

*Résumé*

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## **L'apprentissage des soins de maternité : l'expérience du personnel infirmier en milieu rural**

**Karen MacKinnon**

Deux monographies examinent l'expérience du personnel infirmier prodiguant des soins de maternité dans les milieux ruraux de la Colombie-Britannique, au Canada. Les auteurs de ces études ont d'une part réalisé des entrevues auprès d'infirmières et infirmiers de première ligne, de gestionnaires et de prestataires de soins de santé, et d'autre part observé les pratiques de ceux-ci. L'une des principales difficultés cernées par les infirmières et infirmiers en milieu rural est de veiller à ce que du personnel infirmier compétent et averti dans le domaine des soins périnataux ou de maternité soit disponible en permanence dans les hôpitaux régionaux. Il est aujourd'hui difficile pour le personnel infirmier travaillant dans de petits hôpitaux en milieu rural d'acquérir les compétences nécessaires pour offrir des soins de soutien et de maternité sécuritaires en raison de la baisse des taux de natalité, de l'augmentation des charges de travail et de la diminution des possibilités de mentorat. Les décisions d'allouer au personnel infirmier en milieu rural des congés autorisés et des ressources pour de la formation professionnelle continue (FPC) s'articulaient autour de discours mettant de l'avant la responsabilité personnelle des infirmières et infirmiers à l'égard de la « compétence continue ». Ces méthodes de travail institutionnelles contribuent à accroître le fardeau du personnel infirmier en milieu rural, et ont de ce fait une influence négative sur l'accès des infirmières et infirmiers à de la FPC et sur l'expérience que celles-ci et ceux-ci vivent lors de la prestation de soins de maternité, ce qui a des répercussions tant sur la santé des bénéficiaires des soins que sur la conservation du personnel infirmier.

Mot clé : formation professionnelle continue

# **Learning Maternity: The Experiences of Rural Nurses**

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Two research studies explored rural nurses' experience with the provision of maternity care in rural British Columbia, Canada. Frontline nurses, managers, and health-care providers were interviewed and their practices observed. One of the main challenges identified by rural nurses was ensuring that a knowledgeable/skilled maternity or perinatal nurse was always available at the local hospital. Learning how to provide safe and supportive maternity care is difficult for nurses working in small rural hospitals today due to declining birth rates, increased workloads, and a decrease in opportunities for mentoring. Decisions about the allocation of time off and resources for rural nurses' continuing professional education (CPE) were structured by discourses of personal responsibility for "continuing competence." These institutional work processes increase the burden on rural nurses, negatively affecting their opportunities for CPE and their experiences of providing maternity care, with implications for both patient safety and nurse retention.

**Keywords:** rural nursing, nursing education, continuing professional education, maternity nursing, institutional ethnography

Over a 4-year period, two research studies guided by institutional ethnography (IE) were conducted to explore rural nurses' experiences with the provision of maternity care in the Canadian province of British Columbia. Registered nurses (RNs), managers, and other health-care providers working in nine rural communities participated. Findings from these studies indicated that rural nurses practise autonomously and demonstrate a deep sense of commitment to and responsibility for the people living in their communities. The RNs described caring for childbearing women and their families while at the same time being responsible for the safety of all of the patients in the rural hospital (MacKinnon, 2008). The purpose of this article is to report on an additional analysis of the data exploring one important aspect of rural nursing work: how rural nurses learn to provide maternity care and the social organization of their learning experiences.

## **Background**

Lack of access to maternity services in rural settings increases the stress and vulnerability of childbearing women (Kornelsen & Grzybowski, 2005a). Recent trends reflect an impending crisis in the provision of

maternity care for Canadian women (Kornelsen & Grzybowski, 2005b). In rural Canada there is a shortage of health-care providers, including nurses (Canadian Nurses Association [CNA], 2002). Addressing this workforce shortage will require not only new models of collaborative practice (Minore & Boone, 2002) but also better ways to support the readiness of health-care providers, including nurses, to provide maternity care (Rogers, 2003).

