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Contemporary Nursing in Rural Appalachia: A Hermeneutic Study

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by

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ABSTRACT

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Nurses make up a significant source of direct care for individuals, families, and communities. The problematic distribution of nurses and the potential to lose practicing nurses emphasizes the importance of retention and support of nursing professionals, especially in rural locations. One of the best ways to discover what is important to nurses is to ask and listen to the replies.

The focus for this dissertation is the lived experience of registered nurses in a six-county area in three adjoining states in rural South Central Appalachia. The purpose of this study is to interpret and understand the lived experience of contemporary RN practice in rural Appalachia. The two aims of the study are to 1) understand the lived experience of contemporary nurses in rural Appalachia, and 2) understand the lived experience of nurses as they relate to the place of residence and the place of employment.

The chapters include the research proposal and three manuscripts. Chapter 1 contains the background and significance. Chapter 2 is the literature review. Chapter 3 includes sampling and recruitment in rural areas. The findings are discussed in Chapter 4. Chapter 5 contains an integration of all manuscripts, discussion of the contribution to nursing science, direction for future research, and implications for nursing practice. Manuscripts are ready for submission and will be formatted per author guidelines prior to submitting.

The first manuscript, “Perceptions of Nursing in Appalachia: A State of the Science Paper,” is a literature review. The manuscript reviews the literature surrounding nurses in Appalachia. It was published in the *Journal of Transcultural Nursing* in January, 2018 (Brewer, 2018).

The second manuscript, “The Lived Experience of Nursing in Appalachia: Sampling and Recruitment,” examines the researcher’s experience with sampling and recruitment. The second manuscript will be submitted to the *Online Journal of Rural Nursing and Health Care*.

The third manuscript, “Living and Working as a Nurse in Appalachia: A Phenomenological Study,” provides findings, implications, and future research. This paper describes findings and identifies themes of the data. The third manuscript is ready for publication to the *Journal of Transcultural Nursing.* The conclusion presents dissertation summary comments.

DEDICATION

I dedicate this work to my family. First to my husband who has supported and encouraged me no matter how bogged down I was, without your love and understanding this journey would have been pointless. Second, to my daughters who have been there beside me the whole way. We all shared the journey to a master's degree. I hope you see me as an example of your additional potential even if it is not another degree. Your life is about the journey, not reaching the destination. To my grandchildren and son-in-law, I am sorry for all the games I have missed. I will try to do better from here on out. Thank you to my parents and family for being my earliest influence for becoming the person I am. To my church family, thank you for all the prayers when you saw the dark circles under my eyes and the love you shared even though you did not know the burden. Most importantly, there is no way I can express the depth of my gratitude to my Heavenly Father who called me on this journey and never let me out of the palm of his hand. The comfort of knowing He was there gave me strength to keep going when it was I alone to take another step. I would not be here today without each of you.

Finally, this work is in loving memory of my grandmother, Vinnie Rash, the model of every patient I have ever cared for. Mom-mom, I am sorry I could not finish before you passed, but I did finally clear this milepost. I will tell you, Paw Amos, Paw Dee, Granny, and James about it someday. I miss you all dreadfully still today.

ACKNOWLEDGEMENTS

My special thanks to Dr. Weierbach, Dr. Nehring, Dr. Hall, and Dr. Fletcher for their assistance with this work. You were instrumental in challenging me, encouraging me, and seeing me as a person, not just another struggling student. The scope of your knowledge is awesome and the way you apply that knowledge equally so. You did not let me be satisfied with mediocre but pushed me to higher standards. Your questions of “What more?” and "Why?” caused me to look deeper and deeper. The answer was always far more profound than the superficial and obvious reasons I found so easy to settle with. You set a very high standard for me to attain. As I have said many times before--I will do my best. Thank you for the chance.

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CHAPTER 1
BACKGROUND AND SIGNIFICANCE

What is nursing? What does it mean to be a nurse? The World Health Organization defines nursing as a profession that protects and promotes health, helps prevent disease, and relieves suffering in all echelons of society (World Health Organization, 2019). Nurses work both as independent agents and in collaborative teams to care for clients across the lifespan, individually or in groups, and in all global settings throughout the continuum of health and wellness (International Council of Nurses, 2019). Registered nurses (RNs) are seen as "determined, willing to work, able to overcome, and willing to assume positions as leaders in the profession, the community, and the region" (Brewer, 2018, p. 6). Nurses provide care for clients with chronic disease over long periods of time, building relationships that promote health and optimal quality of life when health falters. Yet, describing RNs as members of the profession and their role in health care is a complex story.

The purpose of this qualitative study was to give voice to nurses and to discover what it means to be a nurse in rural Appalachia. Interviews provided an opportunity for nurses to express personal perceptions of being a nurse in this region. The researcher methodically analyzed the interviews to identify themes of the experience. Through their own voice, nurses were able to describe the job they do and relationships associated with work, place, and the career calling they have answered. Goals of the study were to understand the work of the RN in rural Appalachia and relationships associated with that practice. The resulting insights may be used to support and promote professional practice for nurses in the Appalachian region.

By the very nature of nursing as a giving profession, the voice of nursing most often reflects those cared for rather than that of the nurses themselves. The voice of a nurse is rarely heard. Meager literature exists to describe how nurses feel about their contribution to health care in rural communities. Few studies have explored why they keep going to work. Little is known about the personal significance of their role in rural health care systems or the subjective

meaning of their contribution to the health of individuals in rural communities. Nurses are an integral component of healthcare globally but are often not seen as individuals with a story of their own, forgotten in the narratives of those around them. The literature represents the lack of narrative about the nurse and nursing experiences. Published literature reflects the accepted standard for scholarship and little credence is given to narratives and stories. However, how that contributes to scholarship needs to be taken into consideration. Rich traditions are found in the narratives of Appalachia. This also extends to nursing narratives. However, as rich as that story is, this research is not about Appalachia. It is about the nurse in Appalachia as told by the nurses themselves.

Appalachia follows the Appalachian Mountain Range through parts of 12 states and across all of West Virginia. It covers 205,000 square miles and has a population of over 25 million people. Almost half of the region is rural with steep craggy mountains and deep fertile valleys (Appalachian Regional Commission [ARC], n.d.b). Nurses in Appalachia serve a population that continues to have disproportionately high rates of socioeconomic disparity, lower generalized functional health, and a higher prevalence of cancer, cardiovascular disease, stroke, diabetes, obesity, depression, and substance abuse (Davis, Allen, Childress, Maurer, & Talbert, 2015; Schoenberg, Howell, & Fields, 2012). These health outcomes result from a number of individual and environmental factors including economic stability, education, social and community context, health and health care, and neighborhoods and built environments (U.S. Department of Health and Human Services, 2017).

Poverty has been long associated with the region (ARC, n.d.a) although the distribution is not uniformly spread. Rates of poverty and unemployment are highest in the Central sub-region and lowest in the Northern sub-region (ARC, n.d.a) Data for the six-county area in the South Central sub-region, the focus for this study, demonstrates unemployment rates between

5.7-6.9% and poverty rates between 16.1-43% (ARC, n.d.a). Although the poverty rate is still higher in several sub-regions of Appalachia than in the nation as a whole, the rate is dropping, falling from 31% in 1960 to 16.6% in 2015 (ARC, n.d.a; Center for Regional Economic Competitiveness & West Virginia University [CREC], 2015). The regional average annual income in 2012 was $35,849 as compared to the national average of $44,194 (CREC, 2015). Unemployment rates were comparable with nation as a whole in 2014, a little over 6% (ARC, 2017). Unemployment in the region is multifactorial and historically embedded.

Employment in the 18th and 19th centuries first centered on agriculture, grew to include extractive industries, and finally expanded to include manufacturing during the 20th century. With a decrease of the agrarian lifestyle, Appalachians became less self-sufficient during times of economic hardship, beginning a trend of job insecurity and employment out-migration (Keefe, 2005; Williams, 2002). In the 21st century with an increase in global manufacturing and a decrease in the U.S. manufacturing, the job market shifted to a service sector focus, accounting for more than 75% of the employment in the region, and a majority of the remaining 25% relying on continued manufacturing and extractive industries or government-related employment (CREC, 2015). Many residents left the region to seek employment, often leaving behind those who tend to be less educated, with fewer job skillsets, and less able to break the cycle of unemployment or low-income employment poverty (Mather & Population Reference Bureau, 2004b; Pollard, Jacobson, & Population Reference Bureau, 2011). Additionally, for those who stayed, limited employment opportunities in rural areas often means long commutes to work (Mather & Population Reference Bureau, 2004a) adding associated burdens of time commitment and financial investment.

The continued high rate of socioeconomic challenge hinders efforts to obtain health care

services (Davis et al., 2015; Deskins et al., 2006; Lane et al., 2012; PDA, Inc. & Cecil G. Sheps Center/UNC-Chapel Hill, 2012;). Compounding the problem overall, Appalachian counties have higher health care costs than counties in U.S. as whole or even non-Appalachian counties in their respective states (Davis et al., 2015). Higher health care cost is multifactorial but may include higher poverty levels increasing the risk of poor health; a gap between charges and the amount reimbursed by insurers; additional costs to offset fees not met by insurers; extra cost for transportation of medical supplies in rural mountainous areas as well as transportation of clients to obtain health care services; high rates of chronic diseases like cancer, cardiovascular disease, stroke, diabetes, obesity and substance abuse; and more advanced disease states upon diagnosis with resulting increase demand on fiscal resources (Davis et al., 2015; Griffith, Lovett, Pyle, & Miller, 2011; Lane et al. 2012; Rural Health Information Hub, 2018). Up to 25% of personal income may be dedicated to health expenditures (Lane et al., 2012), a significant demand considering 47.4% of the counties were ranked at or below the worst 25% of the nation's counties based on three-year average unemployment rate, per capita market income, and the poverty rate (ARC, 2017).

Health insurance poses a potential answer to some financial barriers. Overall the prevalence of insurance coverage is slightly higher in Appalachia than in the nation as a whole although there is a high rate of Medicare Disability and Medicaid participation (Lane et al., 2012), potentially skewing perceptions related to fiscal ability to pay for insurance. Private or employer-sponsored insurance, supplemental coverage programs, and free care provide a framework for funding assistance but each has distinct disadvantages. Insurance coverage in rural areas must successfully balance large groups of healthy individuals having low cost of use with smaller groups having a higher cost of use, a condition hard to meet in a rural area with a smaller population many of whom have higher than the national rates of chronic

disease (Lane et al., 2012). Supplemental assistance is also problematic. Some Appalachians cannot access supplemental, income-based, or free care. Denial is based on property resources, which add to the resource pool but do not add to funds available for health care, limiting the ability to qualify (Watson, 2011). Finally, absence of insurance and eligibility for free care has not proven to be the only concern (Davis et al., 2015). Access to insurance did not guarantee access to healthcare support that might reduce mortality from preventable causes nor did access to healthcare imply access to critical specialty care such as cardiovascular, cancer, or focused rehabilitation care (Davis et al., 2015; Lane et al., 2012; McGarvey, Leon-Verdin, Killos, Guterbock, & Cohn, 2011).

Mortality rates, seen as a prime indicator of quality of life, reflect the health of a region. The rising overall mortality rate in Appalachia is concerning. Theories for the increase include the rising prevalence of obesity and diabetes, the aging population, and the lack of access to care (CREC, 2015). Seven of the ten leading causes of death in the U.S. have a higher prevalence in Appalachia than in the rest of the nation: heart disease, cancer, chronic obstructive pulmonary disease, injury, stroke, diabetes, and suicide (Marshall et al., 2017). Additionally, mortality due to poisoning, including drug overdose is significantly higher in the region. This increase is even more marked in the rural counties of the region (Marshall et al., 2017). The lower quality of life and increased mortality rate is an especially concerning governmental issue given the high percentage of the population covered by government insurance (Lane et al., 2012).

Unequal distribution of health care access reflects another consideration in Appalachia (Barney, 2000; Behringer & Friedell, 2006; Davis et al., 2015; Lane et al., 2012). A few large urban centers having a high concentration of health care sites and providers in or near the region exist. The dearth of community-linked, community-responsive systems contributes to health outcomes for Appalachians living in rural areas (Deskins et al., 2006; Halverson, Friedell,

Cantrell, & Behringer, 2012). Even though the infrastructure has steadily improved over the last several decades, more than half of the rural residents have to travel at least sixty miles to get most types of specialty care (Lane et al., 2012), a considerable drain on time and finances. Travel across county, or even state, lines to get care is common in some areas. For RNs, commute times to deliver care is also cumbersome. In some rural areas, nurses must travel over an hour one way to deliver care in the home, at times also crossing county or state lines (Parnicza, 1990). Although more current data was not found supporting commute times for nurses in Appalachia, recent research based on the 2000 U.S. census information and a longitudinal survey of newly licensed registered nurses, found commute times for hospital-employed nurses in small town and rural areas averaged 55 minutes as compared to 20.4 minutes for hospital-employed nurses in a metropolitan area (Rosenberg, Corcoran, Kovner, & Brewer, 2011) and that all health care workers may continue to cross county and state lines to meet employment obligations (Lane et al., 2012).

Challenges occur on the macro- and the micro-level including a mismatch between provider skill mix and community need; increased need for gerontology practitioners to meet the need of an aging population; increased opportunities for dwelling and assistive care for the elderly far from extended family who otherwise could contribute to care; variability in the quality of care in long term care facilities for the elderly; lack of dental services; and finally, inadequate mental health services (Lane et al., 2012; Watson, 2011). Failure to engage in routine screenings is multifactorial, but the factors include financial aspects for the associated costs of care and psychosocial aspects of client's perception of lower investment and caring by unfamiliar healthcare providers, as well as weaker relationships with those health care providers. Patients frequently go to multiple providers who only work part-time, are not part of the local community, and therefore may be less likely to recommend or follow-up on routine screenings.

