Experiences of Rural Nurses who Commute to Larger Communities

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Abstract

Background: Healthcare disparities for rural U.S. populations occur in part due to lack of healthcare providers. Increasing numbers of registered nurses (RNs) commuting away from rural communities for employment contributes to the rural population's challenges accessing healthcare. It is largely assumed in the literature that wages are the driving force behind rural

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nurses' commuting decisions. However, the actual experiences of RNs living in rural communities who commute to larger communities for employment is absent in the extant literature.

Purpose: This descriptive, phenomenological study explored the phenomenon of commuting away among RNs living in rural communities who commuted to larger communities for employment.

Methods: Participants included currently licensed RNs, residing in rural communities with a critical access hospital, that had a population of less than 2,500, who commuted for employment in larger communities. Purposeful sampling with snowballing led to 16 RNs from two Midwestern states, providing rich variations in personal and professional experiences. Data were collected via semi-structured interviews.

Findings: The core meaning, or essence, of the phenomenon of commuting away was found to be "Commuting to achieve personal and professional goals while being a nurse in a rural community." Multifaceted reasons surfaced for RNs to commute for employment. Most noteworthy reasons for employment decisions included opportunities for specialized areas of nursing not available in rural healthcare settings, along with advancement opportunities. Additionally, all RNs in the study were found to appreciate feeling valued as a nurse by members of their rural communities.

Conclusion: The multi-faceted reasons for commuting away indicated that "one size fits all" plans for recruitment and retention efforts will not meet the needs of rural nurses, and neither will simply increasing rural nurse wages. Study results are relevant to policy development, nursing practice, nursing education, and future development, recruitment, and retention efforts of nurses serving rural populations.

Keywords: Nurses, rural nurses commuting, employment, job

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With 46.2 million people in the United States living in rural areas, approximately 14% of the U.S. population lives on roughly 72% of the land (US Department of Agriculture [USDA], 2016). With a relatively small population distributed over such a large landmass, unique challenges are faced by rural populations. Rural populations have a higher prevalence of disease and premature death rates compared to the general U.S. population (Matthews et al., 2017). Healthcare disparities create challenges in meeting rural healthcare needs (National Advisory Committee on Rural Health and Human Services, 2011). The Healthy People 2020 initiative has forged a national effort to create health equity for everyone in the United States (US Department of Health and Human Services, 2014). Yet, the U.S. rural population continues to face challenges resulting in healthcare disparities.

Rural populations typically have inadequate numbers of healthcare providers (National Rural Health Association, 2016), which limits their access to healthcare. One factor contributing to the lack of nurses practicing in rural settings is the increasing number of registered nurses (RNs) who commute away from their rural, home communities to larger communities for employment. A comparison of the 1980 and 2004 National Sample Survey of Registered Nurses (NSSRN) data found that in 1980, 14% of RNs in the rural United States were commuting for employment, but by 2004, the percentage of rural RNs commuting had increased to 37% (Skillman, Palazzo, Hart & Butterfield, 2007). Current commuter trend data for RNs are not available, largely because the NSSRN survey was discontinued after 2008. However, with increasing rural hospital closures and RN employment opportunities available outside rural areas, it is likely that the increasing outflow rates of RNs who live in rural areas to commute to larger communities for employment has continued.

While it is known that rural RNs commuting for employment has increased over time, little is known about their actual experiences. It is widely assumed that wages are the primary driving force for commuter trends among these RNs (Skillman, Palazzo, Doescher, & Butterfield, 2012), but little detailed research has focused directly on specific first-hand reasons rural nurses commute to larger communities for employment.

The purpose of this descriptive phenomenology study is to describe the phenomenon of commuting away among rural RNs who live that experience. The phenomenon of rural resident RNs commuting away was defined as "traveling away from the rural, home community for conventional employment in non-rural settings" (Johansen, 2017, p. 5). For this study's purposes, rural was defined as a community with under 2,500 inhabitants as specified in the U.S. Census Bureau's definition (US Census Bureau, 2015). A qualitative research approach was necessary, in order to understand the phenomenon through the experiences of those who live it.

Research Method

Design

A descriptive phenomenological research approach was employed to describe the experiences of RNs living in rural communities who commute away. Phenomenology as a research method strives to deeply explore and describe the everyday world of the participants providing a means to understand the complex nature of a phenomenon and those who are experiencing it (Dahlberg, Nyström, and Dahlberg, 2008). Focusing on the experiences that make up the everyday world of the RN participants, an open stance was used by the researcher to approach the phenomenon of rural resident RNs commuting to larger communities, allowing the many unique meanings of the phenomenon to surface. The researcher sought participant's descriptions of their experiences, focusing on the rich variations of experiences. Consistent with

descriptive phenomenological methods, the researcher set aside pre-understandings of commuting away to allow the essence (core meaning) of commuting away to surface.

Sample

Purposeful sampling with the snowballing method (Kleiman, 2004) was used to obtain a sample with rich variation in experiences (Dahlberg et al., 2008). Inclusion criteria for the participants were:

1. a currently licensed RN in one of three Midwestern states;
2. a resident in a defined rural community (population < 2,500) with a Critical Access Hospital (CAH);
3. an RN commuting away from his or her home community for employment in a non-rural setting (community with a population of 2,500 or more), and;
4. English speaking.

As the sampling process continued throughout the study, purposeful sampling strategies were used to ensure that the sample included a wide variety of experiences that would lead to a rich, full description of the varying aspects of the phenomenon. Variations were sought in relation to differing genders, ages, work experiences, work sites, years of experience, and levels of education. In addition, participants who represented varying relationships with their rural community were also sought, including participants who were born and raised in the rural community versus those who recently moved into the rural community, or did so in the last 3-5 years; as well as participants who had always commuted for employment and those who had been previously employed within the rural community. And finally, variations were sought in community size to which the RNs commuted, including small rural areas, large rural areas, and urban areas, as classified by Rural-Urban Commuting Area (RUCA) codes (USDA, 2014).

Communities with a population of less than 2,500 residents, in which a CAH was located, were identified within a tristate Midwest region of the United States. Lists of RNs were received from the Boards of Nursing within those states. Prospective study participants received a letter of invitation through the U.S. Postal Service. The prospective participants were able to respond via a form and addressed and stamped envelope, or via email. Participants were then contacted by phone and/or email to determine eligibility for the study, with the use of a screening tool.