### **Literature Review**

Global nursing shortages and the aging nursing workforce have created a crisis situation for the staffing of many rural hospitals in Canada (Stewart et al., 2005). Researchers have identified the provision of affordable and accessible education programs as an important strategy for recruiting and retaining rural nurses (Hegney, McCarthy, Rogers-Clark, & Gorman, 2002). MacLeod et al. (2004) found that targeted funding is needed for education programs that prepare nurses for the realities of rural and remote nursing practice. There are descriptive accounts of such programs (MacLeod, Lindsey, Ulrich, Fulton, & John, 2008; Smith, Emmett, & Woods, 2008). In Canada, most nurses receive their entry-level education in larger centres, but regional programs in smaller cities are rapidly developing. Some nursing education programs have included the option of rural clinical placements to help rural communities recruit new RNs (Neill & Taylor, 2002; Van Hofwegen, Kirkham, & Harwood, 2005; Yonge, Ferguson, & Myrick, 2006).

A Canadian study of nurses' migration patterns determined that the majority of RNs who migrate to a big city to go to school do not return to their original community (Pitblado, Medves, & Stewart, 2005). Partnerships between urban and regional education programs and rural communities have been proposed (McCoy, 2009) and preceptorship programs and/or internships for rural nurses have been recommended to help new graduates make the transition to assuming responsibility for complex and varied rural nursing work (Lea & Cruikshank, 2007).

Jukkala, Henly, and Lindeke (2008) report that rural nurses want educational opportunities that are relevant to rural practice and accessible in rural settings. Challenges to continuing professional education (CPE) include physical isolation, heavy workloads, small professional networks, and financial constraints. Other barriers to CPE access include poor technologic and communications infrastructure and lack of funding to support travel and registration fees (Curran, Flett, & Kirby, 2006). Penz et al. (2007) found that removing the barriers to participation improved job satisfaction, with implications for retention of rural nurses.

## **Rural Nurses' Experiences With the Provision of Maternity Care**

Our research team conducted two projects exploring the social organization of nursing work and seeking to identify possibilities for changes in health policy, nursing education, and nursing practice environments (MacKinnon, 2009). In the first study we interviewed and observed the practice of 16 RNs working in hospital settings and 21 public health nurses serving as expert informants. In the second study we interviewed 42 hospital and 9 public health nurses, resulting in a total of 88 interviews with RNs. In addition, 10 other health-care providers (including physicians, midwives, a physiotherapist, and two Licensed Practical Nurses) and 10 frontline service managers were interviewed about their experiences working with rural nurses. The initial findings of these interviews have been analyzed and are reported elsewhere (MacKinnon, 2008, 2009).<sup>1</sup> The current research explores additional “threads” or areas that emerged from the second study and that warrant further investigation.

### **Methodology**

Institutional ethnography, which was developed by the Canadian sociologist Dorothy Smith (1987, 2005), focuses attention on the *socially organized* character of everyday life. The goal of IE is not to explain people's behaviour but to be “able to explain to them/ourselves the socially organized powers in which their/our lives are embedded and to which their/our activities contribute” (Smith, 1999, p. 8). Beginning from the standpoint of rural nurses provides an entry point into the institutional relations that organize their experiences. In an IE study, researchers identify “threads” or traces of social organization that warrant further investigation. This article is the result of a thread that was identified; something important was going on related to nurses' experiences of learning to provide maternity care in rural settings.

### **Context for Rural Maternity Nursing Work**

Both studies used a working definition of a rural community as less than 10,000 people living beyond commuting distance of an urban setting (duPlessis, Beshiri, Bollman, & Clemenson, 2001). The second study (reported on here) included five communities that fit this definition. The study took place in a mountainous interior region of British Columbia near the Rocky Mountains where high mountain passes, snow and ice in the winter months, and deer on the highways make travel treacherous.

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<sup>1</sup> See MacKinnon (2008) for more details on the research methods.

In one of these communities the hospital had recently closed, forcing women to travel to a neighbouring community to receive hospital care during labour and childbirth.