Furthermore, clients and these providers do not develop strong relationships, adding to a lack of follow-up (Ludke & Obermiller, 2012; Shell & Tudiver, 2004). Political interests continue to both facilitate and hinder local health care delivery and reform (Behringer & Friedell, 2006). Over the last several decades, community health centers funded by federal grants have become an integral component of health care in the region, providing primary care largely through nurse practitioners (Wood-Dobbins, 2006).

Sociocultural characteristics also play a role in health care behaviors. Davis et al. (2015) found individuals were accustomed to the lack of insurance and health behaviors lacked exclusive linkage to financial status. Historically, in the face of healthcare provider shortage and financial limitation, residents utilized resources that were available and affordable, most notable a rich tradition of folk healing, prayer, and persistence (Barney, 2000; Behringer & Friedell, 2006; Couto, 2006; Flexner, 1910; Halverson et al., 2012) for physiologic problems. Although a strong dependence on the current biomedical therapies exists today, this former dependence on alternative methods promoted acceptance of these methods as viable and added to the perception that non-critical illness was simply a matter of endurance, not treatment (Barney, 2000; Cavender, 2003; Deskins et al., 2006; Goins, Spencer, & Williams, 2011). Health literacy holds an important role in ongoing health management as well. Concepts associated with low health literacy include: poverty, low educational attainment or reading comprehension levels, advanced age, minority groups, rurality, and mental or physical disability (Brega et al., 2015; Speros, 2005; The Joint Commission, 2007; Zahnd, Scaife, & Francis, 2009), many of which are found in Appalachian demographical information.

Chronic diseases like obesity, hypertension, and hyperlipidemia, while known to negatively impact health, lack significance until functional disability occurs (Griffith et al., 2011;

Goins et al., 2011). The break in continual health care management often leads to advanced disease states, increased acuity, and poorer outcomes.

Inconsistencies exist in decision-making, perceived risk, and actual risk (Della, 2011). Discord exists in perceptions of tobacco as a vital source of income, along with the cultural norm in the decision to personally use tobacco, and the medical perception of adverse impact on health (Behringer & Friedell, 2006). Diabetes management was likewise controversial. Della (2011) identified a gap between the perceived risk for developing diabetes and the actual risk level, finding participants believed a simple diet change would control/prevent diabetes, an individual decision-making issue, not a collective problem for community intervention—a perception similar to nationwide viewpoints (Powers et al., 2016). Griffith et al. (2011) found over half of the study participants on antihypertensive medications had continued elevated blood pressure, but still indicated they were in good health. Again, individuals failed to view these conditions as problematic seeing themselves as healthy until there was a disruption in function. Preventable risk factors (lack of exercise, poor nutrition, and smoking) contribute to increased rates of chronic disease in Appalachia (Davis et al., 2015; Huttlinger, Schaller-Ayers, & Lawson, 2004). Effective health education and decision-making support could positively influence health for family units and communities alike.

Family plays an important role in health care beliefs, serving as the primary social context for health care. Historically, in times of illness and dependence, as a geographically isolated entity, the family was often the primary care provider. Older family members served as role models for health-related behaviors and assumed responsibility for protecting younger family members (Denham, Meyer, Toborg, & Mande, 2004; Keefe, 2005). Routine health care measures to care for the young, the parents of the young, and the elderly were more consistent (Hansen, 1985) thereby increasing engagement in non-critical therapies for these populations.

Female family members are the guardians of family health (American Psychological Association, 2019; Denham, 1999; National Alliance for Caregiving, 2015) making it important to ensure these key figures are included in care planning and delivery.

Finally, family and community interactions contribute to health outcomes. Definitions of communities in rural Appalachia commonly include informal geographic boundaries and discussion of members who are closest and largely self-sufficient. Family caregivers may avoid imposing on friends and neighbors unless absolutely necessary. Parnicza (1990) proposed two theories to explain this practice: expression of the cultural trait of independence or, alternately, recognition of hardship for fellow community members as well. A third perspective proposed a rationale grounded in the cultural characteristics of pride, a keen sense of privacy, self sufficiency, and dislike of handouts (Behringer & Friedell, 2006). Regardless of the foundational theory, familial experiences contributed meaningfully to discussions of all aspects of health (Denham et al., 2004).

Earlier questions explored what nursing is and what it means to be a nurse. Now the question becomes more refined, addressing the population of nurses in Appalachia. The overall problem question is, within the context of the rural environment, health care systems, and health outcomes for the residents who live in the region, what does it mean to be a nurse in rural Appalachia? This single foundational problem question gave rise to a myriad of additional unknowns explained with this investigation. The following questions demonstrated the gap in knowledge related to this question. Given the previous discussion of health in the region, what did mean to be a nurse caring for well-known friends and neighbors? Did recognition as a nurse in community gatherings mean there is no time away from providing health care? How did it feel to understand the implications of chronic disease conditions viewed as acceptable, expected, and only marginally managed through medical care? How did the nurse inspire the client to leave accepted behaviors to engage proactively in pursuit of more

healthy lifestyles? How was the nurse's sense of proficiency affected when the client made the transition—or not? What motivated nurses in Appalachia to continue practicing nursing day after day, to function as an integral member of the collaborative healthcare team, and try to make a difference in the lives of a single individual or a whole community? How did the nurse cope personally with barriers experienced by the client as described in the literature and what resources supported that coping? How did the nurse use personal and professional knowledge to create positive relationships with health care systems that may not always function optimally? Were the long commutes for nurses peaceful and reflective, frustrating and wasteful, unremarkable and just a way of life, or some other unexplored experience? These questions were answered through the voice of the nurses who experienced these concepts in their work and personal life. Their answers contributed insights that support professional practice for these vital members of the community and health care team.

Problem Statement and Purpose

Nurses who work and deliver care in Appalachia have a great opportunity to make a difference in health outcomes in the region. Communities view "nurses as advocates and trusted members who provide holistic care with empathy, cultural competence, and professionalism" (Brewer, 2018, p. 11). The work ethic, leadership ability, and fortitude of nurses are widely recognized. The literature is rich with accounts of efforts to improve the health of Appalachian residents through regional healthcare systems (Caldwell, 2007; Fletcher, Slusher, & Hauser Whitaker, 2006; Gobble, 2009; Jessee & Rutledge, 2012; Lee, Hayes, McConnell, & Henry, 2013; Snyder & Thatcher, 2014), but the focus is largely on improving outcomes of the residents and communities, not the nurses who support that process. Nurses make up the largest group of health care providers, serve as a primary source of preventive care or health care information, and are in close proximity to patients in the hospital around the clock (Menehan, 2011). Nurses have been rated highest among all professionals for honesty and ethical standards for the last

fifteen years (Norman, 2016).

Nurses have historically served as primary health care providers in the Appalachian region (Hansen, 1985) and continue to be central figures of health care delivery. Yet, there is little to inform others about the value of their role, challenges they face, and opportunities to support them as they make a difference in the lives of others. Scant literature exists to explain what it means to manage the dual roles of being a registered nurse and a rural community member. Therefore, the purpose of this exploratory study was to interpret and understand the lived experience of contemporary RN practice in rural Appalachia.

Research Aims and Questions

The research question for this study was: What is the lived experience of being a registered nurse in the community where you live? A hermeneutic phenomenology design facilitated insight and interpretation of the subjective experience for participants, which explored the meaning of being in the world and choices that resulted from the situational context of participants (Lopez & Willis, 2004). Participants were able to tell their story in their own words.

Two aims for this study were:

Research Aim 1: To understand the lived experience of contemporary nurses in rural Appalachia

Research Aim 2: To understand the lived experience of nurses in relation to the place of residence and the place of employment

Definition of Terms

Advanced Practice Nurse (APRN): Registered nurses educated at the Masters or post Masters level to care for a targeted patient population with the professional license to assess, diagnosis, and manage patient problems, order diagnostics, and prescribe medications.

Appalachian sub-regions: Regions having similar characteristics of topography, demographics,

and economics within the greater Appalachian region developed by the Appalachia Regional Commission for purposes of analysis including that of economics and transportation. The subregions include Northern, North Central, Central, South Central, and Southern Appalachia. The Appalachian sub-region for this study is South Central with a focus on a six-county area in three adjoining states.

Registered Nurse (RN): A nurse who has received educational preparation and passed a national licensing examination as a registered nurse. Duties may include assessment, provision, education, and coordination of care for individuals and groups.

Rural: Defining rurality depends on the application of the term "rural." The U.S. Census Bureau (n.d.a) urban-rural definition is based on quantification of population size and density, i.e. any area not categorized as urban is rural. Urban areas have populations of 50,000 or more people. Urban clusters have at least 2,500 but less than 50,000 people (U.S. Census Bureau, n.d.a). Under this definition, an aerial view of a rural area denotes a high percentage of open country, population densities of less than 500 people per square mile, and settlements of fewer than 2500 residents (U.S. Department of Agriculture Economic Research Service [USDA ERS], 2019d). On the other hand, the U.S. Department of Agriculture Economic Research Service defines rurality differently, incorporating definitions of the Office of Management and Budget (USDA ERS, 2019d). This strategy takes into consideration the flow of a population's labor flow as well as the number of residents. The Rural-urban Continuum Codes (RUCC) differentiates metropolitan (metro) counties and nonmetropolitan (nonmetro) counties (USDA ERS, 2019b). A nonmetro county is considered "adjacent" if it is physically adjacent to a metro area and at least 25% of its workforce commutes to a metro county. Nonmetro counties not meeting these criteria are categorized as "nonadjacent" (USDA ERS, 2019b). This perspective reflects a regional concept including labor-market data and county-level data based on population size and

proximity to metropolitan areas. Higher numeric values (1-9) represent increased rurality. Further classification, core based delineation of urban influence, reflects the population size of metro areas and nonmetropolitan counties by the size of the largest city or town and the proximity to metro and micropolitan areas. The counterpart, noncore counties, is not part of core-based metro or micro areas (USDA ERS, 2019c). Higher numeric values (1-12) represent increased rurality. A final classification is provided through Frontier and Remote Area Codes determined using a combination of low population size and higher geographic remoteness as identified by zip code areas (USDA ERS, 2019a). Higher numeric levels indicate increased rurality based on zip codes with areas not considered frontier and remote designated only as non-frontier/remote. The range, mean, and standard deviation of rural designations for the six-county focus area gives an overview of the classification status for the study's focus area. The range for population per square mile is 35.1 to 163.4 people (M = 77, SD = 46.3; U.S. Census Bureau, 2018). The RUCC classification range is 5-9 (M = 7, SD = *1.7*; USDA ERS, 2019b).The Urban Influence range is 3-10 (M = 8.2, SD = *3.3*; USDA ERS, 2019c). The Frontier and Remote Area Code classification is based on zip codes. Since multiple zip codes exist within each county, focus counties of this study were identified dichotomously as "yes" or "no" if any of the zip codes in a county are classified as any level of frontier and remote areas. Three of the six focus counties in this study have zip codes areas included in the Frontier and Remote Area Code designation (USDA ERS, 2019a). This definition illustrates how classification for the six counties of this study varies depending on which classification scheme is used. Therefore, it is important to note this study adopted the definitions of the U.S Department of Agriculture Economic Research Service as it was anticipated the considerations of workforce flow and proximity to metropolitan centers would be a consideration for some study participants'

perceptions of nursing practice rather than merely population density of the communities where they worked and lived.

CHAPTER 2

JOURNAL OF TRANSCULTURAL NURSING

PERCEPTIONS OF NURSING IN APPALACHIA: A STATE OF THE SCIENCE PAPER

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ABSTRACT

Introduction: Nursing practice is continuously evolving in response to global health care need, sociopolitical culture, and advancing medical knowledge necessitating ongoing evaluation of professional practice. The purpose of this state of this science paper was to explore current perceptions of nursing and critique the depth of knowledge specific to nursing practice in the Appalachian region.

Methodology: A review of the literature in multiple databases was conducted to explore perceptions of nursing in Appalachia.

Results: Categories of perception included the following: (a) perceptions of nurses and education leaders that practice in the Appalachian region, (b) perceptions of communities of Appalachia and Appalachian health care systems, and (c) perceptions of patients possessing inherent cultural characteristics of the Appalachian region.

Discussion: None of the literature specifically addressed perceptions of nursing. Much of the available literature was over five years old. A significant deficiency in understanding perceptions of nursing in Appalachia was identified.

Key words: nurse, nursing, Appalachia, Appalachian, nursing practice

As a professional practice, nursing is responsive to change in global sociopolitical factors, advancing medical knowledge, and health care needs of the clients. Generically, nursing focuses on health promotion, healing, and alleviation of suffering. However, these generic, widely accepted descriptions fail to identify characteristics specific to many areas of professional nursing practice. It is essential to understand factors influencing nursing practice as a central element of support for professional practice. While nursing has long focused on the need for cultural competence in patient care delivery, there has been less interest in discovering how factors affect the practice of professional nurses as culturally diverse individuals. Much of the existing work has focused on culturally distinct nursing populations such as English-asa-second-language nurses or foreign nurses who come to the United States to practice. However, select regions of the United States provide the setting for nursing care that is diverse but not culturally distinct from mainstream of the United States. Appalachia is classified as such (Rosswurm, Dent, Armstrong-Persily, Woodburn, & Davis, 1996).

