THE PERCEPTIONS OF RURAL NURSES TOWARDS ROLE CHANGE WITHIN THE CONTEXT OF ORGANISATIONAL CHANGE

Alexandra McCarthy RN, MNurs, MRCNA is a Nurse Educator, at the Cunningham Centre, and Research Assistant at the University of Southern Queensland, Toowoomba, Australia

Desley Hegney RN, PhD, FRCNA, is the Professor of Rural Nursing, University of Southern Queensland and Cunningham Centre, Toowoomba, Australia

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ABSTRACT

This paper, derived from The role and function of the rural nurse in Australia study, describes the effects of organisational change upon the rural nurses participating in the study. It appears that whilst change is an inevitable and regular feature of rural health service delivery, it does not necessarily benefit rural nurses or communities for reasons unique to rural life. Nurses in the study responded positively to organisational change when it was congruent with the rural norms of community consultation and collaboration, or when it ensured the long-term viability of the health service. They responded negatively to organisational change that caused role overload, role conflict or role insecurity, particularly when they perceived they had little control over the change process. This paper emphasises the need for nurses to actively participate in the change processes affecting their livelihood and their communities.

INTRODUCTION

This paper is derived from a larger study, The role and function of the rural nurse in Australia, which investigated the role and function of nurses working in rural hospitals throughout Australia.

One item in the demographic questionnaire completed by the 129 nurse respondents who collected data for the study, asked whether the facility in which they were employed had experienced organisational change within the previous 12 months. Of the participants, 102 (79%) indicated their health service had undergone significant organisational change. These changes included conversion to multipurpose services, collocation of sites, closure of a large part of the health facility or a restructure which focused upon less acute case loads. Sixty-nine (53.5%) of the respondents offered unsolicited written comments on the personal, professional and organisational effects of these changes. These comments were so extensive that they were entered and analysed on the NUD*IST qualitative data program for emergent themes and sub-themes. The results of this analysis indicate that rural nurses respond positively to organisational change when it is congruent with the rural norms of community collaboration and consultation; when it assures the long term future of their health service or when it extends their professional role. Rural nurses respond negatively to change when it causes role overload, role conflict and role insecurity, particularly when they have minimal control over the change process. The paper stresses the need for rural nurses to become actively involved in organisational change that affects their livelihood and community.

BACKGROUND

Health service delivery throughout Australia has always been subject to change as it is vulnerable to the
pressures of new technology, economic remodelling and shifts in political ideology. Since the late 1960s, health policies have also gradually embraced sociopolitical reforms in response to economic rationalism, the consumer movement and the recognition that consumers have a right to receive care in the most cost-effective and culturally appropriate environment (McConnell 1998). Consequently, many health services throughout Australia have experienced recent and dramatic change in the form of downgrading, closure, co-location, amalgamation or significant organisational restructuring in order to meet these challenges.

Whilst it is recognised that similar changes are occurring in metropolitan areas, rural people have unique health service requirements driven by the collective pressures of rural living which can make recent, imposed, changes in health care delivery difficult for them to accommodate (McCarthy and Hegney 1999; Australian Health Ministers' Conference 1999). In contrast to metropolitan areas the majority of rural populations, both nationally and internationally, are significantly older, poorer and less well educated (Silviera and Winstead-Fry 1997). Coupled with the distance many rural people must travel to attend health services, these factors often result in poorer health status and different health-seeking behaviours to people living in the city (Australian Institute of Health and Welfare 1998). The rural literature also suggests that rural people have not wholeheartedly embraced the concept of preventative health care, usually attending a health professional when their condition is well advanced and they need specialist help or emergency care (McCarthy and Hegney 1999; Humphreys and Rolley 1991).

Another factor influencing rural peoples’ decision to seek health care is their emphasis on productivity. For example, farmers often time their visits to health professionals to coincide with trips to town for supplies and periods when work on the farm, such as harvesting, is less intense (Elliott-Schmidt and Strong 1997). Furthermore, because many rural people define changes in health status in terms of their inability to work (Viens 1997), by their behaviour rural clients are emphasising cure rather than prevention.