Once eligibility was determined, a date and time was scheduled for an interview with the selected participants. Not all eligible participants were interviewed. Rather, only those participants adding to the variability of experiences were included in the study. To determine which participants were included, the population of each of the communities to which participants were commuting to and from were identified and considered, using the RUCA Classification system (USDA, 2014), along with the 2010 U.S. Census data (as cited in Johansen, 2017). Additionally, each of these community's counties were classified according to the 2013 Rural-Urban Continuum Codes (RUCC) (USDA, 2013) to distinguish counties by degree of urbanization and adjacency to metro areas. To ensure variability in the sample, participants were selected based on variations in the RUCA and RUCC codes of the communities where they were employed. Recruitment continued until there was good variability in the RUCA and RUCC codes, as well as variation in other factors that could influence differing experiences, and until the researcher was able to identify the essence of the phenomenon and its meaning.

The final sample included 16 participants. The RNs all held licenses within the tristate region, and one RN was licensed in more than one state. Varieties of settings were worked in, and the RN roles included staff nurses, advanced practice nurses, and nurse administrators. Practice areas also varied, with areas of specialization including homecare, hospice, medical-surgical units,

operating rooms, pediatrics, and maternity care. Further demographic characteristics are found in Table 1. Classification of the communities to which the RNs commuted are found in Table 2.

Table 1

Demographic Characteristics of Sample

Variable	Range	Mean	n	%
Age (years)	24 - 78	44.6		
Caucasian Race			16	100
Years of RN Practice	2 - 57	19.6		
Hours Worked per Week	22 - 44	34.5		
Gender				
Male			2	12
Female			14	88
Education				
Associate			8	50
Bachelors			6	38
Masters			2	13
Years Residing in Rural Home Community	1 - 70	23.2		
Lived in Other Rural Community Prior to Current Community				
Yes			10	62
No			6	38
Years Commuting for Work	1 - 32	10		
Work History				
Previously practiced in a rural community			9	56
Always commuted			7	44

Table 2

Classification of Communities to which the RNs Commuted

Variable	n	%
RUCA ZIP Classification		
Small Rural (2,500-9,999)	3	19
Large Rural (10,000-49,999)	9	56
Urban (50,000+)	4	25
Census Classification		
2,500-10,000	3	19
10,001-20,000	6	38
20,001-30,000	2	13
30,001-40,000	1	6
50,001-60,000	1	6
60,001-70,000	1	6
200,000-299,999	1	6
>300,000	1	6
RUCC County Classification		
RUCC 1	4	25

Variable	n	%
RUCC 2	0	0
RUCC 3	2	13
RUCC 4	0	0
RUCC 5	2	13
RUCC 6	3	19
RUCC 7	5	31

Protection of Human Subjects

Institutional Review Board approval was obtained from the researcher's academic setting (IRB-201510-107), as well as employment setting (F-15-17). Written, signed consent outlining potential risks and benefits of the study was obtained from each of the participants. Participant privacy was protected by assigning numeric codes to the participants and removing identifying information from the transcripts.

Data Collection

Semi-structured interviews, conducted by the first author (LJ), were used to obtain descriptions of the RNs' experiences with commuting from their rural residences to workplaces in larger communities (Brinkman & Kvale, 2015). Interview settings were chosen by the RNs in order to ensure a comfortable, yet private interview environment. An interview guide was used to direct the interview with a set of primary questions that were asked of each RN. In keeping with a phenomenological approach, an open dialogue evolved during each interview and spontaneous questions were asked to obtain both depth and breadth of each RN's description of their experience. All interviews were audio-recorded and ranged in length from 27 to 82 minutes with a mean of 50 minutes. Following completion of each interview, field notes were created by the researcher, including descriptions of observations that were not captured by the audio recordings, any additional interactions between the RNs and researcher, and anything the researcher identified as noteworthy. A reflexive journal was used throughout the study to allow for the expression of researcher feelings, insights, preunderstandings, and reflections, in an attempt to bracket these

from the data collection and analysis (Streubert & Carpenter, 2011). Audio recordings were transcribed verbatim by a professional transcription service. Each transcript was verified for accuracy by the first author (LJ) with all identifying information removed from the transcripts.

Data Analysis

Analysis of participant interviews followed a tripartite structure, moving between the whole of the data, to the parts of the data, and back to the whole (Dahlberg et al., 2008). The first author (LJ) completed analysis and the software platform, NVivo 10.0™, was employed for data management. In the first step of analysis (whole), the researcher was immersed in the transcripts, reading the transcripts and field notes several times, while being open to new understandings. This immersion continued until an overall summary and broad understanding of each interview was established (Dahlberg et al., 2008). During the analysis step, parts of the data became the focus, and the data were broken down into meaning units. "The term meaning units signals that the division of the whole of data into parts is not carried out randomly but with respect to the meaning that one sees" (Dahlberg et al., 2008, p. 243). Participant words were used, whenever possible, as codes were assigned to the individual meaning units. Once all the data were coded, clusters of meaning were identified, again using participant's words whenever possible. Schematic drawings were used as an analytical procedure to help understand the codes and clusters of meaning, and the relationships between them. This led to the final analysis phase (whole), in which all of the individual data parts were reassembled to identify the essence of the phenomenon (or core meaning) that runs throughout all experiences, including the constituents (elements of the essence) and their variations.

Findings

Essence and Constituents

The core meaning, or essence, of the phenomenon of commuting away was identified *as Commuting to Achieve Personal and Professional Goals While Being a Nurse in a Rural Community.* The essence of commuting away meant that RNs were motivated to commute to an employment setting outside of their rural, home community, in order to achieve personal and professional goals that could not be achieved in their home community. At the same time, they remained a nurse in that community, even if they were not practicing there. As a result of commuting away, they experienced different professional connections. Figure 1 displays the constituents that compose the essence of commuting away.