The term "Appalachia" has many definitions and may include cultural, geographical, or political concepts to define a very large, very diverse region. In 2009, the Appalachian Regional Commission (ARC) revised the classification of the region into subregions to aid with analysis of economic and infrastructure systems (ARC, n.d.). The Central and South Central subregions contain Western North Carolina, Eastern Tennessee, Southwestern West Virginia, Western Virginia, and Eastern Kentucky and provide the focus of interest for this article. Defining the regional links is important as attempts to define Appalachia commonly try to link inhabitants and the place (Keefe, 2005). The intensity of "Appalachian" cultural characteristics varies from a strong intensity inside the regional core to less intense on the periphery (Williams, 2002). This

variation is relevant, serving as an influence for Appalachian cultural traits not exclusively unique but varying in degree of importance and congruence with the nation as a whole.

One variation is in health care availability, beliefs, practices, and delivery. Health care in Appalachia often takes shape as one in which the health care professional functions as a guide for health care decisions, prompting expression of patient values, attempting to understand patient values, all the while commenting, and sometimes criticizing, values and behaviors in an attempt to stimulate change toward a more healthy lifestyle (Tong, 2007). Early images of nursing care in Appalachia came from a focus on the "granny midwife" central to women's health or herbalists and lay healers common in the early 20th century who filled a need in the Appalachian communities with few medically educated professionals (Barney, 2000; Cavender, 2003). Later, historical writings focused on exemplary nursing figures influential in delivering care within the region such as Mary Breckinridge, the founder of the Frontier Nursing Service, who was educated in the United States and Europe but had family ties to the Appalachian region where she eventually came to practice nursing (Goan, 2008). Works by nursing figures like Breckinridge brought the science of nursing and professional practice to the Appalachian region (Ruffing-Rahal, 1991). Perceptions of nursing in Appalachia were transitioning from a backwoods, layperson using resources at hand to an educated, trained professional capable of integrating scientific strategies and methods during the delivery of health care.

While perceptions of nursing are evident in the historical context, perceptions of nursing today in Appalachia are obscure. The purpose of this article is to discuss perceptions of nursing and critique the depth of knowledge specific to nursing practice in the Appalachian region. The literature reveals three natural categorizations of the perceptions of nursing: (a) perceptions of nursing held by nurses within the region, (b) perceptions of nursing found in communities and

community structures within the region, and (c) perceptions of nursing as perceived by patients within the region.

Method

Theoretical Concepts

The rural nursing theory is a descriptive, middle range nursing theory, concentrating on the limited perspective of nursing specific to rural areas (Winters, 2013). The theory proposes commonalities of nursing practice in rural regions and differentiates aspects of this nursing practice from that of an urban region. Almost half (42%) of Appalachian region is designated as rural (ARC, n.d.), making the rural nursing theory a good fit as a framework for exploring nursing practice in the region.

Literature Review

To obtain the widest collection of literature, the literature search had no date limitation. Inclusion of older literature added depth to the historic perceptional evolution and supported holistic comprehensive critique of all the available literature. The abstracts served as the field of search based on the recommended use of an abstract by American Psychological Association guidelines (VandenBos, 2010).

Generic search terms ensured capture of all articles relevant to the topic. The initial search terms “perceptions,” “nursing,” and “Appalachia” produced one article, resulting in a widening of search parameters. The limiting search term was identified to be “perceptions.” Subsequent searches dropped this term from the search effort. The final search terms used included “nurse” or “nursing” and “Appalachia” or “Appalachian” under the abstract heading. All possible combinations of the search terms produced a significant number of duplications. Databases searched were the following: Cumulative Index to Nursing and Allied Health

Literature, PubMed, ProQuest Dissertations and Theses, ETSU Digital Commons, and Ovid. The search produced 72 items after elimination of duplications. Detailed examination using the inclusion and exclusion criteria reduced the list to 26 items.

Inclusion Criteria

Only dissertations, theses, and peer-reviewed published articles reporting primary data were included in the review. Articles were included if they portrayed the nurse as a culturally competent, practicing professional in the Appalachian region (i.e., "the nurse did . . .") and if consideration of Appalachian cultural characteristics formed a central focus of nursing practice.

Exclusion Criteria

Nonpeer-reviewed works, works without academic review processes, and articles describing use of secondary data were excluded. Portrayal of the nurse as a theoretical figure providing standardized nursing care also was grounds for exclusion (i.e., "the nurse should . . ." or "the nurse could . . ."). Lack of discussion addressing cultural perspectives was an additional exclusionary factor.

Findings

The literature revealed no direct measurement of or statements about perceptions of nursing in Appalachia; therefore, inference was the method used to categorize the literature. The findings are organized according to the perceptions of nursing: (a) perceptions of nursing by the nursing and education leaders that practice in the Appalachian region, (b) perceptions of nursing by the communities of Appalachia and Appalachian health care systems, and (c) perceptions of nursing by Appalachian patients possessing inherent cultural characteristics of the region. The three categories may also be linked to the rural nursing theory concept of "The Professional Nurse" (H. J. Lee & Winters, 2004; Winters, 2013) as illustrated in Table 2.1.

Table 2.1

Categorizations of Perceptions of Nursing as Aligned With Rural Nursing Theory Concept of "The Professional Nurse."

Theoretical dimension	Perspective of nursing and sources in the literature
Community expectation and responsibility • Generalist role with specialist skill • Multiple community roles • Role diffusion	Perceptions by nurses and education leaders Baker (1997) Blowers, Ramsey, Merriman, and Grooms (2003) Caldwell (2007) Ferguson (2005) Lee, Hayes, McConnell, and Henry (2013) Macavoy and Lippman (2001) McClung (2008) Persily (2004) Ramsey, Blowers, Merriman, Glenn, and Terry (2000).
Interrelationships • Lack of anonymity and separation • Client familiarity and advocacy	Perceptions by communities and health care systems Denham (2003) Fletcher, Slusher, and HauserWhitaker (2006) Florence, Goodrow, Wachs, Grover, and Olive (2007) Huttlinger, Schaller-Ayers, Kenny, and Ayers (2004) Jessee and Rutledge (2012) McDaniel and Strauss (2006) Plattner (1987) Snyder and Thatcher (2014)
Nurse-client interactions • Caring concepts and practices • Provider culture	Perceptions by patients Gobble (2009) Hunsucker, Frank, and Flannery (1999) Lohri-Posey (2006) Lowry and Conco (2002) Mixer, Fornehed, Varney, and Lindley (2014) Parnicza (1990) Presley (2013) Schlomann, Virgin, Schmitke, and Patros (2011) Wallace, Tuck, Boland, and Witucki (2002)

Note. Concepts and theoretical dimensions are further discussed in H. J. Lee and Winters (2004).

Perceptions of Nursing by Nurses and Education Leaders

In this category, there are three subcategories identified: (a) disparity in educational preparation,(b) advanced education and advance practice, and (c) nursing leadership. Four articles focused on perceptions of disparity and the additional challenge of becoming a nurse, two on perceptions of advanced education, and three examine leadership.

Disparity in educational preparation. Appalachia is a region of educational disparity. A contributing factor is widespread poverty with little extraneous financing for advanced education. Although the poverty rate has fallen from 31% in 1960 to 17% during the period from 2009 to 2013, this decrease reflects a transition from an area of widespread poverty to one of economic contrast within the region, not widespread strong economic growth (ARC, n.d.). Nationally, 70% of students attend college; yet in Appalachia that rate is only around 50% with much lower rates in some areas (ARC, 2012). This financial disparity contributes to a significant employment requirement during nursing school with decreased time to devote to academics and heavy dependence on financial aid funding with resultant substantial payback obligations (Behringer & Friedell, 2006; Purnell, 1999). Additional contributing factors include a lack of emphasis and support for higher education (Behringer & Friedell, 2006; Purnell, 1999), increased likelihood of deficient specialized care competence (Behringer & Friedell, 2006), and education (Baker 1997). Finally, cultural differences may be subtle, relatively unnoticeable, and, therefore, more challenging to teach and learn (Williams, 2002) for all nursing students.

Strategies to meet this educational disparity included peer tutoring programs for students who were struggling academically (Blowers et al., 2003; Ramsey et al., 2000), immersion experiences alongside culturally competent nursing professionals (Macavoy & Lippman, 2001), and independent ownership of professional competency in the face of insufficient formal support

structures (Baker, 1997). Although academic challenge was an identified perception of nursing education, these strategies proved efficacious in meeting this challenge.

Advanced education and advanced practice. The literature revealed difficulty in separating nursing perceptions and Appalachian cultural characteristics. Caldwell's (2007) heuristic phenomenological study explored the life stories of eight nurse practitioners born in Appalachia and working at the master's level of advanced practice nursing. Although advanced education modified their viewpoint of cultural patterns such as acceptance of cigarette smoking, alcoholism, and religious practices, it did not minimize the strength of the inherent cultural values and traits (Caldwell, 2007).

Ferguson (2005) examined the impact of cultural norms and nursing practice through a focus on the availability and use of information technology. As a region of health care provider shortage (Behringer & Friedell, 2006) in which web-based technology could serve as an effective vehicle for connection and communication, Ferguson's findings did not support this viewpoint. The lack of computer literacy and technology infrastructure posed no barrier to use; rather, the attitudes about use posed a greater barrier (Ferguson, 2005). Little use of telemedicine and the preference for face-to-face continuing education opportunities seemed to be participant personal choice. Appalachian culture holds the establishment of personal relationships essential to the development of trust and connection (Presley, 2013). Professional isolation (National Advisory Committee on Rural Health and Human Services, 2015) and independence (Russ, 2010) are expected norms in Appalachia. It is possible that neither telemedicine nor online continuing education opportunities fit the model of independence or support for development of personal relationships deemed vital to cultural norms and, therefore, use was negatively affected.

Nursing leadership. There is a distinct perception of nurses as leaders in Appalachia by nurses in the region. In Appalachia's patriarchal social structure, men have customarily been the family provider through traditional male roles demanding physical strength such as hunting and farming (Denham, 2003). However, McClung (2008) found leadership roles in men who stepped out of the expected norms to become nurses. M. L. Lee et al. (2013) found, even as students, nurses were leaders in interprofessional collaboration in a service-learning project aiding a vulnerable population of low-income, chronically ill elderly females.

Leadership is also noted in Persily's (2004) exemplar of professional practice. As an experienced perinatal advanced practice nurse, the author identified an absence of prenatal care and became instrumental in filling that gap. Clients began using the clinic for prenatal care, but they brought their families in for care as well (Persily, 2004), supporting the union of family members into a single unit of care consistent with the cultural norms (Denham, 1999; Denham, Meyer, Toborg, & Mande, 2004). This practice reflects the establishment of trust relationships with health care providers and a means of meeting health care needs in a region of health care shortage (Behringer & Friedell, 2006). As strong as the impact was on care delivery for her patients, greater still was the impact on regional health care. As a preceptor of multidisciplinary students, the author integrated interdisciplinary practice and provided an avenue of interest for these future care providers, some of whom chose to stay in the region to practice (Persily, 2004).

Perceptions of Nursing in Appalachian Communities.

Pertinent literature in this category was further condensed into two subcategories: (a) nurses as advocates and (b) nurses as members of the Appalachian culture. Eight articles are included. Five articles focus on perceptions of community advocacy and three examine influences of cultural norms on within the community.

Nurses as advocates. Three of the five articles support the idea of nurses as community advocates through their ability to bring health care to disparate Appalachian regions. McDaniel and Strauss (2006) and Snyder and Thatcher (2014) identified outcomes for mobile health units committed to communities for an extended period of time. Huttlinger et al. (2004) worked to bring health care to the community for a more limited time.

Sister Bernie came to Southwest Virginia as part of a three-member team in response to the region's association with the poorest health statistics in the state for 1978 (Snyder & Thatcher, 2014). At that time, the county had no hospital, only one clinic, and rural mountainous terrain—all factors that negatively affected health care access. Sister Bernie used her small personal vehicle that became a roving health wagon supported by charitable donations (Snyder & Thatcher, 2014). McDaniel and Strauss (2006) describe development of an outreach mobile health clinic staffed by nursing students which provided health services to underserved populations and professional, culturally competent health care education for students. Huttlinger et al. (2004) also support the idea that nurses were effective Appalachian community advocates through their work to bring rural area medical clinics to the area and to fill in a gap of knowledge about rural area medical attendees. Data collected informed political and health care leaders and advocated for measures to meet health care needs (Huttlinger et al., 2004).

Fletcher et al. (2006) described nursing/community leader collaboration to increase health care access but expanded the role of nursing to include case management, health education, and to a significant level of political service as the president of the board of trustees for a health clinic that served nine rural counties in Appalachian Kentucky. Jessee and Rutledge (2012) presented Appalachian nurses as community advocates through a quantitative study focusing on diabetes self-management education. The Appalachian region has an excessively

high rate of diabetes at 12.5% as compared with the national rate of 8.6% (Denham, Wood, & Remsberg, 2010). However, self-sufficiency and pride in independence prevalent in the Appalachian culture (Marek, Brock, & Sullivan, 2006) support the theory of diabetes selfmanagement (Denham, Remsberg, & Wood, 2010) for Appalachians. Jessee and Rutledge (2012) found participants who took part in the diabetes self-management intervention had improvements in blood glucose levels, A1C levels, and self-management over control group participants. As a community effort, perceptions of culturally sensitive nursing advocacy for successful diabetes self-management would positively affect health throughout the community.

