English and that focused on an urban setting. Additional sources of literature included relevant federal and provincial government and nursing organization reports; these aided in grounding the study within the Ontario context as NP practice in Canada is jurisdictional.

Accordingly, the literature review addresses the following topics: 1) NPs and principles of PHC; 2) rural women's PHC needs and expectations; and 3) client-NP interactions and outcomes.

### ***Nurse Practitioners and Principles of Primary Health Care***

NPs have been practicing in PHC in Canada since mid-1960s (Nurse Practitioners Association of Ontario [NPAO], 2005; Patterson, 2001). However, it has only been within the past ten years that their role has begun to be recognized. Recently the provincial government of Ontario has started an initiative entitled "Grow Your Own NP" (Government of Ontario, 2006). This initiative is targeted at aiding rural and remote communities in the expansion of PHC care services, including NPs. Primary health care is based on five principles (Stewart & Langille, 1995): 1) accessibility of care, 2) public

participation, 3) intersectoral and interdisciplinary collaboration, 4) appropriate technology, and 5) increased health promotion and illness prevention services. Primary health care NPs are registered nurses with extended authority that allows them to communicate diagnoses, prescribe approved drugs, and order and administer approved diagnostic services and therapies. PHCNPs provide wellness care, diagnose and treat minor illnesses and injuries, and screen and monitor chronic diseases such as diabetes and hypertension (College of Nurses of Ontario [CNO], 2008; NPAO, 2005).

In an evaluation study at four rural PHC sites in Ontario, Way et al. (2001) compared the roles of NPs working directly with a family physician with the roles of NPs working autonomously in their own practice. They found that NPs in both areas were underutilized in curative and rehabilitative care, and the authors suspected this was likely because of insufficient knowledge amongst family physicians regarding NPs' scope of practice. The authors also found that NPs provided more care relevant to disease prevention and support systems than did physicians.

Reay, Patterson, Halma and Steed (2006) conducted a research study in Taber, Alberta, to evaluate the integration of NPs into rural PHC. Using a grounded theory methodology, these authors specifically examined the role of NPs and explored the meaning of integrating NPs to rural physicians in eight family practice clinics. The researchers found that clinic physicians "believed that patients received better health care services because of the NP" (Reay et al., 2006, p. 103). Reasons for this conclusion included: 1) physicians were able to take on a larger client load while working the same number of hours; 2) emergency room visits were decreased due to the educational support provided by the NP with clients; and 3) the NP initiated a women's health clinic and asthma services which had great success (measured by the number of clients requesting to see the NP). Finally, physicians also viewed the role of the NP positively due to the overwhelmingly high client satisfaction with the NP.

In summary, NPs can meet the PHC care needs of clients including rural women, provided that physicians, patients, and other health care providers are knowledgeable regarding the nature and scope of NP practice.

### ***Rural Women's Primary Health Care Needs and Expectations***

The first national study of rural, remote and northern women's health (Sutherns et al., 2004) found that rural women across Canada frequently did not have access to primary health care, that they required more diverse health care practitioners, that they often preferred female health care providers, and that rural women often perceived that male physicians lack understanding of rural women's health care needs and expectations. Similarly, in a literature review regarding rural women's health and implications for policy and research, Leipert (2005) found that "women often feel more comfortable addressing sensitive topics with other women and they perceive that female care providers afford more respect, time and care to the women" (p. 111). In a descriptive research study examining NPs in Ontario, Sidani, Irvine and DiCenso (2000) concluded that 95% of NPs in Ontario are female, which suggests that the majority of NPs in Ontario meet rural women's preferences for care provided by females.

Paluck, Allerdings, Kealy and Dorgan (2006), in a qualitative study using eight focus groups with 44 women in rural Saskatchewan, explored the health promotion needs of rural women. These authors found that rural women's health promotion needs vary across the lifespan; for instance, younger women have health needs in regards to

childbearing, whereas older women have health needs in regards to managing chronic health conditions. Such findings support the argument that rural women need health care services that are flexible to meet their health care needs. Leipert and George (2008) in their study of the determinants of rural women's health in Ontario discovered that rural women require voice, power, and participation in health care and in their communities to advance and support their health. PHCNPs have the means to meet these varying health care needs by practicing in collaboration with rural women and other rural health care providers, and by having the expertise to meet the holistic health care needs of rural women of all ages (CNO, 2008; NPAO, 2006). Additionally, NPs have the ability to work in collaboration with the community, help communities mobilize necessary resources, and develop community programs and specialty clinics to meet specific health care needs (CNO; NPAO).

In summary, NPs as nurses who are predominantly female (Sidani et al., 2000) have the ability to meet the health care needs and preferences of rural women. In addition, NPs practice within the five principles of PHC (CNO, 2008; Stewart & Langille, 1995), the basis of Canada's health care system, and thus can help empower rural women by using a holistic and inclusive approach to primary health care (NPAO, 2006).