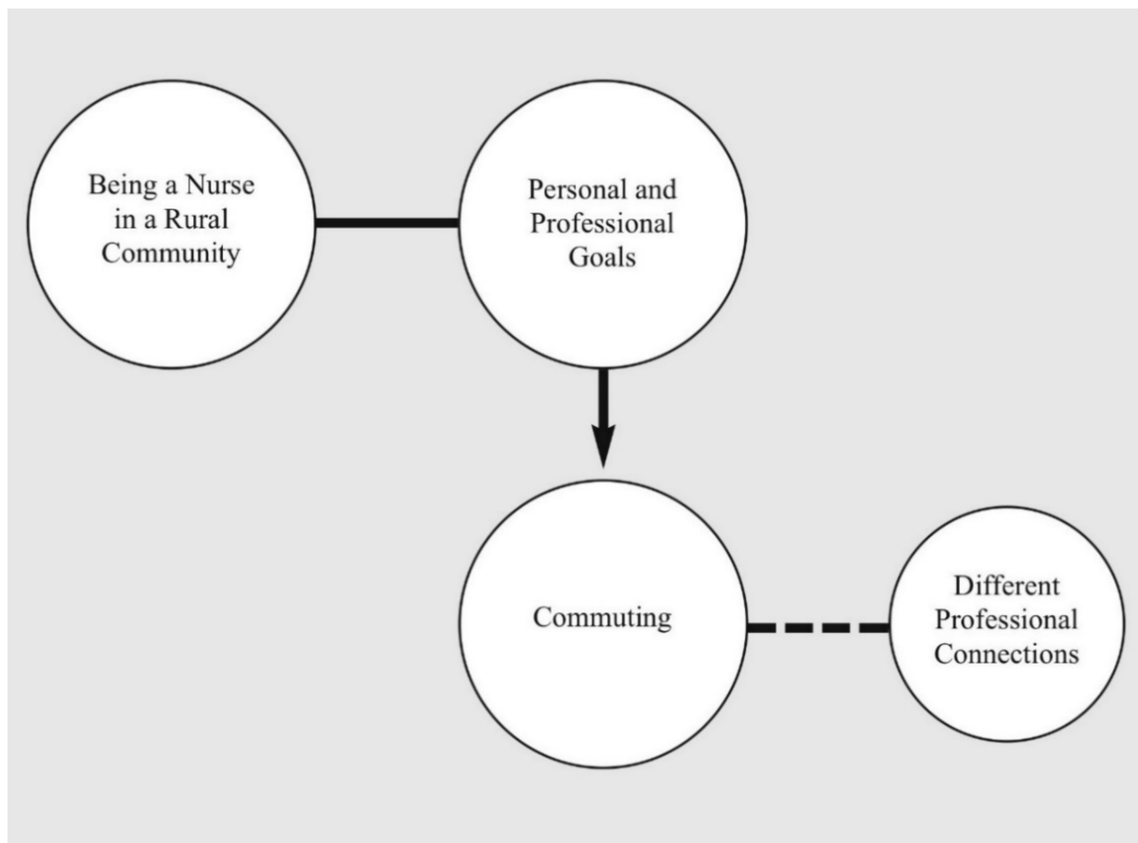

Figure 1. Essence: *Commuting to Achieve Personal and Professional Goals While Being a Nurse in a Rural Community* with Constituents

The first constituent, *Being a Nurse in a Rural Community*, related to the fact that although the RNs were currently commuting away for employment, they were still regarded as a nurse in their home communities. This was true for RNs who had worked in their home communities prior to commuting away, as well as those who had never worked locally. The experience of *Being a Nurse in a Rural Community* had varied meaning among the RNs, which was influenced by their experiences and/or perceptions of rural nursing practice. The second constituent was *Personal and Professional Goals*. The RNs had a variety of personal and professional goals, but in all cases, they were unable to meet some of those personal and professional goals through employment in their rural home communities. Thus, in order to achieve their goals, they made the decision to commute to a larger community for employment. The third constituent, *Commuting*, involved the act of driving to their employment outside of their home community, and involved several unique challenges in the lives of the RNs. Finally, the last constituent was *Different Professional Connections*. This means that the connections to coworkers, patients, employers, and home communities was different in their current employment setting than it was (or would have been) in their rural, home communities. For some RNs, the change in these connections was viewed positively and even helped them meet their personal and professional goals, but for others, the different connections were challenging. The meanings of each of these constituents are described in the sections that follow.

Being a Nurse in a Rural Community

All RNs, regardless of whether or not they had worked in their rural, home community prior to commuting for employment, described both experiences and perceptions of what it meant to be a nurse in a rural community. A full description of this constituent has been described elsewhere (Johansen, 2018). *Being a Nurse in a Rural Community* provided the context that the RNs

continued to live in, even though they were not working in that same home community. The RNs perceived that they continued to be respected and trusted within their home communities, because of their role as a nurse, and this was highly regarded by the participants. What it meant to be a nurse in a rural community was also shaped by their direct experiences and/or their perceptions of the demands of rural nursing practice. This included being "a jack of trades," the need to provide care for neighbors, friends, and family members, a lack of boundaries between their personal and professional lives, and a high visibility because of being known as a nurse in their home communities. Feelings about these issues ranged from neutral to inconvenient and undesirable. The former included feelings such as being viewed as a normal part of living in a rural community as a nurse. The latter feelings were sometimes contributing factors to the decision to commute to another community for employment.

Personal and Professional Goals

While *Being a Nurse in a Rural Community*, the RNs felt an inability to achieve some of their *Personal and professional Goals* within their rural communities. Wages, work hours, staffing patterns, benefit packages, job stability, and technology resources available at their current work were described as means to better meet some of their personal goals. Professional goals involved opportunities for professional growth, including opportunities for advancement and working in specialty practice areas. Pursuit of P*ersonal and Professional Goals* were the primary employment considerations that led to the RNs seeking employment outside of their rural, home communities.

Wages were a consideration as part of their personal goals as one participant explained: *You get paid more but yet you've got to factor all that other stuff in because then are you just coming out even? So then does it really matter what that pay scale is because you have how much more in gas expense, which leads to more oil changes, which leads to more tires.*

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Some RNs reported receiving higher wages after they commuted for employment. However, other RNs reported receiving wages similar to home, or even lower wages. Thus, while the availability of higher wages outside of their rural community was one of the deciding factors for some of the RNs, it was not a deciding factor for all of them. While some received higher wages after they left their rural, home communities for employment, many RNs had to consider the additional costs of commuting.

Another personal goal among many RNs was the desire for work to interfere less with their personal lives. Increased flexibility of scheduled hours, fewer weekend and night shifts, and union regulation of hours were viewed as positive benefits in the larger healthcare settings. *The job hours they offered were better than anything else I could have gotten anywhere else at that time in my life that I needed less hours.*

Work hours, together with staffing patterns experienced in larger healthcare settings, were appreciated by many RNs. Nurses described how in rural hospitals, there would be only one or two nurses on a shift, with ancillary staff, such as lab techs, only available when needed during evening, night, and weekend shifts. One RN shared: *[In the rural hospital] at night, you get a four-vehicle accident with four victims coming and you have two nurses on, and those two nurses are doing your secretarial work, they're caring for the patients already there in the hospital and it's the middle of the night and now you've got to make all these phone calls to try and get people to come in. That would be way too stressful for me.*

In rural healthcare settings, primary care providers were not on the premises 24 hours a day, and generally available on an on-call basis. Thus, high levels of responsibility for patient care fell to the nurse, and several were uncomfortable with the staffing patterns experienced, or perceived to exist, in rural healthcare settings.