Nurses as members of the Appalachian culture. Nurses in Appalachia are also members of the Appalachian community. Denham (2003) examined health care workers' preparation to assess pregnant women for physical and emotional abuse. Appalachian characteristics (poverty, patriarchal viewpoint, geographic isolation, and limited or inconsistent legal enforcement or protection) identify the region as an area of need specific to abuse (Denham, 2003). Denham (2003) identified self-held perceptions by nurses of insufficient education to assess abuse or make appropriate referrals in abuse situations as well as unfamiliarity with workplace policies about abuse. Additional findings suggested potential cultural norms about abuse might predispose nurses to inadequately assess or report abuse situations in the region, because, of the health care workers, 17.6% reported sexual abuse as a child and 9.9% reported violent treatment as a child (Denham, 2003).

Florence et al. (2007) examined the impact of a 3-year interdisciplinary educational program focusing on practice in rural underserved Appalachian communities. The authors found that participants were significantly more interested in working in primary care or rural community settings ($p = .009$), with underserved populations ($p = .025$) using interdisciplinary

collaboration ($p < .001$) if they had participated in the rural practice program (Florence et al., 2007). These results suggest that exposure to factors inherent to regional characteristics during formal education provided students an opportunity to develop the strategies to successfully manage perceived barriers of practice in Appalachian communities.

Finally, Plattner (1987) recounts the historic efforts of the Sisters of Divine Providence during the early 1900s in Appalachian communities during a major outbreak of influenza. A sense of distrust for the nuns as nurses existed in the region yet they overcame distrust, focusing on healing, not religious differences (Plattner, 1987). The nuns were careful to not interfere with traditional mountain health care customs and were diligent to avoid criticizing cultural norms. These actions stimulated mutual acceptance of health care practices and successful integration as part of an Appalachian community.

Perceptions of Nurses by Patients in Appalachia

Another category identified in the literature presents perceptions of nurses through the perspectives of Appalachian patients. Nine studies were appropriate for this category. Eight described nurses as trusted professionals and significant sources of support. Results from the ninth study by Parnicza (1990) were slightly different.

Parnicza's (1990) phenomenological study explored interactions between Appalachian care givers and social support systems. Parnicza found that, although the nurses served as an essential link to keeping family members at home and were major sources of social support, caregiver participants did not identify nurses as a source of emotional support. Research has demonstrated an inherent hesitance of Appalachian residents to accept strangers and that, in times of need, the first expectation of assistance is from family and church members (Marek et al., 2006; Russ, 2010).

Each of the other eight studies illustrated perceptions of nurses in Appalachia as trusted providers and a source of strong personal relationships. Hunsucker et al. (1999) compared perceptions of need for families of critically ill hospitalized patients in rural Appalachia and in large metropolitan settings. An unexpected finding recognized the intensive care nurses in the role of gatekeeper. Appalachian cultural norms support hesitation to accept outsiders (Marek et al., 2006). Patient families refused interviews when the investigator asked but accepted when the unit nurses asked them to participate (Hunsucker et al., 1999) making the nurse a "gatekeeper," a trusted professional, and a significant source of support.

Patient perspectives of nursing portray nurses as competent, accepted professionals in four studies. An ethnographic study of patients living with hypertension identified previous negative patient experiences stemming from perceptions of a lack of respect for the patient as a person, feeling devalued, and alienation by health care providers (Schlomann et al., 2011). This dysfunctional environment may also reflect the cultural norm for a dislike of authority figures and attempts to control behaviors (Pike Community Hospital, 2010; Presley, 2013; Purnell, 1999). Conversely, experiences at the nurse-run clinic were positive and clients expressed satisfaction and personal validation in health care interactions (Schlomann et al., 2011). Nursing professionals provided needed services in a manner that supported dignity and self-worth, concepts especially important in the Appalachian culture where social equality and respect are valued (Marek et al., 2006).

A similar phenomenological study explored the lived experience of being a diabetic in rural Appalachia (LohriPosey, 2006). Participants identified the significant role of nurses in patient education although they were secondary sources of information with primary sources being family members or friends, a finding supported by previous research (Behringer &

Friedell, 2006). Consistent with the cultural characteristics of the region, the unit for treatment was the family, not the individual patient (Denham, 1999; Denham et al., 2004). Participant quotes reflected the significance of family behaviors and understanding in diabetes management. For the nurses caring for these patients, recognition of the family structure was imperative to meeting client need (Lohri-Posey, 2006). This sense of family—and inclusion of the nurses as theoretical family members— minimized the viewpoint of the health care provider as an outsider. Nurses viewed as knowledgeable, nonjudgmental, and respectful were valued.

Two studies examined culturally competent care. Mixer et al. (2014) identified the value of integrating folk and biomedical therapies during end-of-life care. Presley (2013) proposed specific culturally appropriate approaches for nursing students based on specific cultural traits of the region including the expectation of discussion on common topics ranging from general comments on the weather to more intimate disclosure about potential connections based on shared personal or family residence locations. Research has demonstrated direct linkage between personal identity and community and kinship group identities in Appalachia (Russ, 2010). This communication technique supported perceptions that patients want to be seen as individuals who share common bonds with providers, not as a medical diagnosis or a stranger with an ailment. Additionally, nurses in the study served as a trusted instrument in the continuum of care in areas of more complex expert consultation (Mixer et al., 2014), a bridge between residents hesitant to consider acceptance from other culturally diverse health care providers (Presley, 2013).

Perceptions of the significance of nurses in spiritual support are also evident in the literature. Lowry and Conco (2002) explored spirituality with a population of aging adults in Appalachia in a phenomenological study. Most participants supported a framework for spiritual care provision to include reverence, kind treatment, listening, thoughtfulness, kindheartedness,

and responsiveness supporting a perception of spirituality not communicated as a statement but as a demonstration. Participants described spirituality as an inherent trait for nurses, not a skill learned in school, but a naturally occurring characteristic consistent with cultural norms (Goins, Spencer, & Williams, 2011). Patients categorized nurses as either spiritual or nonspiritual based on their caring attitudes, sensitivity, and trustworthiness or the lack thereof (Lowry & Conco, 2002).

Wallace et al.'s (2002) ethnographic study described client perceptions of parish nursing in two churches in an Appalachian community. Members of the churches viewed parish nurses as approachable, friends, counselors, and sources of support. Cultural norms dictate family, friends, and the church as primary sources of assistance (Rosswurm et al., 1996). Integration of physical and spiritual health for the congregation and other community members supported the cultural characteristics emphasizing the collective community focus (Russ, 2010). A deep intimate personal relationship between the congregation members and the nurse developed (Wallace et al., 2002) supporting the significance of loyalty to family, church, and community (Behringer & Friedell, 2006; Pike Community Hospital, 2010).

Gobble (2009) used the story theory method to describe a developing relationship between a nursing professional and a patient steeped in Appalachian heritage and religious traditions. Reliance on faith health healing as personified and practiced by her mother strongly influenced the patient's health care decision. Faith and faith healing are essential cultural norms in the Appalachian culture (Behringer & Friedell, 2006; Deskins et al., 2006; Shell & Tudiver, 2004). Even understanding the biomedical model of care, compliance seemed contradictory to the strong belief in God as the source of all healing—a viewpoint that the nurse practitioner did not share but accepted nonjudgmentally (Gobble, 2009). Appalachian cultural characteristics

value communication techniques that are accepting, nonjudgmental, nonconfrontational, and sensitive (Russ, 2010). Through listening, active engagement in cultural knowledge acquisition, and open-minded care, the nurse practitioner was able to provide culturally sensitive care (Gobble, 2009). Evaluation of the literature supported an inference of communication channels between the two that were solid, comfortable, and mutually respectful although not in total agreement or with complete understanding of the sometimes conflicting perspectives. The patient found a sense of safety and acceptance not only for who she was but for the spiritual views so inherent to her belief system.

Discussion

The literature supports perceptions of nursing from the perspective of nursing and education leaders in Appalachia, of communities of Appalachia and Appalachian health care systems, and of Appalachian patients having innate cultural characteristics of the region. Although educational and organizational disparities exist, the literature demonstrates that Appalachian nurses efficiently found ways to provide effective, proficient care. However, the literature does not reveal how nursing educators can most successfully support prelicensure and postlicensure nursing educational success, how nurses develop specialty skills without specialized training, or how this challenging academic preparation affects later decisions to pursue advanced nursing practice.

Communities recognize nurses as advocates and trusted members of local social structures who provide holistic care with empathy, cultural competence, and professionalism. Native-born nursing Appalachians may use unrecognized personal cultural traits to support successful practice and incorporate advanced practice with cultural norms. Yet it is unknown if cultural training specific to Appalachia would positively advance the professional skills of native

Appalachian nurses as in Denham's (2003) study on abuse. Nurses are seen as determined, willing to work, able to overcome, and willing to assume positions as leaders in the profession, the community, and the region. Still it is unknown how Appalachian cultural characteristics, like independence and determination, influence professional behaviors in practice or how the Appalachian cultural norms may, in fact, be barriers to improved professional practice. Finally, it is unclear how nonnative Appalachian nurses become culturally competent practicing members of the communities. The literature supports theories of restrain and persistence, community involvement, and education of the community and nurses. Nonetheless, it is unclear what this process of community integration looks like, how a nurse becomes a trusted professional, and how academic preparation can support that integration for all nurses in the Appalachian region.

This state of the science paper identified and categorized perceptions of nursing in Appalachia through inference based on current literature on the topic. There was no literature specifically addressing perceptions of what nursing is in Appalachia—a large gap in nursing knowledge. There was a dearth of literature about nursing practice specific to Appalachia and no method for direct measurement or conceptualization of nursing in the region. Much of the available literature is over five years old indicating a significant lack of understanding and growth in perceptions of nursing in Appalachia. However, through simultaneous examination and comparison of literature on nursing in the Appalachian region and literature about regional Appalachian characteristics, perceptions of nursing emerged. Additional research is needed to identify perspectives of nursing specific to Appalachia for the purpose of supporting professional practice in an ever changing health care community.

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CHAPTER 3

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THE LIVED EXPERIENCE OF NURSING APPALACHIA: SAMPLING AND RECRUITMENT

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ABSTRACT

Introduction: Nurses form a central hub of health care for rural communities. However, little is known about the lived experience of nurses who serve in this capacity. This phenomenological study explored stories of those nurses in a six-county area of three adjoining states in rural South Central Appalachia. Research in rural areas presents special challenges for sampling and recruitment. Examples of considerations include smaller sampling population, privacy concerns, and the rural context. The purpose of this article is to discuss the results of sampling and recruitment strategies within this study.

Methodology: Recruitment for the study was completed using social marketing strategies through the state boards of nursing and snowball sampling.

Results: Sampling and recruitment efforts enlisted 15 participants. The sample was deemed representative of the sampling population as participants represented diverse employment contexts, education preparation levels, licensure duration, and multiple generations.

Discussion: Understanding implications of rural setting and cultural context are critical to successful recruitment and sampling. Privacy considerations may still be concerning, however, multiple de-identification strategies serve to help lessen this risk. Social marketing strategies failed to recruit the needed number of participants secondary to the fact that participants from only one state were recruited in this manner. Smaller population pool limitations were eased by snowball sampling, an approved method for recruitment in qualitative research. Future researchers should be cognizant of the influence of rurality norms and cultural context on recruitment and sampling efforts. Social marketing proved less successful than snowball sampling strategies. Further research is needed to develop best practice for recruitment and sampling for social marketing in rural areas. Finally, time and resource commitment for

participation can be a barrier. Flexibility in scheduling interviews, location of interview sites, and the availability of audio/phone interviews served to facilitate agreement to participate.

Key words: rural, nursing, Appalachia, research, sampling, recruitment

The largest body of health care providers is nurses. Nurses provide care around the clock in many health care settings. They serve as a source of preventative care and as the primary source of health care information. Of all professionals, nurses have been rated highest in ethical standards and honesty for the last 15 years (Norman, 2016). Nurses provide care to individuals from first breath to last breath. They are viewed as advocates and trusted members of the community "who provide holistic care with empathy, cultural competence, and professionalism" (Brewer, 2018, p. 11). Their work ethic, leadership, strength, courage, and resilience are widely recognized. However, nurses largely work in the shadows out of the public eye. They work independently and in collaborative teams caring for clients across the lifespan in all global settings and all phases of the health and wellness continuum (International Council of Nurses, 2019). Registered nurses (RNs) are described as "determined, willing to work, able to overcome, and willing to assume positions as leaders in the profession, the community, and the region (Brewer, 2017, p. 6). Their contribution to improving outcomes for clients and communities are noticeably visible while the nurses themselves remain hidden. Many authors have demonstrated efforts to improve health of Appalachian individuals and communities through focused regional healthcare systems (Caldwell, 2007; Cockerham, 2015; Fletcher, Slusher, & Hauser-Whitaker, 2006; Gobble, 2009; Jessee & Rutledge, 2012; Lee, Hayes, McConnell, & Henry, 2013; Snyder & Thatcher, 2014) but rarely through the work of the hundreds of individual nurses. Although they influence hundreds of lives every day, the story of how they get up and go to work every day, the personal significance of what they do, and the challenges they face has not been explored. The purpose of this research effort was to explore and interpret the lived experience of contemporary practice of the registered nurse in rural Appalachia. Qualitative research is an appropriate technique for discovering the stories but only if the appropriate participants could be

recruited to the study. The purpose of this article is to discuss sampling and recruitment processes for the study that addressed discovery of the lived experience of nurses living in rural Appalachia.