### ***Client-Nurse Practitioners Interactions and Outcomes***

Few researchers in Canada have examined client satisfaction and other outcomes with PHCNPs. However, the IBM business consulting services and McMaster University (2005) conducted a study examining the integration of PHCNPs in the Ontario health care system as well as patients' experiences with NPs. A total of 260 individuals (73% of whom were women) completed the written survey. Overall it was concluded that participants were satisfied with the care provided by the NP; this was attributed to the time and the quality of the care the NP provided. This finding is supported by Roblin, Becker, Adams, Howard and Roberts (2004) who conducted a retrospective study related to NP practice in metropolitan Atlanta, Georgia, using a client satisfaction survey. The survey was administered to a random sample of clients of both sexes within two weeks of their PHC visit and examined clients' satisfaction with NPs and physicians. The authors concluded that patients were more satisfied with the care provided by NPs than with care provided by physicians. This was attributed mainly to the fact that clients could arrange to see the NP sooner and the appointment time with the NP was longer, which resulted in increased satisfaction of clients.

Horrocks, Anderson and Salisbury (2002) conducted a systematic review of the literature to determine whether NPs in PHC in the United Kingdom could provide care comparable to that of physicians. They concluded that clients were *more* satisfied with the care provided by NPs and overall health outcomes were similar. NPs communicated in a way that clients found to be empowering and comforting, they tended to be very thorough in their assessments, and they spent time discussing health care concerns with clients, giving them more information than physicians. Moreover, these authors suggested that increasing the number of NPs in PHC would likely increase patient satisfaction and lead to a higher standard of health care. A randomized controlled trial conducted in England comparing cost effectiveness of general practitioners and NPs in PHC (Venning, Durie, Roland, Roberts & Lesse, 2000) similarly concluded that clients were more satisfied with the care provided by NPs even when the length of appointment

time was controlled; clients attributed this satisfaction to the amount of information provided by the NP.

In a study in New England, Johnson (1993) used an ethnographic methodology including individual interviews with three NPs in a PHC setting to examine interactions between NPs and female clients to determine factors that contribute to a high level of patient satisfaction. Johnson found that NPs engaged clients in a meaningful discussion, an essential first step to establish rapport that facilitates subsequent assessment and intervention. NPs asked patients open-ended questions, acknowledged their concerns, developed a partnership, and established a holistic plan of care; these approaches facilitated women's comfort level and trust in their health care provider.

In brief, although these studies were all conducted in PHC settings, they were not all grounded in rural areas or Canadian settings; therefore, the findings may not be transferable to rural areas in Canada. This speaks to the urgent need to examine rural women's experiences with PHCNPs in Canada as the Canadian literature on this topic is limited.

## **PURPOSE OF THE STUDY AND RESEARCH QUESTION**

The purpose of this study was to explore rural women's experiences with rural PHCNPs. Accordingly, this study sought to address the following research question: What are the experiences of rural women with rural PHCNPs in southwest Ontario, Canada?

## **METHODOLOGY AND METHODS**

### ***Study Context***

This study focused on one rural PHC setting located in a small town of 2000 residents in southwestern, Ontario, where two rural PHCNPs work in an autonomous practice and consulted with a local physician as needed. One NP was prepared at a baccalaureate level and the other at a masters level; both nurses held extended registration to provide NP services. The NP office was located in an old building with less than ideal circumstances, for example, very small examining rooms, no air conditioning in summer, and minimal heat in winter. The NPs were on salary and offered PHC services to the surrounding communities. With some of the most fertile soil in Canada, this rural area has abundant agricultural activity.

### ***Research Design***

Researchers use qualitative research methods "when little is known about a topic, [and] when the research context is poorly understood" (Morse, 2003, p. 833). Thus, qualitative methods are appropriate for research that explores rural women's experiences with PHCNPs. The research design of this study used a feminist lens with an interpretive description research methodology (Reinharz, 1992; Thorne, Reimer Kirkham & O'Flynn-Magee, 2004; Thorne & Varcoe, 1998). Interpretive description is "designed to create ways of understanding clinical phenomena that yield application implications" (Thorne et al., 2004, p. 1) by capturing themes and patterns within participants' subjective experiences to inform clinical understanding (Thorne, Reimer Kirkham & MacDonald-

Emes, 1997; Thorne et al., 2004). Interpretive description lends itself well to experience-based questions relevant to rural women's health and the practice-based discipline of NPs.

The underlying principle of feminism is the belief that all individuals, regardless of class, race and culture, deserve equal value, respect, opportunity and access to community resources (Reinharz, 1992; Thorne & Varcoe, 1998). The overarching goal of feminist inquiry "is to see the world from the vantage point of a particular group of women" (Campbell & Bunting, 1991, p. 6), in this study, rural women.

### ***Sample and Sampling Strategy***

Purposeful sampling (selecting informative participants) was used in this research to gain an in-depth understanding of individual experiences (Polit & Beck, 2004). Inclusion criteria were that women: 1) resided in a rural area in southwestern Ontario; 2) were 18 years of age or older, with a minimum of one woman per decade of age; 3) experienced care by a rural NP for at least two visits; 4) were able to read and speak English; and 5) were willing and able to articulate their experiences with a rural PHCNP. To recruit rural women, posters and letters of information about the study were made available at the NPs' office. Recruitment documents invited potential participants to contact the researcher for more information and/or to volunteer for the study.

