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特　集

日本ルーラルナーシング学会設立記念

Japan Society of Rural and Remote Area Nursing

Rural and Remote Area Nursing国際研究集会
－その実践、教育、研究－

プログラム

日　時　　平成17年4月2日（土）～4月3日（日）
場　所　　4月2日　自治医科大学　地域医療情報研修センター
　　4月3日　自治医科大学　看護学部

通訳　柴山森二郎（駿河台大学文化情報学部　教授）

4月2日（土）
9：00－　9：45　受付

司会　成田　伸（自治医科大学看護学部　教授）
9：45－10：10　「Rural and Remote Area Nursing国際研究集会」の目的について
野口美和子（自治医科大学　看護学部長）

Ⅰ　へき地における看護実践と教育

座長　松田たみ子（自治医科大学看護学部　教授）
10：10－11：20　「Rural Nursing is More Than Just Learning Tasks：A Canadian Perspective」
Kathryn Crooks（Medicine Hat College, Canada, Coordinator Undergraduate Nursing）
11：20－12：00　「へき地等地域病院への派遣が看護実践能力向上にもたらす教育的効果」
菊池睦子（自治医科大学附属病院　看護部長）

Ⅱ　へき地における看護実践と研究

座長　宮崎美砂子（千葉大学看護学部　教授）
13：30－14：40　「Elderly People living Independently at Home using Home Telecare and Regional Seamless Services」
Helli Kitinoja（Seinayoki Polytechnic, Finland, Head of International Affairs）
14：40－15：15　「沖縄県の一離島における高齢者の地域ケアシステム構築」
大湾明美（沖縄県立看護大学老年保健看護　助教授）
15：30－16：40　「Overview of Rural Nursing in Australia」
Karen Francis（Monash University Gippsland Campus School of Nursing, Australia, Professor）

4月3日（日）
10：00－12：00　分科会

分科会1　へき地における看護実践と看護教育

ファシリテーター　篠澤倪子（自治医科大学看護学部　教授）

分科会2　へき地におけるネットワーク作りと研究

ファシリテーター　松田たみ子（自治医科大学看護学部　教授）

分科会3　へき地における看護実践と研究

ファシリテーター　成田　伸（自治医科大学看護学部　教授）

Rural and Remote Area Nursing 国際研究集会の目的

日本ルーラルナーシング学会
理事長　　野　口　美和子

みなさん、おはようございます。これから、Rural and Remote Area Nursingに関する国際研究集会を開催いたします。この国際研究集会は、３月３日に誕生したばかりの日本ルーラルナーシング学会の開設記念にいたしました。できたての学会でしたから、また４月という日本ではとても忙しい時でしたので、極小規模になると当初考えておりました。しかし、多勢の方々のご参加を得て、開催できますことをとても嬉しく思います。

本国際研究集会の目的を述べます。まず、第１日目においては、先進的にRural and Remote Area Nursingの実践と教育、研究を進めてこられた方々を外国からお招きし、その取り組みをお聞きし、またわが国で行われている実践、研究の一端をも御紹介して、それぞれのお国柄、それぞれの地域の課題とその実践研究を理解することです。そして、第２日目は、これを受けて、これからのRural and Remote Area Nursingの実践、教育、研究の課題と実践・教育プログラムの開発と研究課題について討論をすることです。これによって、生まれたばかりの日本ルーラルナーシング学会に、光と水をいただけると考えました。

私の所属する自治医科大学看護学部では、平成15年度にへき地に勤務する看護職を対象に調査を行いました。その調査結果から、へき地診療所を利用している患者の中心年代は65歳以上であり、高齢者がその地域に住み続けるために、自立した生活をいかに延長できるか、そのための高齢者に対する看護活動をどう展開していくかということが、へき地における大きな課題であることが明らかになりました。また、全国の傾向と同様、生活習慣病や慢性疾患が多くみられ、そこには地域に特有な食文化や食習慣等が関連している場合もありました。よって、その地域の生活状況を考慮しながら、生活習慣病の予防から自己管理まで支援していく看護活動が必要であると考えられました。さらには、地理的状況から二次医療機関まで遠く、救急時の問題や疾病の発見が遅れるという問題、通院負担の問題、島や豪雪地帯等、閉ざされた生活が関連していると考えられる精神面の問題、社会資源利用に関する住民の意識の問題にも看護が対応していく必要が示唆されました。

一方、へき地に勤務する看護職は、診療の補助以外に救急時・医師不在時の対応、住民に身近な存在としての相談的役割、在宅ケアの実施、社会資源利用に関わる援助、地域住民のつながりを活かした看護活動等、幅広い活動を実施している状況が明らかになりました。しかし、研修・研鑽の機会が少なく、サポート体制の不足も明らかになり、へき地に勤務する看護職の研修・サポート体制の構築が課題であると考えられました。

わが国は、今、平成18年から平成22年の５か年の第10次へき地保健医療計画策定に入っております。第９次へき地保健医療計画においては、無医地区、無歯科医地区等の医療の確保に努めてきましたが、第10次では、「地域の医学関係者の確保に代表される問題等を継続して、第10次計画策定のため、検討すること」となっています。

この大切な時期に看護の立場から、へき地の保健医療に関するニーズの把握とケアチームの開発に関する知見を発信していきたいと考えています。また、21世紀の少子高齢化のなかでわが国のRural and Remote Areaでは、人口の高齢化が極限に達し、これから先は人口減少のなかで、これまで支え合って生きてこられた高齢者が次々に天寿を全うする時代を迎えます。いよいよ看護職の働きが求められるはずです。それに対するケアシステムの在り方の転換が必要でしょう。

本研究集会には外国の方３名をお迎えすることができました。カナダからはKathryn Crooks先生、フィンランドからはHelli Kitinoja先生、そしてオーストラリアからはKaren Francis先生です。いずれもとてもお忙しい方々で、本当に本日、こうしてお越しいただけたのは、ひとえに先生方のわが国のRural and Remote Area Nursingに関する強い連帯の気持によることと深く感謝しています。また、本日は２人の日本人スピーカーからの研究報告もいたします。沖縄県立看護大学の大湾明美先生、自治医科大学附属病院の菊池睦子先生です。いずれも最近の研究報告ということで選ばせていただきました。

参加された方々が、世界の連帯のなかで、各自の課題を見出していただくことを希望します。

Rural Nursing is More Than Just Learning Tasks : A Canadian Perspective

Kathryn Crooks[1)]

"Health care in rural areas has unique requirements and challenges"(Long, Scharff, and Weinert, 1998)

When I married a farmer, little did I understand the consequences that would have for the career I was entering as a new graduate clutching my nursing diploma. As one of the urban educated nurses of the early 1970's I had never actually lived in a rural area. Moving to a farm and seeking work in the nearest hospital, which was a 50 kilometer drive from my new home, was a culture shock that I am still amazed I survived. I assumed that my urban college education would more than outfit me to work in a 25- bed acute care hospital located in a small town in southern Alberta. I was hired to begin work on the night shift as soon as I returned from my honeymoon. Not only had I never worked nights before, but I received absolutely no orientation to the hospital prior to my first shift. Instead, I arrived the first night to find myself working with another registered nurse who like me had graduated just weeks before. She at least had been working in the facility for about two months, which placed her in the position of having to "teach me the ropes". That first night is a blur in my memory. I can only think this might be the result of selective recall on my part. I recollect something about a laboring woman, sutures in emergency, a death, and chest pain, which I should clarify, was the patients not mine.

I remember the long drive home following that first night. It was a crisp autumn morning with the sky just starting to get light. I also remember feeling scared and wondering how I could get myself out of working in that place ever again. Needless to say, being the trooper I was in those days, I returned for the next night and the next. Thus began my career as a staff nurse in rural health care. For the next eighteen years' I worked in three separate rural hospitals and an alcohol treatment center. By the time I left rural nursing, I was just starting to believe that I had come to understand some of the finer points of being a rural nurse. Since I do not believe that I am a particularly slow learner, I have to consider that there is something unique about rural nursing and that this "something" makes nursing in a rural environment distinctive and not easily mastered.

Rural Canada

Canada is a vast montage of diverse weather, terrain, and population groups. Composed of ten provinces and three territories, Canada stretches from the 49th parallel in the south, northward to the Arctic Circle, and from the Atlantic Ocean in the east to the Pacific Ocean in the west. Despite this immense land mass, 2/3 of the population of nearly 31 million people, reside in the provinces of Quebec and Ontario. While nearly 30 percent of the Canadian population resides in rural and remote areas of this immense country, there is no singular acceptable definition of what constitutes rural life (Pong et. al, 1999). The rural environment occupies 95 percent of the Canadian land mass and is inhabited by approximately nine million individuals (Kirby, 1999). Some shifts in rural population have related to the de-population of established communities as young people leave rural Canada for an urban life-style and those who remain in the community get older. However, certain rural areas of the country are increasing in population. At the moment, the greatest number of inhabitants lives in

[1)] Medicine Hat College, Canada, Coordinator Undergraduate Nursing

the southern part of Canada close to the U.S. border (Central Intelligence Agency, 2003) however, shifts in rural population have occurred northward as oil and natural gas was discovered and new settlements have sprung up in territories formerly occupied by Canada's First Nations people. For example in the north-south corridor between Calgary and Edmonton, in the province of Alberta (Statistics Canada, 2003), the rural population has actually increased greatly. This corridor is rich in oil, gas, and agricultural revenue and is within easy driving distance from two large metropolitan areas.

Despite the inability to define what is rural and what is not, a study of the available literature, demonstrates that over the past 10 years the nature of residing in a rural landscape is unique and distinct from the urban culture. While each Canadian rural community exhibits an exclusive dimension distinct to its particular population, there are shared beliefs, values, attitudes, and concerns that provide for identification of a collective cultural designation (Bushy, 2000).

Rural Health

One of the key features of the rural cultural designation relates to the nature of health and health care resources. On television, in the movies and in magazines, the rural environment is portrayed as a place to escape and find clean air and green grass. Most media representations disregard the fact that much of the rural environment can be dangerous and hazardous to individual health. While there are many affluent communities that are located close to urban areas, the more distant a community is from an urban environment the less prosperous it tends to be (Kinsley, 2002). This situation has an immediate impact on the health and well-being of those rural residents. For example, in a survey conducted in Quebec, it was found there was a steady decline in personal health as individuals moved outward from communities bordering urban areas (Pong et al, 1999). Moreover, residents of small rural Canadian communities are found to have higher infant mortality rates (Kinsley), a shorter life expectancy as well as higher rates of long-term disability and chronic illness than urban dwellers (Pong et al).

Determinants of Rural Health

Agriculture, followed closely by mining, forestry, and fishing, has been identified as one of the most dangerous occupations, not only for its incidence of injury, but for the residual effects of long-term exposure to chemicals, pollutants, and the elements. Wright (1993), in one of the early works regarding rural nursing, identified not only singular issues related to agriculture but the collective concerns related to the extreme level of injury and illness experienced by family's who live on the farm.

Rural populations in Canada demonstrate an over-representation of senior citizens, children, and individuals under the age of 20 years (Kirby, 1999). Persons residing in rural communities are noted to have less formal education as well as correspondingly high levels of unemployment (Kirby). One result of this demographic disparity is a reduced contribution to the economic infrastructure of a community yet an increased need for the type of services supported by a sound economic base.

More than one-half of Canada's 1.4 million First Nations People live in rural areas (Kirby; Kinsley, 2002). First Nations People in Canada demonstrate an array of specific health concerns that stem from such things as poverty, chronic unemployment, and deficient housing (Kinsley). Moreover, First Nations people, known to be statistically younger than the remainder of the Canadian population, are also increasing at double the rate of the rest of the country (Kinsley). This rapid growth increases the urgency to ameliorate the negative impact of health related social issues as well as to insure increased access to health care for all rural residents.

Specific Health Problems

The Kirby Report (1999) points out the lack of information on the health of rural Canadians. From

information that is available, it is known that there are health concerns that are distinctive to rural environments. In Alberta alone, there were 1376 farm injuries reported in 2003 (Government of Alberta, 2004a). Farming and mining are related to an increased incidence of various cancers (Pong et. al, 1999). Rates of alcohol consumption, smoking, physical inactivity, and obesity are higher than the national average in parts of rural Canada (Kinsley, 2002). Domestic violence, while a problem in urban areas, is even more of a concern in rural areas because of distance from services (Scott, 1995). In addition, in rural areas, because income is frequently directly related to place of residence, that is farm or town, the victim of domestic violence may lack the personal economic resources to leave the abusive situation.

Children living in crop-growing areas have been found to have a high frequency of asthma (Dickinson, Denis, & Li, 1995), while rural First Nations children have been noted to have a high incidence of exposure to second hand smoke (Hemmelgarn & Ernst, 1997). Access to safe drinking water is a concern for many people in rural and remote parts of Canada (Kinsley). Much of the concern regarding rural health and rural health care relates to the accessibility of rural Canadians to appropriate providers (Canadian Policy Research Networks, 2001).

Access to Health Care

The majority of rural Canadians have expressed concern regarding the inability to access appropriate health services without traveling great distances (Kinsley, 2002). For example, in northern and remote regions of the country many residents live more than 100 kilometers from health care services (Kinsley). Because the majority of nurses and other health care providers are concentrated in the more populated regions in southern portions of the country, the rural population, which often requires urgent health care, is chronically underserved (Kinsley). It is essential to understand however, that though the majority of Canadians reside close to the American border, there are vast expanses of under populated regions even in the southern parts of this sparsely populated country (Central Intelligence Agency (CIA), 2003). Moreover, it is known that while 30 percent of the Canadian population resides in rural and remote areas, only 18 percent of registered nurses practice in these areas leaving a large number of rural residents severely underserved (Kinsley). It is likely that this situation will become more acute as the country experiences a severe shortage of registered nurses.

The Nursing Shortage

Over 10 years of government cutbacks in health care, nurses entering the workforce at an older age, and fewer people entering the profession has created an overall deficit of nurses predicted to reach 78,000 by 2011 (Canadian Nurses Association, 2002). The Canadian Nurses Association (2005) reports that one in three nurses will reach retirement age within the next five years. The increasing age of all nurses has had a negative impact on rural areas and what was once a relatively stable workforce is faced with engaging in efforts to recruit new staff.

Changing Times

Bushy (2000), points out that "nursing practice in rural environments are very similar in Canada, the United States, and Australia" (p. 236).Despite a long history, rural health care and particularly rural nursing are recent additions to scholarly inquiry. Rural nursing has been written about for approximately 15 years with the majority of the information coming from the United States and Australia. I was introduced to this literature ten years ago. At the time, I was the only nurse with rural nursing experience in the faculty where I work, and so I was asked to be involved in the development of a course in rural nursing for the proposed undergraduate curriculum of a generic baccalaureate program. While I was excited about the prospect, I must say conducting a literature search was frustrating because of the paucity of information. The first thing I came across was an article entitled *Rural Nursing: Developing the Theory Base*. This piece of writing provided substantiation for me and all the other

rural nurses who felt like the "poor relations" of the nursing profession. Despite many an urban nursing specialist's attempts to make me and other rural nurses feel that the care given in our facilities was second best, we knew we made a difference. Finally, this difference was being recognized, and theories relevant to its existence were being discussed. Scharff (1999) identifies that the desire by rural nurses to be recognized "...stems from the frequent, albeit unintended, distortion of truth about rural nursing communicated by those who do not fully understand what it means to walk a mile in a rural nurse's duty shoes" (p. 20).

Long and Weinert (1989/1999) point out that though rural nursing shares much in common with other areas within the profession, it is the "intersections ... the dimensions ... the philosophy ... responsibilities, functions, roles, ... skills, ...boundaries ..." (p. 14) that make rural nursing distinct from its urban cousin.

Extended Roles

Diffusion of roles, driven by necessity, describes the ability of rural nurses to assume other than the nursing role, and is one of the hallmarks of rural nursing practice (Long & Weinert, 1989). In remote northern parts of Canada, nurses frequently take on an advanced practice/nurse practitioner role providing medical care to patients because of the scarcity of physicians. Even in the more populated southern parts of the country, rural facilities, from time to time, have limited access to medical resources as well as a deficiency of allied health personnel.

Nurses in rural facilities in Canada often perform the functions of respiratory therapist, physiotherapist, unit clerk, pharmacist, and cleaning personnel. Health care cutbacks, coupled with a limited supply of certain allied health personnel, make round the clock access difficult. As a result, nurses are pressed into fulfilling these tasks. All of these duties are interspersed with the regular nursing role of providing safe, ethical, quality patient care. As human resources in rural areas become increasingly scarce, concerns surrounding role diversification become more obvious. One of the primary concerns related to role diversification of rural nurses relates to the lack of peer support with little or no support to obtain the necessary skills (Bushy, 2000).

Emerging Technology and Education

Scarcity of resources impacts the nurse in other ways as well. Distance from services routinely creates concerns for the nurse related to updating existing skill sets or acquiring new skills. Increasing technology has provided nurses access to higher education in the form of theoretical content. However, access to updating existing skills or acquisition of additional skills continues to be a problem. Telehealth as it presently exists with interactive video does not generally assist with this problem. The reason for this relates to the difficulty in becoming competent when utilizing equipment if given limited opportunities to work with the equipment. Emerging technologies in patient care mean that the rural nurse must keep abreast of changes and new ways of providing care because it is usually the nurse who must teach the patient and family how to use the equipment (Bushy, 2000), or to "trouble shoot" should the equipment malfunction. Bushy points out rural nurses must become proficient with increasing technology because of the "corresponding increase in the number of legal, ethical, financial, and policy issues" (p. 240) that results.

Opportunities for simulation are essential but the expense associated with the purchase of simulation equipment or for staff to travel to centralized equipment is often prohibitive. With staff shortages it is becoming more difficult for nurses to get time away from work to attend simulation sessions in centralized areas. Additionally at the moment most simulation equipment does not incorporate nursing specific situations therefore its use is limited to advanced cardiac life support sessions.

The centralization of educational resources in urban health regions has created a situation in which there is a tendency to forget the unique nature of rural health and rural nursing particularly in an effort to cut costs. It is essential that each centralized health region that encompasses a rural area must have educators that are familiar

with the distinctive facets of rural health and nursing so that both staff and patients are well served.