This focus on cure rather than prevention has been reinforced by the health care delivery models of the majority of rural hospitals, which have been consistently organised upon biomedical models of care and where the emphasis has been on the delivery of acute services. This health care delivery has been funded on an historical basis rather than on a set criteria such as Diagnostic Related Groups. The reforms that have been introduced by the majority of Australian States and Territories, which are driven by economic rationalism and sociopolitical issues, have resulted in alterations in health service delivery – especially in the smaller rural hospitals. Rather than historical funding, rural health facilities in some Australian States are now expected to meet Casemix targets and justify expenditure by measurable health outcomes. Other Australian States, for example Queensland, continue to fund small rural hospitals on historical criteria.

Another change that is occurring, especially in small rural hospitals in Australia, is a change of focus in health care delivery from acute care to aged care. The introduction of the Multi-Purpose Model of health service delivery, which emphasises the principles of primary health care and the pooling of funds is resulting in new models of health service delivery in many rural communities (Humphreys et al 1997).

Similarly, the geographical and professional isolation of many rural nurses limits access to appropriate and affordable education and training programs and therefore their ability to update their knowledge and skills in order to accommodate these changes (Hegney et al 1997; Hegney 1996). The evidence indicates that change, particularly change driven by economic imperatives, does not necessarily benefit rural communities (Human Rights and Equal Opportunity Commission 1999) nor the nurses who care for them.

LITERATURE REVIEW

Characteristics of organisational change

In the past, similar to the majority of organisations, most rural health facilities were characterised by long periods of stability involving relatively slow-paced change. Several models of change propose that these stable ‘evolutionary’ periods are then interrupted by ‘revolutionary’ change, in which major organisational restructuring occurs (Duncan et al 1992). Revolutionary change in health services is triggered by external factors such as political, economic or social crises and by internal factors such as technological advance, human resource conflict or budget over-runs (Kreitner and Kinicki 1995).

The role of change

Whether the trigger for change is internal or external, evolutionary or revolutionary, change is a component of every modern health care delivery system and affects all employees within that system (Kitson 1997). If the tension generated by change is used creatively, it can harness personal and professional enthusiasm. The most effective change processes utilise deliberate actions which are embraced by nursing staff because they meet the demands of a given health care situation and will improve the quality of client care (Short 1997).
However, if the tension generated by change is not well managed, nurses within the organisation will feel vulnerable. They will be uncertain about their commitment to that health service and deliver less than optimum client care. They will also exhibit dysfunctional role stress reactions. According to Short (1997) these include:

- **Role overload**, which occurs when the demands of the new role exceed the nurse’s time and energy.
- **Role conflict**, when role changes result in dissonance between personal and organisational values, expectations and goals. For example, it is not uncommon in times of organisational change for managers to expect nurses to increase productivity and at the same time reduce resources.
- **Role ambiguity, role incongruity, role incompetence and role over-qualification**, all occur when nurses are under- or over-prepared for their new role, or are unsure of what is required of them within the new organisational structure.

**Strategies for change**

Different strategies for change are appropriate for different contexts. According to Baird (1998) the three most common strategies for implementing change are:

1. **The power-coercive strategy**, where those in positions of authority impose change from above. This approach is useful in situations demanding prompt or emergency action, such as the need to address acute budget over-runs which threaten the viability of a health service. Nurses often have minimal control over the change process when this strategy is employed, usually resulting in active and passive resistance to the change.

2. **The rational-empirical strategy**, where the view that the rationale for change is ‘marketed’ to nurses and they are informed about all aspects of the change, they will make reasoned and logical decisions concerning that change. However, the fundamental shortcomings of this strategy is that people rarely react rationally when they feel vulnerable in a changing organisational environment.

3. **The normative re-educative strategy**, which emphasises participation by key stakeholders in the change process and invests the power for change with these stakeholders. This approach assumes that nurses are committed to the cultural norm of altruism and will therefore accept change because it benefits their clients or their health service (Hagerman & Tiffany 1994). If used successfully, the normative approach harnesses nurses’ concern for ethical, informed decision making and challenges nurses’ entrenched norms, resulting in quality, client-centered care that is appropriate for the context of that health service. Unfortunately, because this strategy is time-consuming and assumes nurses want to participate in the change process, it is difficult to implement in times of revolutionary change when prompt and decisive action is required.