Interpretive description research is consistent with smaller scale qualitative research that may include a sample size of 8-10 participants (Thorne et al., 2004). Sample size was also determined by data saturation, the "point at which no new information is obtained and redundancy is achieved" (Polit & Beck, 2004, p. 308). Data saturation was achieved after interviewing nine participants. Data saturation may have been achieved with this size of sample because all study participants came from similar rural backgrounds and they were all patients of the same two PHCNPs.

### ***Data Collection***

Prior to conducting the study, ethical approval was received from The University of Western Ontario Ethics Review Board for Human Subjects, protocol number 12666E. In-depth face-to-face interviews using a semi-structured interview guide were conducted in participants' homes. In-depth interviews are consistent with a feminist lens and an interpretive description design because they allow participants to openly discuss issues that are important to them (Campbell & Bunting, 1991; Thorne et al., 2004). Topics discussed during the interview included: (a) rural women's overall experiences of PHC; (b) rural women's experiences with their rural NP; and (c) rural women's perspectives of how living in a rural area affected their PHC experience. Interviews were 1 to 1.75 hours in length and were audio-recorded. Throughout data collection, field notes of observations encountered during the interviews, and a reflexive journal which captured the researcher's perspectives after each interview were completed (Morse & Field, 1995).

### ***Data Analysis***

Data analysis was guided by the interpretive description research design and used an inductive approach to construct meaning from participants' experiences (Thorne et al., 2004). In interpretive description research, "the researcher constantly explores such questions as: Why is this? Why not something else? And what does this mean?" (Thorne et al., 2004, p. 11).

Data analysis occurred concurrently with data collection; this strategy helped the researchers to make meaning of the interviews and to identify areas for further exploration in subsequent interviews (Aryes, Kavanaugh & Knafl, 2003; Thorne et al., 2004). To ensure accuracy and completeness, each interview was transcribed verbatim and the transcript was compared to its audio-recording. In addition, the nine transcripts were reviewed several times to uncover implicit meanings as well as commonalities and variations (Aryes et al.; Thorne et al., 2004). As common themes emerged, data were recontextualized into smaller meaningful data sets. To assist in data management and coding, NVivo (QSR International, 2006), a qualitative data management computer software program, was used.

## FINDINGS

A total of nine Caucasian women ranging in age from 18-80 participated in this research study. The employment status of seven women was retired or working part-time, one participant worked full-time and another participant was a full-time university student. Study participants reported having a NP as their consistent PHC provider for diverse periods of time, from two months to four years, and they drove between five and 30 minutes to reach the practitioner's office. Frequency of visits varied between once weekly to twice yearly. The women reported seeking NP services for annual physical examinations, management of chronic diseases such as diabetes and hypertension, family planning, and acute episodic illnesses such as earache or sore throat. The women who participated in this research study were all eager to share their personal experiences with their rural PHCNP.

### *Access*

Study participants spoke about challenges in accessing PHC services in their rural communities, such as difficulty in accessing physicians, having to wait up to one-and-a-half months to get an appointment, and driving up to one-and-a-half hours to obtain services. One elderly woman underscored the extent of access challenges when she noted that she "would be dead and buried before being able to get an appointment [with her prior physician]". Moreover, when participants did manage to get an appointment with their previous physician, they often spoke of how they "felt rushed and didn't have time to ask questions"; and that "you could only...[address] one thing [per appointment]". Participants discussed many disempowering experiences with physicians and quite frequently throughout the interviews would compare the care received from the NP with that of their prior physician. These comparisons seemed to aid the women in articulating their experiences.

All participants reported learning about NPs through word of mouth as NPs provided PHC services to women in the local and surrounding communities. The majority of the participants reported having little knowledge of what a NP's role was prior to seeking out services: "No, I hadn't heard of them [NPs] prior [to first seeing one]...So I went in with an open mind...more or less just thinking...I haven't lost anything, I haven't gained anything". The women reported that they requested that their medical records (from their prior physician) be transferred to the NP as this provided their medical history and facilitated the transition between PHC providers. The study

informants reported being very satisfied with the care provided by the NPs and offered suggestions about how to improve rural women's knowledge about and access to NPs.

The findings that emerged from the data can be conceptualized as a triangle (see Figure 1). The foundational findings (the base of the triangle) were the nursing knowledge of the NP, the time the NPs spent with the participants, and the thoroughness of the care provided by NPs. These foundational elements of the participants' experiences with rural NPs created a sense of trust and respect, which lead to a collaborative partnership between the NP and the rural woman. Additional findings that emerged from the data related to barriers and facilitators to rural women's experience of NPs' practice.