The rural nurse routinely provides care to patients from across the lifespan with a variety of diagnosis and health conditions (Bushy, 2000). Rural nurses have the quintessential generalist practice (Bushy, Scharff, 1998) and are described as expert generalists (Long & Weinert, 1998). The blurring of boundaries and the blending and extending of roles that occur in rural practice require the nurse to have a broad range of knowledge and skills facilitated by a large measure of flexibility. Hegney et al (1997) point out that" ...it is feasible that a nurse would utilize knowledge and skills related to midwifery, accident and emergency, pediatrics, medical nursing, surgical nursing and operating theaters in any one shift" (p. 82).

Some of the literature on rural nursing suggests that because much of rural practice is of an advanced nature it is essential that those that practice in this environment be prepared at a post-graduate level. The reality however is much different. The majority of nurses working in rural Canada do not have post-graduate degrees. In fact as of the year 2000, only 18 percent of rural nurses had obtained a bachelor's degree in nursing as their highest level of education (CIHI, 2002). While access to graduate education is becoming more convenient, frequently issues related to home, family, and finances prevent many rural nurses from taking advantage of these opportunities.

More Than Just Tasks

Relational Concepts

Despite the presence of extended roles and a generalist practice, the foundation of nursing practice is not essentially different in urban or rural settings. However, there is a sense of community integration in rural that sets apart the two entities (Hegney et al., 1997; Scharff, 1998).

The core of all nursing is care, and care is the substance of the relationship between nurse and patient; consequently what happens in the core of rural nursing is something apart from what happens at the core of nursing anywhere else (Scharff, 1998, p. 20).

The strength of the relationship between the nurse and the patient is frequently the result of a prior association. Often, rural nurses have an existing close relationship such as neighbor, friend or relative. Even if the relationship only extends as far as a sense of belonging to the same community, an association exists. This event is often called a "dual relationship" and occurs because in most rural communities, people are at least acquainted with each other (Bushy, 2000). Many rural nurses express the benefit of having at least a degree of prior knowledge about the patient. They believe the existence of a dual relationship with the patient adds a contextual dimension to care that is absent in an urban setting (Rosenthal, 1996). MacLeod (1999) suggests it is the "...personal dimension that figures prominently in their ability to provide high quality care to a wide range of people" (p. 170). The visibility and familiarity encountered because of a dual relationship provide a foundation for the intimate therapeutic relationship that features so prominently in the recent general nursing literature. The dual relationship however does create an additional source of stress to the nurse who is often expected to provide care for a neighbor, friend, or family member (MacLeod, 1999). The additional stress, experienced from the existence of dual relationships are often the elements that new nurses are not prepared to experience. The literature supports the notion that more people are unsuccessful in their careers through lack of interpersonal skills than for any other reason. It is only in the past 15 to 20 years that many schools of nursing have provided courses that set out to enhance these relational skills in their students. It is interesting to consider why this might be the case particularly when these skills are so vital to a successful nurse-patient relationship.

The relational concepts, which assist the rural nurse in developing a deep therapeutic association, require the presence of so called "soft-skills" such as warmth, empathy, genuineness and respect (Balzer-Riley, 1998).

These "soft-skills" are often undervalued, in present day western society, which continues to value detachment and disconnection (Crooks, 2001, p. 19). Moreover, the "soft-skills" do not lend themselves to study in a society such as Canada that continues to value quantifiable "hard" evidence. The "soft-skills" ultimately are, regulated to a subordinate position despite the fact that they play such a vital role in providing safe patient care. I find it interesting that this paradox is present in a practice such as nursing, which claims to value not only subjective knowledge (Crooks) but to place a high value on the relational concepts such as caring. In the nursing profession in Canada, status is given to those elements that are closely aligned with the practice of medicine. For example, someone who works in an emergency department, works in an intensive care unit, or functions as a nurse practitioner is assured higher status then the nurse who works with a geriatric population. It is unfortunate that something as foundational to nursing as the caring nurse-patient relationship is relegated to a lower status then the ability to perform various psychomotor functions.

I believe the nurse's ability to navigate relational concepts insures the success or failure of nurses in the rural setting. While, Kenny and Duckett (2003) suggest assessment skills, mental health knowledge, advanced cardiac life-support, and management and leadership skills are essential for the new graduate in a rural setting; I would add that an understanding of the relational component of rural nursing, that is the dual relationships and the lack of anonymity, is also vital to successful practice in the rural setting. One of the best ways for graduate nurses to fully understand the unique nature of rural relational concepts is to become immersed in a rural community at some point during their nursing education. Forneris (2004) notes that students come to understand through the experience of interacting within a context. Murphy et al. (1995) suggests that a positive rural nursing experience for students increases the likelihood of the student choosing rural nursing as a career following graduation. In Canada, despite the large rural population, only 43 percent of nursing programs, at the basic or graduate level, actually provide courses specific to rural health or nursing (Minore et al., 2001). The University of Calgary program at the Medicine Hat College site is one of the few programs that provide a required rural nursing theory and practicum course at the foundational level.

Rural nursing and gerontology form the focus of the Medicine Hat College curriculum (University of Calgary degree at the Medicine Hat College site). Students receive instruction in biology, microbiology, psychology, sociology, health assessment, therapeutic communication, medicine, surgery, gerontology, obstetrics, mental health, community nursing, health education, nursing research, philosophy, and statistics before they enter into the rural nursing course at the end of their third year of education. They must have successfully completed all other course requirements to enter into the rural nursing course. Emphasis is placed on evidenced based practice throughout the program and health promotion and illness prevention themes are evident in all courses as is reference to pertinent elements of rural health.

The rural nursing course consists of 39 hours of theory, taught in a block format i.e. the students spend most of the day in class for a period of 5-7 days. The content is divided into five themes: "What is Rural", "Rural Populations", "The Rural Nurse", "Issues in Rural Health Care" and "Rural Environmental Issues"

The teaching strategies utilized consist of selected readings that are updated yearly; guest speakers (e. g. a community health nurse dealing with an ethnically diverse population, an addictions counselor who works with troubled youth, and a nurse practitioner who works in a primary health care setting) may be invited to come and speak to the students; lecture, class discussion, and case studies, are also utilized.

In the theory course there is an emphasis on personal exploration of issues which culminates in the students choosing a rural topic to debate – topics are selected from a group of issues that are current to rural health. Students are expected to seek resources and information to help develop their argument. The list of topics changes from year to year depending on what is currently a concern for rural health care. One group of students is expected to assume the positive side of the argument and the other group the negative. This makes for a lively exchange and occurs the day before they leave for their practicum experience.

Individual examination of the meaning of rural nursing in relation to personal values and beliefs is essential for the students if they are to successfully deal with the relational concepts that are a crucial aspect of rural nursing practice. To facilitate this process, students are placed in a rural acute care or home care setting for 195 hours of practicum experience. Students are precepted by a Registered Nurse that is an employee of the practicum site. Students are given 7 aims that are to be fulfilled during this experience. Students are expected to:

- Gain an understanding of rural culture by exploring the nature of a rural community.
- Integrate the understanding of rural culture with the nursing of individuals and families in rural settings.
- Experience the concepts of rural nursing as they apply to a variety of settings.
- Engage in the nursing care of rural individuals and families.
- Integrate previous learning with the concepts specific to nursing practice in a rural environment.
- Integrate research on rural health and nursing into practice.

While there is ample opportunity for the students to practice skills and tasks, the emphasis of the course is on the exploration of the community and personal values and beliefs related to the aspects of rural that have been introduced in class. This process is facilitated by:

- Choosing two of the broad determinants of health and writing an 8 page scholarly paper outlining any disparities in health that occur because of the rural setting. Students are expected to use appropriate examples of this disparity from the community in which they are doing their rural placement as well as to provide suggestions that would enhance the health and well-being of that particular rural population.
- Reflection on experience has been identified as a means of connecting theory to practice and solidifying new knowledge (Forneris, 2004). To facilitate this students are asked to choose two significant events during their rural practicum that made them think "...this is what rural nursing is all about". They are to analyze the event and find out what the rural literature suggests about the event.
- Each student is expected to have weekly contact with the faculty advisor. The nature of the contact should be related to the way the student is meeting the course aims through the practicum experience. Therefore all entries are to be related to rural theory.

These 3 essential elements are all tied to the culminating assignment, which consists of a poster presentation related to their experience of being immersed in the rural community for the past 6 weeks. Students are asked to outline their experiences as themes and illustrate those themes by developing a poster presentation. Students who have been placed in the same region are encouraged to work together on the poster. The poster is then displayed and judged by the 3 instructors involved in the practicum portion of the course as well as 3 guest judges – these are usually the nurse managers from various rural sites within the region. The posters are displayed in the lobby of the college and because this event usually happens during Rural Health Week representatives from the media are invited to come and speak with students and discuss their posters.

During the practicum the faculty advisor makes one trip to the site if possible (depends on location) or makes phone contact with the preceptor and student. This can be time consuming because of the distance traveled but is necessary particularly when we utilize a site for the first time. Although preceptors and students are provided with a resource manual it is often necessary to reinforce the information or to answer questions that the preceptor might have. Many preceptors also indicate that it is much easier to contact one of the faculty advisors once they have met them in person. Students also indicate that they enjoy a visit from the faculty advisor – sometimes because they just need to see someone familiar and sometimes to proudly display all they have learned in their rural site. Student clinical performance is evaluated by the advisor and the preceptor with input from the student. Faculty advisors are available to the preceptor and the student 24/7 either by phone, computer, or site visit. If a student is experiencing difficulty in the site, they are removed and brought to a site closer to the college. On the evaluation form there are elements that are considered crucial to patient safety. If the student

fails to meet any of these crucial elements they will fail the course.

The rural nursing course consistently evaluates well with students. Students experience a tremendous growth in confidence related to their knowledge level and ability. This is the first time students are percepted by a staff member without the on-site presence of an instructor and students appreciate this opportunity for personal growth.

- "This experience has given me a great opportunity for personal growth".
- "Now I really know I can think like a nurse".
- "I was scared when the rotation first started but now my confidence is through the roof".
- "this is the best course yet".

Preceptors indicate appreciation for the students' ability to communicate with patients, perform psychomotor skills, and to organize and prioritize patient care. Many of the preceptors also express approval for a rural nursing course at the undergraduate level as a means of preparing nurses to face the peculiarities of living and working in a rural community. Key to this approval is the recognition of the necessity of experiencing the relational elements of rural nursing as a means of promoting recruitment and retention of nurses in the rural setting. Preceptors find that the experience of being a rural preceptor is beneficial to them as well. For example they make statements such as:

"I find it very rewarding to be able to share some of my experiences with students. Being a rural nurse has unique challenges and it is great to share this with the student".

"Having a nursing student helps me to keep up with skills and new theory".

"I learned to appreciate a young student's nursing heart. I hope I inspired her to continue with life long learning".

"I enjoyed the role of teacher, and I also learned a lot from the students fresh take on ideas".

"It was a pleasure to have a student come to our rural hospital who felt that rural nursing was something special. From her comments I gathered that the uniqueness of rural nursing was conveyed to her through her class on rural nursing prior to coming to our facility".

"We enjoy having students as they teach us as we are teaching them – we also learn new things".

Following completion of the rural course, students spend one more 13 week semester doing an advanced consolidation experience. During this same time they also take a 39 hour theory course in management, as well as another 39 hour course in trends and issues in nursing. Both of these courses are via a distance education format utilizing the blackboard computer system.

The rural nursing course, in its present manifestation, has been in progress for the past three years. Preceptors and students are asked to evaluate their experience and provide suggestions for course improvement. Each year it is taught there have been changes made to the readings, the course content, the teaching strategies used, and the assignments used to evaluate the students. This course will continue to evolve as the years go by and as the understanding of rural health and rural nursing increases in Canada. Because there is so little information available in Canada regarding rural health and rural nursing it has been possible for our program to take a concept and develop an entire curriculum around that concept.

While we have information regarding student and preceptor satisfaction about the course we presently do not have any data that tells us which of these students are working in a rural facility and if taking the course helped them to choose this option. This is an area of evaluation that I would like to take on as soon as I finish my doctoral work because I believe it will help us to strengthen this course.

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Educational Effects of Dispatch of Nurses to Hospitals in Rural Area, on their Nursing Practice Competence

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INTRODUCTION

The purpose of this research is to clarify educational effects of dispatch of nurses of Jichi Medical School Hospital to local hospitals in rural area by examining experiences of those who participated in the dispatch program.

Jichi Medical School was established in 1972 in order to ensure and improve the level of medical services provided in remote areas where medical resources are scarce. The aim of the school is to turn out humane doctors with highly advanced clinical skills, and to make progress in medical science and in the promotion of community health.

Jichi Medical School Hospital was opened in April, 1974 as a teaching hospital. It provides residents in the area with comprehensive medical services and also works as a teaching unit for our students. Now it is with 1,082 beds, 31 specialties with nursing staff approximately 900. Starting from 1990, the hospital sends nurses for one to two years to some of the Jichi Medical School related hospitals near by and rural area. In 2004, nurses were dispatched to 8 different hospitals.

The primary aim of the dispatch is to improve nursing practice and management competence of those who are sent. For that purpose, the candidates for dispatch are limited for junior nurses who have been working more than two years and those who are management staffs such as head nurses and chefs. We have heard many voices from those who participated in the program that they had excellent experiences. However, we have not clarified what they have learned from nursing experiences in the hospitals in rural area and what are the effects given to their nursing practice abilities. To clarify this would give us important resources to place the dispatch program in the life long education program of our hospital which necessary to create carrier rudder for nurses according to the founding idea of the Jichi Medical School.

METHODS

Subjects

The subjects were those who gave us consent of participating in the research out of 84 nurses who were dispatched certain period to local hospitals in rural area from our hospital.

Data collection and Data analysis

We took two surveys in order to summarize various experiences participants learn through the dispatch.

First survey was self administrated open question survey about nursing experiences at the hospital they were dispatched in order to grasp whole picture of what they have learn. Two questions, "Contents of the nursing experiences at the place where you were dispatched" and "What you have gained or leaned through dispatch" were open ended questions.

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Contents of nursing experience at the place dispatched and what the person have learn through dispatch were extracted from the answers and classified according to the framework of 19 items of nursing practice competence according to the *"Achievement goals of university graduates for enrichment of nursing practice competence"* (Figure) which was reported on March 2004 at the "Committee to Examine State of Nursing Education", called by the Ministry of Education. The nineteen practical abilities were divided into 5 categories and each category contains precise items. While more and more nurses will be educated in university revel, we can regard these nineteen items as the basis for the nursing practice competence. For that reason, we used this framework to examine the nursing practice competence of our research participants. Valid responses came from 72 respondents. Collection ratio was 85.7%. Contents of what have experienced and learn were classified into 48 items (Table 1).

At the first survey, "What were negative points about dispatch" and "Your opinion and request for the dispatch program" were asked as open question. The data was analyzed qualitatively and five tasks of dispatch program were classified.