Rural Appalachia

Appalachia is marked by diversity and contrast--gently sloping hills to fertile valleys, craggy mountain slopes to deep hollows, and urban municipalities to rural regions. The Appalachian Region follows the Appalachian Mountain Range through 12 states and all of West Virginia, covering 205,000 square miles with a population of over 25 million people. The Appalachian Region is subdivided into regions having similar characteristics of topography, demographics, and economics (Appalachia Regional Commission [ARC], n.d.). Almost half of the region is rural (ARC, n.d.). The focus region for this research study is a six-county area three adjoining states in the south central region of ARC.

Definitions and representations of rurality vary. However, central concepts of rurality are common among all definitions. The concepts include population size and density (U.S. Census Bureau, n.d.), labor flow (U. S. Department of Agriculture Economic Research Service [USDA ERS], 2019b), proximity to urban areas (USDA ERS, 20119c), and geographic remoteness (USDA ERS, 2019a). Based on the application of rural within the context of national demographics east of the Mississippi, the six-county focus area of Appalachia supported the use of rural classification for the study. Rural classification guidelines provided by the U.S. Department of Agriculture Economic Research Service formed the foundation for defining rurality with the anticipated likelihood of influence on participants' perceptions of workforce flow and proximity to urban areas. Rural classification information for the six counties of this study is shown in Table 3.1.

Table 3.1

County Specific Data for Rural Classification

County	[a]U.S. Census Bureau Population per Square Mile	[b]U.S. Department of Agriculture Economic Research Service RUCC Codes	[c]U.S. Department of Agriculture Economic Research Service Urban Influence Codes	[d]U.S. Department of Agriculture Economic Research Service Frontier and Remote Area Codes
County A	47.5	9	10	Yes
County B	35.1	9	12	Yes
County C	64	7	10	Yes
County D	163.4	5	8	No
County E	91.1	6	3	No
County F	61.1	6	6	No

Note. Adapted from county specific data of: [a]U.S. Census Bureau, (2018), *Quick facts*. [b]U.S. Department of Agriculture Economic Research Service (2019b), *Rural-urban continuum codes* (RUCC). Higher numeric values (1-9) indicate more rural areas. [c]U.S. Department of Agriculture Economic Research Service (2019c), *Urban influence codes*. Higher numeric values (1-12) indicate more rural areas. [d]U.S. Department of Agriculture Economic Research Service (2019a), *Frontier and remote area codes.* Categorized by zip codes, higher numeric values indicate more rural areas with areas not considered frontier and remote designated only as non-frontier/remote. Dichotomous "yes" or "no" identify counties with any zip codes categorized as frontier and remote.

Rural Nursing

Rural health care differs from urban health care. Historically, medical education, medical facilities, and the number of medical providers were more robust in urban areas. The low population census in Appalachia, as with all rural areas, failed to provide the fiscally stable

environment for practice resulting in a shortage of health care services (Barney, 2000; Behringer & Friedell, 2006; Mulcahy, 2006). Second, rural communities are different. Individuals living in rural areas are more likely to experience environmental and social barriers to health and well-being. These obstacles include poverty, educational attainment, health literacy, adequate community infrastructure, access to healthy and affordable food/housing and transportation (Rural Health Information Hub, 2019). Third, health care access is different. Distance may be a barrier to access for primary health care as rural residents may have to travel long distances that places a considerable drain on time and finances (Deskins et al., 2006; Lane, et al., 2012). Travel across county, or even state, boundaries is common in many areas.

Fourth and most importantly, rural nursing practice is also different. Rural nurses typically earn less, frequently work during staffing shortages, encounter professional challenges in the work environment, navigate poorly funded public systems, overcome inconsistencies in educational opportunities, and deal with everyday life barriers inherent to rural living such as housing and child care (Baernholdt & Mark, 2009; Jackman, Myrick, & Yonge, 2012; Long &Weinert, 2013; Newhouse, Morlock, Provonost, & Sproat, 2011; Roberge, 2009; Robert Wood Johnson Foundation, 2010; Rohatinsky & Jahner, 2016; Sellers et al., 2019; Thrill, Pettersen, & Erickson, 2019).

In the literature, characteristics of rural nursing and the Rural Nursing Theory reflect many perspectives of nursing in Appalachia (Brewer, 2018; Winters, 2013). Professional isolation, leadership, and professional autonomy are expected norms for nursing practice (Brewer, 2018; National Advisory Committee on Rural Health and Human Services, 2015; Persily, 2004; Russ, 2010). Examples of nursing leadership are demonstrated by nurses serving as community advocates bringing needed healthcare services to underserved communities

(Cockerham, 2015; Fletcher, Slusher, & Hauser-Whitaker, 2006; Huttlinger, Schaller-Ayers, Kenny, & Ayers, 2004; McDaniel & Strauss, 2006; Snyder & Thatcher, 2014; Winters, 2013). Nursing students must work as well as attend rigorous nursing programs to meet the financial needs of self and families, decreasing time for study and increasing the burden of student loan debt (Baker 1997; Behringer & Fridell, 2006; Purnell, 1999). Nurses work to improve outcomes for clients and communities as illustrated in the literature. However, a large gap exists in knowledge about the personal experience of nursing. Little is known about the firsthand story of being a nurse in Appalachia and how to recruit nurses in rural Appalachia.

Study inclusion criteria were defined as a registered nurse who works and lives in Appalachia, willingness to allow voice recording of the interview, English as the spoken language, and over the age of eighteen years. Exclusion criteria included lack of experience as a registered nurse, under the age of eighteen years, inability to speak English, or refusal to allow voice recording of the interview. To answer the research question of the lived experience of the registered nurse in Appalachia, careful consideration was given in defining the targeted population. The first decision was in defining a practice and educational level of the nurse participants. Licensed practical nurses were excluded from the study as this level of practice and education lacks the scope necessary for many leadership and professional roles. However, registered nurses and nurses with graduate degrees and/or advanced practice have the same initial educational preparation and licensing process, with recognition of additional licensing and education for advanced practice, both levels were included in the study. Increasing the breadth of inclusion criteria for all levels better represented the targeted population (Bonevski, et al., 2014).

Another consideration was the embeddedness in the context of Appalachia. Selection of only native Appalachians would reveal the lived experience through a cultural lens. However,

the six-county region in Appalachia has seen a lot of growth. It contains a large tourism industry, a large retirement population from other areas of the nation, many vacation homes, and a large regional state university. The identification of the nurse to the Appalachian culture would be difficult to ascertain. Therefore, it was deemed appropriate to include all RNs who practice within the six-county region. The primary goal was to understand the lived experience of being a registered nurse who lives and works within the defined geographic area. Prior to recruitment, the study received approval through IRB processes at the regional university where the study originated.

Access to participants was somewhat problematic. The researcher is a resident of the region and it was presupposed that she might know or be known by some of the participants. This common knowledge and lack of anonymity is an established component of rural nursing practice. It was recognized that it was impossible to eliminate this small-town, rural characteristic, and any associated "insider" implications (Lee & McDonagh, 2013). Care was taken to recruit participants as objectively as possible as described by social marketing strategies (Bonevski et al., 2014). To that end, the researcher asked the state boards of nursing to send an email containing information about the study to regional members; however, participants were enlisted from only one state via this strategy leading to initiation of snowball sampling. When potential participants answered the recruitment email, additional information was given, and the decision for inclusion as a participant was mutually agreed between researcher and informant. Four participants were recruited using this approved social marketing strategy. This relatively small number of participants recruited this way limits the potential for interfering with the representativeness of the sample. Exclusive recruitment through state professional membership very likely might produce a sample of mostly advanced practice or upwardly mobile nurses yet

miss the majority of rural nurses who may be unable to afford membership fees or who have other barriers for membership. Nurses were recruited from two of the three states.

A far more productive and equally acceptable recruitment strategy was snowball sampling. Snowball sampling strategies involve informant member identification of other candidates suitable for inclusion (Bonevski, et al., 2014; Creswell, 2007) although this strategy presented some challenges as well. The researcher has lived in one of the targeted counties for 50+ years. She has worked as a registered nurse in two of the counties for 20+ years. The extended time in the region was challenging with both positive and negative implications. In this case, perceptions of the rural "insider" served to facilitate recruitment strategies (Bonevski, et al., 2014). This could present a threat to representativeness so the researcher was very intentional when discussing snowballing strategies with participants and care was taken to recruit without bias or preference. Equal attention was given to avoid all sense of pressure for participants to provide additional potential participants. It is possible that some prior association could unintentionally influence recruitment efforts. To lessen this potential, all participants who met the inclusion criteria were interviewed without exception on a first-come, first-interview basis whether they knew the researcher or not, an ethically sound strategy (Margolis, 2000; Reel, 2011). Five of the participants knew the researcher. Three additional participants had heard of but did not know the researcher. Seven participants had no prior knowledge of the researcher.

Sampling in qualitative research is cyclical, recurrent, and emergent (Higginbottom, 2004; Maxwell, 2013; Miles & Huberman, 1994). The initial effort of recruitment was through the social marketing strategy that produced a sample size far short of the required number. However, during the interviews with these individuals, the snowball recruitment strategy was introduced to informants and a new list of potential participants was created. With each cycle of

interviews, new informants were identified until it was determined that no additional interviews were needed. This cyclical pattern facilitated introduction of multiple participants unknown to the researcher. Additionally, it supported timing of the interviews so analytic procedures could occur between interviews as befitting qualitative research protocols (Maxwell, 2013).

Sampling Outcomes

Sampling and recruitment for this study produced fifteen participants from two of the three states. All of them have been employed in various positions including school nurse, nursing education, primary care, mental health, hospital staff nurse, skilled nursing facility, university health clinic, home health, and outpatient surgery to name a few. All have worked in the hospital setting at some point in their career. Half of them still work in the hospital. Only two participants did not provide direct patient care in some capacity. This diversity supports the representativeness of the sample. To understand the context of the work environment better, Table 3.2 provides an overview of hospital services in the targeted counties. The researcher resides in County C. She has worked in Counties C and D.

Table 3.2

Hospital Health Care Service for Targeted Counties

Hospital Qualification	County A	County B	County C	County D	County E	County F
Critical Access/ Acute	Critical access	No hospital in this county	Critical access	Acute	Acute	Critical access
Governance/ Ownership	Voluntary nonprofit/ Private	No hospital in this county	Voluntary nonprofit/ Private	Government/ Local	Government/ Local	Voluntary nonprofit/ Private
Number of beds	25	No hospital in this county	25	117	120	2
Number of RNs (FTEs)	22.5	No hospital in this county	48.3	114.5	202.5	11
Annual total patient days	1,355	No hospital in this county	5,285	14,368	15,145	56
Obstetric Services	No	No hospital in this county	Yes	Yes	Yes	No
Surgical Services	Yes	No hospital in this county	Yes	Yes	Yes	No
Emergency Room Services	Yes	No hospital in this county	Yes	Yes	Yes	Yes
Intensive Care Services	No	No hospital in this county	No	Yes	Yes	No

Note: Adapted from information obtained from the following sources: American Hospital Directory, 2018, *Free hospital profiles,* retrieved from https://www.ahd.com/search.php ; Hospital and Nursing Home Profiles, 2019, retrieved from www.hospital-data.com ; Official U.S Government Site for Medicare, n.d., *Hospital Compare,* retrieved from https://www.medicare.gov/hospitalcompare

Demographics of the nursing participants show an older nurse population. This could be an outcome of sampling strategies but, equally possible, the prevalence of older nurses is reflective of the aging nurse workforce (National Council of State Boards of Nursing, 2019) or as

a characteristic of rural populations (Winters, 2013). Another observation of the demographics demonstrates the diverse levels of education even though the nurses were educated in many different sites both inside and outside the focused six-county region. One third of them worked as a licensed practical nurse (LPN) before pursuing additional education. Eight have an associate's degree in nursing (ADN). Eleven have a baccalaureate degree in nursing (BSN). Eight participants have a master's degree. Three of the fifteen have a terminal degree (PhD and DNP). One had less than one year of experience as a registered nurse but eleven have over 20 years of experience. Years of practice in Appalachia show nurses tend to stay in the region for long periods regardless of their place of origin. Years at the current job indicate that, even with advancing years, nurses are open to changing jobs, beginning new experiences. Table 3.3 provides an overview of participant demographics.

Table 3.3

Participant Demographics

Age (bracketed by 10 year increments)	Number of participants	Average years as an RN (range; *SD*)	Average years employed at current job (range; *SD*)	Average years practice in Appalachia (range; *SD*)	Educational background/ Degrees held
60-69	5	33.6 years (23-41; 7.44)	8.82 years (1 month-20 years; 7.83)	22 years (3-35; 15.07)	LPN, ADN, BSN, MSN, PhD,
50-59	4	27.75 years (25-33; 3.77)	15.75 years (3-30; 12.09)	25.25 years (15-36; 10.78)	LPN, ADN, BSN, MSN, DNP
40-49	2	21.5 years (20-23; 2.12)	5 years (5; 0)	21.5 years (20-23; 2.12)	ADN, BSN
30-39	2	13.5 years (11-16: 3.54)	5.25 years (5-5.5; 0.35)	12.5 years (11-14; 2.12)	LPN, ADN, BSN, MSN, FNP
20-29	2	1.6 years (3 months-3 years; 1.94)	1.6 years (3 months-3 years; 1.94)	3 years (5; 0)	LPN, ADN, BSN

Note: SD = standard deviation

Discussion

Sampling and recruitment for research in rural areas may present special considerations. Researchers should be knowledgeable of and accommodating to rural setting and cultural context prior to attempting recruitment efforts (Cudney, Craig, Nichols, & Weinert, 2004; De Chesnay, 2015; McCormick et al., 1999; Rural Health Information Hub, 2019). Use of community members, including "insiders" and local researchers, known to potential participants may increase trust, perceptions of familiarity, and, thereby, agreement to participate in the study (Bonevski, et al., 2014). For this study, knowledge of the researcher facilitated recruitment efforts which was a key consideration of potential bias for the researcher during analysis. The balance between ease of recruitment and analysis bias must be considered during the planning phase for qualitative research.