### ***Nursing Knowledge***

The study participants felt comfortable knowing that the NP was a registered nurse with additional educational training. A positive view of nursing facilitated a positive perspective of NPs; participants felt that the nursing background contributed to the care that the NP provided. A participant commented that:

Nurses spend more time with the hands on care...in my experience they tend to be more nurturing and more caring...the doctor might come in and say 'We are going to do this and this' and then he hands you off to the nurse...I have always found that nurses have given me comfort, they've spent the time and they've stayed with me. There's just such a comfort in nursing.

Study participants also reported that the NP explained things in understandable language and sought additional resources when needed. A participant stated, "[the NP will] look in books and get on the internet and check-up...the latest thing. They [the NPs] keep themselves up to date...I never saw any of my doctors look things up". In essence, the up-to-date knowledge base of the NPs and the women's ability to understand and assess NPs knowledge allowed the women to entrust them with their care.

### ***Time***

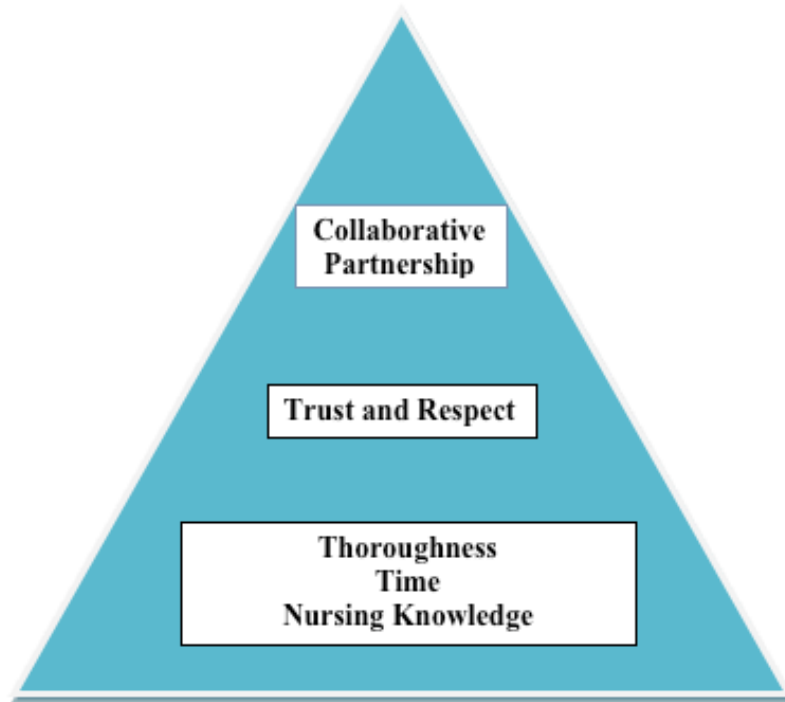
All participants spoke passionately about the quantity and quality of time that the NP spent with them; this made them feel as though they and their health were valued. As one participant described it:

She took the time to listen to my concerns, answer my millions of questions...she didn't rush the appointment, my appointment took longer than it should have...but she gave me that time and attention that I felt I needed...It made me feel good, it made me feel comfortable, safe, and like she had my best interest at heart. It wasn't about the paycheck, it was about me.

Several participants commented on how this time provided them with comfort and the ability to discuss all health concerns, as one participated stated: "I feel more comfortable...[as the NPs] have the time to spend with you and go through all your



Figure 1. Rural Women's Experiences with Rural Nurse Practitioners



worries". Compared to their experiences with physicians, the increased amount of time spent with the NPs afforded participants more time to develop a collaborative partnership with the NP, founded on trust and respect.

### ***Thoroughness***

Several participants discussed the thoroughness of care provided, frequently comparing the care they received from the NP to that of their former physician. One woman illustrated this comparison (while also speaking to the nursing knowledge of a NP) as follows:

The NP is a lot more thorough, being a nurse and probably having more experience to ask a lot of questions to see and understand what is going on...and get to the root of the issue. Whereas doctors, sometimes they don't even listen to everything you have to say and once they have made their assessment, they are gone.

When the participants discussed the thoroughness of NPs, they appeared to be amazed to be receiving this quality of health care and often equated it to the care an 'old fashioned doctor' would provide. As one woman aptly put it, "she [the NP] even makes house calls...I was amazed 'cause you really don't get that except back in the horse and

buggy days”. Participants felt that they could go to the NP with any health concerns knowing that “...she makes sure that anything I’ve brought to her attention is investigated completely- any kind of test, referral...[and] she has always been prompt”.

Several participants also spoke of never having had such a thorough annual health exam prior to seeing the NP. One woman stated that the NP “map[ped] out all of [her] moles...and check[ed] everything”. The thoroughness of the examinations created a sense of reassurance for the women. By valuing their health concerns and making them feel as though their health was important, NPs facilitated a sense of trust and respect.

### ***Trust and Respect***

These three aforementioned aspects of rural women’s experience with NP care (nursing knowledge, time, and thoroughness) created a sense of trust and respect with the participants. Informants discussed the non-judgmental attitude of the NPs, described by one participant as: “they [the NPs] wouldn’t bat an eye” to any clients’ health care needs. For example, a participant spoke of her need to lose weight and how the NP respected her efforts by “provid[ing] her with information...to incorporate a healthy, lifestyle...and not [passing] judg[ment]”. This attribute of being non-judgmental helped to create a sense of trust and respect for rural women.