**Rural nurses’ reaction to change**

Regardless of the cause of change and the strategies used in its implementation, change in any health service arouses personal and professional conflict for nurses, who often do not welcome dramatic changes in organisational culture (Short 1997). In rural areas, personal and professional conflict in the face of change is likely to be triggered by factors different to those reported in metropolitan areas. This is because nurses usually provide more than health care in rural areas and it is often not only their nursing role at stake (Hegney et al 1997). Rural nurses and the health services in which they work are elemental to the economic and social fabric of the rural community (Strasser et al 1994). The closure or restructuring of a health service can therefore markedly effect not only the employment prospects of nurses, but also adversely affect the economic viability of the rural community. For example, rural hospitals are often the major employer and purchaser of goods and services in non-metropolitan communities. Closures and downsizing of rural hospitals also impact on other organisations within the community such as shops and pharmacies (Strasser et al 1994). It is well documented that the loss of nursing and medical services in rural areas has accelerated the recent decline of rural communities (Hegney 1996).

Restructuring the health service also precipitates the questioning of long-term loyalties and affiliations. In this climate of constant change it is becoming uncommon for metropolitan nurses to devote their professional nursing life to the one health service in return for job security and guaranteed promotion. Nurses in mid-career are the most adversely affected by radical organisational change because they have fewer opportunities for promotion, are forced into early retirement or their jobs within the organisation are eliminated altogether (Hegney et al 1997). For rural nurses, enforced career change is a significant threat as employment prospects in rural areas are limited unless they can leave the community to seek employment elsewhere. Many rural nurses who have partners who are farmers or in long-term employment, do not have this option.

As nursing is becoming increasingly profession-oriented, many rural nurses are experiencing conflict between their professional caring role and the economic restrictions imposed by organisations in a climate of change. As resources diminish, many nurses object to econometric models of health service delivery dictating the standard of health service delivery, as responsibility
and accountability for nursing care is central to the concept of nursing as a profession (Della and Lewis 1995). Coupled with the innate conservatism of rural nurses (Hegney et al 1997) the threat of role change provokes resistance as a natural coping strategy. For many rural nurses, it is safer to retreat behind a wall of familiar limitations until they have determined whether the change will be positive or negative, rather than invest energy into coping with a new system (Baird 1998).

This paper presents part of the findings of a national study of rural nurses and rural health services undertaken in 1996 (Hegney et al 1997). Rural nurses' perceptions of role change precipitated by organisational restructure are explored with reference to the work of Short (1997). Dysfunctional role stress reactions are discussed in terms of role overload, role conflict, role ambiguity, role incongruity, role incompetence and role over-qualification. The role stress reaction of role insecurity, not previously documented in the nursing literature, will also be described.

RESULTS

TYPES OF ORGANISATIONAL CHANGE OCCURRING IN RURAL AREAS

Quantitative data

Of the 129 facilities surveyed, 102 (79%) had experienced organisational change within the previous twelve months. Some facilities had undergone more than one of these changes. These included:

- conversion to Multipurpose Services (n = 24; 23.5%)
- amalgamation with other facilities (n = 20; 19.6%)
- implementation of Diagnostic Related Groups and/or Casemix funding (n = 6; 5.9%)
- preparation for, or awarding of, Australian Council of Health Standards (ACHS) accreditation (n = 6; 5.9%)
- unspecified closures (n = 8; 6.2%)
- unspecified expansion (n = 7; 5.4%)
- closure or decrease in midwifery services (n = 7; 5.4%)
- expansion of midwifery services (n = 5; 3.9%)
- downgrading (n = 5; 3.9%) or upgrading (n= 8; 6.2%) of surgical services
- increase in aged care caseload (n = 10; 7.7%).

Qualitative data

Of the 129 nurse respondents, 69 (53.5%) offered unsolicited comment about how such changes affected them personally, or the impact of change on the culture of the organisation. It is important to note that these comments are made in a context of high overall satisfaction with rural nursing practice amongst nurses participating in the study (Hegney et al 1997).

Positive response to change

Eight nurse respondents discussed how change caused by regional service restructuring had contributed to their role satisfaction. The main advantage appears to be the streamlining of services, rendering them more appropriate to the specific needs of the rural community. For example:

A newly created position of Patient Outcomes Co-ordinator to arrange preadmissions/admissions/transfers/discharges has revolutionised the care given here, as it is now well co-ordinated re: length of stay, appropriateness of management and good networking with all the community services for discharge.

Service restructuring can also be welcomed as a 'saviour' by rural nurses as it 'may be the only survival mechanism left' in some instances.