Benefit packages were also factors considered when making decisions about employment location. One RN explained: *I'm the insurance holder, so that's a huge thing. Retirement, 401(k), flex spending, that's huge. Short-term disability, long-term disability – there are so many more compared to what I've ever been offered at other [rural] facilities.*

However, not all of the RNs were in agreement that benefit packages were better at larger healthcare facilities. Another RN stated: *I gave those [benefits] up to have the flexibility to stay employed [while working in a non-rural healthcare setting].* Overall, better retirement plans, insurance packages, sick leave, and vacation time were sought by several of the RNs.

Increased availability, and use, of technology resources was considered a benefit for RNs seeking employment in larger healthcare settings. One RN described how less available technology in rural healthcare settings was *"like everything was backwards."*.

Lastly, some RNs feared a lack of financial stability in their rural, home hospital, and many described feelings of increased job stability in larger healthcare settings, because of the better financial stability of the institution. One RN shared: *I would say there is more job security involved being at that organization. It's a [regional health system] and it's pretty well run. . . . They're financing it all. So I would say financially it's a very secure and stable security blanket, I guess is what I would call it. There's really no risk of them shutting the place or anything like that.* Overall, having a consistent, secure source of income was an important personal goal for RNs.

In relation to professional goals, opportunities for advancement were often a motivating factor for the RNs to seek employment outside of their home communities. Advancement opportunities related to the ability to practice in specialty areas of nursing, such as maternity care, as well as possibilities to climb the professional ladder, were found when commuting for

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employment in larger communities. As one RN stated: *[Specialty area] was one of the main things that brought me [to employment away from my home community].*

On the other hand, not all RNs shared the appreciation of specialty nursing opportunities, and these RNs appreciated and even missed the generalist role of the rural nurse. As one RN explained: *Now there's so many minute specialties. That's great but you lose that basic skill set of being a nurse. I think people get lost . . . in larger communities, you have to be a specialty.*

It was noted that specialized practice was available in their rural communities, but it was largely limited to gerontological nursing, and many were not interested in that type of specialization. *Just because I'm commuting away from my community doesn't mean that the opportunities aren't there [at home]. They're there but in a different capacity.*

In the end, RNs not only considered their experiences and perceptions of being a nurse in a rural community when making employment decisions, but they also considered their *Personal and Professional Goals.* Decisions to commute for work in larger communities were multifactorial, but the RNs determined that the overall opportunities and benefits of commuting outweighed those available to RNs in their rural, home communities.

Commuting

When RNs determined that some of their personal and professional goals could not be met while being employed in their home community, they chose to seek employment in another location, which required they commute for employment. The constituent of *Commuting* was defined as the act of driving to a larger community for the purpose of employment (this concept differed from, but was part of, the entire phenomenon of commuting away). The act of *Commuting* affected the RNs' personal and professional lives, and many challenges surfaced.

Commuting on rural roads created personal safety concerns such as uncontrollable road conditions, irresponsible drivers, and unexpected obstacles while driving. One RN stated: *Perpetual deer that like to jump out in front of your car at dusk and dawn, that is a very big challenge.*

Commuting also had an impact on the RN's family. The time spent *Commuting* meant less time available to spend with their families. Two of the RNs drove to multiple destinations for employment. The remaining RNs in this study commuted 20 to 57 miles each way, with an average of 30 miles. One RN lamented: *When I'm gone, you just might as well mark me off for the day. I'm not going to see you [family].*

For RNs with young children, decisions related to childcare also presented challenges. Nurses needed to make decisions about where to obtain childcare, whether in their home community or in the community where they were employed. Finding childcare that was available during the hours needed for nurse schedules was also challenging. Weather related emergency plans for family, and driving distances with children in the car, also distressed some of the RNs. *No day care takes them that early in the morning. . . . Where do you bring your kids when you're commuting? Do you bring them all the way to [the community where you are working] for daycare with you or do you find something somewhere here [in home community]? . . . Once they got to school age . . . what if school gets out early? What if they're snowed in here or there? You're that much further away.*

Likewise, RNs who had responsibilities for adult family members needing assistance shared some of the same concerns.

Concerns such as weather and alertness were also an issue with *Commuting*. A common expectation of healthcare facilities was for nurses to be at work regardless of weather conditions.

Thus, when inclement weather was expected, nurses needed to go to work early to assure they would be available for their scheduled hours. At the end of their shifts, they sometimes could not go home because of weather or the lack of replacement nurses. Sometimes nurses remained at work for several days during winter storms. *A 3-day blizzard . . . We had small children, and I was stuck away from home. . . Winter commuting is challenging.* Some decisions to commute hinged on whether they knew someone on the commuter route, or in the commuter community, in case they had car troubles or weather challenges.

Many RNs were concerned about the time and money spent driving to work as well as lack of alertness while driving. Nurses needed to leave home earlier for work. Thus, the time spent driving to work added to the time spent at work, and travel expenses for *Commuting*. [*Where I work] there's a lot of things that you have to deal with that you don't have to deal with in the rural [area], like parking. There's parking issues and you pay for parking. In the rural, you don't even realize that that exists . . . [then] gas money, repairs on my car.*

A lack of alertness while driving was also a concern for RNs, with a sense that the lack of alertness spilled over into the patient care setting once the nurse arrived at work. *The drive can be kind of tiresome . . . you drive and you're still kind of tired and you're kind of groggy, and you get to work and you're still kind of groggy for the first couple of hours or whatever. Professionally I think that can be a factor, especially depending on how far you have to drive. You're not really tuned in for a while. That's one thing I did kind of factor in as well, because sometimes when you drive you just kind of zone and when you get to work you still just kind of feel groggy, even though you've been up for the last couple of hours, because you get up, you get ready, then you drive to work, but it's just that drive in the morning. You're not mentally with it.*

Concerns with *Commuting*, especially of those related to personal safety and time to commute, posed challenges for RNs and even potential challenges for their patients.

While RNs identified the difficulties faced as they commuted, there was one aspect of the drive that they viewed positively, the ability to have downtime. One RN explained: *The 30 minutes are fabulous to and from work when there are not road conditions or deer issues. It's decompression time for me. In the morning, it's more eating a little breakfast, listening to the radio, pretty relaxed. But then on the way home, if I've had a really stressful day, maybe somebody passed away close to the end of my shift, and I'm still kind of wound up a little bit from that, that 30 minutes before I get home is wonderful, because it's me and the radio again. I have a thing in my car where I can call from my steering wheel. It's a Bluetooth. I love that. I cannot believe how much time I spend on the 30-minute commute home making phone calls to friends and my parents to catch up. And then when I get home, I'm strictly home with my husband doing our thing. I love that 30-minute commute.*

Many of the RNs expressed appreciation of the downtime that they experienced as they drove to and from work, because this provided an opportunity for them to decompress and personally reflect upon their work before they got home.