Many participants reported having the ability to talk directly to the NP when needed. As one woman stated, “I could call her right now...and if...[the NP] isn’t available immediately she will call me back”. Another informant remarked, “I could see the NP on the street and say ‘Did you get my blood work back?’ and she’d say ‘Oh yeah I will give you a call tomorrow’”. Behaviours such as these created a sense of security amongst the participants, further reinforcing how their health was valued by the NP. One participant eloquently captured this vital trust and security, “...I have no problems trusting...[the NP] with my care, with my life, with my child’s life, and trusting her to keep everything confidential”. Overall, the trust and respect that rural women felt with the NP, founded on the basis of nursing knowledge, time and thoroughness, in turn, fostered a collaborative partnership.

### ***Collaborative Partnership***

Collaborative partnership was seen as the overall outcome of the participants’ experiences with rural NPs. A collaborative partnership led to a sense of individualized personal care which was seen as important as this allowed the women to feel that they were valued. A participant explained, “the NP focuses on me...when I go in, she looks at me, and she studies me. Doctors come in...a lot of them don’t even look into my eyes...they’re so busy mumbling at a chart...and then they walk away”. The participants valued this collaborative partnership and personal relationship, as this participant remarked:

It is kind of like she [the NP] is your mom or your friend and you can just go in and talk to her and she tells you all this information. Rather than going to the doctor, she is there...to help and he [the doctor] is there to cure you and move you out.

Another woman suggested that the NP “can provide...a hundred percent or a hundred and ten percent personal care”; this totality of care and the way it was provided resulted in participants feeling secure, valued, and included in a collaborative relationship with the NP.

The respect that NPs showed to participants laid the foundation for mutually exploring solutions to a health problem: “I find [the NP] gives you a lot of respect, she listens to what I have to say...she asks me questions whether or not I agree with her, so we work together to find a solution”. The feeling of respect the participants felt with the NP facilitated the development of a comfort zone so the women could become actively involved in their health care.

### ***Barriers to the Nurse Practitioners’ Practice***

Participants described barriers surrounding NPs practice in rural areas, namely unreliable remuneration, lack of NP recognition, and citizen lack of knowledge regarding NPs. Regarding unreliable remuneration, a participant explained:

There was a town council meeting, and they were gonna get rid of one of the NPs because of the funding...and I thought, ‘Oh my god! Please don’t!’ So they decided to try it for another year, so if that funding isn’t there again this year...we’re going to lose a NP ...then we’re no further ahead than what we were two years ago.

This situation demonstrates the need for secure, sufficient, and sustainable funding for NPs.

Participants provided several examples of the limited or lack of recognition afforded to NPs. In one instance, the NP could not be a signatory to a form required by a woman “to get orthotics...[the insurance form] had to be signed by a doctor...I called the lady at the medical place...she says ‘...You can’t get reimbursement unless a doctor signs [the form]’”. To overcome this barrier, insurance companies and other agencies need to revise their policies to acknowledge NPs as PHC providers and as legitimate signatories on insurance and other forms. Several participants spoke about going to the hospital for diagnostic tests and needing to give a name of a physician instead of the name of their NP. They also talked about the repercussions of having to put a physician’s name rather than the NP’s name on reports; this policy resulted in the report being sent to a physician who was not involved in their care, rather than to the referring NP, and lead to the NP having to dedicate precious time to tracking down reports. This is especially problematic for NPs who do not have access to the support of administrative personnel.

Limited or lack of knowledge about NPs and their roles was remarked upon by the majority of the participants in this study. Recommendations for ways to promote the role of the NP in rural areas included presentations at schools, churches, and community groups, and increased use of television, radio, local newspapers, and other media. Without exception, all of the women in this study felt that there should be increased knowledge of and access to NPs in rural areas. The comment by this participant echoes the perceptions of many in this study:

I think everywhere should have them [NPs], I think they should be part of the medical system...they should be available just like doctors. I have

never heard of them before. I didn't even know what a NP was [prior to seeing one]. If I was educated [in regards to] NPs I would have been to one ages ago.

Overall, the participants in this study saw the role of NPs as a necessity in every rural community as they identified NPs as being critical to their health. The NP provided appropriate and respectful access to PHC services. Furthermore, participants stressed, "NPs make it more accessible to get...good healthcare".

### ***Facilitators to the Nurse Practitioners' Practice***

The main facilitators to NPs' practice that the rural women discussed related to the NPs' ways of practicing, the way that NPs are financially remunerated, the gender of the NP, and the nursing background of the NP.

Regarding ways of practicing, participants noted that NPs in rural areas were taking on new clients and having flexible appointment times. These actions facilitate access to PHC services in under-served rural areas. Access and quality of care were also enhanced, participants perceived, by the way that NPs were remunerated, as this participant noted:

...doctors are paid by OHIP [Ontario Hospital Insurance Plan] per patient...[the NP] is on a salary...so she doesn't get any more money by staying with me for twenty minutes than she would by staying with me for five minutes...Where a doctor...they slot people in every fifteen-twenty minutes and the doctor just goes, boom-boom-boom, and tries to see as many [clients] as he can in a shorter period of time.