Travel and time commitment influence agreement to participate in research. Rurality implies greater demand on time and resources, including interference with employment responsibilities (Morgan, Fahs, & Klesh, 2005). This study countered these barriers though researcher flexibility in timing, meeting sites, and the ability to do audio/phone interviews. Another strategy could be through use of online meeting platforms or a visual/auditory conference such as FaceTime. When considering use of these mediums, privacy would also be of prime consideration. More research is needed to explore security and availability of these modalities in rural populations.

The concepts of knowing/being known and the lack of anonymity in rural communities are widely recognized as considerations (Lee & McDonagh, 2013). Much of the previous work on anonymity centers on the client as participant (McCormick et al., 1999). However, less information is available on anonymity of the nurse as the participant, an especially concerning problem as nurses are privy to a great deal of restricted information for their clients and institutions of employment. Rurality increases the risk due to the increased familiarity not only of people but also of situations even though de-identification processes are enabled (Rural Health Information Hub, 2018). It was likely that nurse participants might anticipate inadvertent breach of confidentiality, a serious ethical issue. The informed consent was used as a tool to inform participants of the risk and measures to lessen that risk in this study. Measures included in the study included requests to participants to refrain from using identifiable statements, de-identification of data in the transcripts, destruction of audio recordings, exemption of situations that increased risk of recognition, and a final round of de-identification when reporting results. Release of the informed consent document prior to agreement to participate with ample time to understand planned measures and to clarify concerns served to increase recruitment.

The population pool is smaller in rural areas so sample sizes may be adversely affected but use of interviews or focus groups may help ease this restriction (Rural Health Information Hub, 2018). Larger geographic areas along with fewer potential participants result in higher costs for recruitment financially and timewise (Cudney et al., 2004). However, the barriers of small population pool and higher burden of recruitment may be eased by obtaining thick, rich data through purposeful sampling of individuals who have in-depth knowledge of the focused topic (Higginbottom, 2004; Maxwell, 2013). Social marketing recruitment was effective in only one of the three states, leading to snowball sampling which was effective in recruiting participants from a second state. The criteria of inclusion and exclusion for this study led the researcher to participants who directly experienced the phenomena of interest and were able to provide that desired quality of data.

Another widely used recruitment strategy is through use of incentives (McCormick et al., 1999; Singer & Couper, 2008) especially when the response rate is low as with the beginning of recruitment in this study. Singer & Couper (2008) propose three reasons why individuals agree to participate in research: altruism, interest in the survey topic and/or the researcher, and egotistic reasons, i.e. receipt of monies or incentives. Undue influence typically is associated with external factors that sway participant decision-making processes, especially when there is a difference in power or authority over another person (Resnik, 2015). The rationale for lack of incentive use in this study is related to not wanting to impose undue influence on participant decision-making processes. Since the researcher was native to this area, it was decided to not offer incentives so there would not be a sense of undue influence. The researched decided to not offer any incentive outside of the sense of benefit of contributing to the profession of nursing and

nursing knowledge which reflects the rationale of altruism (Singer & Cooper, 2008) and is one of the reasons individuals agree to participate in research.

Evaluation of the sample provides insight of the body of participants and the effectiveness of the recruitment strategies. Participants revealed the full scope of nursing educational preparation. Many started their nursing career as LPNs but all had pursued additional education with a majority having attained a BSN degree. The high proportion of participants with a BSN and/or a master's degree may reflect the success of distance/online opportunities instituted in response to documented challenges for education opportunity in rural areas (Brewer, 2018). This characteristic contradicts findings of Newhouse et al. (2011) who found a majority of nurses practicing in rural areas are educated at the associate level. However, the low number of participants with a terminal degree may question similar effectiveness of education at that higher level of preparation.

Finally, the majority of the nurses are older and they hold most of the experience for patient care, implying much of the knowledge will leave with them when they retire. It is possible that the sample representativeness did not adequately capture the balance of older to younger nurses. However, the adequacy of this recruitment is supported by other research showing that nurses are indeed growing older. The National Council of State Boards of Nursing and The Forum of State Nursing Workforce Centers reports 50.9% of registered nurses are 50 years old or older and the Health Resources and Services Administration estimate that more than 1 million registered nurses will reach retirement age in the next ten to fifteen years (American Association of Colleges of Nursing, 2019).

Limitations of the study include use of a single six-county area as the region of focus as it limited the sample to a somewhat homogenous group. Although diversity in age, experience, and

education was demonstrated, the lack of gender, ethnic or racial diversity was a limitation of the study. This was not intentional but was a foreseeable result as the region as a whole is highly homogenous. Nursing has traditionally been a female-dominated profession (McClung, 2008). The latest data shows 87.3% of all registered nurses are women (US Census Bureau, 2017). Additionally, data retrieved from the U.S. Census Bureau (2018) indicates the focus six-county area's racial origin average is 89% Caucasian/ non-Hispanic, 5.2% Hispanic or Latino, and 2.75% Black or African American origin. Based on these facts, a final sample consisting of white females could be expected. A final limitation of the study was the fact that the researcher was a member of the community.

Implications

Implications of sampling and recruitment strategies for recruitment and sampling in rural areas are subtle but important nonetheless. Understanding cultural considerations is important but rurality adds an overlay of complexity to the context for research. The fact that the researcher possessed knowledge of the region and culture served to facilitate this study, however, recommendations for future sampling should include knowledge of rural characteristics as well as cultural characteristics. Anonymity and confidentiality are especially problematic in rural research but when coupled with professional ethical standards for nurses, extra caution is required. Future efforts should explore how to best overcome those risks and yet produce the highest quality of data. The smaller population pool of a specific region presents challenges. Use of multiple sites to explore a phenomenon may increase the population pool as well as the depth of insight about the topic. It also may decrease the likelihood of a homogenous sample as found with this sampling strategy. Future efforts to counter the small sample pool and homogeneity may be inclusion of additional regions of both the Appalachian region and comparable rural

regions across the nation. Finally, social marketing produced a smaller number than anticipated. It is unknown if the lack of successful participant buy-in through social marketing via state boards of nursing hindered sampling significantly, however, in this study, the mark of success as a recruitment strategy is limited. Additional research is needed to increase the effectiveness of social marketing in this targeted population. Future research also needs to include additional sites as well as effective and intentional recruitment of other ethnic groups and men.

Conclusion

Recruitment and sampling in rural research can be problematic. Simultaneous use of multiple recruitment strategies and multiple sites can increase the likelihood that an adequate, representative sample is obtained. Transparency in strategies for de-identification may ease privacy concerns arising from the lack of anonymity common to rural areas. Other strategies to improve recruitment include use of incentives and flexibility in timing or location of interviews. Nursing practice is central to well-being of rural populations. It is important to identify and ease barriers of recruitment and sampling so this population can be studied in depth. Their voice is the truest reflection of the lived experience of being a nurse in a rural area. Appropriate sampling and recruitment will facilitate discovery of those perspectives and, thereby, support effective professional practice.

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CHAPTER 4

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LIVING AND WORKING AS A NURSE IN APPALACHIA

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ABSTRACT

Introduction: The nurse is a commodity and a central figure in health care in a rural community, however is frequently invisible with little known about their experiences and professional practice. Previous researchers have described nursing practice from the perspectives of health outcomes, education, patient advocacy, and community engagement, but not from the nurses themselves as individuals or professionals. The purpose of this paper is to describe the lived experience of nurses who live and work in present-day rural South Central Appalachia.

Methodology: A phenomenological study was conducted to explore perceptions of being a nurse in rural Appalachia.

Results: Themes identified from the study include embedded in place, ownership of nursing practice, destined to be a nurse, and rewards of being a nurse.

Discussion: This study identified the close relationships of the lived experience of being a nurse, rurality, and the culture of the region.

Keywords: rural, nursing, Appalachia, phenomenology

A nurse is one who protects and promotes health, prevents disease, and relieves suffering (World Health Organization, 2019). Nurses do their job, rarely looking for or receiving applause. Rated highest among all professionals for honest and ethical standards for the last fifteen years (Norman, 2016), nurses are motivated to just keep doing what they do best--caring for others. Their voice is not "wasted" on self-acclaim, because it is used so often to advocate for a client or a cause not their own while their story remains largely silent.

Appalachian nurses fit this profile. Nurses living in the region have been described as patient educators (Baker, 1997), caregivers in community and mobile clinics (Fletcher, Slusher, & Hauser-Whitaker, 2006; Gardner, Gavaza, Meade, & Adkins, 2012; and activists on the behalf of women and children (Goan, 2008). They are direct caregivers, community leaders, patient advocates, and proficient educators (Brewer, 2018). However, little is known about the nurses themselves. A gap in knowledge about nurses, especially in rural health has been identified (Lauder, Reel, Farmer, & Griggs, 2006; Lee & McDonagh, 2013). Why do they do what they do? What does it mean to be a nurse? Few answers exist.

Background and Significance

Appalachia is a region of diversity and change, one of strong traditions and stronger residents. First inhibited by Native Americans and later settled by ethnically and racially diverse northern European immigrants, it was a region of opportunity for freedom from feudal systems and riches from the seemingly endless natural resources (Abramson & Haskell, 2006; Drake, 2001; Williams, 2002). Geographical features served to create relatively isolated, independent, self-supporting communities who met their own needs of reciprocal support, governance, socialization, and commerce (Rosswurm, Dent, Armstrong-Persily, Woodburn, & Davis, 1996; Warren, 1963; Williams, 2002). Fundamental cultural characteristics evolving from this

settlement pattern were kinship relationships, self-sufficiency, autonomy, and love of the land (Drake, 2001; Keefe, 2005; Williams, 2002). Appalachians are hardworking, stoic, socially equal, resourceful, independent, family-centered, present-day oriented, fundamentally religious, and non-confrontational (Keefe, 2005; Parnicza, 1990; Purnell, 2003; Reeves, 2004). A distinct Appalachian culture has been challenged. Perhaps it is more accurate to say Appalachia has a culture, not detached from the nation, but with degrees of difference as influenced by the history and context of the region (Burriss & Gantt, 2013; Keefe, 2005; Williams, 2002).

Appalachia has changed over the centuries. Communities are no longer so isolated. Inward and outward migration has added to the diversity of the region. The pervasive poverty, disparity, poor infrastructure, little education, and lack of technology are not as prevalent (Appalachian Regional Commission, n.d.; Keefe, 2005; Parnicza, 1990; Williams, 2002). However, vestiges of cultural traits and earlier societal barriers remain, playing an essential role in the perceptions of nurses who work and live there.

A study was conducted to describe the lived experience of being a nurse in Appalachia. The purpose of this article is to discuss data analysis and the findings of that study. Sampling methods and participant recruitment are discussed in a different article. The current article focuses on data analysis and resultant findings.

Methodology

Prior to designing the study, the researcher expansively searched the literature about Appalachia, Appalachian health, and Appalachian nurses. The literature review provided the basis for the study question and design. The regional university where the study originated granted IRB approval. The researcher is native to this area and has intimate knowledge of being a nurse in this region of Appalachia. Therefore, before interviewing participants, the researcher

participated in a bracketing interview with a team of methodology and content experts to increase awareness of bias that might skew interviewing processes or interpretive analysis. The philosophical underpinnings of this study lie in the realm of social constructivism, a framework for understanding the world in which individuals live and work (Creswell, 2007). This approach supports participant construction of the meaning of the experience (Creswell, 2007).

Nurses were potential participants for the study if they had worked as a registered nurse in Appalachia, would allow voice recording of the interview, spoke English, and were at least eighteen years old. Exclusion criteria included not meeting any of the inclusion criteria. An email sent through state nursing association contact lists and snowball sampling served to recruit participants in a three-state, six-county area in South Central Appalachia. Fifteen participants were recruited from the focus area. Participants were representative of the pool population, having a wide range of ages, years of experience, educational preparation, and areas of practice.

After informed consent was obtained, the interviews were conducted using a semi-structured interview guide (Table 4.1) to elicit thick rich descriptions of being a nurse. Interviews were recorded using a digital voice recorder. The researcher listened to the recordings immediately after the interview to validate content and to assist with completion of field notes. After the interviews were transcribed, the researcher listened to the recordings and validated the interview transcripts. The recordings were then erased to ensure anonymity of the participants. After validation, the transcripts were downloaded into *NVivo 12* (QSR International, 2018) which was used to organize and analyze the data.

Table 4.1

Interview Guide

1. Grand tour question: What is the lived experience of being a registered nurse in the community where you live?
2. Secondary explanatory question if the grand tour question needs clarification: Tell me what it is like to be a nurse in the community where you live.
3. Tertiary questions based on participant's comments if needed to stimulate conversation:
    a. Can you tell me more about that?
    b. Tell me what were you thinking.
    c. How did you feel?
    d. What happened next?
    e. Who said what?
    f. What did you say?
    g. What else did can you remember?