As RNs faced the many challenges presented to them while *Commuting*, some of them indicated they would prefer to not commute. However, motivation to achieve their *Personal and Professional Goals* outweighed the challenges they faced as they commuted to work.

Different Professional Connections

As RNs commuted for employment in larger healthcare settings, they found their connections to patients, coworkers, employment facilities, and home communities to be different than those connections when they had practiced in a rural healthcare setting (for those nurses who had

previously practiced in their home community); or were different than what they perceived they would face if they were practicing in their rural, home community (for those who had never practiced there). Nurses found higher activity levels while working at larger healthcare facilities, along with greater numbers of patients to care for, in comparison to a rural healthcare setting. Such practice settings led some nurses to feel less connected to their patients, coworkers, and work environments, with connections feeling less personal, and more distant.

The experience of caring for patients in a rural, healthcare facility was different from the experiences found caring for patients in larger facilities. Nurses tended to not personally know their patients when they commuted for employment. For some RNs, this greater anonymity was appreciated, and was described positively as "a distance" from their patients. *That's one relief. [While commuting,] I don't really know the people; this is just how it is. . . . In the area of chemotherapy . . . here, they're my patients for that day. . . . I'm kind of glad I don't have to do it with somebody that I really. . . like if it was a close friend or a family member. . . . I don't really know them; just, they're my patients. I'm their nurse and they're my patients . . . there's a distance.*

Additionally, this "distance" allowed the patients the opportunity to feel safer in disclosing sensitive information with the nurse, as one RN described: *I think that I was able to approach patients differently as an outsider because I was not so close to their base. Confidentiality wasn't such an issue. They were more likely to open up and talk to me.* The element of "distance" in the commuting away experience provided an anonymity of the patient that RNs found they appreciated.

The RNs also experienced different connections to their patients outside of the healthcare setting. Nurses generally found it less common to have personal-professional boundary violation issues, compared to what they experienced in their home communities. They were asked about

confidential patient matters in public settings much less, which was dramatically different from experiences while working in their home communities. Nurses were also less likely to encounter their former patients outside of the healthcare setting, compared to when they were in their home communities. For some, this was appreciated, while others missed those dual, close relationships.

> *I about had somebody run into me [shopping] the other day. Unfortunately, I always feel terrible because I don't remember their names. Maybe here in our community I know who they are, but we have 500 deliveries every year, and I'm not in on all 500 but I'm in on a lot. When they are coming up to you a year later, they look different and I just don't remember their names. And so then you feel terrible. I feel bad that way. . . . That's kind of a negative because I'm like "oh, I wish I could just remember their names, because they obviously remember me."*

While boundary issues were less common, the feeling of disconnection from patients when interacting outside the professional sphere was still expressed as a loss for some RNs. There were also changes in the connections RNs had with their coworkers. In the rural health care setting, the bond between coworkers was viewed as tighter. *"The relationship that you had with the rest of your staff, it was a tighter bond, because there were a smaller number of you, and you knew that you needed to be there for each other."*

Additionally, the RNs noted that in practice in their rural, home community, a sense of family developed, with coworkers attending social events together, including special occasions for family members. *In the smaller communities you went outside of your job and you went and had supper with them. You went out and your kids played ball together.* This relationship did not exist with their coworkers at the employment to which they commuted.

Nurses had a greater sense of obligation to their rural coworkers and healthcare facilities as a result of these strong connections. In their rural, home communities, this strong connection also

led to the RNs feeling obligated to come in to work when needed and pick up extra hours. *It was almost too easy for me to pick up [hours] because I was too convenient. . . . I was way too accessible.* Thus, when employed in their rural communities, RNs felt like they were at work all the time.

Conversely, while working outside of their rural, home communities, there was more of a distance in the relationships with coworkers, and the RNs' personal lives were less likely to intersect outside of the work setting. *In eight hours, I'm there and gone, and I didn't have any relations with the workers. It was like they weren't my friends; they were just coworkers, and everybody was there just to put their time in and go home. So it's a different atmosphere than the rural . . . it's just not like a family. . . . There's not a connection.*

Feelings varied in relation to these different connections with coworkers. Some RNs missed having closer connections to their coworkers, while others really valued the feeling of distance in those relationships.

One thing expressed by the RNs, regardless of where they worked, was a strong need for peer support in the workplace. The RNs desired to have a formal peer support system, because the personal nature of their practices exposed them to joys and sorrows shared with their patients, and these emotional aspects of their jobs often weighed heavily on their minds. Formal peer support systems were highly valued, but were generally not present in any employment setting, regardless of where they worked. Because of the confidential nature of caring for patients, the RNs were unable to decompress with family and friends. Thus, the RNs were generally not able to find the emotional support needed to meet their needs.

Along with feeling less connected to coworkers, the RNs also felt less connected to their work environments and employment settings, leading to feeling a lower sense of obligation to their

employer. Some valued the actual distance between work and home, feeling less guilty to decline when they were asked to work extra shifts. *In eight hours, I'm there and gone. . . . I could walk away. . . . The big thing is I can leave after eight hours, and I don't even think about it. I don't think about that place. I walk out the door and that's it. Where I never did that [working in home community].* Considering the commuting away experience, RNs worried less about work when they were not working.

Lastly, RNs also felt less connected to their home communities, as a whole, after they commuted for employment. Some expressed that this change in connection was a relief, as one RN noted: *[Commuting away] kind of removes you from the community you live in. Because when I come home, I'm just busy doing my stuff, and I don't find myself getting involved hardly at all in the community. So I've kind of lost contact with certain things. So kind of like, I don't really fit anywhere . . . I come home and we watch TV, I go to bed, and I repeat the same thing. It's like I don't have a community . . . so life is much easier I think."*

Conversely, other RNs longed for the connections to their home communities that they no longer had. *I can certainly think of a lot of disadvantages [to commuting for employment]. One of them is . . . that social disconnect with the people in my own community. That is a very real thing for me.. . . . I used to be invested in this community and I no longer am. . . . Every small community probably has cliques of people and I am no longer in it. . . . Back in the early days of my life . . . I knew every single person. . . . I grew up here. . . . That would not be the case anymore. I would not know anybody up on Main Street, nor would I feel connected to them. Very different . . . I'm not invested here and I never had been invested in the community where I worked. . . . I never participated in any community events.*

In reality, descriptions of the RNs experiences encompassing the phenomenon of commuting away show a blending of experiences throughout all of the constituents, rather than a demarcation of experiences within each constituent. This blending of experiences together creates a sum of the parts of data that are, in the end, greater than the whole of the data (Dahlberg et al., 2008).