In essence, informants felt that the salary structure of the NP supported the time that the NP spent with each client, which facilitated access, trust and respect, collaborative partnerships, and quality care.

This research supports the findings of others (Leipert, 2005; Sutherns et al., 2004) that reveal that rural women often prefer female health care providers. Participants commented that "...a female is more thorough and she has time to...talk to you...where doctors [males] are too clinical-like", and "tend to look down on females". Participants also felt that a female health care provider is "more in tune with what the female body is doing". Therefore, the participants in this study perceived that the female gender of the NPs was a facilitator in their practices and in rural areas, where few female health care practitioners are available.

All participants were aware and took comfort knowing that a NP was an experienced registered nurse prior to becoming a NP. When asked about the importance of NPs having a nursing background, a participant commented, "...I definitely think [it is important], most nurses are very caring...we have had a very positive experience". This relates to the nursing approach and knowledge of NPs which facilitate a sense of trust and respect leading to the ultimate collaborative partnership.

## **DISCUSSION**

This study highlighted several key insights regarding rural women's experience with PHCNPs. Although the majority of participants had no prior knowledge of NPs

before seeking their services, all participants claimed an overwhelming sense of satisfaction with the care provided by the rural NP. The foundational findings that emerged from this study were the nursing knowledge of the NP, the time the NPs spent with the participants, and the thoroughness of the care provided by NPs. These foundational elements of the participants' experiences with rural NPs created a sense of trust and respect, which lead to a collaborative partnership between the NP and the rural women.

Study participants remarked extensively on the satisfaction they felt with the comprehensive, collaborative, and quality care provided by the NP. This finding supports the findings of others (Bigbee, Gehrke, & Otterness, 2009; Leipert, 1999; MacLeod, Kulig, Stewart, Pitblado, & Knock, 2004) that reveal the complex, skilled, and vital care that nurses who practice in rural settings provide. This study also elaborates on the care provided to women in rural settings by rural NPs, and draws attention to the need to sustain and further promote the role of NPs in rural areas.

The NP role is still emerging within the Ontario, and indeed, the Canadian health care system. Findings of this research importantly illuminate rural woman's expectations regarding rural NP practice, which in turn provide insight to NPs, public health nurses, physicians, and others regarding the nature and expectations of their practices to meet the needs of rural women. In particular, the nursing knowledge, time spent with clients, and thoroughness of assessments which created a sense of trust and respect that lead to collaborative partnerships are noteworthy specifications of the nature of valued health care practice for rural women. Thus, this exploratory study provides important new information for effective rural women's health care and for future research that further elaborates on the nature and value of NP practice in rural Canadian jurisdictions.

Participants discussed barriers within the health care system that hindered rural NPs, for instance, lack of sustainable remuneration, lack of recognition, and lack of awareness of NPs. It is important that these barriers are addressed to ensure that the role of the NP becomes pivotal within Ontario and Canadian health care initiatives. Recently, IBM and McMaster University (2005) and the CNPI (2006) recommended continued support for the inclusion of NPs in the Canadian health care system; these recommendations are supported by findings in this study. IBM and McMaster University (2005) and the CNPI (2006) recommended: (a) a common definition of a NP be adopted across Canada to eliminate misunderstandings of the NP's role. This is supported by the findings of this study as several participants reported little or no prior knowledge of the roles of the NP before consulting one; (b) secure and standardized long-term funding. Participants discussed issues surrounding lack of secure funding and feared the loss of a NP with every funding renewal; (c) consistency and standardization within all NP educational programs across Canada. Rural women in this study were unclear as to the educational background of the NP, thus if NP education was standardized the public would have a better understanding of the qualifications of NPs; and 4) the importance of interprofessional collaboration with the medical profession. Although several participants in this study spoke of how the NP and the physician seemed to work collaboratively, some participants noted problems in these relationships. Recent developments in the Ontario health care system, such as the creation of family health teams (FHTs), community health centers, and NP led clinics (CHCs) (Ontario Ministry of Health and

Long-Term Care [OMOHLTC], 2002, 2006), may help to facilitate an interprofessional collaborative approach to providing health care.

This study further highlights the need for the public to be informed about the role of NPs, especially as the role of NPs is further integrated within the Ontario health care system through FHTs, CHCs, and NP led clinics (OMOHLTC, 2002; 2006), and as participants in this study noted having little or no prior knowledge of a NP prior to seeking their services. The rural women in this study offered important strategies on how the role of a NP could be promoted in rural areas. These are important considerations to inform the public of the value of NPs in rural areas. Participants also spoke of the lack of recognition of NPs; this could be improved by high profile media campaigns that highlight the important work of rural NPs, and by advocating for hospital, referral, and other policies that recognize NPs as equal members of the interprofessional health care team. The many enhancements to care that salaried, rather than fee for service, remuneration supports, as described by the participants in this study and other research (Canadian Health Services Research Foundation [CHSRF], 2001) suggest that other health care providers, such as physicians, would benefit from this type of compensation.