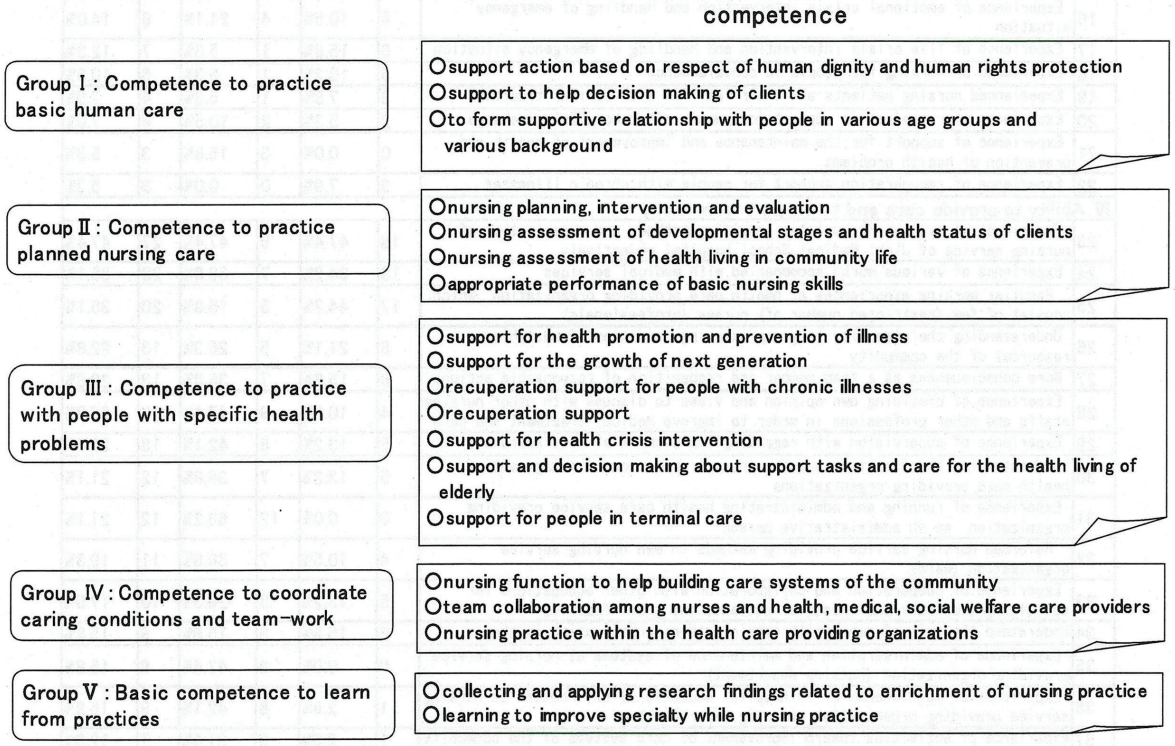

Figure. Component of nursing practice competence

Table 1. Learning experience which was important for itself

	Contents of learning experience	Staff Nurse (N=38)		Others (N=19)		Total(N=57)	
		人	%	人	%	人	%
Ⅰ. Ability to practice basic human care							
1	Formed relationships with people of various age groups	14	36.8%	8	42.1%	22	38.6%
2	Grasped thoughts and intentions of patients and their families	9	23.7%	8	42.1%	17	29.8%
Ⅱ. Ability to operate planned nursing care							
3	Experienced nursing techniques never have performed before	27	71.1%	3	15.8%	30	52.6%
4	Widened knowledge necessary for nursing	22	57.9%	5	26.3%	27	47.4%
5	Experienced nursing practices rarely experienced in Jichi Medical School	18	47.4%	2	10.5%	20	35.1%
6	Widened view to assess daily life, family life and community life of patients and their families	10	26.3%	6	31.6%	16	28.1%
7	Gained awareness on dangers and risk-management on nursing practice	6	15.8%	6	31.6%	12	21.1%
8	Took care of patients in various developmental stages	9	23.7%	2	10.5%	11	19.3%
9	Recognized importance of applying nursing technique with understanding its aim, need and method	4	10.5%	1	5.3%	5	8.8%
Ⅲ. Ability to practice with people with various health problems and various health status							
10	Experience of decision making about support tasks and care for the healthy living of elderly	8	21.1%	5	26.3%	13	22.8%
11	Experienced nursing for patients and their families with various health	9	23.7%	3	15.8%	12	21.1%
12	Experience of nursing at the time of emergency conveyance	6	15.8%	5	26.3%	11	19.3%
13	Deepened attention for the recuperation after hospital discharge	6	15.8%	5	26.3%	11	19.3%
14	Experience of nursing for people in terminal care	8	21.1%	2	10.5%	10	17.5%
15	Experience of assistance for a mother and a child in pregnancy/delivery	9	23.7%	0	0.0%	9	15.8%
16	Experience of emotional crisis intervention and handling of emergency situation	4	10.5%	4	21.1%	8	14.0%
17	Experience of life crisis intervention and handling of emergency situation	6	15.8%	1	5.3%	7	12.3%
18	Experience of nursing for people in convalescence	5	13.2%	1	5.3%	6	10.5%
19	Experienced nursing patients and their families with various treatment	3	7.9%	1	5.3%	4	7.0%
20	Experience of recuperation support for people after hospital discharge	2	5.3%	2	10.5%	4	7.0%
21	Experience of support for the maintenance and improvement of health and prevention of health problems	0	0.0%	3	15.8%	3	5.3%
22	Experience of recuperation support for people with chronic illnesses	3	7.9%	0	0.0%	3	5.3%
Ⅳ Ability to provide care and to support team-work							
23	Experience of evaluating quality, providing method, and organization of nursing service of Jichi Medical School hospital objectively	18	47.4%	9	47.4%	27	47.4%
24	Experience of various works accompanied with medical services	13	34.2%	7	36.8%	20	35.1%
25	Peculiar working experiences at health care providing organization which consist of few (restricted number of) nurses (professionals)	17	44.7%	3	15.8%	20	35.1%
26	Understanding the necessity to grasp existing condition of health care resources of the community	8	21.1%	5	26.3%	13	22.8%
27	More consciousness as a team member and recognition of responsible actions	6	15.8%	7	36.8%	13	22.8%
28	Experience of providing own opinion and views to discuss with other nursing staffs and other professions in order to improve medical treatment and care	4	10.5%	9	47.4%	13	22.8%
29	Experience of supervision with regarding improvement of cost awareness	5	13.2%	8	42.1%	13	22.8%
30	Understanding the formation and the present condition of management of health care providing organizations	5	13.2%	7	36.8%	12	21.1%
31	Experience of running and administrating health care service providing organization as an administrative person	0	0.0%	12	63.2%	12	21.1%
32	Reformed nursing service providing methods in own nursing service organization (ward)	4	10.5%	7	36.8%	11	19.3%
33	Experience of cooperation and collaboration with other occupations for satisfying the individual needs of patients and their families	5	13.2%	5	26.3%	10	17.5%
34	Understand the role of own health care providing organization in the	6	15.8%	3	15.8%	9	15.8%
35	Experience of administration and maintenance of systems at nursing service providing organization (nursing department)	0	0.0%	9	47.4%	9	15.8%
36	Experience of maintenance of in-hospital educational environment at nursing service providing organization (nursing department)	1	2.6%	8	42.1%	9	15.8%
37	Experience of activities toward improvement of care systems of the community	1	2.6%	6	31.6%	7	12.3%
38	Understanding abilities desired for the nursing professionals in own health care providing organizations	5	13.2%	2	10.5%	7	12.3%
39	Experience of administration and management at the nursing service organization (ward)	1	2.6%	6	31.6%	7	12.3%
40	Experience of integration and maintenance of nursing standard at nursing service providing organization (nursing department)	1	2.6%	6	31.6%	7	12.3%
41	Deepened understanding of necessity of cooperation and collaboration between nurses in order to satisfy individual needs of patients and their	3	7.9%	3	15.8%	6	10.5%
42	Experience of coordination with other sections of health care providing organizations	0	0.0%	6	31.6%	6	10.5%
43	Experience of participation in integration and improvement of services at nursing service providing organization (nursing department)	0	0.0%	4	21.1%	4	7.0%
Ⅴ. Ability for life-long improvement of specialty as a nursing profession							
44	Strengthen the consciousness of occupational ethics as a nursing profession	7	18.4%	4	21.1%	11	19.3%
45	Deepened understanding about nature and specialty of nursing	6	15.8%	4	21.1%	10	17.5%
46	Understand what nursing professions should be (accumulation of nursing practice experience and continuation of carrier life)	5	13.2%	3	15.8%	8	14.0%
47	Experience of demonstrate to analyze and solve tasks and questions in own nursing practice	2	5.3%	2	10.5%	4	7.0%
48	Deepened recognition of necessity of grasping own nursing practice and related matters objectively	1	2.6%	0	0.0%	1	1.8%

Next, the second survey, using self administrated questionnaire, asked about each of these 48 items whether it was important or not in their own dispatch experiences. Among 84 candidates, participants were 81 people who were working in our hospital and able to answer the questionnaires at the time of the research. Valid responses came from 57 respondents. Collection ratio was 70.3%.

The second survey also asked about tasks of dispatch program whether it was necessary to improve or not.

Ethical Considerations

With the questionnaire, we have enclosed a letter explaining purpose of the study and acknowledged that they agreed to participate on returning the filled questionnaire. The questionnaire was anonymous and it was clearly indicated that no disadvantage would occur regardless of their answers. To open the envelopes and analyze the questionnaires were administrated by faculties of the medical school nursing department. No administrators or staffs of the hospital were involved.

RESULT

Characteristics of the respondents

The average career experience was 9.0±7.1 years. Average length of dispatch was 1.3±0.7 years. Position at the time of dispatch are nurse or midwife; 75.4%, and chef, chef nurse or administrative position in the nursing department; 24.6%. 93% of places dispatched were hospitals and lest were clinics etc.

Total number of learning experience classified by group

Group Ⅳ had most number of variety and Group Ⅲ, Ⅱ, Ⅴ, Ⅰ are follow. Group Ⅳ had most accumulative number of answers and Group Ⅳ, Ⅱ, Ⅲ, Ⅰ, Ⅴ, are follow.

The contents of learning experience related to nursing practice competence of each group

The contents of learning experience related to Group Ⅰ：Competence to practice basic human care" was "1. Form relationships with people of various age groups" and "2. Understand thoughts and intentions of support users." About 40% and 30% each answered these items were important.

As for Group Ⅱ：Competence to operate planned nursing care, 53% people answered "No.3, Experienced to using techniques never have performed before" important. "No.4, Widened knowledge necessary for nursing", 47%, "No.5, Experienced nursing practices rarely experienced in Jichi Medical School Hospital", 35%, "No.6, Widened view to assess daily life, family life and community life of patients and their families", 28%,

As for Group Ⅲ：Competence to practice with people with various health problems and various health status, "No.10, Experience of decision making about support tasks and care for the healthy living of elderly", 23%, "No.11, Experienced nursing for patients and their families with various health problems", 21%, "No.12, Experience of nursing at the time of emergency conveyance" and "No.13, Deepened attention for the recuperation after hospital discharge", 19% were the top four.

As for Group Ⅳ：Competence to provide care and to support team-work, about 50% answered "No.23, Experience of evaluating quality, providing method, and organization of nursing service of Jichi Medical School Hospital objectively" , about 35% answered "No.24, Experience of various works accompanied with medical services" and "No.25, Peculiar working experiences at health care providing organization (a hospital, clinic, etc.) which consist of few (restricted number of) nurses (professionals)" and about 23% answered "No.26, Understanding the necessity to grasp existing condition of health care resources of the community", "No.27, More consciousness as a team member and recognition of responsible actions", "No.28, Experience of providing own opinion and views to discuss with other nurses and other professions in order to improve medical treatment and care", "No.29, Experience of supervision with regarding improvement of cost awareness" were

the top seven.

As for Group Ⅴ, 20 % of participants answered "No.44, Strengthen the consciousness of occupational ethics as a nursing profession" important and 17.5% answered, "No.45, deepened understanding about nature and specialty of nursing".

Within these 48 items of learning experiences, all were selected as meaningful experience in some extend. In the second survey, we have asked to write if they can think of any other learning experience besides listing but no additional answers were returned.

Tasks regarding dispatch program (Table 2)

The content of the answer were sorted A. to clarify the purpose of dispatch:60%, B. Orientation before dispatch and organizational preparation at the hospitals receiving:50%, C. Clarify positioning in career rudders such as on what basis a person is nominated for dispatch and how the dispatch experience reflected to ones career:44%, D. Follow-up of the person dispatched during the period such as mental support and to give opportunities to participate in seminars: about 40%, E. Financial support for transfer: about 30% and F. Other.

Table 2. Takes regarding dispatch program

Tasks		Staff Nurse (N=38)		Others (N=19)		Total(N=57)	
		人	%	人	%	人	%
A	To clarify the purpose of dispatch	20	52.6%	14	73.7%	34	59.6%
B	Regarding orientation programs before dispatch and preparation of the hospital to receive personnel	20	52.6%	8	42.1%	28	49.1%
C	Clarify positioning of the dispatch program in career rudders. Ex. on what basis a person is nominated for dispatch and how the experience reflected to	14	36.8%	11	57.9%	25	43.9%
D	Support for the person dispatched during the period such as mental support and to provide opportunities to participate in seminars	14	36.8%	9	47.4%	23	40.4%
E	financial support for transfer	10	26.3%	8	42.1%	18	31.6%
F	Other	7	18.4%	1	5.3%	8	14.0%

The result comparing group of nurses and midwives and group of chefs and person in administrative positions (Table 1)

Let's look the result comparing group of nurses and midwives (from now on, call this group as STAFF) and group of chefs and person in administrative positions (from now on, call this group as ADMINISTRATORS).

As for Group Ⅰ, there were no differences.

As for Group Ⅱ, most number of people (70%, 27 out of 38) answered "No.3, Experienced nursing techniques never have performed before" and 60% answered "No.4, Widened knowledge necessary for nursing" 50%" No.5, Experienced nursing practices rarely experienced in Jichi Medical School Hospital". among the administrators, about 30% (6 people out of 19) answered "No.6, Widened view to assess daily life, family life and community life of patients and their families", and/or "No.7, More awareness on dangers and risk-management on nursing practice" followed by "No.6, Widened view to assess daily life, family life and community life of patients and their families", 26%.

As for the Group Ⅲ, 24% of Staffs answered "No.11, Experienced nursing for patients and their families with various health problems" and "No.15, Experience of assistance for a mother and a child in pregnancy/delivery term" important

Followed by 21%, "No.10, Experience of decision making about support tasks and care for the healthy living of elderly" and "No.14, Experience of nursing for people in terminal care". No one selected "No.21, Experience of support for the maintenance and improvement of health and prevention of health problems" as important learning experience. Among chiefs, head nurses and administrators, about 26% answered "No.10, Experience of decision making about support tasks and care for the health living of elderly." "No.12, Experience of nursing at

the time of emergency conveyance." and "No.13, Deepened attention for the recuperation after hospital discharge." as important learning experience. And 21% answered "No.16, Experience of emotional crisis intervention and handling of emergency situation." No one selected "No.15, Experience of assistance for a mother and a child in pregnancy/delivery term" or "No.22, Experience of recuperation support for people with chronic illnesses".

As for the "Group Ⅳ, Competence to provide care and to support team-work". Among staffs, about 50% answered "No.23, Experience of evaluating quality, providing method, and organization of nursing service of Jichi Medical School Hospital objectively" and about 45% answered "No.25, Peculiar working experiences at health care providing organization (a hospital, clinic, etc.) which consist of few (restricted number of) nurses (professionals)" and about 34% "No.24, Experience of various works accompanied with medical services".

No one selected "No.43, Experience of participation in integration and improvement of services at nursing service providing organization (nursing department)", "No.42, Experience of coordination with other sections of health care providing organizations", "No.35, Experience of administration and maintenance of systems at nursing service provider organization (nursing department)", "No.31, Experience of running and administrating at health care service provider organization as an administrative person" Among administrators, 60% answered; "No.31, Experience of running and administrating at health care service provider organization as an administrative person" and 50% answered; "No.23, Experience of evaluating quality, providing method, and organization of nursing service of Jichi Medical School Hospital objectively" "No.28, Experience of providing own opinion and views to discuss with other nurses and other professions in order to improve medical treatment and care" and "No.35, Experience of administration and maintenance of systems at nursing service provider organization (nursing department)" and 42% answered; "No.29, Experience of supervision with regarding improvement of cost awareness", "No.36, Experience of maintenance of in-hospital educational environment at nursing service provider organization (nursing department)"

The ratio of answers regarding Group Ⅴ was same as the answers of whole group.

The Tasks of dispatch program comparing STAFF and ADMINISTRATORS (Table 2)

As for the tasks of dispatch program, about 50% of staffs answered "A. To clarify the purpose of dispatch" and "B. Regarding orientation programs before dispatch and preparation to receive dispatched personnel at the hospitals" need to be examined. Among administrators, 70% answered "A. To clarify the purpose of dispatch" and 60% answered "C. Clarify positioning of the dispatch in career rudders such as to clarify on what basis a person is nominated for dispatch and how the experience reflected to ones career" and 50% answered "D. Support for the person dispatched during the period such as mental support and to provide opportunities to participate in seminars"

Comparison accumulative number of cases between STAFF and ADMINISTRETORS

Among staffs, accumulative number of cases was 312 and about 30% are Group Ⅳ and Ⅱ, about 20% are Group Ⅲ. Among administrators, accumulative number of cases was 218 and about 60% answered Group Ⅳ and 15% Group Ⅲ.

DISCUSSION

1. The result from this study clarified the contents of the learning experience related to nursing practice competence during dispatch program of Jichi Medical School Hospital as well as the fact that the nursing experience provided by dispatch program has positive effect on improvement of nursing practice competence of the participants. Most number of responses of the meaningful learning experiences was included in No.4 Group "Competence to provide care and to build team-work". The participants may have experienced this because the

local community hospitals are so small compare to the Medical School Hospital where they were from, with much less number of nurses and other professionals, they need to communicate, understand and coordinate each other in order to facilitate nursing practice effectively.

Next to the Group I, many number of participants answered items in "Group II: Competence to operate planned nursing care" and "Group III: Competence to practice with people with various health problems and various health status" as important learning experiences.

Even at the Medical School Hospitals, these can be experienced by transfer to ward and so on, however, at the local community hospitals, because they tend to be small and with limited number of professionals, dispatched staff members could experience these learning opportunities to practice with people with various health problems and various health status in limited time.

2. Among staff members, many people answered Group IV, Group II, and Group III. Among the administrators, many people answered Group IV as important learning experience. From these results, we can see that it is important to place the dispatch program in career development system which meets the founding idea of Jichi Medical School Hospital. In order to do so, selection of the person dispatched should be considered in relation with abilities need to be developed and experience of dispatch should have appropriate place in career rudder of the person dispatched.

3. From the founding idea of Jichi Medical School Hospital, it is continuously important to support hospitals and nursing professionals in rural area. Previous researches indicate nursing activities below should be advanced nursing practice in rural clinics.

1) Nursing activities based on understanding of cooperative life in the community.
2) Cooperation with related organizations as a member of home care team.
3) To share health problem of residents and work together with public health nurses for health promotion of the community population.
4) Support of the healthy living of community people as a near-by advising institution.
5) Quick and appropriate judgment on emergency situation and cooperation with larger hospitals.

From this view point, learning experiences listed such as;

"No.6, Widened view to assess daily life, family life and community life of patients and their families"
"No.27, More consciousness as a team member and recognition of responsible actions"
"No.28, Experience of providing own opinion and views to discuss with other nurses and other professions in order to improve medical treatment and care"
"No.33, Experience of cooperation and collaboration with other occupations for satisfying the individual needs of patients and their families"
"No.37, Experience of activities toward improvement of care systems of the community"
"No.12, Experience of nursing at the time of emergency conveyance"
"No.17, Experience of emotional crisis intervention and handling of emergency situation" are very important.

4. From this research, tasks of the dispatch program are clarified. Using this result as a base, the Medical School Hospital should try to clarify the purposes of dispatch and have follow-up of the person dispatched during the period of dispatch as well as to cooperate with the counterpart institutions in order to improve their systems of receiving the dispatch staffs.

Elderly People Living Independently at Home Using Home Telecare and Regional Seamless Services

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BACKGROUND FOR THE ELDERLY CARE

In Europe the share of population over 60-year-olds will be doubled by the year 2025. The demographic structure of Finland will age more rapidly during the next five years than that of any other EU Member State or the USA. One reason is that subsequent generations in Finland have been exceptionally small. (STM 1999 b, Statistics Finland 2002.) In the period of 2000-2010 the relative change in the age group over 65-year-olds will be in Finland 18.1 per cent, in Sweden 12.6 per cent, average in the EU countries 12.6 per cent and in Japan 28.6 per cent. The United States has lower numbers than Finland or Japan. (Demographic Statistics 2000.) In Finland life expectancy for males is 74.6 years and for females 81.5 years (Stakes 2003).

The majority of the elderly, 86 per cent of those at least 75-year-olds, live in an ordinary home. Living alone is also common, for more than half of the women and nearly a quarter of the men over 75-year-olds live on their own. Moreover, the hospitalisation period during an illness is increasingly shorter. All of these facts stress need for new kind of services for the elderly. (STM 1999 b, 2001 a.)

In Finland nine out of ten people at least 75 years of age have some chronic disease or disability weakening their functional capacity. The most common diseases affecting the elderly are cardiovascular diseases and illnesses in the locomotors system, but also diabetes, cancers, stroke and dementia. However, elderly people in Finland are interested in many things, and most of them lead an active life. Only one in ten Finnish aging people feels bored for lack of things to do. The elderly in Finland participate in several social activities and social interaction has an important meaning for the elderly. Loneliness and insecurity are still the appreciable problems in Finland. More than one in three people of over 60-year-olds often or sometimes feel themselves lonely. In the age group of over 80-year-olds the corresponding figure is one out of two. (Kitinoja & Hyyppä 1997, STM 1999 b.)