Discussion

The rural RNs in this study found importance and respect in being a nurse in a rural community. However, they were unable to meet some of their *Personal and Professional Goals,* and this led to them *Commuting* for employment in larger communities away from their rural, home communities. This, in turn, led to *Different Professional Connections* with patients, coworkers, employers, and their home community at large.

Being a Nurse in a Rural Community was important to every RN, regardless if they were a new member of their rural, home community, or had been a life-long member of the community. Many of the findings within this constituent are supported by the Rural Nursing Theory (Long & Weinert, 1989), including the crossing of personal and professional boundaries, the lack of anonymity/high visibility of rural RNs, and the generalist role of nurses.

A lack of anonymity in rural work settings was identified as a factor that precedes job dissatisfaction (Roberge, 2009). In this current study, "the blurring of professional boundaries and the lack of privacy in rural communities, with everybody knowing everybody, led to decreased satisfaction in some of the nurse's personal and professional lives" (Johansen, 2017, p. 190-191), and motivated them to seek employment elsewhere. The blending of personal and professional boundaries led to anxiety for some RNs, as they feared caring for their family and friends. These findings are consistent with other studies of rural nurses (Malone, 2012; Roberge, 2009; Scharff, 2013).

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In an ethnographic study describing the type and scope of nursing for rural nurse generalists in 1987, Scharff (2013) found that nurses believed their familiarity with the people they cared for improved patient outcomes. Additionally, Scharff (2013) reported strong connections between rural coworkers, finding the rural nurse to have a personal familiarity with all the workers in the rural employment setting, creating the potential for deeper connections to coworkers, which were unique to rural settings. In this current study, connections to rural coworkers were found to be rewarding, but sometimes created challenges regarding feelings of obligations between coworkers and employers.

Nurses chose to live in their rural, home communities for many reasons. Some of their *Personal and Professional Goals* were not attainable through the employment opportunities in those communities. The *Personal and Professional Goals*, and/or combination of goals that led to their decisions to commute to a larger community, were largely varied, and no specific goal was identified as the single factor that led to the RNs' employment decisions. For some, employment benefits, including better health insurance, higher wages, desirable work hours, technology resources, and increased job stability, were factors that contributed to the RNs' decision to commute for employment. Using the NSSRN data, Skillman et al. (2012) found that salary gaps between non-rural and rural healthcare settings have dramatically increased over time. In 2004, wages for nurses working in more urban areas were approximately 22% more than rural areas (Skillman et al., 2007). The Imerman, Orazem, Sikdar, and Russell project from the Iowa State University revealed the Iowa RN licensing database found similar salary gaps for years 1994 – 2005 (as cited in Johansen, 2017). Thus, it has been largely assumed that wages are the driving force among nurses who choose to commute to larger healthcare settings for employment. However, it is important to note that in the current study, wages were not the driving force for all

the RNs. In the current study, while some RNs did seek and attain employment with higher wages, others reported that their wages did not increase, and in some cases, their wages even decreased. Thus, the assumption that wages are the driving force for why rural nurses leave their home communities for employment elsewhere, was not found to be true in this study for three Midwestern states; a finding that has been supported by a few earlier studies (Kovner, Brewer, Wu, Cheng, & Suzuki, 2006; Molanari, Jaiswal, & Hollinger-Forrest, 2011).

Beyond personal goals for wages and other employment benefits, the RNs also had a desire to meet professional goals. Professional development opportunities were valued, and RNs perceived a greater availability of these opportunities in larger healthcare settings. Stewart el al. (2011) researched factors that are predictive of retention issues for nurses in rural healthcare settings and found that desires for advancements in professional careers were predictive of nurses seeking other job opportunities. The findings from this current study support this. Nurses in the current study also sought specialized nursing practice opportunities outside of their rural, home communities, as well as means to advance their careers. Some RNs in this study perceived that the only specialty practice available in rural areas was gerontological nursing, and they specifically desired other specialty nursing opportunities. Some clinical areas of practice have been found to have more popularity than others, among nurses as a whole. Work environments that are considered dynamic, lifesaving, and highly technical have been found to be preferred, while opportunities to care for mentally ill, or older adult patients, being less desired (Wilkinson, Neville, Huntington & Watson, 2016). Fewer opportunities for nurses to practice in specialty nursing positions in rural settings have created challenges in retaining nurses in rural healthcare settings (Stewart et al., 2011).

The perceived inability to meet some of their *Personal and Professional Goals* in their rural, home communities led these RNs to commute to employment some distance from their homes. *Commuting* for employment is not an uncommon practice among rural nurses. One study found that just over 10% of nurses living in primarily small towns and rural areas outside metropolitan areas traveled at least 50 minutes one way for employment (Rosenberg, Corcoran, Kovner, & Brewer, 2011). The RNs in this study were somewhat under that average, as they commuted 30 miles one way, on average (although some did commute 50+ miles each way).

In the current study, RNs voiced appreciation for the downtime while *Commuting*, as it allowed them to decompress and spend time in self-reflection. However, in a study about mind wandering, monotonous driving was found to negatively impact a driver's performance, especially with the repeated task of driving the same route, unaccompanied, while the driver focused on reflections and inner thoughts that could lead to distracted driving (Berthié et al., 2015). Such driving practices were found to influence driver safety and the potential for motor vehicle accidents. It is of concern that none of the RNs in the current study indicated any awareness of the personal safety risks associated with this kind of distraction while *Commuting*. There is a need to educate nurses who commute for employment about the dangers associated with distracted driving, in the form of a focus on self-reflection and decompression from their previous shift work experiences, and teach them about the importance of and strategies for mindful driving.