The four remaining hospitals ranged in size from eight acute-care beds (two hospitals with residential or long-term care provided in an adjoining building) to 20 acute-care beds (also two hospitals). Over the last 5 years the average number of births in these hospitals has ranged from 26 to 94 per year (see Table 1). Day surgeries were provided in all but one of these small community hospitals. The hospital with the lowest number of births was struggling to maintain “low risk” obstetrical services (no oxytocin inductions were initiated and few women gave birth to their first baby in this hospital). The other three hospitals had experienced periodic operating room closures when it was not possible to guarantee the availability of the skilled health-care providers (physicians and nurses) needed to ensure a safe emergency Caesarean delivery.

**Table 1** *Number of Births per Year, by Hospital, for the Years 2003–04 to 2007–08*

	2003–04	2004–05	2005–06	2006–07	2007–08	Average
Creston (20 acute-care beds)	85	65	75	56	75	71.2
Elk Valley (20 acute-care beds)	94	104	88	81	103	94
Golden (8 acute-care and 26 residential beds)	63	65	74	77	60	67.8
Invermere (8 acute-care and 35 residential beds)	20	30	28	31	21	26

Source: [www.bcphp.ca/Deliveries%20by%20Maternal%20Residence%20Tables.htm](http://www.bcphp.ca/Deliveries%20by%20Maternal%20Residence%20Tables.htm)  
(retrieved November 15, 2009).

### ***Investigative Methods***

In an IE study, participants do not constitute a sample but rather serve as a panel of expert informants. This study began from the standpoint of rural nurses, with the goal of exploring how nurses’ experiences of providing maternity care are influenced by institutional practices. Data-collection methods for both studies included observations of/interviews with nurses, textual analysis, and follow-up interviews with informants. In the current analysis, we reviewed the nurses’ experiences of learning

to provide maternity care in a hospital setting and investigated how those experiences were organized such that they are repeated across time and place.

### ***Institutional Analysis as an Analytic Approach***

In IE, the goal of analysis is to make visible the complex practices that coordinate the actions of women, nurses, and other health-care providers (Campbell & Gregor, 2002). Analysis of the nurses' interview transcripts included describing the complexity of the nurses' work, listening for traces of social organization in their talk, and mapping out how their experiences intersected with those of the managers and the other health-care providers. Participant observation in the hospital setting helped to identify the key texts that mediated the interactions between the women, the nurses, and the other health-care providers. Further analysis of these transcripts and texts was guided by the work of McCoy (2006).

### ***Ethical Considerations***

Ethical approval for the study was obtained from the research ethics boards of the university and all three health regions involved. The integrity of the study (Koch & Harrington, 1998) was addressed by making the decision-making process as transparent as possible through the use of field notes and reflective journals. We also sought confirmation of the findings by asking for feedback from the nurses/other participants in response to Community Information Sheets that summarized the key findings developed from the preliminary analysis.

### ***Limitations***

The findings of this study are necessarily limited to the particular historical and social context explored in one western Canadian province. However, the social relations identified may be of interest to other researchers concerned with investigating the social organization of rural nurses' work and nurses' experiences of CPE.

## **Findings**

The analysis that follows, which has not been previously reported on, focuses on the experiences and concerns of nurses who work in a rural hospital setting. These rural nurses experienced difficulty learning how to provide safe and supportive maternity care. Nurses' learning was found to be particularly difficult in communities with low birth rates. In many of these communities the birth rate was considerably higher in the past and many of the older nurses had learned "how to do" maternity nursing

“on the job” and from each other (sometimes with support from a British-trained nurse midwife).

### ***Experiences of New Nurses***

Nurses were asked to describe their experiences of providing maternity care. Almost without exception, new nurses (which we defined as nurses with less than 5 years of nursing experience) said that initially they were scared (“scared to death”). One new nurse described a recent experience:

*It was a night shift, and right when we came out of report at 8 [o'clock] at night I already had 11 patients. And then a maternity walked in . . . We were so busy . . . and understaffed, it was crazy . . . and then we had this maternity that walked in. And she said, “I’m in active labour!” So I called the doctor and I went . . . I’ve only done a vag exam once, so I don’t even know what I’m feeling.*

*. . . I think the doctors are upset that we don’t have enough staff, or qualified staff, to look after the maternity. They get a little upset that not all of us have the same background. And there are things that they’ve been doing for years and they get quite upset — “Well, everyone knows you’re supposed to do that!” And it’s like, “Well . . . I’m new, I don’t know what I’m doing. So, you know what? You have to spell it out for me, because I don’t know.” And, you know, it’s just not safe. Well, it’s turning me off of maternity, really.*

This new nurse was learning to provide maternity care in an environment that did not support her learning. She was also concerned about the physician seeing her as an “incompetent nurse” so had become reluctant to provide maternity care for women in her rural community.