Change has empowered three of these nurse respondents. One nurse explained how recent implementation of the career structure in her health service proved a professional benefit:

(The career structure has) ...changed our approach to staff development and education ...(we now) routinely conduct inservice to meet the needs of staff and community ... (change has) resulted in positive steps towards care delivery at hospital and community level.

Personal empowerment is expressed by one nurse as:

... enjoyment of the role of a rural nurse, looking forward to the changes that are most likely to occur...

whilst another reflects that recent change has made ... protocols and procedures much clearer, and so is my role.

The many organisational changes caused by pursuit of accreditation are often perceived as beneficial because, in addition to streamlining services and promoting 'team-building', accreditation is an indication that the health service will continue to operate in the midst of uncertainty. One nurse found it 'reassuring to our continuing role as a regional hospital'.

Negative response to change

Comments on role changes were, despite overall satisfaction with rural nursing, more negative than positive. Many nurse respondents outlined one or more dysfunctional role stress reactions to organisational change as proposed by Short (1997).

Role overload

Role overload occurs when the health service delegates more responsibility to the nurse than they have either the time, energy or experience to fulfil adequately (Kreiner and Kinicki 1995; Tappan 1995). Seventeen nurses discussed nursing role overload within the context of
organisational change. Within the framework of this study, role overload was caused firstly, by health service reform requiring nursing staff to assume extra roles; and secondly, by changes causing a loss of nursing staff with no replacements to meet the same workload. Additionally, the continued loss of medical staff remains an important issue for nurses in rural areas. Whilst some nurses relish the challenge of ‘filling gaps’ in service delivery left by the departure of medical staff, they are ambivalent regarding the changes that ensue. As one nurse stated:

All this results in many RNs doing different courses, eg, first line emergency drugs. While we enjoy the extra challenge, the increased responsibility due to lack of doctors has increased stress in the workplace, no pay increase and no recognition.

The following three excerpts demonstrate that changes caused by preparation for accreditation, whilst ensuring the continued viability of the health service, also generate role stress, increasing the amount of work rural nurses are expected to accomplish within the same time frame:

*Developing manuals in small rural hospitals requires expertise, computer skills, time commitment and a willingness to put in additional time out of hours.*

*Because of the pressure placed on the hospital to become accredited there is increased workload but not increased staffing.*

*The workload has generally increased, it is no longer a joy to come to work, it is very stressful as there are not enough staff to cope with the workload ... I am currently undertaking a Graduate Diploma in employment relations so I can change my profession.*

Recent funding restrictions have also increased nursing workloads. As one nurse stated, this has:

*...created a situation where staff are working harder. Increases in documentation and workload with no extra staff ...*

The trend in many rural areas to reduce or out-source acute services, replacing them with cheaper aged care facilities, contributes to nursing role overload. One nurse notes an

*...increase in nursing staff dissatisfaction due to an increase in geriatric clients and therefore an increased workload.*

Whilst another mentions that the recent reduction in acute surgical funding means ‘no replacement of staff for ADO’s (annual leave) and no sick leave’, necessitating remaining staff doing extra work for the same pay.

**Role conflict**

Role conflict occurs when different departments within the same health service, such as corporate and nursing divisions, expect the nurse to comply with different sets of role expectations (Short 1997; Tappan 1995). It also occurs on a personal level, when nurses attempting to deliver patient-oriented care clash with organisational directives to conserve resources or comply with early discharge requirements (Kreitner and Kinicki 1995). Whether an organisational or a personal conflict, compliance with one role expectation precludes compliance with another. One nurse discusses this in terms of

*... tremendous stress and time consumed in attending meetings, answering phones etc due to the setting up of an MPS (Multi Purpose Service). We nurses are caught between the government and non-government bodies associated with this power play, which is now affecting client care.*

Another expressed concern that recent changes ‘have multiplied nurses’ organisational responsibilities, for example, increased documentation. This contributes to the ‘frustration staff experience’ in fulfilling the employer’s expectations whilst attempting to ‘provide reasonable patient care’.

Change theorists describe role conflict in terms of differing values or expectations associated with job performance. Tappan (1995) and Short (1997) extend the standard description of role conflict to incorporate the sub-categories of role ambiguity, role incongruity, role incompetence and role over-qualification. These sub-categories occur when employees are over- or under­prepared for their role, or uncertain of the employer’s expectations of their job performance. According to this interpretation, if a nurse is moved from a familiar position to a new position in an organisational restructure, such a role change may increase the nurse’s role conflict. This reaction could occur either because of lack of skills to perform the new role, or boredom and frustration if the skills they possess are not utilised in the new position. These four sub-categories of role conflict emerged as themes during data analysis.