This presentation represents the elderly care in Finland. The presentation concentrates in clarifying the methodology of supporting the independency of the elderly living at home.

SERVICES FOR THE ELDERLY IN FINLAND

In Finland in the production of social welfare and health care services the main priority is health management and support for independent life. National framework for high-quality care and services for older people in Finland emphasises home care, service housing and residential care for elderly people (STM 2001 b, Saranummi 2001).

The main type of services for supporting the independent living of the elderly in Finland are 1) support services, 2) home help services and home nursing, 3) support for housing, 4) support for informal care and 5) health services. Support services include services that promote coping in daily life activities and in social interaction that means meals on wheels, day activities, transport and cleaning services and emergency

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telephones. Home help and home nursing services provide assistance when the client, owing to illness or reduced functional capacity, needs help at home in order to cope with routine daily activities. Support for housing includes renovations at older people's ordinary homes and living in a service home or a group home and getting there outside support and assistance on a daily basis. Support for informal care given by the municipality includes support for family members caring their elderly. This support could be financial or services that support the care. (STM 1999 b.)

In addition to offering long-term care and other services for the elderly the municipal health centre is usually also responsible for the service of aid devices for the elderly. Elderly people can borrow the aid devices they need, free of charge or by paying a small fee. The payment depends on the monthly income of the elderly. For receiving specialized health care services in a Central or University hospital elderly people have to have a referral from a health center doctor or a private medical doctor. (STM 1999 b.)

The health care in Finland can be divided into primary health care and specialized medical care. The municipality is responsible for providing primary health care and social welfare services for its residents. These services are produced mainly by the municipality itself or together with neighbouring municipalities. In Finland there are about 450 municipalities and altogether 265 health centres. The health center hospital treats people who have fallen ill suddenly and provides care for patients, especially for elderly patients, transferred there for follow-up or rehabilitation after specialized medical care. A large patient group in a health center hospital is elderly people receiving long-term care. The municipality can also purchase services for instance from private enterprises or from other municipalities. The proportion of social services purchased from private service-providers is on the rise. The municipality must ensure that the principles, personnel, facilities and actions of the service providers meet the required level of the quality of services. (STM 1999 a, b, Vaarama & Kautto 1999.)

Municipalities are responsible also for organizing specialized medical care. For that Finland is divided into 21 hospital districts. Each hospital district has a central hospital, five of which are university central hospitals offering more demanding forms of specialized medical care. Each municipality belongs to one of the hospital districts. Patients have to have a referral from a health centre doctor or from a private medical doctor to the specialized medical care. In the central and university central hospitals there are 3.7 beds for every thousand inhabitants, while in health center hospitals there are 4.5 beds for every thousand inhabitants. In 2000 the mean length of stay in specialized somatic hospital was 4.6 days and in health centre about 33 days. (STM 1999 a, b, Vaarama & Kautto 1999.)

The services of social welfare and health care are financed mainly (90 per cent) through public funds raised by municipal and state taxation. At present clients finance about 14 per cent of the cost of home help services for the elderly, about 10 per cent of the cost of health care services and about seven percent of the costs of specialized health care. Concerning the services of old peoples homes client fees cover 20 percent of the costs. All people resident in Finland are entitled to the benefits of health insurance. The health insurance contributions are collected from earnings and pension income. Reimbursement for medications prescribed by doctors (about 40 per cent of the medication's cost), for trips to consult a medical doctor, and for private doctors' fees, the costs of the treatment and tests they provide (under half of the costs), are paid from the health insurance. (STM 1999 b.)

INDEPENDENT LIVING AS A PURPOSE OF HOME CARE

Health centres are responsible for home nursing, which is besides day hospital care, one of the most important health care services for dependent elderly people. The visits vary depending mainly of the age structure of the municipality, as most of the people covered by home nursing visits are over 65. The amount of help needed by elderly people depends on their health, family relations, living conditions and functional capacity. (Vaarama & Kautto 1999.)

The aim of the Finnish policy for the old-age is to promote well-being and health of the elderly people and to support their independent living as long as possible whether they live at home or in an institution ("ageing in place"). The Finnish National Recommendation for the Development of the Quality of Care and Services for Older People is given by the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities in May 2001. National framework for high-quality care and services for older people in Finland emphasises home care, service housing and residential care. The Finnish National Public Health Programme "Health 2015" also underlines the importance of the continuous improvement of the average functional capacity among people over 75 years old. Based on the results their functional capacity has improved during the last 20 years. (STM 2001 a, b.)

The focus of health care in Finland has been shifted from specialized care to primary health care and from care in an institution to non-institutional care. In 2001 there were in an institutional care 4.4 per cent of the elderly over 65-year-old; in 1990 the corresponding number in Finland was 6.7 per cent. The share of elderly people living in service housing has in turn increased especially during the 1990s. The amount of service recipients among the elderly over 65-year-old has been stable during the last ten years; in 2001 it was 13.8 per cent. Also the amount of the elderly living at their ordinary home has been stable. (Stakes 2003.)

Table 1. Service recipients among the elderly over 65-year-old in Finland in 2001

Services	Service recipients among all over 65s (%)
Long-term inpatients in health center hospita	1.7
Long-term inpatients in specialized health care	0.1
Old peoples home	2.6
Service housing with 24-hour assistance	1.3
Service housing for the elderly	1.5
Regular home care services	6.6

Source: Stakes 2003

Some sort of assistance, provided for instance by the spouse, children or municipal home help and home nursing services, is received by 36 per cent of the over 60-year-olds. Assistance provided by the spouse has increased in the past few years, as has also assistance provided by neighbours and friends, although this is still not very widespread. (STM 1999 b.) It is estimated from population surveys that about 25-36 per cent of people over 65 years need some social or health care services, but only about five per cent of them are in severe need of help. Based on earlier research, about 50 per cent of the over 75-year-olds need some services, 10 per cent of them on a daily basis, and of those over 85-year-olds between 63 and 90 per cent need regular help with at least some functions. (Vaarama & Kautto 1999.)

In Finland the individual and family focus are the strongest in public health nursing practice (Eriksson 1993, Koponen 1997) and the community focus is more rare (Simoila 1994, Koponen 1997). Community focus is existent especially for the PHNs working in small rural communities Koponen 1997). However, the work orientation is changing more and more towards family and community focused care and the services will be developed multiprofessionally based on the needs of the clients and the results of research (Vaittinen 1995, Pelttari 1997). Home care of the client is based on his/her individual Care and Service Plan which is usually prepared in a working group in collaboration with the client and his/her immediate family. The working group usually includes a social worker, a home help worker and a home nurse, sometimes also a general practitioner. Usually the home nurse coordinates home care and home nursing and he / she is working independently. The monitoring and follow-up of home nursing is the responsibility of the client's primary general practitioner at the local health care centre (Care Work with Older People 2003).

During recent years, the rehabilitative work approach has been strongly brought to the field of care work with older people. Each care and nursing situation must be carried out in a way that recognises and mobilises the client's own resources as much as possible in all care settings. In practice this means that in any care and nursing situation the client is encouraged to do everything he/she is capable of doing himself/herself. There are three fundamental priorities of the care of older people, a client-centeredness and a holistic perspective to the clients' life situation and circumstances and family-centred care. (Care Work with Older People 2003.)

HOME TELECARE SERVICES FOR THE ELDERLY

Hospitals and health centres in Finland use widely computerised medical devices (e.g. EEG) and software tools for data handling and communications (e.g. Electronic Patient Records, videoconferencing) (Mäkelä & Järvinen & Heikkilä 1996, Kitinoja et. al. 2002). The mobile use of clinical analysers is common, too. In these mobile cases measured signals (e.g. blood glucose, pulse, blood pressure) will be transferred via GSM (Group Special Mobile) network or telephone line to the home nurse or to the medical doctor. Mobile analysers are mainly used in ambulances, home nursing and home care services and in home hospitals. There will also be a growing number of clinical analysers used at home by patients themselves supporting independent living. Self-measured results will be sent via Internet, telephone line or GSM links to the family doctor or home nurse. At present 20 percent of the health care institutes in Finland use an e-mail consultation via the secure web. New projects related to the development of the regional network systems support also the possibility to access client's own health information using secure web-services. (Kajander & Konttinen 1996, Gates & Hemingway 1999, Ministry of Social Affairs and Health 2001 a, Nyberg & Reponen 2001.) In this article home telecare means using ICT-based applications in elderly home care.

Information and communication technology is already tested in elderly care support systems around the world. Care via interactive video-telephone for the elderly has been tested in many countries. (Rooney & Studenski & Roman 1997, Magnusson et. al. 1998, Wootton et. al. 1998, Johnston et. al. 2000, Arnaert & Delesie 2001, Ezumi et.al. 2002.) Wheeler (1998) stated that the cost of the video-telephone intervention was about two-thirds that of an on-site visit and it allowed the nurse to attend to between 10 and 20 more clients per day. According to the study made in Japan (Ezumi et. al. 2002) the elderly people using video-phones every day clearly expressed their satisfaction with the video-phone. It was also noted a perceived improvement in functional independence and an increase in active communication in more than half of the subjects. According to the study in USA (Johnston 2000) remote video technology in the home health care settings was shown to be effective, well received by patients, capable of maintaining quality of care, and to have the potential for cost savings. Financial assistance will be needed to create a viable and attractive video-phone network and telecare services for frail elderly people living at home (Bratton & Cody 2000, Ezumi et. al. 2002). Local cable systems have also been effective in creating high-quality telemedicine audio and video systems for the elderly at the rural sites and individual patient profiles have shown improvement (Lindberg 1997). In a pilot study in USA (Bratton & Cody 2000) the participants, generally healthy elderly residents, were pleased with the experience they had with the computer system recording their vital signs.

According to the earlier studies user perceptions regarding home telecare are positive. In a study of Agrell, Dahlberg and Jerant (2000) most of the elderly had either neutral (60%) or positive (33%) outlook regarding home telecare already before their enrolment in the home telecare pilot project. Following enrolment, all the respondents were either very satisfied (67%) or somewhat satisfied (33%) with services they had received. Almost all of them (93%) were willing to receive home telecare services also in the future. Similar perceptions of the elderly can be seen in the results of other various studies, too (Johnston et. al. 2000, Chae et. al. 2001, Demiris & Speedie & Finkelstein 2001, Guillen et. al. 2002). Chae et. al. (2001) noticed that elderly living in their homes were more satisfied with telecare than elderly in nursing homes. According to the study of Guillen

et. al. (2002) medical staff was reasonably satisfied with how the telecare service supported their work. They also agreed that an improved quality of health services was offered through telecare.

Based on the results of the comparative study in Finland and in Japan it seems that the elderly in Finland are quite active in the area of getting information and learning. Most common is to watch TV, so is also in Japan. This offers a new challenge for developing new kind of ICT-based applications for the home care of the elderly and utilizing TV for that. Also according to the results of the earlier studies nearly all of at least 60-year-olds in Finland read newspaper, listen to the radio and watch television. In this study, however, user perceptions regarding devices for entertainment and regarding electronic exercise equipments are not very positive in Finland, neither in Japan. (Kitinoja et. al. 2003.)

In the area of communication and interaction Japanese elderly need more assistance for independent living in moving than the elderly in Finland. In a study made in five European countries 86 percent of the elderly required help with transfer, too. (Magnusson et. al. 1998). Although Japanese elderly live usually with their family they need support in contacting relatives and friends, and also medical staff. The elderly in Finland participate in several social activities but in Japan it is not so common. However, based on the earlier studies social interaction has an important meaning for the elderly both in Finland and in Japan (Kitinoja & Hyyppä 1997, Ministry of Social Affairs and Health 1999, Kimura 2000). So, in this area there are also markets for new ICT-based elderly care applications. Based on the results of this comparative study there are positive user attitudes in both countries towards movement sensitive sensors installed at home and cameras connected to medical staff. (Kitinoja et. al. 2003.)

In the management of medication and health there is a need for new elderly care applications and best practices of home telecare in both countries. User perceptions are also positive in both countries regarding devices that remind medication and treatments and also regarding electronic memory aids and sensors attached to the person. According to the results of the study elderly people need support in the area of security, too. In this study the user perceptions are most positive regarding home telecare applications related to security. (Kitinoja et. al. 2003.)

Subjects in both countries showed an overall positive attitude towards using new ICT-based applications in home care. For the elderly it was sometimes difficult to imagine the utilization of these applications but the experienced interviewers helped them in that case. The findings are in agreement with the earlier studies (Whitten et. al. 1998, Agrell et. al. 2000, Demiris et. al. 2000, Johnston et. al. 2000, Chae et. al. 2001, Guillen et. al. 2002).

Gerontechnology is a new area of research and it has been developed in Europe in the early 1990' s. It is a combination of gerontology, the scientific study of aging-related phenomena, and technology, the research and development of industrial methods and products for gerontology. Gerontechnology is thus a multidisciplinary and inter-professional science. It involves technological research from the perspective of gerontology and aims at a good living and good working environment and conditions, as well as high level of care, based on the needs of aging people. Gerontechnology combines technical solutions and services and through concentrating in gerontechnology, the independent life of the elderly can be well supported. (Graafmans 1999, Kaakinen & Tärmä 1999, Kuusi 2001, Saranummi 2001.) In gerontechnological research the primary target is opportunities for care, information transfer and coping at home made available by modern technology (Ministry of Social Affairs and Health 1999). According to Graafmans (1999) gerontechnology can be applied in the areas of 1) information and learning, 2) communication and interaction, 3) aging and health and 4) security and quality of life.

REGIONAL SEAMLESS SERVICES FOR THE ELDERLY

Home-living elderly people usually require care, support and assistance from a number of different

professionals. Ideally, they are offered a seamless, high quality system of services. Their illness often entails transfers from one organization to another; from home to health centre, from health centre to hospital and from hospital back to health centre before their discharge. To ensure seamless, effective and safe services, the organizations and professionals should focus on finding new action models. Special attention should be paid on the (increasingly early) discharge of elderly people, which often results in re-hospitalization. Successful seamless multiprofessional collaboration is needed not only during transfers between institutions, but also at discharge. (Pihlaja 1991, Noro & Aro & Jylhä & Pohjolainen & Ruth 1992, Kitinoja & Hyyppä 1997, Heikkilä 1998, Kitinoja et al. 2000, STM 2001 a, Seinäjoen kaupunki 2003.) A seamless system consists of pathways of specialized medical services, primary health care and social welfare services, based on the clients' needs and created by means of flexible teamwork. It seems that we are undergoing a shift from the organization-centred provision of services towards seamless, client-centred service pathways. (Asikainen & Jaatinen & Sch?nroos 2000, STM 2001 c.)

The importance of creating an information system that enables the appropriate flow, availability and management of relevant information is stressed by Korpela (1999). From the perspective of information management, the care and service pathway can be seen as a body of information on the care and service process, gathered according to pre-set criteria and necessary for the management, supervision and monitoring of the care and service pathways. (Stakes 1999). The participants to this process should always be able to control the situation, regardless of which unit is currently providing the care or other services. In the ideal case, the client can be unaware of the shifts from one organization to another. (STM 1998, Asikainen & Jaatinen & Schönroos 2000.)

To sum up, the purpose of regional information systems is to contribute to the provision of seamless health and social services, which will, among other things, enhance the independent living and coping of elderly citizens. The information systems will help to bridge the gap between specialized medical services and primary health services, between public and private services and also between professionals, clients, families and other members of the community. (STM 2001 b, Raportti Hallitukselle 2002, STM 2002.)

CONCLUSIONS

New information and communication technology (ICT) facilitates new practices of care, prevention and health promotion, information transfer and seamless client centred care services and independent living at home. A challenge is to develop ICT-based services especially for preventive health care and home care. In this way time and other resources can be spared in home care, but the quality of home care can be improved, too. The matching of appropriate technologies with corresponding customer needs is of prime importance if the objective of promoting independent living is to be fulfilled. Based on the results of the studies the perceptions and beliefs of the elderly concerning new technology are identified as positive. So this is an encouraging factor for planning new ICT-based services and devices for home care nursing.