### ***Learning Experiences***

New nurses told us that their nursing education programs had little content on maternity care. New RNs said that that they may have had one “theory” course but it was often “integrated” with other specialty areas, including mental health and pediatrics. Participants described learning to assess and provide care for postpartum women and their newborns but said that they had very little exposure to childbearing women during labour and birth. The following comment illustrates new nurses’ educational preparation:

*P1: As for our schooling, we did 4 weeks practicum, so really, nothing. . . . I’m not comfortable with maternity at all.*

*P2: Four weeks, but 2 days a week . . . so 8 total days of maybe 6 hours a day. And the first week was, like, seek and find.*

These nurses had spent a total of 48 hours learning to provide maternity care in a hospital setting. When asked specifically about opportunities to provide nursing care during labour and birth, most new nurses told us that they had observed one or two births, and frequently one or both of these was a Caesarean.

### ***Learning Maternity Nursing “On the Job”***

Many experienced nurses told us that they learned maternity care “on the job” under the watchful eye of an experienced maternity nurse or a British-trained nurse midwife. They stressed that in the past the number of births was higher and childbirth seemed less complicated and required less technology. Some of the more experienced nurses stressed that they had learned that birth is a healthy life process for most women, although some also shared their experiences of having to deal with difficult situations.

New nurses explained that it is difficult to learn maternity in small rural hospitals today, in an environment where few staff members are available and little education is provided. When speaking of her early experiences, one new nurse said:

*I graduated and went to [northern hospital] . . . and talk about throwing me in! . . . I had six orientation shifts and during those six orientation shifts there were no babies.*

When we asked specifically about orientation provided for maternity nursing, we learned that practices varied considerably. One new RN described her orientation as follows:

*It was all of about 45 minutes . . . And I was given a book to read. And we went over the infant warmer that we have . . . But it's not really . . . I mean, you can't just do things once and then expect to know it. That's just not the way it is. And that's not the way I learn, especially things that are brand, brand new to me.*

This nurse stressed that she had informed her employers that she had no maternity experience, although she did have experience in medical/surgical and intensive care nursing. Another new nurse told us that in the 6 months she had been working at the rural hospital she provided maternity care five times and in three of these cases she was the only RN available, and therefore was not mentored or supported by a more experienced nurse. Some new nurses learn maternity by being “thrown in,” without the benefit of mentoring by a more experienced nurse and in an environment where safe maternity care is almost impossible, thus contributing to nurses being “turned off” providing maternity care.



Other new RNs were supported in obtaining additional education before being “allowed” to provide care for women in labour. The following nurse received funding to take part in a Perinatal Nursing Certificate program. As part of the program she went to a regional centre to gain some maternity experience 1 year before the interview. She also assisted at a birth the morning of the interview:

*We did a practicum at the end. I went to [regional centre] for a . . . whole month and got really good experiences. I actually got to deliver a few babies. And when I came back here I delivered a baby in the toilet one day. It was a good experience.*

*I'm a new nurse and it's a bit scary only because you don't see [a sufficient] volume of maternity patients to stay experienced. It'll be a few months, and the anxiety goes up. And this morning it was like that in a sense, but it was nice because it wasn't her first baby. She was relaxed and everything was good for her. And you just have to feel like you know things . . . the baby's healthy, the mom's healthy . . . It can be a little bit nerve-racking . . . I'd like to have more courses, for sure. I'd like to have the whole program. But I think with experience it will be better . . . I'll take any [maternity] courses that are available.*

This nurse's account contrasts sharply with that of the previous speaker. Her experiences were “a bit scary” and her concern was more about staying “experienced,” or retaining her newly acquired skills. This new nurse also worked in a setting in which an experienced maternity nurse was always available as a mentor. Some of the hospitals we visited had established a requirement whereby a nurse had to have “education plus experience” *before* being expected to provide maternal care during labour and birth (unless an experienced nurse was working somewhere in the hospital and was available in case an unusual situation should arise).