Facilitators to rural NP practice related to rural women's ability to access a NP. This is an important finding as rural dwellers generally have limited access to primary health care and nursing services (Leipert, 1999; Statistics Canada, 2004). The rural women in this study reported being more comfortable with a female health care provider, a finding that further supports previous research (Leipert, 2005; Sutherns et al., 2004), and they thought being an experienced nurse first was an asset. In summary, rural women in this study confirmed and elaborated on the importance of and the need for more NPs in rural settings.

### **LIMITATIONS**

This study included one research site. These NPs were not affiliated with a FHT or a CHC and there may be some uniqueness to this practice setting. Therefore, future research should examine rural women's experiences with rural NPs in other practice settings such as FHTs and CHCs, as well as in NP led clinics. In addition, this study focused on the client's experience; further research should address the rural NP experience for their elaboration regarding rural NP practice with rural women. It would also be instructive to conduct a similar study in other rural areas that are more remote, and to determine rural women's health needs from various cultural perspectives, such as with Amish, Mennonite, Hutterite, and Aboriginal women. In addition, although participants were probed for negative NP experiences, it is possible that they were reluctant to disclose this information as the researcher was a nurse. Finally, the participants' choice to see the NP may have positively influenced their NP experience. Due to the nature of this small exploratory study, findings are not generalizable, although they do provide important considerations for other rural settings.

### **CONCLUSION**

This study, which explored Canadian rural women's experiences with rural nurse practitioners, revealed that study participants were overwhelmingly satisfied with the care

provided by rural PHCNPs. In particular, they valued the nursing knowledge of the NP, the time the NPs spent with them, and the thoroughness of the care provided by NPs. These foundational elements of the participants' experiences with rural NPs created a sense of trust and respect, which lead to a collaborative partnership between the NP and the rural woman. This study, which used an interpretive description methodology to "make sense of something that clinicians ought to understand" (Thorne et al., 2004, p. 8), thus, gained insights that are important for NPs, nurses, and other rural health care providers to inform their clinical practice. As NPs are set to play a pivotal role within the Ontario and health care system (OMOHLTC, 2002; 2006), this research provides important information for future health care practice and policy, NP education, and rural research. Nurse practitioners need to play key roles in determining rural health care policy and practice in the evolving Canadian health care system, rural health care issues and expectations need to figure prominently in NP education, especially as rural settings are often where NPs practice, and further research regarding the collaborative place of NP practice with other rural health care providers, such as public health nurses and physicians, should be conducted.

## REFERENCES

- Ayres, L., Kavanaugh, K., & Knafl, K. A. (2003). Within-case and across-case approaches to qualitative data analysis. *Qualitative Health Research, 13*(6), 871-883. [MEDLINE]
- Bigbee, J., Gehrke, P., & Otterness, N. (2009). Public health nurses in rural/frontier one-nurse offices. *Rural and Remote Health, 9*: 1282. [MEDLINE]
- Campbell, J. C., & Bunting, S. (1991). Voices and paradigms: Perspectives on critical and feminist theory in nursing. *Advances in Nursing Science, 13*(3), 1-15. [MEDLINE]
- Canadian Health Services Research Foundation (2001). Myth: User fees would stopwaste and ensure better use of the healthcare system. Retrieved January 2, 2010, from [http://www.chsrf.ca/mythbusters/html/myth4\\_e.php](http://www.chsrf.ca/mythbusters/html/myth4_e.php)
- Canadian Nurse Practitioner Initiative. (2006). Nurse practitioners: The time is now. Retrieved August 3, 2006, from <http://www.cnpi.ca>
- College of Nurses of Ontario. (2008). Practice standards of registered nurses in the extended class. Retrieved January 14, 2010, from [http://www.cno.org/docs/prac/41038\\_StrdRnec.pdf](http://www.cno.org/docs/prac/41038_StrdRnec.pdf)
- Government of Ontario. (2006). McGuinty government creating more nurse practitioners. Retrieved August 1, 2006, from <http://www.ogov.newswire.ca/Ontario/GPOE/2006/02/06/c4261.html?lmatch+&lang+e.html>
- Health Canada. (2002). Rural health in rural hands. Retrieved February 17, 2006, from [http://www.phac-aspc.gc.ca/rh-sr/rural\\_hands-mains\\_rurales\\_e.html](http://www.phac-aspc.gc.ca/rh-sr/rural_hands-mains_rurales_e.html)
- Horrocks, S., Anderson, E., & Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *British Medical Journal, 321*, 819-823. [MEDLINE]
- IBM Business Consulting Services and McMaster University. (2005). Report on the integration of primary health care nurse practitioner into the province of Ontario. Toronto, ON: Ontario Ministry Health and Long Term Care.