沖縄県一離島における住民参加の活動プロセス
—住民参加のモデルとの比較—

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Ⅰ．はじめに

沖縄県は有数の離島県であり、「沖縄振興開発特別措置法」第２条第２項に規定する指定離島は、平成16年12月末現在で39島（平成14年４月制定の「沖縄振興特別措置法」第３条第３項の規定では40島）、架橋などで陸路が確保されている島、人口10人以下の島、高齢者１人の島を除くと27島である。広大な海域に大小さまざまな島が点在し、52市町村中46.2％の24市町村が離島または離島を有している。離島は、“狭小性”、“孤立性”、“隔絶性”のゆえに、社会基盤の弱さを背景とする「公助」（法定サービス及び行政機能が直接的に関わるもの）の弱さや、高齢化率の高さを背景に独居高齢者や老夫婦世帯の多いことによる「自助」（本人、家族単位の助け合い）の弱さが、高齢者ケアの「不利性」として強調されてきた。しかし一方、離島の特徴としての“狭小性”、“孤立性”、“隔絶性”は、生活の全体性および地域の捉えやすさ、保健医療福祉の統合性の捉えやすさ、情報収集や提供、活動の実施および評価等の容易性、外界からのバイアス除去などにつながるものである。しかも、人と人とのつながりが濃厚に維持され、「互助」（関係者間の助け合い）が高い。それらは逆に離島の「有利性」として位置づけることができる（図１）。

報告者らは、「不利性克服型」から「有利性伸展型」へという逆転の発想で、沖縄の有人離島を市町村行政との関係で類型化し、相互扶助体系（公助・互助・自助）の視点から、地域ケアシステム構築の方向性を明らかにした[1)]。そして、類型化したタイプからモデル島を設定し、「互助」の機能に着目し、住民参加を意図した参加型アクションリサーチを展開した。

ところで、住民参加に関する研究は、主体としての住民参加の重要性や参加プロセス、阻害要因、成功事例紹介など保健福祉や建築学、行政学、開発協力など多様にみられるが[2-6)]、住民参加の定義は定まらず、時代や分野および立場で異なる。しかし、多くは「ものごと、特に行政の計画策定の場に当事者が参加すること」と述べている。1990年代から、保健分野では、ヘルスプロモーションの理念による住民参加の新しい活動モデルとしてPRECEDE-PROCEEDモデル[7)]、地域づくり型保健活動（SOJO-Model）[8)]、Project Cycle Management（PCM）[9)]等がある。これらの活動モデルは、専門家主導の客観性を重視した問題分析中心の疫学的手法に行政や住民も一緒になって知恵を出しあう、主観的かつ問題解決的な手法として誕生した。すなわち、住民の思いを政策下に繋げるために新しい活動モデルを提唱し、現状打破を図ろうとするものである。しかし、これらの活動モデルは始まったばかりであり、活動方法論についての課題は山積し[10)]、地域特性が十分に取り入れられているとは考えられない。しかも、保健医療福祉や介護制度の狭間にある離島における活動モデルとしての運用の可能性は薄い。また、農村地域については住民参加型農村開発法[11-14)]もあるが、住民の役割は計画立案に留まっている。したがって、「互助」の機能の高い離島において、その有利性を活かし、住民参加による新たな活動モデルに関する研究が求められている。

本論では、報告者らの先行研究[1)]において「互助」の機能が最も期待できる一離島における５カ年間の住民参加の活動プロセスを明確化し、先行モデルと比較し、その特徴を明らかにすることを目的とする。

Ⅱ．研究方法

１．対象地域の概要

「互助」の機能が高い地域として波照間島を事例として選定した。竹富町の波照間島は、日本最南端の島で八重山諸島の主島の石垣島から南西へ53kmの位置にある。介入時の住民基本台帳人口は

[1)] 沖縄県立看護大学
[2)] 女子栄養大学

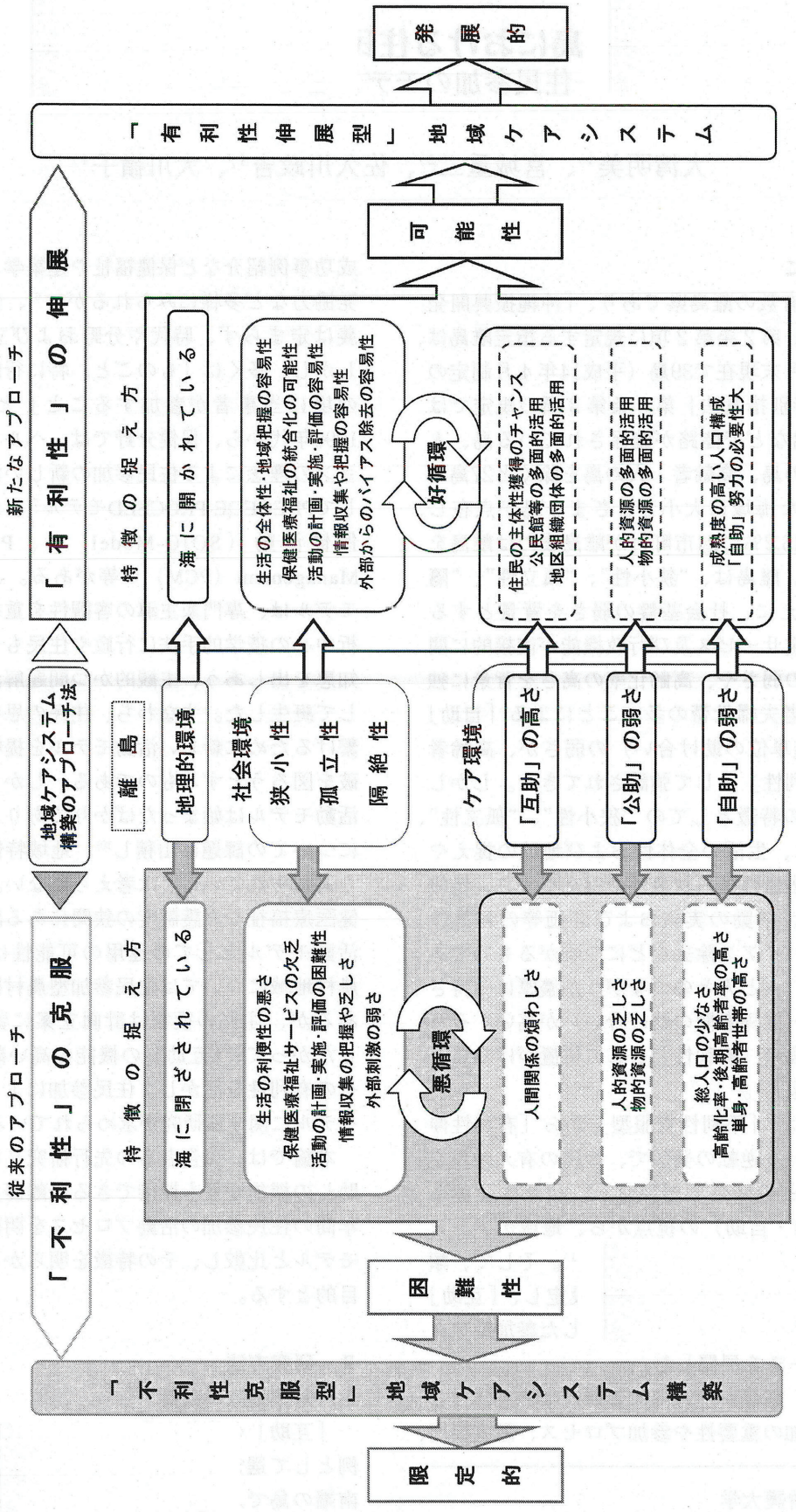

図１　離島における「不利性」の克服から「有利性」の伸展への転換

564人（平成11年12月末現在）、高齢化率は38.5%で、介入終了時の人口は600人（平成17年２月末現在）、高齢化率は34.0%で、少子化は進行しているが、県外出身者の社会増により過疎化の進行が緩やかである。

島では、共同農作業の「ゆい」が色濃く残っていること、集落ごとに共同売店を運営し、かつ、集会所を持ち、定期的活動や公民館活動が活発なこと、老人会や婦人会、青年会、ボランティア団体等の各種の地区組織活動が盛んなこと、主島との日中の往来が不便なため、医師・看護師や学校教師などは生活基盤を波照間島に置いており、その専門性が島民との生活の共有を通しながら多面的にいかされていることが、波照間島の「有利性」といえる。

２．研究方法

波照間島の事例研究の期間は、平成11年４月の地区踏査から介入を開始し、平成16年12月までとした。その間、現地訪問（月１回を原則に50回以上）、質問紙による調査（高齢者在宅福祉サービス調査、高齢者共同施設「すむづれの家」のあり方についての島民意向調査、生きがい型デイサービス利用希望者の活動方法に関する調査、ボランティア等に関する意識調査、ゴミだしの実態および希望調査、栄養調査、今後の地域づくりに関する調査、活動評価調査）、保健医療福祉などの活動や伝統行事への参加（「すむづれの家」活動報告会や島最大の伝統行事「ムシャーマ」参加など）による参加型アクションリサーチでデータを収集した。

今回は、報告者が専門職の立場で、月１回を原則に「ワーキング会議」に参加したデータを基礎としている。ワーキング会議内容は、参加メンバーの許可を得て毎回録音し、逐語録でテープをおこし、その内容から住民参加の活動プロセスに関する情報を整理した。住民参加については、活動プロセスを中心に、先行モデルとの比較を行い、その特徴を明らかにした。比較は、ヘルスプロモーションの活動モデルとしてPRECEDE-PROCEEDモデル、地域づくり型保健活動（SOJO-Model）、Project Cycle Management（PCM）、および住民参加型農村開発法として、簡易農村評価Rapid Rural Appraisal（RRA）、参加型農村評価Participatory Rural Appraisal（PRA）である。比較モデルの選択理由は、波照間島の事例は、住民参加の地域活動であり、農村地域であることによる。

Ⅲ．結　果

１．住民参加の活動プロセス

波照間島の住民参加の活動プロセスは、「基盤整備」、「ニーズ把握」、「計画策定」、「実施」、「評価」になっていた。

１）基盤整備

報告者ら（以下、「専門職」と記す）は、介入に際し、住民参加の基盤整備を第一とした。基盤整備のキーワードとして、「住民組織づくり」と「情報共有」を位置づけた。地域住民の「参加型」、すなわち、従来の行政計画に住民代表者を参加させるという参加ではなく、地域のニーズ把握に基づいた計画づくり、活動の実施及び参加、活動実施の住民評価という全プロセスに参加を意図した新たな住民組織が主体的に参加するための住民組織づくりを支援した。また、住民組織の活動の共有および全住民の活動参加により「互助」の強化を目的とした情報公開を支援した。

具体的方法として、介入初期に住民組織づくりは「ワーキンググループ」（以下、「ワーキング」と記す）の誕生、情報共有は「（ぱいぬ島）通信」の発行を提案した。

①住民組織づくり

ワーキングの組織構成の理念として、「新たな組織」、「ボトムアップ」、「有利性の活用」、「生活者中心」、「柔軟でオープン」という住民参加を意図したパラダイムの変化を試みた（表１）。取り組み方は、参加型の活動展開には、既存組織や既存役割にとらわれることなく、新たな住民組織づくりをした。しかし、従来の役割や専門性等を有利性として活かすため、横断的な組織構成とした。また、トップダウンに馴染んだ役場職員と住民の関係をボトムアップへの転換を図るために、行政や専門職は支援者として位置づけた。さらに、都会とは異なり、狭小な離島では、島民の力関係の影響を受けやすいため、地域特性に配慮し、生活に直接的に力関係の絡みそうな役職は排除した。

ワーキングメンバーは、地区組織団体の代表、島内で生活を共にする保健医療福祉関係者、学校関係者などで構成され、役職交替や人事異動等により変更する。また、その状況や必要性に応じてメンバー追加があり、柔軟でオープンな組織で、

年々メンバーが増加していた（図2）。平成12年度から平成15年度までのワーキングメンバーの実数は55人、性別は男2対女1の割合で、年齢は20歳代から80歳代まで各世代が加わっていた。

ワーキングは、従来の縦割りの地区組織を横断的にすると同時に、新たなメンバーを加え波照間島の住民参加で「互助」を活性化する組織の中核と位置づけた。

② 情報共有

ワーキング誕生と同時（平成12年12月）に、離島の狭小性を有利性として「みんなで」、「みんなのもの」にし、「現状打破」をめざし、「ぱいぬ島通信」発行が決定した。

この通信配布による情報共有の流れは、図3のとおりである。通信発行に際し、ワーキングで目的、内容、作成方法、配布方法が検討された。通信は、住民の往来が日常的である5集落の共同売店に置き、自由に自主的に受け取る方法が採用された。しかし、第2回の通信発行後、売店に通信が山積されていることがワーキング会議で問題になり、配布方法の検討が行われた。売店での適切な通信置き場の確保が困難であることがあがり、ワーキングで配布方法の見直しが行われた。ボランティア代表者から「メンバーの高齢者の役割として担当したい」という希望に応じ、ボランティアによる各家庭配布となった。

その後、平成15年2月のワーキング会議では、通信の購読に関することが話題となった。その際、高齢者が「通信は高齢者のもの」と思い込み、自分で購読し、家族にみせずに保管するため、同居世帯の若い世代が通信を読む機会がないことが話題にあがった。その結果、従来の方法と公民館などの集会所配布と地区組織団体への複数部追加配布方法が採用された。

このように、ワーキングの住民参加の活動内容が、タイムリーに全戸に情報共有されるしくみができた。その結果、問題発生による見直しを住民組織のワーキング会議で繰り返しながら、通信の定着化が図れた。さらに、ボランティア団体や地区組織団体にも新たな役割が付加され、「互助」が強化されていった。

2）ニーズ把握

専門職による介入時のワーキングの位置づけは、住民の意見を反映する住民代表とした。しかし、後述する計画づくり体制時に当事者主義の重要性が討議され、当事者としての高齢者のニーズ調査が繰り返された。研究期間中にワーキングが実施した調査は、前述した質問紙による「高齢者在宅福祉サービス調査」以外の全てであり、ニーズ調査が中心で、その内容は当事者からみた地域ケアの必要性の確認、利用対象者の把握、利用方法や内容の希望把握などであった。調査の流れは、図4のとおりである。ワーキングで地域ケアの必要性が検討され、高齢者全数のニーズ調査が計画される。調査方法や内容などの具体的実施方法が討議され、決定される。対象者を正確に把握するため、住民基本台帳による対象者リストを役場に依頼する。調査項目は、討議内容を基に、専門職（大学教員）に調査票（案）の提案を依頼する。調査票（案）はワーキングで検討され、調査票が完成する。住民には、討議内容が通信により公開され、調査協力の記事が掲載される。調査は、ワーキングメンバーが集落単位で構成し、通信に調査員の名前が公開され、実施される。調査後の調査票は専門職が集計し、ワーキングに報告する。ワーキングは、地域ケアの必要性を確認し、地域ケア実施のための計画づくりに着手する。実施方法の検討では、地域ケアの希望者（ニーズあり者）を対象に再調査する。

このように、ワーキングは、実態把握とニーズの有無を中心に高齢者全数を調査し、さらに「ニ

表1　ワーキンググループの組織構成の理念と取り組み方

理念		取り組み方
1．新しさは新たな組織で	→	既存の特定組織に新たな役割を付加しない
2．トップダウンからボトムアップへ	→	住民の「陳情要望型」から「参加型」への改善に向け行政・専門職は支援者の位置づけ
3．地域の有利性の活用を	→	地区組織団体、島のリーダー、診療所、学校の活用
4．地域の生活者中心で	→	島の力関係、利害払拭のため影響ある関係者は排除
5．柔軟でオープンに	→	プロセスは住民に開放し、メンバー構成はプロセスで変更

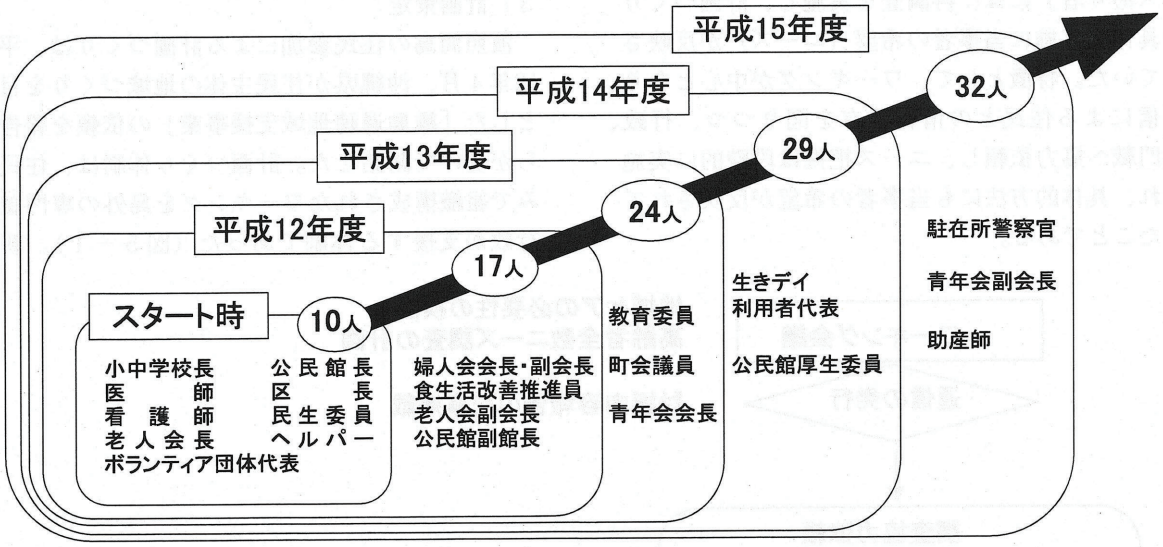

図2　ワーキングメンバーの広がり

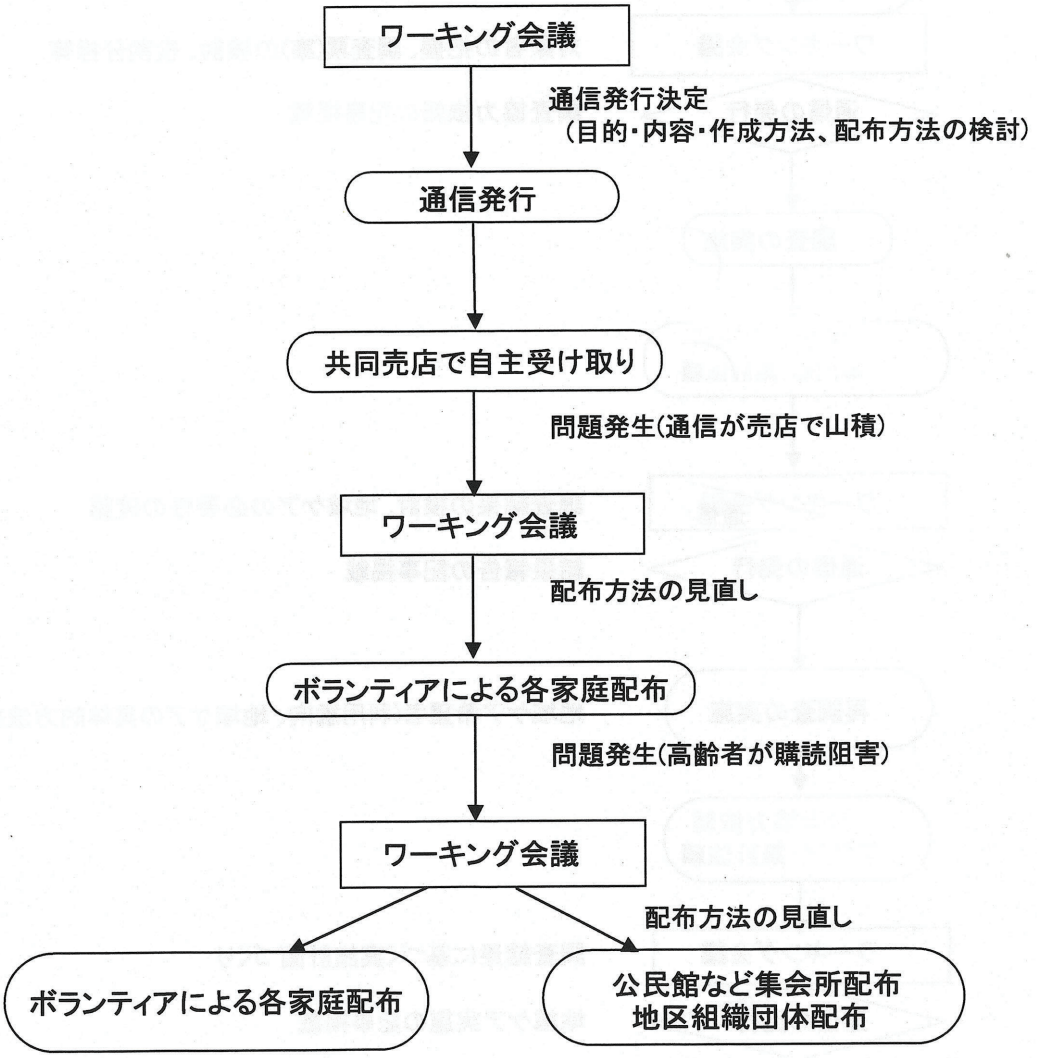

図3　情報共有の流れ（通信配布を中心に）

ーズあり者」には、再調査を実施し、計画づくりや具体的実施に当事者の希望（ニーズ）が反映されていた。特徴として、ワーキングが中心となり、通信による住民との情報共有を図りつつ、行政、専門職へ協力依頼し、ニーズ把握は段階的に実施され、具体的方法にも当事者の希望が反映されていたことである。