As a consequence of *Commuting* to employment outside their home communities, RNs felt less connected to their work settings, coworkers, and patients, and some reported having diminished feelings of obligation to their employers. This finding is supported by Medves, Edge, Bisonette, and Stansfield (2015) in their study of rural Ontario nurses. It should be noted that feelings of obligation and feelings of commitment are two different things. A literature review of

nurse's employment intentions found that intention to continue employment at a worksite was increased with a relationship that created a sense of dedication and commitment (Cowden & Cummings, 2012). However, achieving work-life balance has been found to be important among nurses, with appreciation for the ability to feel free from work activities and feelings of obligation on their non-work days (Jamieson, Kirk, & Andrew, 2013). Castaneda and Scanlan's (2014) literature review, examining job satisfaction among nurses, found that the social and professional relationships nurses experience in work settings were important to job satisfaction. In fact, social relationships were often a top predictor of nurse's satisfaction with their jobs. Rural employers can strive to foster relationships that nurture nurses' feelings of dedication and job satisfaction but should not align those feelings with feelings of obligation that can lead to dissatisfaction with employment.

In this current study, the RNs also felt more disconnected to their home communities after they experienced *Commuting* for employment. Nurses had fewer contacts with community members at home, as they spent less time in those communities. Richards, Farmer, and Selvaraj (2005) found similar experiences while researching the retention of healthcare workers from rural communities who commuted. In this current study, RNs had varying feelings about the loss of connections to their rural communities. Understanding these feelings is important to increase awareness of factors influencing employment decision making.

Limitations

The current study has a number of limitations that need to be recognized. The sample included nurses from a small geographic area in the Midwest United States, and lacked racial diversity. Additionally, while all of the RNs were commuting away from their rural, home communities for employment, many were still working in other rural communities, whether small

rural or large rural, as defined by RUCA codes. Only 25% of the RNs commuted to urban communities of 49,999 or more people. Thus, the experiences of rural nurses who commute to only urban settings may not be fully represented in this study. Additional studies with more diverse populations, different geographic rural locations beyond the Midwest United States, and with those who only commute to urban employment settings are warranted to determine if the meaning of commuting away is consistent across populations of rural nurses.

Implications

The findings from this study have implications for nursing practice in rural settings and educating nurses about rural employment. Results will inform rural healthcare employers about recruitment and retention strategies, as well as implications for future policy development and research.

Nursing Practice

The roles of rural RNs need to be acknowledged, recognizing the wide knowledge base and level of expertise needed to provide quality healthcare to rural residents. The public commonly does not understand the complexities and responsibilities of the profession of nursing (Brewer, Zayas, Kahn, & Sienkiewicz, 2006). It is imperative that, among the profession of nursing, perceptions that rural nurses are less skilled, or less useful, must change to acknowledge their value as professional nurses. Rural nursing requires specialized knowledge and skills, and thus, should be considered a specialized practice. Perhaps if rural nurses were recognized for this specialized practice, among their peers and the public at large, they would feel less need to seek other types of specialization.

Employers of Nurses in Rural Settings

The findings from this study can help inform the recruitment and retention efforts of rural healthcare facilities. The general assumption that wages are the primary driving force for rural nurses to seek employment in larger healthcare settings was not substantiated in this study. Rather, there were multiple and varied *Personal and Professional Goals* that were unmet by the employment options in the nurses' rural, home communities. Unique, individualized strategies for the recruitment and retention of nurses in rural healthcare settings should be developed to benefit not only employers of rural nurses, but also the rural population they serve. This current study found that RNs' goals, both personal and professional, were multifaceted. The one-size fits all strategy to recruit and retain nurses in rural healthcare settings will not be efficient or effective.

Employers of rural nurses need to recognize and support the diverse and complex roles required of their nurses. Assessing the comfort levels of nurses, presently employed or being recruited, with the expert generalist rural nurse role, along with the nurse's connections to patients and community members, could lead to the creation of individually tailored resources for these nurses. By understanding nurse's needs, comfort levels, and goals, individualized support systems and resources could benefit both the nurses as well as their patients. Mentorship programs based on the nurse's previous exposures to and comfort with rural nursing, along with orientation programs specifically focusing on the creative, and flexible, roles of rural nurses, can help meet the needs of nurses new to the rural healthcare environments.

Although job satisfaction was not the focus of this study, the complexities of job satisfaction for nurses practicing in rural healthcare settings should be considered in relation to the findings. The Herzberg Motivation-Hygiene Theory identifies both motivational factors, and factors that cause dissatisfaction, for employees at work. Herzberg found that factors that truly motivated

people at work were different from factors that led to job dissatisfaction. Motivating factors lead to satisfaction and were associated with people's capability to achieve psychological growth: responsibility, recognition of accomplishments, advancement, and the actual work accomplished. Factors leading to dissatisfaction, called hygiene factors, included items such as wages, work conditions, status at work, policies, supervision, and relationships at work (Herzberg, 1968). Satisfaction and dissatisfaction are not opposites. Rather, the opposite of dissatisfaction would be "no job dissatisfaction." Frequently, employment strategies focus on hygiene factors, which can lead to less dissatisfaction. However, Herzberg purports that less dissatisfaction is generally temporary, and does not mean there is job satisfaction. Motivating factors can create long-term satisfaction by creating a feeling of worth and fulfillment for employees (Herzberg, 1968).

The Herzberg Motivational Hygiene Theory can explain some of factors that caused the nurses to seek employment outside of their home communities. Nurses sought work place motivators, such as advancement and growth opportunities, not available in their home communities, in order to achieve a higher level of job satisfaction. Hygiene factors were present in their desires for employment benefits and work conditions that they perceived as better than those available to them in their home communities, leading to less dissatisfaction once they commuted. Following Herzberg's theory, there were motivating factors that led to job satisfaction, helping explain why hygiene factors, such as wages, were not as notable in the employment decisions for all nurses. Hence, motivators need to be prioritized, but both motivators and hygiene factors need to be considered in recruitment and retention strategies for rural healthcare employers to create a balance of motivation and the prevention of dissatisfaction.

Providing motivating factors for nurses to meet their desires for both advancement and specialization opportunities is key to the successful retention of rural nurses. With rural nurses

wearing "many hats," spreading out the "many hats" could create advancement positions for more nurses, increasing their motivation and satisfaction. Additionally, specialty knowledge that nurses bring with them from practices in larger healthcare settings could be acknowledged and integrated in the nurse's roles as rural specialty experts. These nurses could be called upon to utilize their expertise through telehealth mechanisms, or clinical opportunities. For example, perhaps a rural nurse expresses a desire for specialization in obstetrics (OB), but the rural hospital only infrequently does deliveries. These nurses could be offered an opportunity to receive a paid, mentored experience with a nurse at an OB unit of a more urban facility. That nurse could then return to their home community and be a designated OB nurse specialists who responds to and cares for newly admitted OB patients.