Experienced nurses acknowledged that they had been mentored to “learn maternity” by an experienced maternity nurse and that they had *never been left alone until they knew what they were doing*. They said that birth rates and staffing levels have changed and expressed concern that such practices as mentorship were no longer available for new RNs:

*I think for a lot of new nurses they get so [few] deliveries. We had an RN here we were training for nursing, and she's been involved in one delivery. That's all she's had in her whole training. One. And so what kind of training is that? You stick this person . . . in a labour room without much help, because the rest of the floor has gone crazy — whatever else [is] happening in a rural setting — this person is lost.*

Experienced nurses did not believe that one birth was enough for a nurse to learn how to provide safe and supportive care during childbirth. They

were also concerned about “keeping their own skills up” and described the provision of maternity care as “hit or miss.” One nurse spoke of low birth numbers and her “comfort level”:

*We only have about 35 deliveries a year. You dilute that down between — how many nurses? There’s probably 20 RNs . . . So even if you like maternity and you think you know your stuff, sometimes I go through a dry spell and I won’t have a maternity for 4 months.*

Experienced nurses working in small rural hospitals wanted an opportunity to “refresh” their skills by working a few shifts in a slightly larger regional centre. Most of them also told us that it would be difficult for them to get away for more than a week because of family commitments. Experienced RNs also told us that they valued opportunities to hone infrequently used skills (such as handling a breech birth, shoulder dystocia, or a newborn in distress), preferably within interprofessional teams, since “we all have to work together.” Programs such as ACoRN, MORE,<sup>OB</sup> and ALARM<sup>2</sup> were identified as exciting opportunities for team learning.

### ***The Social Organization of Continuing Professional Education***

Rural acute-care nursing has been described as “multi-specialty” practice (MacLeod et al., 2008), and nurses in our studies described the difficulties they encountered in maintaining all the required “certifications,” particularly in this era of “evidence-based practice” and professional responsibility for “continued competence.” The rural nurses told us that their greatest challenges in terms of care were emergency, acute mental illness/substance use, and maternity, and that all but maternity could be learned in the rural setting. We also learned that, since the operating room is intimately tied to the ability to perform a Caesarean section, peri-operative nursing is similar to “maternity nursing” in that it calls for experience gained at a larger, regional hospital. Our participants were also adamant that going to a big city to learn maternity nursing “does not work,” because a rural hospital nurse is not able to access all the “fancy teams” available to RNs working in the city and childbirth at a rural hospital is “low tech” and “more normal.”

One younger nurse described how fortunate she was to be able to take a perinatal nursing course that was funded by her employer, but she was concerned because funding had recently been cut, affecting one of her colleagues:

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<sup>2</sup> Information about ACoRN can be obtained from the BC Perinatal Health Program Web site at [www.bcphp.ca/ACoRN.htm](http://www.bcphp.ca/ACoRN.htm). Information about ALARM and MORE<sup>OB</sup> can be found at [www.sogc.org/index\\_e.asp](http://www.sogc.org/index_e.asp).

*Another girl took the same course I did, but that funding has been cut so she still hasn't done the practicum . . . She said she would go do it if there was money . . . you're spending your own time . . . you're learning and you're improving your nursing knowledge and experience. . . it's hard to go take those courses away from your job . . . you'd have to take a leave and use your holidays or something.*

Another new nurse told us that she was frustrated at being unable to attend the required neonatal resuscitation program (NRP):

*I know they provide courses, but they're not always convenient . . . the NRP [course] was offered but I couldn't take it . . . I was a full-time employee . . . all the casuals took the course and I couldn't get time off to take it . . . It's crazy, because I'm there all the time. So now I just say, "Well, I'm not doing the baby." You know, I'll go in, and I'll do mom, but I'm not . . . going to do the baby, because they set themselves up for it.*

She clearly understood that to be the "baby nurse" at a delivery one needs to have NRP certification. Since she was not given an opportunity to take this course, she felt that she should decline to care for the newborn.