3）計画策定

波照間島の住民参加による計画づくりは、平成12年4月、沖縄県が住民主体の地域づくりを目的とした「離島過疎地域支援事業」の依頼を報告者らが受けて開始した。計画づくり体制は、住民のみで組織構成されたワーキングを島外の専門職や行政が支援する体制であった（図5－1）。新た

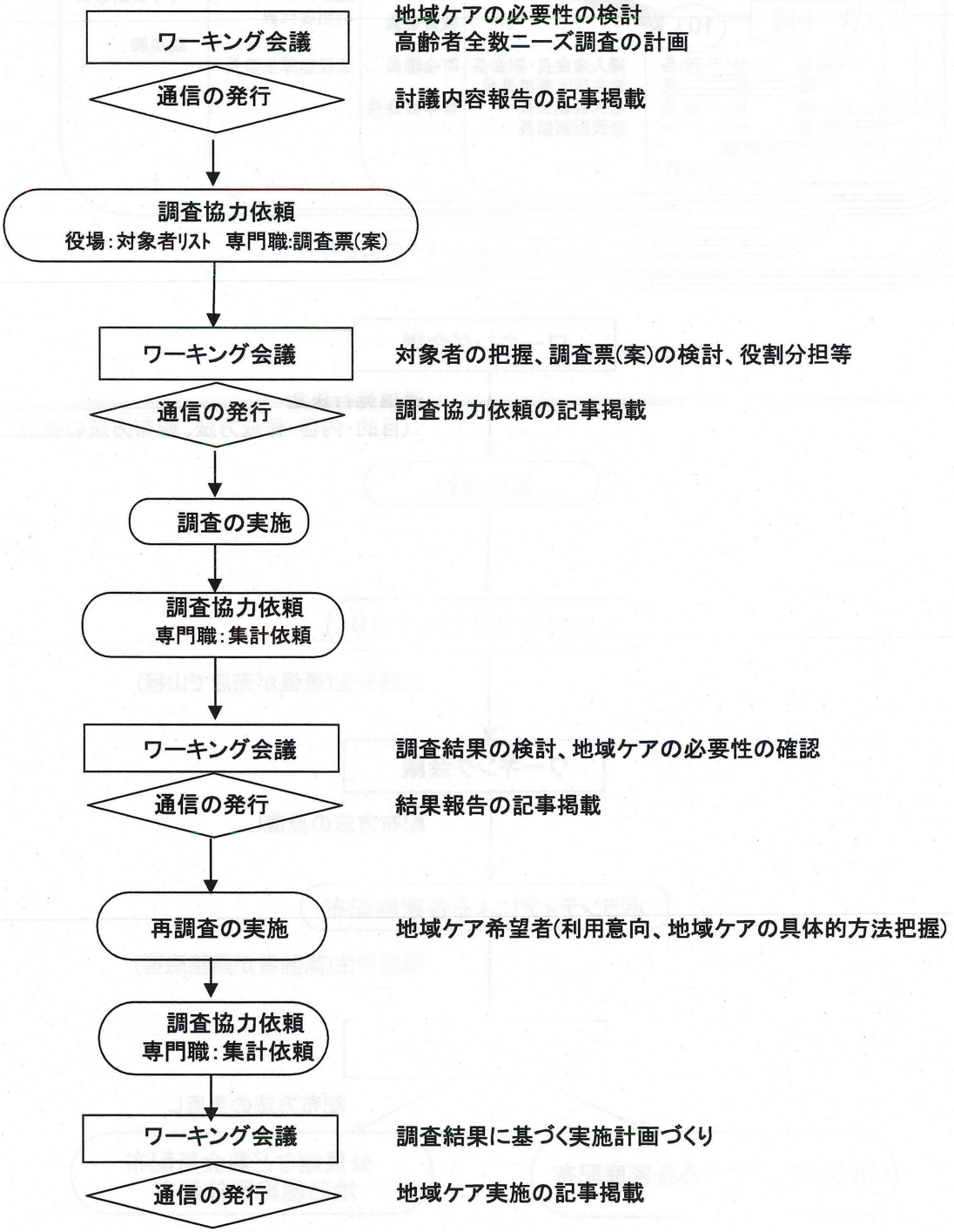

図4　ニーズ調査・分析の流れ

な組織への新たな役割付加には専門職が技術支援として介入し、行政は参加による見守りとした。ワーキングは、地区組織団体のリーダー等による横断的な組織構成であり、地域住民の意見が十分に反映可能と考えた。ワーキング会議での意見聴取に際し、「当事者である高齢者一人一人の意見を聞く必要がある」という意見がだされた。また、「特に高齢者は介護保険制度の知識が乏しく、意見聴取に際し学習会が必要」とされ、支援体制に地域住民の意見聴取及び学習会が追加された（図５－２）。

当初、住民参加の計画づくり体制として、住民組織であるワーキングの参加を住民参加として捉えていた。しかし、ワーキングでは、高齢者の意見を尊重する当事者主義の重要性が討議された。当事者の意見聴取のためには、介護関係の知識獲得が前提であり、老人クラブを中心とした学習会の開催につながった。結果として、住民参加は、住民代表としての住民組織と住民の二重構造となり、ニーズ把握のための調査を繰り返しながら、その結果を計画策定に反映していた。

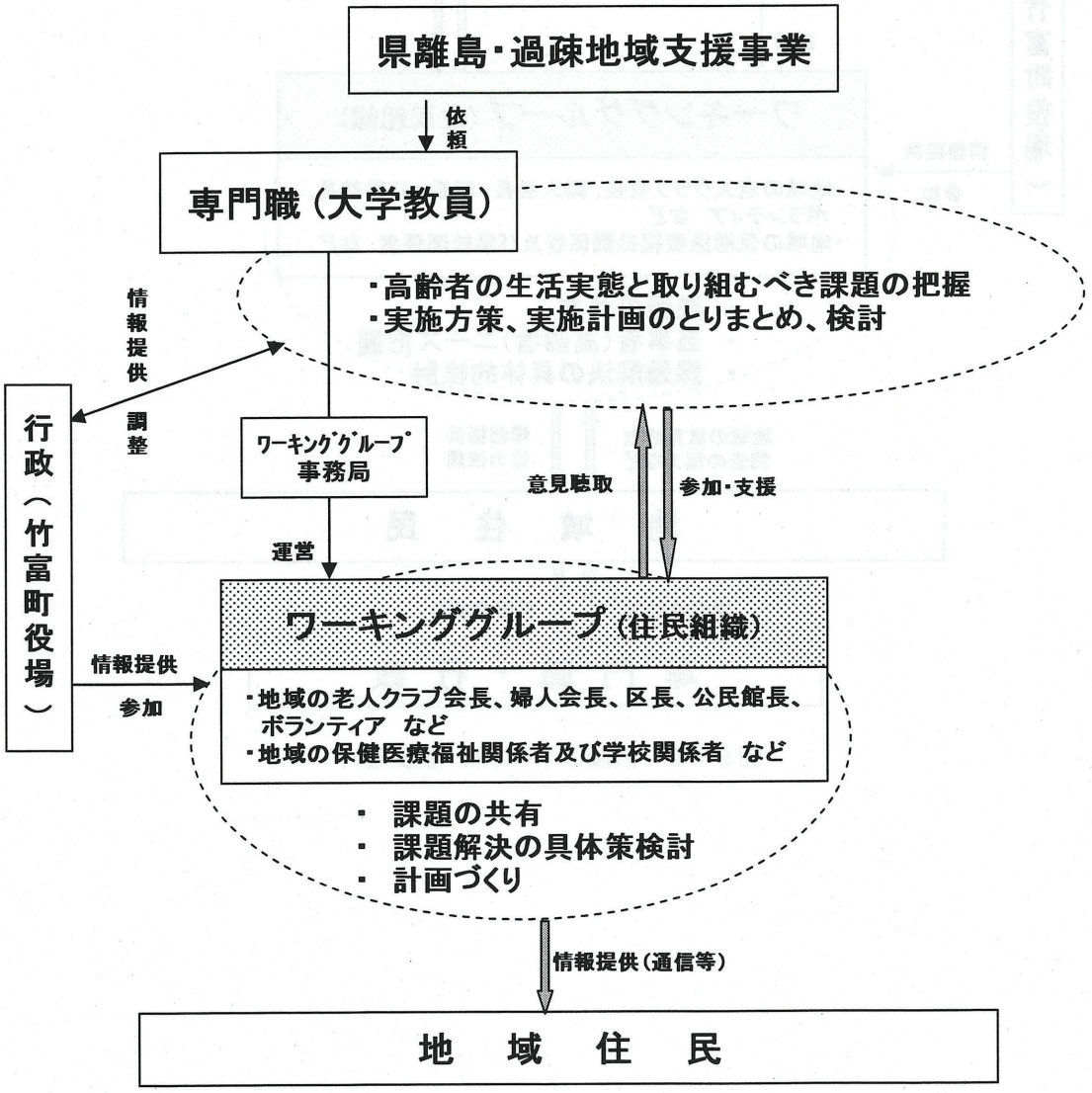

図５－１　計画づくり体制（変更前）

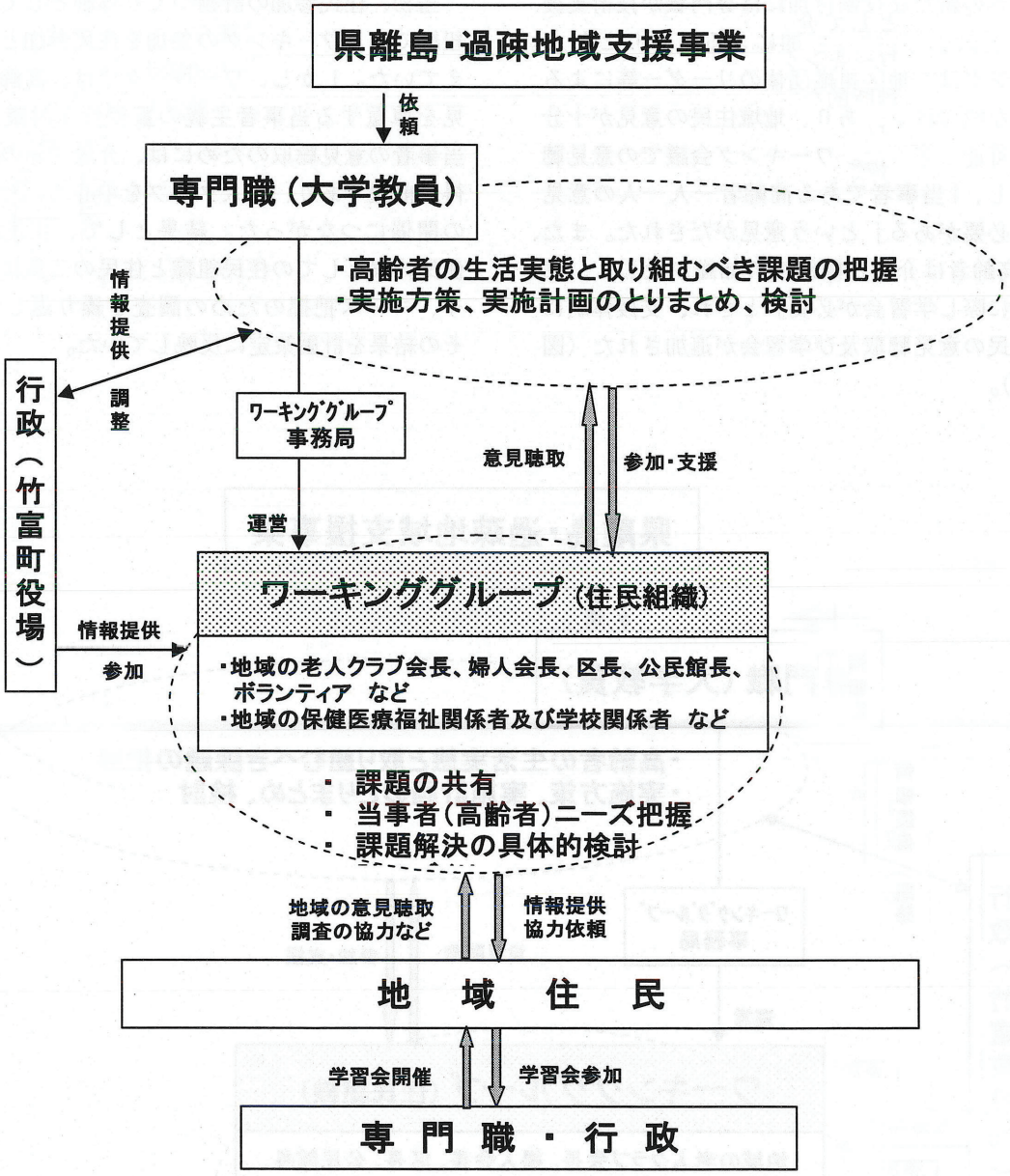

図５－２　計画づくり体制（変更後）

4）実施

実施体制は、ワーキングと市町村行政が両輪で協働活動をする（図6）。計画づくり体制で介入により技術支援を行った専門職は、後方支援となった。ワーキングは、計画づくり体制で習得した「当事者主義」を導入し、当事者へのニーズ調査を繰り返しながらサービス実施体制をつくっていった。

5）評価

地域ケア（サービス）の評価は、専門職や行政が直接的に評価する従来の形態ではなく、ワーキングと地域住民が行う（図7）。専門職や行政は、ワーキングの地域ケア評価への提言や情報を提供し、地域ケアについてはワーキングを経由して間接的に評価する。ワーキングは、地域住民からの活動評価を受けつつ、サービス提供者（すむづれの会）に実績報告を求め、サービス評価を行う。ワーキングは、平成13年12月に20歳以上の全島民を対象にアンケート調査を実施し、地域住民からの評価を受けていた[11]。ワーキングという住民組織は、自らの活動を住民全体から評価を受ける必要性を討議し実施していた。

また、今後の展開に向け、従来の任意団体（すむづれの会）の限界から、さらなる事業実施の基盤強化のために、NPO法人の必要性が討議された。島民集会を開催し、島民からの支持を受け任意団体「すむづれの会」は会員拡大を図り、NPO法人申請が決定し、平成16年6月に許認可を受けた。

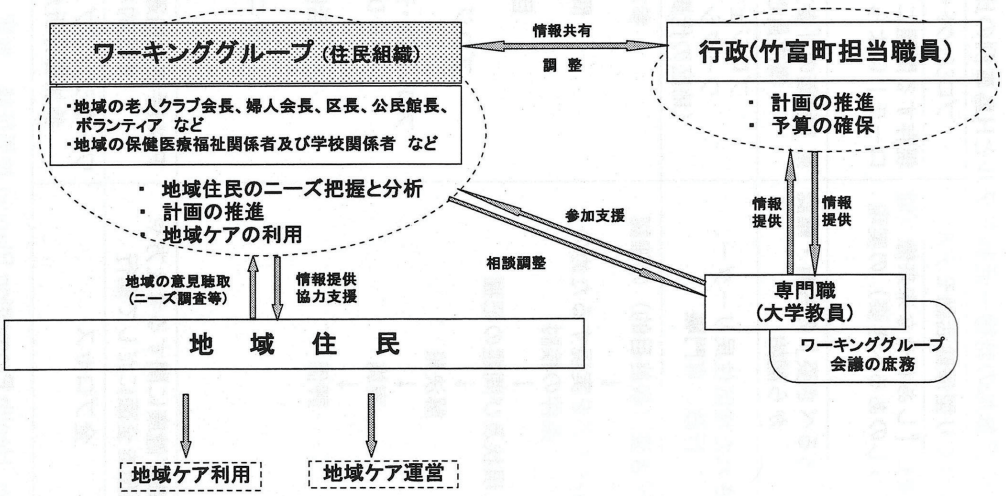

図6　実施体制

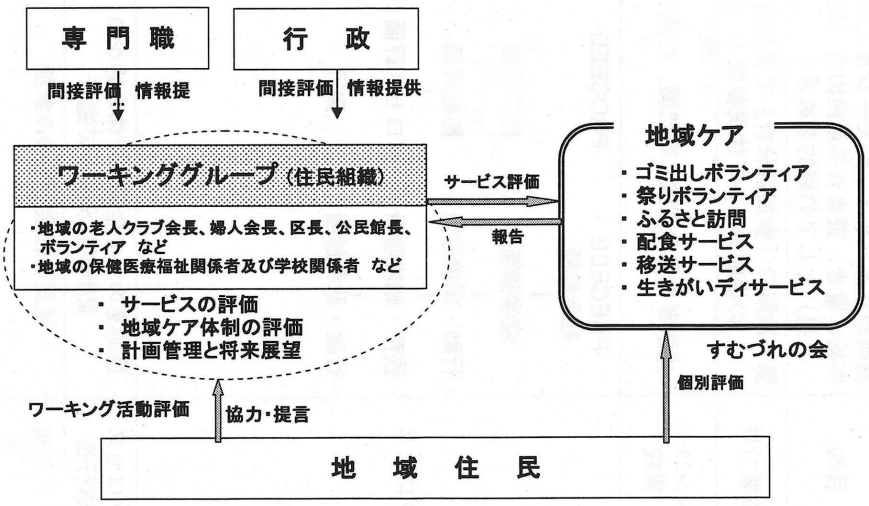

図7　評価体制

表2　住民参加の特徴ー活動モデルとH島事例の比較ー

	PRECEDE-PROCEEDモデル	地域づくり型保健活動モデル	プロジェクト・サイクル・マネジメント	波照間島事例
目的	健康教育をヘルスプロモーションの中核に置き、望まれる最終出力（結果）としての目的をめざす	住民の望む「しあわせな未来像（健康な暮らしのあるべき姿）の実現	現存する問題について「分析的なアプローチ」によって「問題解決」を図る	「互助」のエンパワメントによる介護が必要になっても安心して暮らせる地域ケア システムの構築
位置づけ	第1段階の「参加者分析」で参加者の構成員として住民参加	住民と「あるべき姿」の共有・確認から開始	第1段階の「参加者分析」で参加者の構成員として住民参加	介入初期に地区組織代表などの横断的グループ構成
メンバー構成	当事者とその家族、専門職、行政	選択された地区住民リーダー、行政、専門職	プロジェクトメンバーとワークショップメンバー（地区の代表、行政、専門職）	島民のみ（地区組織代表全て、島の専門職、学校代表、その他）
プロセス	PRECEDE 社会診断 ↓ 疫学診断 ↓ 行動・環境診断 ↓ 教育・組織診断 ↓ 行政・政策診断 → PROCEED 結果評価 ↑ 影響評価 ↑ プロセス評価 ↑ 実行	あるべき姿（最終目的）の確認 ↓ あるべき姿を実現するための条件の検討 ↓ 現状及び問題の把握 ↓ 解決策 ↓ 実施 ↓ 評価	参加者分析 ↓ 問題分析 ↓ 目的分析 ↓ プロジェクトの選択 ↓ プロジェクト・デザイン・マトリックス（ＰＤＭ）の作成 ↓ 活動計画表 ↓ モニタリング ↓ 評価	住民参加の基盤整備 ↓ あるべき姿の確認 ↓ 課題の把握 ↓ 課題の優先順位づけ ↓ ニーズ調査 ↓ 実施計画 ↓ 実施 ↓ 評価
プロセス進行役	目的をめざす企画者が体系的かつ批判的に分析して進行	専門職が健康に関する考え方や価値を全面にだして進行	PCM手法に精通したモデレーターが中立的な立場で進行	課題把握までは専門職、課題の優先順位づけから住民代表が進行
住民参加の範囲	住民は社会診断のみ参加	全プロセス	ワークショップメンバーの地区代表は参加者分析からPDMまで参加	全プロセス