**Role incompetence**

Seven nurses describe role incompetence in the face of organisational change. Some rural nurses accept this pressure as a professional challenge and an opportunity for growth. For example, as one nurse said:

*My (new) role as nurse manager is one I am still adjusting to with some difficulty, eg, management of co-workers and peers (hence) my involvement in a management course to rectify the areas in which I feel inadequate...*

*Surgical wards now closed and (surgical patients) now admitted into medical and obstetric wards mean staff had to become more multiskilled. ... (Due to theatre closure) midwives are currently being trained as instrument nurses for caesarian sections...*

Other nurses are perceived as failing to meet such challenges. One nurse describes rural colleagues facing
Role ambiguity

The failure of health services undergoing change to clarify their expectations to nurses and clients is problematic. Two nurses described the conflict that ensues:

(The introduction of) casemix funding is difficult ... the RN very tactfully attempts to change the expectations of an aged community who expect a long stay in hospital, only to find a different message has come from the medical officer.

We are working towards an MPS and accreditation (but) because of the continuing changes in the health system, eg new governments, regionalisation, budget cuts ... there is so much uncertainty with regard to job security, changes of job description and contracts. This is causing much anxiety to all.

Role incongruity

The findings of this study reinforce the need for health service managers to consult with nurses before implementing organisational change (Hegney et al 1997). The following response illustrates this:

Until 12 months ago my ratings of satisfaction would have been higher (but the) changes here have been monstrous. There is also a pressure to model work practices and manuals exclusively on the larger hospitals ... there is a loss of dignity and worth amongst nursing staff.

Role over-qualification

Change can be a threat to an employee's perceived expertise or status. This is magnified when change is beyond the employee's control and fails to utilise hard-earned skills. For example, loss of the local medical officer has meant one service is:

...now offering generous accommodation and support to a growing number of malingers who would not get in the front door of any other hospital. The effect of this on the nursing staff is a feeling of uselessness. Our skills are under-utilised and will gradually deteriorate, we worry about becoming complacent and possibly overlooking something serious. Morale is rock bottom.

Role insecurity

Finally, a sub-category of role stress not discussed in the metropolitan literature emerged as a distinct rural theme during data analysis. Nine nurse respondents mentioned the uncertain future of their organisation. According to these nurses, many rural health services operate on year-to-year funding or the chance of imminent closure as a fact of life. Such uncertainty presents a continual threat to the stability and security of rural nurses dependent on such services for employment. For example:

The centre is funded on a year to year basis which is a worry...

We lack job security due to the uncertainty of the future of our hospital.

This health service has amalgamated with another two, all of the administrative changes have not been completed to date and we are not sure what these changes will mean.

DISCUSSION

Characteristics of change in rural health services

The Role and function of the rural nurse in Australia study from which this paper is derived indicates that 79% of the health services surveyed had undergone significant organisational reform in the previous twelve months. Restructuring in these facilities included:

• A shift from acute medical services to multipurpose services with a primary health or aged care focus;
• Amalgamation or collocation with other services in the region;
• Closure or downgrading of services offered by the facility;
• Expansion of surgical and midwifery services;
• Implementation of Casemix and/or Diagnostic Related Group funding; and
• Major reform in preparation for accreditation.

Whilst only eight of the nurse respondents perceived these changes as positive, the comments made by the other nurses in this study regarding change should, however, be seen in the context of their overall satisfaction with rural nursing practice, as described in the parent study.

Because the nurses' comments were unsolicited, no part of the original questionnaire specifically investigated change in rural health services and it is often not possible to determine whether these changes were sudden or planned, or precisely which change strategy was used to restructure the health service. However, the intensity of the reaction to health service restructuring among nurse respondents indicates that the changes occurring are 'revolutionary' in nature. They are describing major change, driven by external factors such as political and economic reform and necessitating prompt, decisive power-coercive action imposed from above. The reform they describe is not typical of the past when slower 'evolutionary' transitions characterised a stable health care environment, where preparations for change were made slowly and with consultation, and where nurses generally accepted them and accommodated them with relative ease (Short 1997)
The responses also indicate that recent policies guiding rural health initiatives are ignored. According to these data, changes in rural health services are often driven by collaboration and consultation (McCarthy and Hegney 1999; Strasser et al. 1994) oblivious to accepted frameworks of service delivery for rural people based on needs analysis and community consultation (AHMC 1999).