The following nurses were part of a small focus group and are talking about how local staffing rules influenced their ability to participate in continuing education:

P1: *If I decide to take 4 hours off for something [CPE], it's really difficult . . . they don't like that because they don't . . . it has to be the full shift—*

P2: *—and we're not able to give away a shift either. Sometimes there are casuals who are looking for shifts . . . When I worked in Alberta as a casual nurse, they [full-time RNs] would say, "Can you work this shift for me, and this?" And I'd say, "Yeah." And they'd fill it in and they'd take the days off as LOAs [leaves of absence] or vacation. Here, you can't give up a shift; you have to repay.*

These comments suggest that decisions about the allocation of time off and resources for rural nurses' CPE are structured by something other than the learning needs of the nurses involved. Rural nurses also described having family commitments that made it difficult for them to leave their community for CPE. Nurses who worked full time told us that it was difficult for them to leave because there was no nurse available to replace them at the hospital. Having skilled nurses available to provide maternity care in hospitals during labour and birth is therefore becoming increasingly difficult.

Although there are few registered midwives (RMs) working in rural British Columbia, we spoke with some RNs and RMs who had been working together. We learned that nurses who had worked alongside RMs had collaborative relationships with them and the two professionals were open to learning together. In British Columbia, and in most of Canada, midwifery and nursing have separate regulatory bodies. Since midwives have been recognized as the “experts” in normal childbearing, they can play an important role in educating and supporting rural nurses. Canadian educators, regulators, and health-service planners could look to international models where nurses and midwives work closely and learn together.

## **Discussion**

Nurses have revealed that the skills required for managing normal labour and birth (and for resuscitating/stabilizing the woman/newborn) are the most difficult for them to acquire/maintain. Applying IE methods, we can evaluate how discourse — the organizer of experience — affects the work of these rural nurses. Discourse can be understood as the circulation of ideas or concepts through talk, text, and media or other images. Two discourses stand out in this study: tensions between generalist and specialist work, and issues of professional responsibility.

### ***Exploring Generalist and Specialist Tensions***

Nurses clearly identified maternity nursing as a form of specialized practice, and it was the care of women during labour and birth that caused them the most concern. Nurses described their work as the “intensive care” of the perinatal period and indicated that things could “go south” very quickly, with devastating results. Perinatal loss has been shown to be traumatic for both nurses and physicians, affecting their willingness to continue providing maternity care and/or to remain in their rural community (Grzybowski, Kornelsen, & Cooper, 2007).

In Canada, perinatal nursing is a recognized specialty and is understood as providing nursing care for childbearing women from conception through the postpartum period. The specialty discourse reflects the range of settings (including the woman’s home) where nurses provide care for childbearing women and their families (CNA, 2009). Although generalist nurses working in small rural hospitals described having benefited from education around the entire childbearing period, most hospital nurses needed to focus their *initial learning* on a narrower range of competencies, particularly those required for the intrapartum and immediate postpartum periods.

Because of health-care reforms over the last decade, employers have had their education budgets severely reduced so that they can no longer provide a sufficient variety of continuing education programs. Nurses working in different specialty areas now have to compete for continuing education funding or pay for the education themselves.

### ***Discourses on Professional Responsibility***

Recent changes to the scope and regulation of nursing work have resulted in the assigning of responsibility for “continuing competence” to individual nurses:

Registered nurses (includes licensed graduate nurses) are lifelong learners who continually assess and improve their practice. To be eligible to renew practising registration in British Columbia, CRNBC registrants must meet two continuing competence requirements: practice hours, and personal practice review. When registered nurses meet CRNBC’s annual continuing competence requirements, they indicate to the public that they take their professional development obligation seriously and that they are maintaining their competence to practise. Meeting the obligations of continuing competence is one way registrants maintain the public’s trust. (College of Registered Nurses of British Columbia [CRNBC], 2009a)

This text provides a concrete example of how continuing competence is being constructed as the responsibility of the *individual* RN. This ongoing competence discourse can have a negative impact on rural nurses’ opportunities for CPE. Nelson and Purkis (2004) show how self-surveillance procedures shift responsibility for professional development from the employer to the individual nurse.