出典：Lawrence W. Green, Marshall W.Kreuter, Health Promottion Plannig,神馬征峰，他訳, ヘルスプロモーション1997 ,P30-41.岩永俊博,地域づくり型保健活動のすすめ,1995,p30-44.FASID,PCM手法の理論と活用2001,1-30より一部抜粋して作成

表3　参加型農村開発法と波照間島事例の比較

	RRA (Rapid Rural Appraisal) 簡易農村評価	PRA (Participatory Rural Appraisal) 参加型農村評価	波照間島事例
目的	外部者による住民からの学習	住民のエンパワメント	「互助」のエンパワメントによる地域ケアシステムの構築
外部者の役割	調査員としての役割	提案・触媒の役割	ファシリテーター（改革の促進者）・コンサルタントの役割
住民の役割	調査の回答者としての役割 情報の提供者と問題の対応者としての役割	情報収集・分析・計画立案の役割 自分自身による問題把握と解決を通してエンパワーする役割	調査の実施者・回答者としての役割 情報収集・分析・計画・実施・評価者の役割 地域の問題把握と討議や地域ケア実践を通して「互助」をエンパワーする役割

出典：Michael Schonbuth & Uwe Kievelitz, Participatpry Learning Approaches, Deutsche Gesellschaft fur Technisce Zusammenaarbeit(GTZ) GmbH,1994,P13 及び河村能夫,住民参加型農村開発のための計画立案の方法-参加の過程を促進する方法の模索-2002,p70より一部抜粋して作成。

2．ヘルスプロモーションの活動モデルと波照間島事例

波照間島の住民参加の特徴を明らかにするために、ヘルスプロモーションの活動モデルと比較した。活動モデルは、ヘルスプロモーションの理念により住民参加が求められ開発された3モデル、PRECEDE-PROCEEDモデル、地域づくり型活動モデル（SOJO-Model）、プロジェクト・サイクル・マネジメント（PCM）とし、住民参加の目的、位置づけ、メンバー構成、プロセス、進行役、住民参加の範囲で検討した（表2）[7-9]。

波照間島の住民参加は、他の活動モデルと比較して、目的、位置づけ、メンバー構成、プロセス、進行役、住民参加の範囲に特徴があった。波照間島事例は、その目的が地域ケアシステムの構築であったが、活動モデルは、健康の実現や問題解決であった。介入初期の住民参加の基盤整備に基づき、住民組織づくりの理念を掲げ、地区組織代表などを横断化し、共に生活する専門職などを加えグループ編成し、島民のみで構成されていた。また、住民は通信による情報共有やニーズ調査への協力者として参加していた。このように、活動プロセスは住民参加の基盤整備から開始し、ニーズ調査が加わっていた。さらに、プロセスの進行役は、課題把握までは島外の専門職が行い、課題の優先順位づけ後は住民代表が進行し、住民参加の範囲は全プロセスであった。

3．参加型農村開発法と波照間島事例

参加型農村開発法の「簡易農村評価」（Rapid Rural Appraisal：RRA）、「参加的農村評価」（Participatory Rural Appraisal：PRA）については、外部者の役割と住民の役割で検討した（表3）[12-15]。参加型農村開発法と波照間島事例を「目的」、「外部者の役割」、「住民の役割」で比較した。波照間島事例の特徴として、外部者の役割は、調査員や提案・触媒の役割ではなくファシリテーターやコンサルタントの役割で、住民の役割は、調査の実施者、回答者としてだけでなく、計画の立案者、実施者や評価者として、地域の問題把握や解決者として役割が拡大されていた。

Ⅳ．考察

1．プロセスからみた住民参加の特徴

1）住民参加の基礎基盤の整備

基礎基盤として、住民組織づくりと情報共有を位置づけた。住民参加の目的としての地域ケアシステムの構築に際し、自治会や婦人会や青年会、ボランティア団体などの既存の地区組織に依存することなく、その目的に沿った新たな住民組織（ワーキング）が理念に基づきつくられた。既存組織には組織の目的があり、縦断的に役割機能が遂行されている。その活動を有利性としつつ、今回の目的に添って横断的に組織を構成した。新井[16]は、これからの健康福祉の活動モデルは、行政や専門職と共に住民参加による新たなパラダイムが求められていると述べている。住民参加のために、地域の有利性を活用し、新たな柔軟な組織で、生活者中心のボトムアップの住民組織づくりは、住民参加の基礎基盤の一方法として位置づけられると考えられた。

基礎基盤としての情報共有は、「みんなで」、「みんなのもの」にすることをめざし、全戸配布が住民の手で実現した。巴山ら[17]は計画作成で最も重要なことの一つに「住民との情報の共有化」を挙げている。情報共有による住民参加は、主体的参加への第一歩である。情報共有を容易にしたのは、離島の狭小性と「互助」の機能の高さという有利性であると推察された。

2）住民からのニーズ把握優先

住民参加の活動プロセスで重視したのは、「住民のニーズ」優先であった。ニーズ論については、国内外で議論があり、その定義は曖昧である[18-21]。しかし、WHOの国際生活機能分類（International Classification of Functioning, Disability and Health）やわが国の社会保障構造改革の流れは、専門職者の捉えたnormative needs（規範的ニーズ）に加え、felt needs（個人的ニーズ）を重要視している。このような観点から、計画づくりに際し、専門職者や行政が捉えたニーズ（normative needs）より、住民からのニーズ把握を優先した波照間島の事例は、時代の流れに沿い、住民参加の基盤となり、住民の参加を容易にした要因と考えられた。

3）計画策定における住民参加

計画策定における住民参加は、住民組織（ワーキング）により当事者主義の重要性が討議され、住民組織と住民（当事者）の二重構造であった。計画策定における住民参加は、ニーズ把握のための調査協力、意識を持った住民が住民運動の形で要望書提案、住民の代表による計画策定委員会への参加などのパターンがある。これらの計画策定は、行政や専門職の主導による一部への住民参加である。しかし、波照間島の計画策定への住民参加は、ニーズ把握を繰り返しながら住民組織も当事者も全プロセスへの主体的な参加が特徴といえる。

4）実施における住民参加

離島の住民は多面的に役割があり、計画づくりと実施が同一人物で重なることは予測されるが、波照間島では、計画づくり、実施をワーキングが中核となり、その役割を意図的に重複させていた。永田[22]によると、住民の価値意識の変革・変容は、情報の提供や福祉教育の強化のみの達成は容易でなく、活動や運動への参加による実践的体験が地域ぐるみの協働活動につながると述べている。また、佐瀬[23]は、住民参加による主体形成過程で活動参加の重要性を述べている。

波照間島の住民参加は、当事者のニーズにより住民組織が作成した計画を、地域住民が利用、運営し、住民参加を強化していることが特徴と考える。

5）評価における住民参加

地域ケア（サービス）の評価では、従来、行政の予算に基づく定量的な実績評価が実施されている。しかし、波照間島では、地域住民が住民組織と地域ケアの評価、住民組織による地域ケアの評価を行い、行政は住民組織を間接的に評価していた。

Gubaら[24]は、評価を、歴史的に測定主義、形成主義、総合的認定、参加協調型の4タイプに分類し、評価の主観性を重視している。このような観点から、波照間島の住民参加が評価に関与していることは意義があると考える。

波照間島の住民参加は、地域の課題、アセスメント、計画、実施、評価の全てのプロセスに当事者（住民）が主体的に関わり、住民のニーズが尊重され、展開されていた。

2．活動モデルとの比較

ヘルスプロモーションの3つの活動モデルとの比較で、共通点は介入初期の段階で住民参加を位置づけていたことである。いずれも、住民の「思

い」を根幹に据えた活動展開を試みている。波照間島が他のモデルと異なる点は、メンバー構成が島民のみであること、プロセスに住民参加の基盤整備を第一にしていること、当事者（高齢者）のニーズ調査に基づいていること、プロセスの進行役を住民代表が担っていることなどであった。

田中[25]や宮坂[26]らは、保健分野で当事者としての住民参加の重要性について、プライマリ・ヘルスケアやWHOの健康の概念まで遡り論じている。しかし、専門性が故に住民の主体的な参加の困難さも指摘し、あるべき住民参加に近づくことを求めている。

最近、保健医療福祉分野だけでなく、建築や都市計画分野では、住民参加に関する研究が増加傾向にあると報告されている[27]。また、「高齢者介護研究会報告書」における2015年の高齢者ケアビジョンでは、「高齢者の尊厳を支えるケア」の実現を基本に据えている。そして、その実現には、「生活の継続性を維持するための新しい介護サービス体系」が必要であり、住民を主役とし、住民や地域のエンパワメントが課題であると述べられている[28]。さらに、PRECEDE-PROCEED モデル提唱者のGreenらが強調している住民参加の意義は、「専門家主導型のモデルとしての限界」が指摘[29、30]されながらも、従来の手法との比較で対象者のQOLへの配慮や周囲のサポートへの拡がりを特徴とし、現実的な住民参加の方法を提案している[31]。

国民的課題としての高齢者の介護問題は、保健医療分野と比較し、専門職と住民の専門知識の格差や距離感が少なく垣根が低い。しかも、住民はサービス利用者として実感する必要の切実さ、不便さなどの点では専門家より優れた発想を持つとも考えられる。波照間島での住民参加の地域ケアシステムの構築にあたり、高齢者の介護を話題にしたことが住民参加を容易にした要因ともいえる。住民参加に慣れない住民が介護問題を入り口にして経験を積むことにより、さらに健康づくりへの主体的参加をも期待できると考える。

このように、過去から現在まで保健医療福祉の分野で住民参加の重要性については、議論を重ねてきたが、住民参加の位置づけや、参加の範囲、住民の役割など具体的展開は不十分といえる。地域特性を考慮した住民参加の実証的研究としての波照間島の事例は評価し得るものである。

V．結　論

「互助」の機能が期待できる波照間島の住民参加の活動プロセスを、先行モデルと比較し、その特徴を明らかにした。

1．活動プロセスからみた波照間島の住民参加の特徴は、離島の「有利性」を活かし、「互助」の機能に着目した展開をしていた。

2．その特徴は、①住民参加のための基盤整備（住民組織づくり、情報共有）を第一に位置づけたこと、②ニーズ把握に基づく計画策定、③住民参加の範囲が計画策定、実施、評価の全プロセス参加、④プロセス進行役は住民代表であった。

3．住民参加は、過去から現在まで保健医療福祉や建築学、行政学、開発協力など多様な分野で、その重要性については議論が重ねられている。有利性伸展型の発想で「互助」の機能の高さに着目し、参加型アクションリサーチで展開した波照間島事例は、従来の保健活動モデルとは異なる新たな活動モデルであることが示唆された。

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The Activity Process of People's Participation in an Isolated Island in Okinawa
－A Comparison with People's Participation Models－

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Abstract

Purpose : The purposes of this study are to clarify the five years activity process of people's participation in an isolated island in which "mutual assistance" is expected the most, to compare it with precedent people's participation models, and to identify its characteristics.

Subjects : Hateruma Island was selected as the highest "mutual assistance" region. The population is 600, and the rate of elders is 34.4%.

Methods : The research period was from September 1999 to December 2004. This was a participatory action research. The data gathering was made through the visit in the island for attending the people's meetings, investigations by questionnaires, attendance to medical-health-welfare activities and traditional events in the island. The comparison with precedent people's participation models were made with health promotion action models and with participatory rural development methods.

Results and discussions :

1) The characteristic of the activity process of people's participation in Hateruma Island was to make good use of the superiorities of the isolated island, the high mutual assistance, between the people.
2) It contained ①improving of infrastructure for people's participation first (organizing a residents' group and sharing information), ②making of people-centered plan which was based on residents' needs, ③the portions of activities were planning, implementation, and evaluation (the whole process), ④the who in charge of expediting the proceedings were the representatives of residents.
3) The people's participation has been discussed for many years in the medical-health-welfare, architecture, public administration and development assistance fields. This research was started from the point of extension of superiorities of the high level of "mutual assistance", and was developed by a participatory action research method. The results of this research suggest that this study is a new action model, which is different from any precedent people's participation models.

Key words : isolated island, elders, people's participation, community care, activity process

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Rural Nursing Practice in Australia

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1. Introduction

The development of rural nursing as a new discipline maybe traced to the inauguration of a professional association, the Association for Australian Rural Nurses (AARN). This association was formed in 1991 in response to growing awareness that rural nursing practice is different to nursing practiced in non-rural environments (Hegney et al 1997, Handley 1998, Francis et al in National Review of Nursing education 2002). The practice of Australian rural nurses is diverse, and by necessity, they must be experts in a range of clinical nursing specialties (Hegney 1998). Australian rural nurses' practice in hospitals and in community based facilities with little or no collegiate, medical and/or allied health support. They are often the only health professional servicing the community and are expected to provide 'womb to tomb' care. This paper will describe the role of rural nurses in Australia and will profile the development of rural nursing as a new nursing discipline. The challenges of practice in this context will also be portrayed and contemporary issues threatening the delivery of health care services to the people of the Australian bush outlined.

2. The rural health workforce

In Australian rural environments the composition of the health workforce is determined by the degree of rurality. A number of studies have shown that rural Australia is under served by general practitioners and specialists (Medical Workforce Data Review 1995, NSW Health Department 1995, Overs 1989, Rosenman & Batman 1992). In Australian capital cities there are 1,043 people per general practitioner and in rural Australia there are between 1,400 and 1,745 people for every general practitioner (Commonwealth Department of Health and Family Services 1996). This reduced access to medical practitioners and allied health professionals has led to an increased scope of professional practice for rural nurses compared with their metropolitan colleagues. This greater scope of practice is characterised by an increased independence (Anderson & Kimber 1991) and a greater generalisation of skills and wider clinical experiences (Hope 1993, Sturmey & Edwards 1991). In most Australian states/territories new nursing career paths have been established that provide for legitimisation of this expanded role, namely 'nurse practitioner' positions. The initial role out of these positions was in rural areas in NSW (the most populous Australian state) as the broader 'scope of practice' of rural nurses was acknowledged by government and rural health services who were finding it increasingly difficult to recruit medical practitioners. While it may be argued rural nurse practitioner positions may have been established to 'gap fill' medical service needs it is now obvious that the nurses endorsed for practice as Nurse Practitioners have established role descriptions that are within the remit of nursing (www.nrb.gov.au, www.nursesreg.nsw.gov.au).

3. Rural Nursing: the context

Nursing the sick in isolated and remote settings is a not a new phenomena (Bushy 2000), however, acknowledgment by nurses who work in rural environments, that their practice is different to nurses who practice in metropolitan areas, is new. Moreover, the acceptance by the nursing profession, medicine and government that this context of practice is a legitimate speciality is ever evolving. Rural nurses have argued that there practice is diverse and that they must be multi-skilled experienced in a broad range of clinical specialities

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to practice effectively in rural contexts.

Contemporary Australian rural communities are characterized by diverse populations that include indigenous and non-indigenous Australians and immigrant peoples (Smith 2004). Rural communities are declining, with people from the bush moving to larger urban centres in search of work and social opportunities. Jensen (1997 in Smith 2004) describes these changes as the 'rural crisis' indicating that this phenomenon is attributed to 'new managerialist' practices, years of drought and a government policy that has embraced centralization as an efficiency strategy (Francis et al, in National Review of Nursing Education 2002). Health service provision in rural Australia has not escaped the impact of globalisation. The provision of health services is largely determined on a population based formula (GMAHS 1998). This means that service provision is reduced with distance from centres of high population density.

The rationalisation of health services has included the closing of hospitals and associated community services in many rural towns, and the regionalisation of specialist and more complex services to towns of higher populations. One–third of Australia's population live outside capital cities and metropolitan centres which are concentrated on the coastal fringes of the continent and where approximately 84% of the Australians live on 1% of the land mass (Handley 1998).