An iterative process formed the basis for analysis. Each interview was read in its entirety with categories created using emic and etic coding. The hermeneutic circle guided the analysis by using a continual repetitious approach of reading text and coding throughout the process. The text was reduced to themes and subthemes identified within the context of the whole. Researcher field notes and surrounding text served to help explain sections of text that needed clarification (Maxwell, 2013). An audit trail consisting of the researcher's journal, audio memos, and transcript notations document decision points of the analysis and analytic reflections of the

researcher. The researcher regularly consulted with a content and expert methodology consultant during the iterative process of analysis. The codes, categories, and themes were discussed to capture the voice of the lived experience for participants. Interviews, transcription, and data analysis occurred over a 10-month period.

It is important to consider rigor in qualitative research. The detailed iterative process along with the use of an audit trail and field notes demonstrates credibility and resulted in production of believable, recognizable findings (Cope, 2014; Lincoln & Guba, 1985). Authenticity refers to the degree the researcher can report a vivid, rich lived experience of others using the hermeneutic circle (Polit & Beck, 2008) and is evidenced in this study by reporting authentic verbatim participant quotes. Confirmability focuses on the absence of researcher bias and reflecting the participant's viewpoint, not the researcher's (Cope, 2014; Polit & Beck, 2008). The researcher demonstrated this through use of bracketing, field notes, expert consultation, and journaling processes. Dependability is demonstrated through consistency of findings with previous literature and effective use of hermeneutic research processes. Both were identified in this study. However, transferability is particularly challenging in qualitative research because the lived experience is unique to each individual and each situation. For this reason, study findings may not be transferable to other areas. Nonetheless, rigor in this study is demonstration by effective use of techniques for credibility, authenticity, confirmability, and dependability.

Findings

There were four thematic categories of findings from the study. One addresses place. The others address professional practice. The four themes are embedded in place, ownership of nursing practice, destined to be a nurse, and rewards of being a nurse.

Embedded in Place

Embedded in place, defined as a state of being in which one belongs and is connected to one's surroundings physically, socially, emotionally, and mentally, recognizing the implications of that relationship and the role one holds within that network, was a significant theme identified by participants. Four subthemes exist within the main theme of embedded in place: location, people, culture, and connections.

Location. The first subtheme of place, location is described as where the nurse lives and works. One participant clearly identified the option of being somewhere else. "It was a choice to be a nurse in this area. I could have gone somewhere else but I chose to come back to this just simply because of family roots." Another participant revealed a rationale for identifying with and never leaving. "It's like when people are born and raised in the area and their families are here and their roots are here…they're staying here because this is where they are from and this is their home." Aesthetic features formed the basis of choice. "People tend to come here because they love the area, it's beautiful, and it's a wonderful quality of life." Nurses recognized limitations in their choice to live here. When discussing employment options, one said, "There would be better opportunities somewhere else." Another discussed cost of living and buying a home in one of the more metropolitan areas within the region. "There are people in region who moved away from (town) essentially because they couldn't own land here because it was so expensive." Yet another informant said, "they saw themselves working in those places forever. That was their life. That's what they wanted to do. All their families were there. Families were intact…people very rarely left." No matter the challenge, place still held people in the region.

Infrastructure contributes to the sense of place. "Here in our neck of the woods, it has been an issue…to have cell phone reception." The nurse was discussing the need to call the

physician and the uncertainty of being able to do so. Similarly, another nurse pursuing advanced education identified difficulty completing her program. “I found...in higher education…the people that usually do these programs... are not the people that have the knowledge to really discuss what logistical aspects…are going to be in your rural area.” While improved, infrastructure was still problematic both technologically and organizationally.

Topography, geography, and built environments are closely related. An informant who moved to the area within the last five years remarked:

> “This feels rural to me because of the…setting of the mountain and the fact that it just is not easy to get anywhere. To get to highways, you have to go down a mountain…and be on curvy roads and turn here and go over there…It’s an issue of accessibility.”

Discussing distance for work and health care needs, another commented, “it feels more self-contained, (doing anything) takes effort and planning, and you have to have a vehicle.” The built environment includes educational characteristics. “I work in an area (where the) literacy rate is pretty low” and “so many of our patients couldn’t read and write,” said two participants.

People. The second subtheme is people. Core groups of people include family, friends, and neighbors. “It is the mountainous area. It is the people that have their old-fashioned ways, their wives’ tales. This is our community. This is the mountains. This is the way we are.” These held special value for participants when discussing community.

Concepts of knowing, being known, and unity in shared experiences were also identified. “Down here everybody is friendly…We’ve all grown up together.” Another said “we’re just raised different…we’re not like the city people.” Participants were positive about relationships within the community. Participants put it this way. “Part of nursing in a small community is that

sense of belonging." "One thing that's absolutely amazing about the community is you get to know your patients." "If I'm introduced to somebody out in the community, 'this is my nurse.' That sounds good. (It) adds some satisfaction to your job." Issues of trust and value are also grounded in shared knowledge of place and people. "The patient kind of trusts you more…they're like, 'oh, such and such knows you." Another put it this way, "When you go to somebody's home and they don't have running water…it changes how you nurse…you always respect their area and how you could build a relationship." Earned trust was important.

Relationships with coworkers tended to be solid and fulfilling. "Your co-workers are probably the biggest facilitator of what you do and your support and strength behind what you do." Nurses also acknowledged understanding of the never-ending role expectations. "My work never ended, which I really liked…it was a seamless existence. I'd be at the…gas station pumping gas and parents would come up, 'Ms. (name) will you look at this rash?'" Most times, nurses coped in non-confrontational, socially acceptable ways. For example, when discussing confidentiality concerns, one said, "I have to play hide-and-seek in the store…I'll see them…turn around and go the opposite way. It's not that I don't like them. They see you and you're a nurse. 'You should be able to tell me stuff.'" Boundaries were challenging at times.

Culture. The third subtheme is culture. Customs contributed to a sense of place and formed a huge part of the nurses' perceptions. They were challenged to understand and incorporate customs into care delivery. Traditional lack of health care engagement was recognized. "They have been taught to be self-sufficient, to do things on their own and they're private." Even when illness occurred, accessing health care wasn't guaranteed. "We didn't go to the doctor unless we were dying," and "if it's not bothering me bad, why should I go to the doctor?" One nurse related how she interceded for her patients. "I always tell our patients when

they would go to bigger hospitals…to be honest...(they are) just tough,…our people don't complain." Another said "It's gonna take multiple generations to sway what I would consider the mountain people in order to get them in line with the rest of the nation so to speak." The forecast for the future health in the region was hopeful but realistic.

For many informants, belief systems were of the Christian faith, an essential element of being and practice. "I don't think I could be an atheist nurse…there's just too much proof of God's existence." Faith served as a source of hope. "We know that there is a greater physician and, if the patient's heart is right with the Lord, then there's worse things than death." It served as a coping mechanism. "If I didn't know that some of these people that passed were saved, I don't know how I'd have dealt with it." Faith also serves as a guiding hand. "There's a lot of times that I'm on my hands and knees…saying, 'Lord, please guide these hands because I don't know if I'm going to do this or not'." Faith supported both professional and personal well-being.

Connections. Finally, the fourth subtheme, connections were found in health care systems. Participants liked the continuity of care "which, for me, has been the highlight of what I've done throughout my career." They also found expediency in earlier patient connections. "They don't have to tell me their whole history again because I'm going to remember them." A sense of community involvement and connectedness was identified. "We have people at the hospital that live somewhere else part of the year. They come here to have their procedures because of the familiarity, the really intimate relationships that we can establish with our patient." However, connections also require that participants understand the context of where they are. "Just because you're in a small place that looks like it's pretty contained doesn't mean that anything about it is simple…it's very complex and requires a lot of understanding of how all those things fit together and work together, or not." The nurses understood the context of care.

Ownership of Nursing Practice

Ownership of nursing practice is defined as way participants accepted the responsibilities of being a nurse including the limitations and scope of their practice. This theme included two subthemes: owning their practice individually and their roles in the community.

Individual Practice. The nurses recognized the potential for harm in what they do. “You could kill somebody.” They expressed the need for equity in care regardless of how the client reacts. “Granted, I may cuss and gripe in the background but I’ll go and take care of them and I’ll be nice to them…because that’s what you do.” There was distain for nurses who failed to meet their standard. “I worked with somebody (that) said ‘Well, don’t make me...touch the patient.’ That was appalling to me because, why did you go into nursing if you don’t want to touch the patient?” Tolerance given to clients was not available to “substandard” nurses.

The lack of self-advocacy was identified although they were firm in their stance for clients. “We’re very good at standing up for our patients but not for ourselves.” Caring for clients is “more socially acceptable.” They acknowledged responsibility to the work place. “Rarely do I call in…that’s my family and I know that I’ve got to be there.” “Your responsibility is to be at work.” Sometimes that responsibility conflicted with personal values. One participant discussed a change in strict parental rules on church attendance. “He said, you’re going into nursing. It’s different…God will forgive you because you’re not there every time the doors are open.” They revealed how they owned aspects of nursing continually. “It’s not just something you turn off at the end of the day.” Most of all they recognized the degree of investment and responsibility they have undertaken. “You need to nurse with your heart. Not just with your mind and not just with your hands, but definitely not from the pocketbook.” The participant’s message was very clear.

Community Roles. The nurses saw themselves as members of the community. They understood community relationships and were able to navigate inherent barriers. “Let them get to know you a little bit before you…start prying…They…were going to tell you exactly what you wanted to hear so you would leave.” Expectations were different. “In a smaller community, you don’t have to prove yourself over and over.” However, standards for expectations were not lower, only more integrated and congruent in a shared community context. “People get better care in a community from nurses in the community.” Nurses were a vital part of the community.

Destined to be a Nurse

Destined to be a nurse is defined as fulfilling a role dictated or guided by a force outside self. Two subthemes for this theme are physiological factors and unconscious influences.

Physiological factors. Participants were very clear in their beliefs around biological factors. “Some people just have it in their DNA.” “I really believe it’s either in your blood or…it’s not. I don’t think you can make it be there if it’s not.” Another participant said, “Some of it has to do with…how their genetics are” Participants were guided to nursing by physiological factors that were beyond their control. .

Unconscious Influences. Unconscious influences include faith, family and individual characteristics. Faith reflects perceptions of a higher being that supports, cares for, and directs one’s life. “I just feel like I was called. God works through me.” Another expanded this thought,

> “My faith tells me that God created every human being to be very special…and we are all made to be unique contributors to society in some way. It is my special privilege to be able to take care of anyone who might have a need.”

This topic was clearly very emotional for some participants one of whom started crying. “I just felt like God really opened up that door for me and called me to be a nurse...I think He gives each of us skills and has a purpose for each of our lives.” Her comments were truly heartfelt.

Family and individual characteristics were motivators identified by participants. “My parents were…very supportive and encouraging…but at the same time, they didn’t understand.” One informant discussed her niece who aspired to be a nurse. “She’s gonna have to get some thicker skin…She’s just a tenderhearted, good kid, very nurturing, very selfless…all good qualities of nursing.” Nursing education will only add skill to inherent personal characteristics. One informant illustrated this as “the desire to help.” Participants recognized that education builds on individual characteristics with one participant saying “You can teach a monkey to do anything…but to actually give a bed bath, you communicate with patient.” Another participant observed, “There is no way to teach them that.” Collectively, influences beyond the control of the individual are present in this subtheme.

Rewards of being a Nurse

Reward is defined as positive personal perceptions of self-worth and value attributed to their fulfillment of the duties of nursing, i.e. how they made meaning of what they do and how they felt about being a professional nurse. “It may be a benefit to get paid for what you do, but the rewards to me are what I feel on the inside and being satisfied at the end of the day.” “It makes me feel like you make a difference.” Some informants found long-lasting promise. “I just think the reward is not only earthly. It’s eternal.” Through it all, they were realistic. “It is challenging. It is wonderful. It’s hard. It’s tedious. It’s everything you expect it to be.” The rewards the participants discussed transcend time and place. Findings of this study demonstrate contemporary nurses in rural Appalachia are first of all nurses. The setting makes this practice

different. Just as Appalachia has similarities and differences with other areas of the nation, the nurses share similarities and differences. Understanding this diversity makes a stronger practice. Hearing the emic viewpoints validates the etic observations. One may observe the care and attention given during nursing practice but only the voice of the nurse can give meaning to what is taking place.

Discussion

Previous research has demonstrated how little is known about nurses and how nursing care in Appalachia is influenced by the culture of the region. The majority of what is known centers on how the nurse provides care to the client, not the nurse as a person (Brewer, 2018). The intent of the study was not to focus on a cultural perspective, however, it would be highly negligent to miss the cultural components of the study findings. Appalachian culture recognizes connections to place and the individuals that live within the mountains known as Appalachia (Drake, 2001; Keefe, 2005; Russ, 2010; Williams, 2002). Choosing to live within a defined cultural area has both negative and positive connotations, however it is evident that study participants feel a strong affinity for place, supporting previous findings of linkage to the location and views of "home" (Drake, 2001; Keefe, 2005; Russ, 2010; Williams, 2002). The choice to live in the region is associated with the concept of place and perceptions of well-being and contentment as proposed by Lee and McDonagh (2013) in the Rural Nursing Theory.

Within the concept of place, barriers are present which may affect well-being and contentment. Poverty remains a persistent factor in Appalachia. This is an important consideration and a factor for why some residents had to move from one area of a county to another to meet living expenses and access health care. Additionally, poverty contributes to

mental illness, chronic disease, higher mortality, and lower life expectancy (Healthy People 2020, 2019). Participants mentioned these related factors as important to the care they provided.