Also, in the past nursing associations played an important role in helping nurses to acquire/maintain the knowledge and skills needed for professional nursing practice. In British Columbia the introduction of the *Health Professions Act* in 2005 meant that the professional nursing association was replaced by the College of Registered Nurses, which has a regulatory mission. The primary role of the CRNBC moved towards protecting the public through “quality assurance.” In a recent paper on “working within limited resources,” the CRNBC described employer responsibilities as follows:

Employers are responsible for ensuring that there is a sufficient number of competent staff. Employers must also ensure that registered nurses are supported to work within their own level of competence. (CRNBC, 2009b, p. 16)

This document is silent on any employer responsibility to support nurses’ CPE.

Collective bargaining agreements can also provide a means to interpret the issue of professional competence and personal responsibility. We found that bursaries are available to members of the British Columbia Nurses Union, depending on the “member’s job classification and collective agreement” (British Columbia Nurses Union [BCNU], 2009b). However, the institutional structure of the unions rewards seniority and disadvantages younger nurses and those who do not have a full-time position. Rewarding seniority without regard to work setting can serve to obscure differences in the knowledge and skills needed for nursing work.

We learned that if the employer “requires” or “approves” the education program, the employer is responsible for the RN’s expenses:

An employee shall be granted leave with pay to take courses at the request of the Employer. The Employer shall bear the full cost of the course including tuition fees and course required books, necessary traveling and subsistence expenses. Courses identified by the joint OH&S Committee to promote a safe and healthy workplace and approved by the Employer, shall be treated like Employer requested leave. (BCNU, 2009a)

However, when a nurse requests CPE, the employer is obliged to grant only 1 education day and to reimburse the nurse for expenses. Analysis of the collective bargaining agreement reveals why CPE for nurses has become “contested ground,” particularly in this era of health-care reform and budget cuts. Since RNs are the largest group of employees working in acute-care hospitals, support for nursing CPE can be an expensive budget item, requiring justification and close scrutiny. The experiences of rural nurses have also been influenced by management discourses of scarcity, cost-effectiveness, and practices grounded in decentralized cost accounting (Rankin & Campbell, 2006), which can have far-reaching effects on health care and many other sectors that receive public funding.

Researchers have demonstrated that investment in CPE for nurses can result in cost savings due to lower turnover rates and improved retention (Levett-Jones, 2005). In our study, local managers were shown to be very creative in finding money for “their” nurses. However, increased funding and more transparency would permit better cost-benefit analysis. More flexible staffing processes might also enable local solutions and informal arrangements between nurses. Rural nurses need to be recognized for their contributions to maternity care and for their complex and multi-specialist work in hospital settings. Further research is needed on how to support a culture of lifelong learning among acute-care and rural nurses.

## Conclusion

We have shown that rural nurses' experiences of "learning maternity" are influenced by declining birth rates, increased workloads, and a dearth of mentoring opportunities. Current discourses locate responsibility for CPE with the individual nurse, while the need for education in multiple "specialties" adds to the burden of rural nurses. Employers and nursing leaders need to recognize the unfair burden placed on rural nurses. Nursing unions could play a role in addressing the issues entailed in recognizing differences in the knowledge and skills required for nursing work in different settings.

"Specialty" discourses and the social construction of responsibility for continuing competence displace local knowledge about the needs of rural nurses. Nursing regulatory bodies need to focus their efforts on supporting nurses' learning/maintaining the complex knowledge and skills required for rural nursing as a strategy for ensuring patient safety and fulfilling their mandate to protect the public. We need to break down the professional barriers to interprofessional collaboration and learning now, to avert the "crisis" in rural maternity care in Canada. Collaboration with the College of Midwives could be explored. At stake are the future of some of our most vulnerable citizens and the viability of our rural communities.

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