- Johnson, R. (1993). Nurse practitioner-patient discourse: Uncovering the voice of nursing in primary care practice. *Scholarly Inquiry for Nursing Practice: An International Journal*, 7(3), 143-157. [MEDLINE]
- Leipert, B. (1999). Women's health and the practice of public health nurses in northern British Columbia. *Public Health Nursing*, 16 (4), 280-289. [MEDLINE]
- Leipert, B. (2005). Rural women's health in Canada: An overview and implications for policy and research. *Canadian Women Studies*, 24(4), 241-253.
- Leipert, B., & George, J. (2008). The determinants of rural women's health: A case study in southwest Ontario. *Journal of Rural Health*, 24 (2), 210-218.
- MacLeod, M. L., Kulig, J. C., Stewart, N. J., Pitblado, R. J., & Knock, M. (2004). The nature of nursing practice in rural and remote Canada. *The Canadian Nurse*, 100(6), 27-36. [MEDLINE]
- Morse, J. M. (2003). A review committee's guide for evaluating qualitative proposals. *Qualitative Health Research*, 13(6), 833-851. [MEDLINE]
- Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2<sup>nd</sup> ed). Thousand Oaks: Sage.
- Nurse Practitioner Association of Ontario. (2005). Primary health care nurse practitioner: Historical perspective. Retrieved September 27, 2006, from <http://www.npao.org/history.aspx>
- Nurse Practitioner Association of Ontario. (2006). Primary health care nurse practitioner: RN(EC) designation. Retrieved May 27, 2006, from <http://www.npao.org/phcnp.aspx>
- Ontario Ministry of Health and Long-Term Care. (2006). Community Health Centres. Retrieved May 22, 2007, from [http://health.gov.on.ca/english/public/contact/chc/chc\\_mn.html](http://health.gov.on.ca/english/public/contact/chc/chc_mn.html)
- Ontario Ministry of Long-Term Care. (2002). How family health teams work. Retrieved April 24, 2007, from <http://www.hwalth.gov.on.ca/transformation/fht/fhtwork.html>
- Paluck, E. C., Allerdings, M., Kealy, K., & Dorgan, H. (2006). Health promotion needs of women living in rural areas: An exploratory study. *Canadian Journal of Rural Medicine* 11(2), 111-116. [MEDLINE]
- Patterson, C. (Ed.). (2001). *Nurse practitioners...the catalyst of change*. Brantford: JPatt.
- Polit, D. F., & Beck, C. T. (2004). *Nursing research principles and methods* (7<sup>th</sup> ed.). Philadelphia: Lippincott Williams and Wilkins.
- QSR International. (2006). *NVIVO 7*. Doncaster, AUSTRALIA: QSR International PTY Ltd.
- Reay, T., Patterson, E. M., Halma, L., & Steed, W. B. (2006). Introducing a nurse practitioner: Experiences in a rural Alberta family practice clinic. *Canadian Journal of Rural Medicine*, 11(2), 101-107. [MEDLINE]
- Reinhartz, S. (1992). *Feminist methods in social research*. New York: Oxford University Press, Inc.
- Roblin, D. W., Becker, E. R., Adams, E. K., Howard, D. H., & Roberts, M. H. (2004). Patient satisfaction with primary care does type of practitioner matter? *Medical Care*, 42(6), 579-590. [MEDLINE]



- Romanow, R. (2002). Rural and remote communities: In R. Romanow, Building on values: The future of health care in Canada: Final Report. Ottawa: Commission of the Future of Health care in Canada.
- Sidani, S., Irvine, D., & DiCenso, A. (2000). Implementation of the primary health care Nurse Practitioner role in Ontario. *Canadian Journal of Nursing Leadership*, 13(3), 13-19. [MEDLINE]
- Statistics Canada. (2004). Canadian community health survey. Retrieved August 1, 2006, from <http://www.statscan.ca/Daily?English?040615?d040615b.htm>
- Stewart, M. J., & Langille, L. L. (1995). Primary health care principles: Core of community health nursing. In M. J. Stewart (Ed.), *Community nursing: Promoting Canadians' health* (pp. 62-88). Toronto: W. B Saunders Canada.
- Sutherns, R., McPhedran, M., & Haworth-Brockman, M. (2004). Rural, remote and northern women's health policy and research directions. Winnipeg: Prairie Centre of Excellence for Women's Health.
- Thorne, S., Reimer Kirkham, S., & MacDonald-Emes, J. (1997). Focus on qualitative methods interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing and Health*, 20, 168-177.
- Thorne, S., Reimer Kirkham, S., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods*, 3(1), 1-21.
- Thorne, S., & Varcoe, C. (1998). The tyranny of feminist methodology in women's health research. *Health Care for Women International*, 19, 481-493. [MEDLINE]
- Venning, P., Durie, A., Roland, M., Roberts, C., & Leese, B. (2000). Randomised controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care. *British Medical Journal*, 320, 1048-2053. [MEDLINE]
- Way, D., Jones, L., Baskerville, B., & Busing, N. (2001). Primary health care services provided by nurse practitioner and family physicians in a shared practice. *Canadian Medical Association Journal*, 165(9), 1210-1214.