Linkages exist between Appalachian nursing and the Rural Nursing Theory. The first theoretical statement recognizes perceptions of health differ but encompass perceptions of health as a state of balance and a way of life, being able to do desired activities, and to work and be productive (Denham, 2006; Goins, Spencer, & Williams, 2011; Lee & Winters, 2004; Winters, 2013). Individual self-reliance and use of informal systems are viewed as initial sources of health care (Behringer & Friedell, 2006; Denham, 2006; Denham, Meyer, Toborg, & Mande, 2004; Lee & McDonagh, 2013; Lee & Winters, 2004). These perspectives are supported by study findings.

Rhetoric of "insiders" and "outsiders" as well as stereotypical negative perceptions of Appalachian identity has clouded the significance of the problem of inequalities economically and in social structures within and without the region (Cooke-Jackson & Hansen, 2008: Birdwell & Hurst, 2006). "Appalachia is not, nor has it ever simply been, about "insiders" versus "outsiders" (Fletcher, 2016, p. 284). Negative perceptions of "insiders" by others and "outsiders" are changing (Lee & McDonagh, 2013), however, for some of the participants, the insider/outsider concept continues to exist.

Common knowledge is challenging for rural nurses because they are viewed as a source of shareable health information contributing to concerns of continuous work and confidentiality as supported by earlier literature (Brewer, 2018; Lee & McDonagh, 2013). However, the nurses viewed this as inherent to the job and even beneficial as evidenced by the comments about remembering clients from former care situations or making use of family connections. Familiarity, the lack of anonymity, and role diffusion, viewed as both barriers and facilitators of nursing practice are identified in the Rural Nursing Theory and previous research (Brewer, 2018;

Lee & McDonagh, 2013; Lee & Winters, 2004). Participant comments support each of these theoretical statements as congruent with Appalachian viewpoints and cultural norms.

Preventative and proactive care was especially problematic, sometimes leading to poorer outcomes (Davis, Allen, Childress, Maurer, & Talbert., 2015; Della, 2011; Huttlinger, Schaller-Ayers, & Lawson., 2004). These perceptions could potentially link to definitions of health as the ability to work and play, not just an absence of illness (Lee & McDonagh, 2013). Perspectives of the nurses supported these perspectives. Further, Appalachians tend to be stoic (Keefe, 2005; Parnicza, 1990; Purnell, 2003; Reeves, 2004) and uncomplaining, choosing to endure, rather than actively seek care for disorders that might have been improved with the appropriate treatment. Informants also supported these concepts found in earlier works. Finally, fatalism has been proposed as a negative barrier to seeking care (Deskins et al., 2006), however the nurses did not discuss this as a barrier to care or their ability to meet the needs of their clients.

The nurses identified continuing infrastructure barriers although the region has had sweeping improvements over the last few decades. The willingness and ability to continue nursing care despite barriers demonstrate the diligence and work ethic of the nurses as they overcome obstacles. Previous research shows nurses in rural areas are more actively engaged professionally and personally but additional research is needed to understand how much or little nurses contribute to health care access, a finding congruent with the Rural Nursing Theory (Lee & McDonagh, 2013).

Limitations

Limitations of the study include the location of the study as a relatively small area, a six-county region of three adjoining states. A second limitation is that findings of the study have limited ability to transfer to other areas. Inclusion of additional regions would increase the

potential for transferability. A third limitation is failure to limit participation to only individuals who identify as Appalachian. The homogeneity of the sample is a fourth limitation. Although the six-county region is about 90% Caucasian (U.S. Census Bureau, 2018) and nationally, 87% of all nurses are female (U.S. Census Bureau, 2017), targeted recruitment of minority and male participants could add depth and breadth to the findings of the study. However, the reality is that they were not present in this study.

Implications

Additional research is needed to more fully develop knowledge connecting culture and nurses as individuals as well as practicing professionals. Nurses are central figures in the health of individuals, families, and communities through assessment, problem identification, and interventions such as health education, health promotion, care coordination, and evaluation of nursing action. Caring is an essential element of professional nursing as identified by participants and the Theory of Human Caring (Watson, 2019). It is important to understand relationships between culture, individuals, and the nurse as a professional health care provider. Understanding the significance of diverse roles of individual nurses may eliminate barriers to nurses' personal and professional growth. It will give recognition to things important to them and empower them to make still larger differences in the lives of others and yet positively change their own lives.

Conclusion

The Appalachian culture has changed, and, at times, been misrepresented by the media with resulting misunderstanding by the rest of the nation. It is important to understand relationships between culture and the nurse as a professional and as a person. Additional research is needed to explore perceptions of nurses in Appalachia as well as other rural regions. For all

nurses give and contribute, increased insight into their experience is not too high a price to pay--and likely the reward will be even greater for those they serve.

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CHAPTER 5

CONCLUSION

This dissertation explored perceptions of being a registered nurse in rural South Central Appalachia. The purpose of the study was to describe the lived experience of being a registered nurse in a rural six-county area of three adjoining states in South Central Appalachia. Aims of the study were to understand the lived experience of contemporary nurses in rural Appalachia and the lived experience of the nurses as they relate to the place of residence and employment. Hermeneutic phenomenology provided the study framework. Participants were recruited using emails through regional state nursing association list serves and snowball sampling. Emailed recruitment strategies enlisted participants from only one state, but snowball sampling added participants from a second state. Although no participants were recruited from the third state, the close geographic proximity and tight community bonds between participants and their friends who were also nurses and coworkers, albeit across state lines, support similar perceptions despite the deficiency of data collected in that county. Saturation occurred with fifteen interviews. The transcripts were analyzed using an iterative approach consistent with the hermeneutic circle, considering each text separately and then as a part of the whole. Field notes and the researcher's journal were used to inform analysis efforts. Texts were reduced to reveal major themes and subthemes. Four major themes were identified: embedded in place, ownership of nursing practice, destined to be a nurse, and rewards of being a nurse.

The dissertation includes an introduction, three manuscripts, and a conclusion. The completed work provide a comprehensive look at a phenomenological study beginning with introduction of the study rationale, progressing through the literature review, sampling and recruitment, analysis, reporting of findings, and directions for future research. The work provides

the only research exploring the lived experience of registered nurses specific to the focus area in South Central Appalachia to the best of the researcher's knowledge.

Appalachia, as a whole region, is very diverse, having characteristics of the greater United States tinted with brush strokes of a unique place and time separate from the rest of the nation. These characteristics include geographic, infrastructure, cultural, political, distribution, and resource availability and accessibility. Nurses who work in each distinct part of the region are practicing professionals who apply the tenets of their profession within the environmental context where they live and work, recognizing the uniqueness inherent to the area and the people particular to where the nurses live and work.

Earlier literature related to nursing practice in the Appalachian region as a whole provides viewpoints of nurses as leaders, community advocates, and as patient care givers (Brewer, 2018). However, the meaning and significance of the profession are generally understood to be personal, not discussed or explored outside individual internal reflection. The nurse's personalization and adaptation of a professional role are significant, manifested through dedication, relationships, improved patient outcomes, and the success of health care institutions in the region. This study provided insight from the nurses themselves about their feelings and perceptions associated with being a practicing professional, how relationships within the community support the nurse as a member of the community, and the value attached to their identity as a nurse. This new information is significant because it gives voice to an otherwise silent population integral to the health and well-being of both individuals and a community. The opportunity to be widely heard lends validation to their sentiments and strength through unity in their opinions.

Implications

Implications of this study may be discussed through linkage with rural nursing, nursing theory, nursing practice, nursing research, nursing education, and policy implementation within the targeted South Central region of Appalachia. This discussion is not to be considered comprehensive but an introduction for future planning and investigation.

Implications for Rural Nursing

Specialty practice opportunities for nurses are expanding. One area implicated by this study is that of a specialty in rural nursing. The themes Embedded in Place and Ownership of Nursing Practice give credibility to this idea. Recognition of specialty practices assists in making resources, such as initial and advanced education, available. Specialties assist in focusing education and assuring clinical educational placements in rural communities. A specialty practice might also provide an incentive for more nurses to become experts in traditionally shortage areas through recognition and the potential increased financial reimbursement. Most importantly, recognition of rural nursing as a specialty practice will assist in ensuring individuals living in rural communities have professional nurses that are competent in the delivery of care.

Implications for Nursing Practice

Implications for nursing practice include the continuation of efforts to develop and promote the scope of nursing practice across all care environments, including rural areas. In the themes Ownership of Nursing Practice, Destined to be a Nurse, and Rewards of being a Nurse, participants revealed how they saw themselves as nurses first. They did not expound on the scope of practice or shout ethical proclamations. They demonstrated ownership of both scope of practice and ethical standards through the things they said and the views they held. This fact supports the effectiveness of current processes. However, in an environment of change and

evolution, nursing practice must continue to hold core concepts while change is occurring with new ideas and new processes. This includes nursing practice in rural areas.

Implications for Nursing Theory

Many perceptions identified by participants align with those of the Rural Nursing Theory (Lee & McDonagh, 2013; Lee & Winters, 2004). As noted in the theme Embedded in Place, nurses who practice in rural areas often experience a loss of anonymity due to client familiarity in the communities and health care centers where they work. Nurse-client interactions are described by patients as caring and inclusive. The theme Ownership of Nursing Practice revealed that communities have expectations of nursing practice and responsibility. Nurses are expected to be a specialist in a generalist role. Nurses must successfully navigate multiple community roles and perform efficiently in the presence of role diffusion. Participants understood these expectations and responsibilities, seeing them as natural to their professional practice as any other nursing skill needed to provide care to the patients they serve as identified in the subtheme Individual Practice. However, additional research is needed to further refine theories of rural nursing or perhaps to identify new theories to improve understanding of the challenges faced by nurses who practice in these areas.

Implications for Nursing Research

Participants demonstrated understanding of the context of employment and the clients they served. However, it is unknown if formal education would better support that knowledge. The researcher understood and accepted many cultural traits identified by participants such as the significance of place, belonging, and faith influences; but, like many participants, she failed to recognize the significance of these traits and their impact on nursing until challenged to use that understanding. It is possible formal education during nursing school would support

understanding sooner and help the new nurse progress to the expert practitioner faster. In the theme Embedded in Place, participants discussed how they recognized and contributed to reflections of the area, however, research bringing the cultural focus into view instead of leaving it unacknowledged as "just the way it is" may improve nursing care, validate customs as valuable and appropriate, and support additional positive relationships within the close-knit rural community setting.

Additional research is also needed to explore the lived experience of being a nurse in rural communities. The homogeneity of this study participant sample, while anticipated and acceptable, did not add new insight of the participant who is not Caucasian or female. Future research should actively target a diverse sample population, including minorities and male participants thereby increasing the breadth and depth of insight. It is also important that future research include licensed practical nurses as they hold central positions in rural health care institutions and the communities where they live.

Implications for Nursing Education

Implications for nursing education identified by study participants suggests a need to provide creative avenues for nurses to pursue advanced education while balancing a career, family, and inherent characteristics of a rural environment. Implications for nursing education were identified within the themes Ownership of Nursing Practice and Embedded in Place. More colleges in and near rural areas are needed to provide advanced nursing education, especially clinically focused programs. One of the barriers to rural nursing education is a deficiency of clinical opportunities in rural areas. More partnerships are needed between urban and rural health care institutions and schools of nursing in rural areas. Nursing programs should build

partnerships with clinical facilities to facilitate more local learning opportunities through outpatient centers and satellite offices in specialty practices

Another implication identified within the theme Embedded in Place was the need to recruit deans, associate deans, and program directors who understand the complexity of nursing education, the profession of nursing, and graduate nursing concentration requirements within the context of the rural community. Education in and of itself is hard but barriers inherent to rurality may be overlooked by institutions of higher learning. Rural graduate nursing students may be considered a minority; however, they have the same requirements as their urban peers. Rural travel, infrastructure, and available mentors in the community are challenges present for the rural graduate nursing student that may be impossible for them to overcome without moving to a non-rural area. Registered nurses' formal education at all levels related to leadership skills, such as conflict resolution, management, and governance, are paramount for effective independent professional practice in the rural setting.

Implications for Policy Implementation within the Region

Participants identified barriers of travel time, increased distance secondary to few main highways, and unreliable cell phone service in the six-county focus area as discussed in the theme Embedded in Place and within the Location subtheme. Implications for policy makers and political leaders include emphasis on infrastructure improvements. In the same discussion, the lack of specialized care in the rural setting was a second concern verbalized by participants. Efforts to increase access to this care are within the realm of government structures and should become an integral component of political platforms.

Final Thoughts

This study demonstrates awareness of cultural influence, environmental context, professional awareness, and rewards of being a nurse in the region. The themes identified, embedded in place, ownership of nursing practice, destined to be a nurse, and rewards of being a nurse, were not based on technical skills or academic accomplishments, but rather to the essence of what they do within this place. The themes clearly address the study aims of describing the lived experience of contemporary nurses in rural Appalachia and relationships between the nurse and the place of residence and the place of employment. One thing was very clear--nurse participants value their role in the community and hold the standards of their profession dear. A strong sense of place leads one to wonder if the participants are now individually unique because of that adaptation--and then answer the question quickly in the affirmative. It is apparent that place can influence who an individual is in a short time, although it may take generations to change a body of people, a perception recognized by some of the participants. While the study focused on the lived experience of the nurse, knowledge was also present about current day Appalachia. It takes both professional practice and knowledge of the people and context of care for nurses to effectively care for individuals entrusted to them. As participant said, “you nurse from the heart,” an apt description of the way these participants viewed their professional nursing practice in Appalachia.

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