Striving to decrease employee job dissatisfaction, employers need to be attentive to the benefits being offered to their employees. Even though wages were not found to be a key to all nurse's employment decisions, nurses do need to feel a sense of fairness and equity surrounding wage and benefit packages (Kovner et al., 2006). Rural nurse desires to prevent work schedules from interfering with their personal lives needs to be a consideration. Flexible self-scheduling has been found to decrease nurse dissatisfaction with their jobs (Leineweber et al., 2016). For healthcare facilities that do not currently have flexible scheduling options, such interventions may be an effective recruitment and retention strategy.

Connections between nurses and their rural, home communities need to be considered by healthcare employers. Understanding the desires for some nurses to feel connected to their communities, with others desiring just the opposite, should lead to individualized employment strategies. For those nurses desiring to be connected to their communities, creating opportunities for the nurse to represent the healthcare facility in community projects may be beneficial.

Understanding the lack of boundaries between nurses and their rural community members could also lead to educational interventions at the community level that could decrease the nurse's concerns about lack of anonymity in the rural communities. An example could be to provide nurses with interpersonal communication training specific to compliance with confidentiality standards, helping provide strategies to nurses when they are approached by community members about confidential matters. Community members could also be invited to meetings hosted by the healthcare facility, where discussion about helping nurses to maintain a boundary between their personal and professional life could help to establish new social norms in relation to how rural community members interact with their nurses.

The uniqueness of connections between nurses and their coworkers needs to be considered, since rural nurses have been found to have deeper connections to their coworkers when working in rural healthcare settings (Scharff, 2013). Even with the unique connections between nurses and their coworkers, the need for peer support surfaced in the current study, with a lack of emotional support available to the nurses inside and outside of their employment settings. Rural healthcare facilities need to incorporate a healthy work/life balance for their healthcare providers, creating feelings of dedication and commitment, rather than feelings of obligation that can lead to dissatisfaction. Creating informal peer support mentors, establishing formal end-of-shift debriefing sessions, and support hotlines could conceivably create an atmosphere of peer support.

Nurses in this study all experienced a sense of appreciation from feeling valued and respected by their rural community members. Given that recognition for accomplishments and work done well was valued, rural employers can capitalize on the rural communities' respect and trust for nurses in their communities, thereby increasing job satisfaction and potential for improved

retention. Tailored recognition programs, such as monthly or quarterly awards for outstanding nursing practice, published in the local newspaper, could demonstrate this type of appreciation.

Nursing Education

The role academic institutions play in preparing nurses for future practice is instrumental in the future of the healthcare provided to rural populations. Previous research has found that exposures to clinical opportunities in rural settings are necessary to prepare nurses for future nursing practice in rural settings (Molanari et al., 2011). Curricular content of nursing programs has been shown to influence the knowledge, skills, and attitudes of nurses. Simulation has been effective component of nursing curriculum in producing learning opportunities that address real-life situations (Norman, 2012). Simulations should be designed to prepare nurses to care for family, friends, and neighbors in rural healthcare settings, and build communication skills needed to converse professionally during public interactions with rural community members (O'Hagan et al., 2013). Growth of confidence and interest in rural nursing practice may be enhanced with strategies such as simulation.

Nursing education programs should carefully consider how curricular content is presented to students, in order to avoid an urban bias. McCann, Clark, and Lu (2010) found nursing program emphasis on healthcare settings, focusing on technical skills and acute care, may coincidentally discourage future career choices of nurses caring for older adults. The future of nursing education should not only focus on acute care and highly technical specializations, but should also include rural clinical experiences, in order to make nursing positions caring for older adults, and rural nursing practice, more desirable. Further, rural nursing practice needs to be conceptualized by nursing faculty as a specialized practice, with its own unique knowledge base and skill set, thus

elevating the perceived status of rural nursing, and perhaps making it more attractive to new graduates who are seeking to “specialize.”

Policy Development

State and federal governmental efforts have historically aimed to improve the recruitment of rural healthcare providers. Loan repayment programs, and scholarships, were created to recruit healthcare providers to designated healthcare shortage areas, including rural areas. Even though financial incentives have historically been part of recruitment packages for some rural healthcare professionals, there is limited evidence that such programs create long-term success (Mbemba, Gagnon, Paré, & Côté, 2013). Following Herzberg’s theory, recruitment and retention incentives should not only include financial incentives, but also motivating factors, such as professional growth and opportunities for advancement. With the inclusion of such strategies, an increased success with the recruitment and retention of rural nurses could be realized. National nurse credentialing agencies, such as the American Nurses Credentialing Center, should expand their credentialing policies to offer certification in rural nursing, as a nursing specialization.

Research

With limited research available specifically addressing rural nurse job satisfaction, further research is needed to understand factors that lead to rural nurse motivation, along with factors that dissatisfy, to create the most effective recruitment and retention strategies. The creation of a balance between strategies to empower motivation, and minimize dissatisfaction, could be guided by the development of an assessment tool which employers could use to assist in creating individualized strategies for rural nurse recruitment and retention strategies.

Tracking the current, and projected, commuter trends for rural nurses, such as previously possible with the NSSRN, would benefit rural healthcare facilities and the rural population they

serve by understanding how effective recruitment and retention strategies work. An important safety issue identified in this study was the possible distracted driving that may be occurring with rural nurses who commute, while they are engaged in self-reflection and decompression on their drive home. Additional research is needed to identify the prevalence of motor vehicle accidents among nurses who commute significant distances and examine the potential association between distracted driving because of decompression from work, and motor vehicle crashes. Some RNs in the current study also noted that they experienced a lack of alertness on the drive to their work setting, and that lack of alertness sometimes continued into their work. The potential exists for patient safety to be influenced by nurses who commute. Research should be conducted to determine if there is any association between *Commuting* and risks to patient safety, because of lack of alertness.

Conclusion

To achieve health equity for the rural population throughout the United States, actions need to address access to healthcare. The gap in knowledge surrounding RNs commuting away from rural communities for employment in larger healthcare settings needs to be better understood. The results of this study are critical to future effective recruitment and retention strategies for rural healthcare facilities and for the health of the rural population served.

Understanding the experiences of nurses living in rural communities, who commute to larger communities for employment outside of their rural, home communities, takes us beyond previous assumptions that wages are a driving factor leading to employment decision of these nurses. Rural nurses' decisions about where to work are multifaceted. Creating appropriate, individualized strategies, recognizing, and promoting rural nursing as a specialized practice, could lead to increased numbers of nurses practicing in rural areas. The end result can be the reduction or

elimination of serious RN scarcity within rural communities. This can help rural populations achieve health equity through access to comprehensive and quality healthcare, including an adequate number of RNs.

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