**Nurses’ functional reaction to change**

Nurses in the study responded positively to changes when they accorded with the rural ethos of community collaboration and consultation (McCarthy and Hegney 1999), for example, when the changes harnessed a team spirit to streamline services and meet the expressed needs of the community and nursing staff. Changes were particularly welcome when they led to clarification of procedures, or assured the viability of the health service in an unstable sociopolitical environment.

Well-managed change results in organisational and professional enthusiasm. It generates creative approaches to long-standing problems, greater productivity and functional adaptation to reform (Gordon 1996). On an organisational basis, successful change is more likely when all involved understand the need for change, have clear goals and objectives, and share an explicit set of values to guide the reform (Nolan and Grant 1993). The literature indicates that it is also important to consult and collaborate with the key groups affected by the change process and to ensure adequate feedback and corrective action following the implementation of change (Petro-Nustas 1996; Geraci 1996). On a professional level, successful change allows for nursing care that is holistic, co-ordinated, continuous and consistent (Kitson 1997). If nurses are able to develop and maintain their own responsibilities, they are better able to cope with major restructuring.

**The dysfunctional reaction to change**

Negative responses to change in the study occurred when the nurses perceived they had minimal control over the process and the change was clearly implemented by way of the power-coercive strategy. Organisational restructure imposed without nursing consultation resulted in resentment of extra workloads; inappropriate models of nursing practice; minimal perceived personal or professional benefit from the change; conflict between community, nursing and organisational expectations of role performance; failure to utilise the skills of nurses or downgrade them; and threats to job security.

The literature describes numerous maladaptive personal responses to major organisational change, all of which emerged during the study (Short 1997; Gordon 1996; Petro-Nustas 1996). They include denial, fatigue, withdrawal, anger, depression, anxiety and feelings of worthlessness. On an organisational level these reactions may result in reduced productivity, poor morale, lack of commitment to the health service, high rates of absenteeism and sick leave, high staff turnover and workplace violence (Short 1997).

**The role of the nurse in change**

A refrain that emerged during analysis of the negative comments can be described as the ‘nurse as victim’. While the study did not actively seek the data concerning change, these casualties of change give no indication that they sought any form of external support or information, or chose to be actively involved in the change process. McConnell (1998) argues that even if nurses have minimal control over health service restructures, they still have choices. They can choose how they will approach these changes and which personal skills they can transfer to the new order. They can choose to participate, to learn the economics of health care and the internal and external factors that trigger change. They can choose to ask questions, to seek knowledge and to use that knowledge to benefit themselves, their clients and their profession. Ultimately, accorded control over the health service restructure or not, whether they survive and thrive during the change to a great extent depends on the attitude of the individual nurse.

**The role of the manager**

It is obvious that for role changes to be fully accepted, nursing staff need to be involved from the planning stage and adequately supported through the change process (Petro-Nustas 1996; Geraci 1996; Nolan and Grant 1993). When change is imminent, management should ensure a sound and flexible plan to implement the transition. Staff should be kept fully informed through consultation, team-building and education sessions. In addition, management must be open about any actual or potential role or job losses (McConnell 1998). The key to successful health service reform in rural areas is flexibility and enabling local groups of nurses and community to influence the bigger picture.

**CONCLUSION**

Change has been an inevitable and regular feature of rural health service delivery that has not necessarily benefited rural communities or rural nurses. Rural nurses respond positively to such reform when it accords with the rural ethos of community collaboration and consultation. Functional reform is also perceived by rural nurses as streamlining the organisation to enhance the long-term viability of the health service, in addition to empowering the nurse and clarifying or extending their professional
Rural nurses respond negatively to change that causes role overload, role conflict or role insecurity, particularly when they have minimal control over a change process that does not accord with rural norms which value community collaboration and consultation.

It is important for rural nurses to become actively involved in the change processes that affect both their livelihood and their community. It is also important for health service management to encourage nurses' involvement in planning change. As a result of the consistent comment by these rural nurses on the effects of organisational change upon their personal and professional roles, the Role and function of the rural nurse in Australia study recommended that health service managers undergo training. This training should enable them to implement flexible strategies to deal with change in rural areas, focusing upon improving interdisciplinary and community involvement and co-operation.

REFERENCES