Australian governments are committed to ensuring that all citizens have access to health services. To achieve this goal at a cost that is affordable the health services that are provided in rural/remote areas are dependent on clinicians having multiple skills to meet community needs (Malko 2001). These factors coupled with the realisation that the rural health workforce is primarily a nursing workforce (65% and above) has led to rural nurses being described as 'Jills of all trades and masters of many (Hegney 1997).

4. Rural nursing practice

Rural nurses are generalist nurses with advanced practice skills and knowledge. Their practice demands that they have expertise across the lifespan and are capable of managing effectively any situation that arises including but limited to trauma, birthing, workplace injury, surgical intervention, palliative and end of life care, health education and promotion activities in response to local need. They must have well developed pharmacological, patho-physiological, and human science knowledge. Moreover, they must be effective clinical decision makers who are capable of functioning in resource poor environments.

Rural nurses are recognised as being resourceful people within the Australian health care system. There is acceptance by the broader nursing profession, medicine and government that they have an extended role (NSW Health 1998). Hegney contends (1999, 1997) that rural nurses use similar core skills to remote and metropolitan nurse colleagues but the skills required for rural nursing practice are more generalist than specialist in nature and that the range of skills required for practice expands with decreasing community size.

The practice of rural nurses is often in environments with limited medical, collegiate and other support and requires nurses to assume high levels of responsibility (Francis et al 2001). Kreger (1991 in Hegney et al 1997) suggests rural nursing is the practice of nurses who work in environments with limited access to medical support, while Hegney et al (2000, p.183) believe rural nursing is nursing practiced in environments where "... no medical practitioners are employed full-time in a hospital, but are located within the town, or in community health or district nursing service located outside a capital city or other major urban environments (that is less than 80,000)". Thornton (1992 in Hegney et al 1997, p.46) however, defines rural nursing as "... the practice of nursing in communities with a population between 500 and 10,000 who have access most of the time to at least one medical practitioners living within the town". Anderson and Kimber (1991 in Handley 1996, p.3) define rural nursing in the USA as "the practice of professional nursing within the physical and socio-cultural context of sparsely populated communities". While each definition embodies characteristics of rural nursing practice, Francis et al (in Heath 2002) believe the following is a more accurate description of rural nursing:

Rural nursing is the practice of professional nurses in rural environments as defined by the Rural, Remote and Metropolitan Areas Classification (RRMAC) with or without medical and/or allied health support.

The Rural, Remote and Metropolitan Area (RRMA) classification system defines 'rural' communities as those with a population of 5,000 - 99,999 and 'remote' communities as those with populations less than 5,000 (Australian Government 2005, www.health.gov.au). It is therefore argued that the practice of nurses in rural environments is determined by the employer and the needs of the community.

5. Recruitment and retention of rural health professionals including nurses

It is claimed that there is a reluctance by many health professionals particularly medical practitioners to work in small rural areas and an inability by health services to employ (due to the cost) a range of allied health professionals (Hegney 1997, AMWAC 1996, Best 2000). Traditionally rural nurses have filled gaps in health service provision in rural areas however the contemporary rural nursing workforce is ageing and new graduate nurses are reluctant to apply for rural nursing positions (Hegney 1997, AMWAC 1996, AIHW 2001). There are a number of reasons offered to explain why nurses are reluctant to take up the challenge of rural practice. Bell, Daly and Chang (1997, p.2/11) consider that rural practice has its "... own unique stressors" and inadequate training for rural area practice may push nurses to the limit in what is already recognised as a stressful occupation. They argue that authorities fail to provide cost effective education for rural health professionals and that access to available professional development education and training is restricted because of an inability by employers to provide back-fill to release staff. Rural nurses highlight their frustration that they are unable to maintain their knowledge and skills and are threatened by potential legal actions should they make a mistake (Hegney 2000, Heath 2002). Many rural nurses have suggested that they feel unable to cope with the increasing numbers of people presenting with acute mental health episodes and voice concern that their personal safety is at risk (AARN 2005). Francis et al reported that rural nurses often work in isolated practice settings and have little opportunity to debrief with colleagues and/or seek counsel when they necessary. AARN is to implement a mentor program for rural nurses that will provide professional and social support to rural nurses in an attempt to address this need. This project is being funded by the Australian government who have noted that unless strategies are initiated to assist the rural nursing workforce service needs will not be met. There has also been acknowledgment by rural nurses that they are often practising beyond the legal parameters of their designated roles, justifying themselves on the grounds that lives are at stake and they are the only health professional in attendance (Hegney 1997, Francis et al in Health 2002). The nurse registration authorities in each state and territory in Australia have indicated that will not tolerate practice that is beyond legally defined scopes of practice. The potential for nurses who continue with this practice to face prosecution and loss of their nursing practice licence is great (www.nrb.gov.au, www.nursesreg.nsw.gov.au).

6. Preparation for rural practice

Preparing nurses for the challenges of rural practice is identified as necessary by nurses (Francis et al in Heath, 2002). The literature describes the breath of curriculum content that rural nurses believe is required to prepare nurses for this type of practice that includes clinical, educational, management and generic topics (See Fig 1.).

Clinical
- Pharmaceuticals and pharmacology
- Accident and emergency
- Diabetes
- Cardiac care
- Paediatric care
- Midwifery
- Geriatric care
- First line emergency and advanced life-support
- Nursing procedures and processes
- Nutrition and diet management
- Physical assessment skills
- Nursing standards

Education
- Health Education and Promotion
- Teaching skills

Management
- Financial management
- Management/Administration
- Computer skills/systems
- Human resource skills
- Time/self management skills
- Leadership skills

Generic
- Communication skills
- Legal aspects of nursing care
- Counselling skills
- Problem solving and decision making

Figure 1. Proposed curriculum content for rural nursing programs (Francis et al in Heath 2002).

The breath and depth of knowledge required for rural practice is extensive and advanced clinical decision making skills essential. A curriculum that is able to address these needs at the undergraduate level is beyond the capacity of traditional Bachelor of Nursing programs. Monash University, School of Nursing and Midwifery developed a new 4 year bachelor of Nursing/ bachelor of rural Health Practice specifically for students seeking a career in rural nursing practice. Positive evaluation of this program from the perspectives of students and rural health employers is testament to the usefulness of this preparation (Francis et al 2004). It is expected that as rural nursing evolves as a specialist nursing discipline undergraduate programs of this nature will flourish.

Rural clinical placements are offered to students in most health education programs, as a recruitment initiative. There is concern however, that some rural students maybe disadvantaged if rural clinical placements do not provide them with opportunities to develop an extensive range of clinical skills particularly those associated with high technology and high dependency features (Francis et al in Heath 2002).

The need for rural nurses (post registration) to have current knowledge and skills has been highlighted and is a challenge that educationalist are addressing through the adoption of new teaching techniques and modalities of program delivery. The literature highlights that rural nurses appreciate post registration and post graduate courses that have face to face content, and "hands on skill" development. Furthermore, research suggests that rural nurses do not like distance education courses or computer based courses (Francis et al in Heath 2002). The research that this finding was based on however, relates to the existing rural nursing workforce that is an older population of nurses who may have meagre computing skills. As new graduate nurses enter rural practice it is likely that the opposition expressed by the current rural nursing workforce toward computer based learning, will disappear.

Rural Australia is still not well serviced by internet telecommunications. Access in many areas is limited and many health facilities have inadequate or no computers available for staff use (Barnet et al 2004). The time taken to download attachments has also been identified by rural nurses as problematic given the poor telecommunication system available. Until this impediment to online learning is addressed the concerns voiced

by rural nurses are realistic. Moreover, rural nurses are often unable to leave their workplaces, as there is no locum relief which limits their capacity to engage in education that is clinically focussed and requires skill development.

6. A new specialist nursing discipline

Rural nursing is emerging as a new specialist discipline. The Association for Australian Rural Nurses was formed in 1991 led by an Australian rural nursing academic Professor Desley Hegney. She and a group of like minded people felt that the practice of rural nurses was different and that there was no forum in which they could raise their concerns and lobby for change. Hegney launched the Association for Australian Rural Nurses (AARN) whose mandate was to raise the profile of rural nurses and to influence State and Territory and the Federal Governments about issues facing rural communities and health professionals (Buckley in Seigloff 1997). She argued that remote and metropolitan nurses' interests were represented politically through professional associations (e.g. CRANA, RCNA, NSWCN) which legitimated their claims for credibility. Rural nursing she believed remained invisible until the formation of AARN in 1991. Today AARN provides rural nurses with a political voice, representation on national and state executive committees and is the conduit for needs of 'bush' nurses to be addressed (Hegney, 1999).

With the establishment of AARN, a plethora of research has been generated to describe the practice of rural nurses. Educational programs have been developed to prepare undergraduate and postgraduate nurses for practice in this context. 'Rural nursing' is now a global phenomenon, and it is therefore argued it is a specialist discipline with nursing.

7. Conclusion

Nursing practice in rural Australia is qualitatively different to nursing practice in metropolitan and remote areas. Research contends that rural nurses are resourceful people within the health service (Hegney 1996), and that they must be multi-skilled (NSW Health 1998). Their practice is often undertaken in environments characterised by limited medical, collegiate and other support. Rural nurses assume high levels of responsibility and must be expert clinical decision makers. Rural nurses use similar core skills to remote and metropolitan nurse colleagues and the skills required for rural nursing practice are more generalist than specialist in nature (Hegney 1999, 1997). Practice is challenging and also rewarding. Supporting nurses to consider rural practice as a career opportunity is perhaps the responsibility of my colleagues and of the nurses gathered her today.

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分科会１「へき地における看護実践と看護教育」報告

ファシリテーター　篠澤倪子（自治医科大学看護学部）

（司会）：第１分科会にご参加いただきありがとうございます。この分科会には、国際研究集会でご発表いただきました、カナダからいらっしゃいましたKathryn Crooksさんと自治医科大学附属病院看護部長の菊池睦子さんをお招きしまして、「保健医療福祉関係機関等の機能と役割を踏まえたへき地における看護実践の課題」、「へき地における看護実践に関する学士課程教育」、「卒後研修、大学院を含めた生涯教育、Rural and Remote Area Nursing教育についての取り組み」などについて討議したいと思います。

午前の発表などから、カナダのへき地は、面積が広く、町から隣町までの距離があり、その間居住者はなく、公共交通機関はなく、すべて車で移動する。到着するのに、直線で数時間はかかるとのことでした。日本のへき地は、山間地、半島、離島、豪雪など、地域により特徴があります。面積が小さいが、到着するまでに起伏や迂回した道、離島など船でいかなければならないなどです。日本とカナダのへき地の違いが話題になりました。

このような地域の特徴と看護活動について、日本やカナダの状況について意見交換をしながら看護実践の課題について、まず話し合っていきましょう。

（沖縄県）：沖縄県の特徴は、離島が多いこと、周りが全部海で囲まれていること、船で乗り継ぎをしていくことです。ここでは、遠隔看護が行われており、現在、テレナーシングを研究して３年になります。島看護師と保健師、大学と３者でアクションリサーチをしているところです。遠隔看護のよい方法は、離島の看護師とインターネットで繋ぐことです。

久米島は、沖縄にある39離島のなかでもいいところですね。久米島には40床弱の小規模病院があり、そこに看護師が22名います。そこに３～４人の常勤の保健師がいて、外来看護師と連携しています。たとえば、検診で要医療と言われたら、うまく連携しています。医師がいます。そのほかは、診療所に看護師は１人です。

（Kathryn Crooks）：コミュニケーションをする目的は何ですか。

（沖縄県）：外来に来る患者の情報を大学側が島の看護師に提供するためです。高血圧と糖尿病が大きな問題で、たとえば介入の方法とかケアの仕方など、大学と島とで連携して勉強会をしています。費用ですが、以前は大学の研究費で、現在は国の科学研究費で行っています。

（Kathryn Crooks）：カナダの北部では、ナースステーションがあり、そこに看護師が２人いて、医師とは電話でやりとりをしています。患者さんは原住民です。北極点に近い所に小さなナースステーションが沢山あります。重症患者の場合は、飛行機でMedicine Hatへ搬送します。医師はお金にならないから行かないですね。

ルーラルナーシングで一番大切なものはコミュニケーションです。現場ではコミュニケーションが難しく、また、その経験がないですね。リレーションシップを持つことが大切です。国際的にカナダとオーストラリアと日本で学会ができましたので、これらのコミュニケーションの経験を全部出し合ってやるといいと思います。

（栃木県）：コミュニケーションのリレーショナルスキルについて、教育のなかでどのようにしていますか。

（Kathryn Crooks）：教育についてですが、看護学部の１年生には、コミュニケーションスキルからはじ

めます。患者にどう対応するか、3年生までにもう少し多く（実習）ローテーションを組みます。（実習）ローテーションでもって、個々の経験を積んでいきます。3年生になったら教えなくてはならないのは、地域のコミュニケーション（人間関係）は、病院とは違うということです。ひとつ大切な点は、地域での患者と看護師の関係は病院とは違うことです。病院では境目がはっきりしています。地域での看護師はすべてのことを知られています。そのため、地域の看護師はプライバシーを持つことはできません。そのため、まずは、そのことを学生に伝える。そして、学生を地域に出し、そのことを知ってもらう。帰ってくると、1．患者と看護師の関係に境目がないこと、2．すべてを知られていてプライバシーがないこと、そして、3．すべての人と何かしら関係があるということを学ばせます。そのことを教えたうえで、本当に地域看護にコミットしたいのか、学生に聞きます。私が地域看護に入ったときは、そのことを知らなかった。地域の状況に対して学生をしっかり準備させます。そのことを知らずに地域看護をするのは、とても難しいことです。地域看護で失敗する看護師は、だいたい人間関係が原因ですので、こういった状況をよく学生に伝えることが重要です。こうした狭い人間関係でもよい点があります。こうして対人関係がうまくいくと、患者の状態をよくわかり、看護がよくできます。厳しい面は悪いことが起きた場合なのです。たとえば、高齢者の病状の急変が起きる。その結果、人が死ぬと感情的になり、ぶつけてくるなど、影響がすぐでます。

（菊池）：卒業して地域に行くまでに研修などはありますか。

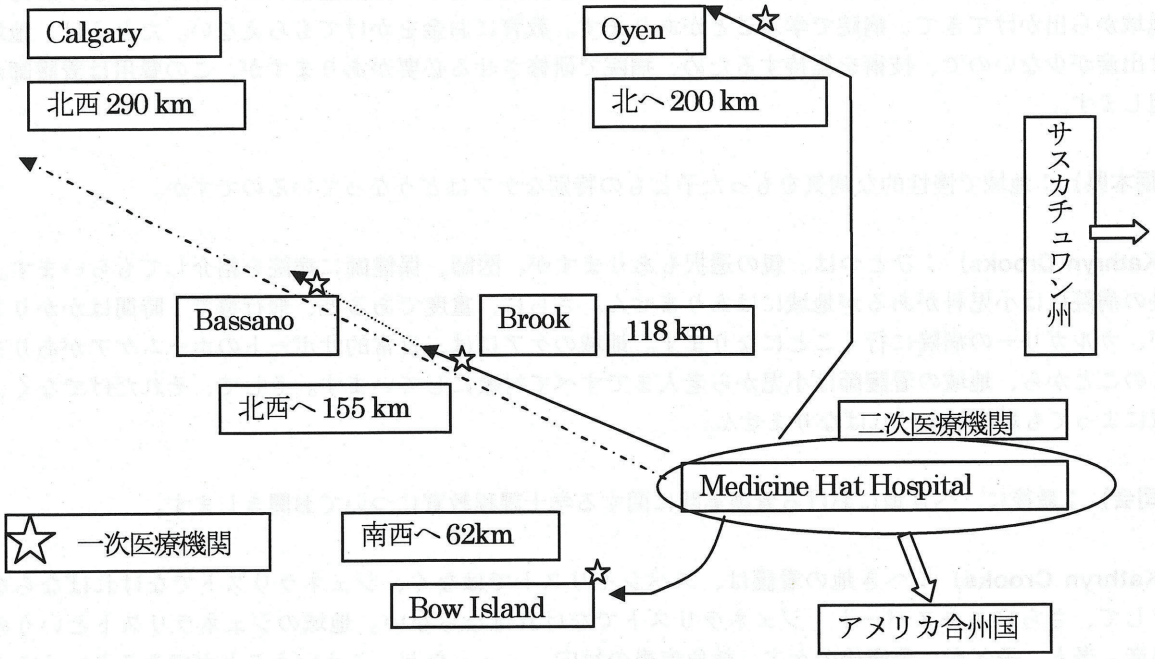
（Kathryn Crooks）：カナダでは、学校と働く場所が離れています。その地域（働く場所）のオリエンテーションは地域で行います。今のところ雇用者の方が働く場所や条件を説明していますが、専門的な教育はしていません。日本ではどうですか。

（菊池）：私どもの病院では、専門的な教育をしておりません。へき地の病院が8箇所ほどあり、派遣しています。実施されている看護の概要は話せますが、詳細な内容までは話ができない状況です。15年位、派遣しています。これを、派遣先で研修を受けられるようにしていただかねばならないと考えています。

（栃木県）：カナダに行って感心したことは、看護師さんへの支援方法がすごいことでした。新人ナースのオリエンテーションがよく行われているようでした。具体的に教えてください。

（Kathryn Crooks）：カナダでは健康区域が9つの地域に分かれています。診療所看護師はこの組織のなかに入っています。Medicine Hat Hospitalは二次医療機関（中核病院）です。ここでは、教育計画を立てプログラムを実施しています。教育担当者もおります。この中核病院と診療所はテレビ電話でつながっています。個人的な相談もします。たとえば、スタッフの子どもが事故で死亡したときなどの相談にのるのです。そして、地域にストレス対策チームがあって、ひとりひとりに面接し、事情を聴きます。ただ、問題もあります。それは、中核病院の人が地域を理解していないことです。地域のスタッフが中核病院まで行けないことです。Bow Island、Bassano、Brook、Oyenは一次医療機関、診療所です。健康増進活動をする保健師もおります。その他にNurse、初診、治療をきめるNurse Practitioner、理学療法士、栄養士、給料をもらっている医師がおります。ここすべては、公的な機関です。州政府がこれらの健康区域を賄っています。

次の図は、Kathryn Crooks先生が指し示したアルバータ州の地図を要約したものです。



(沖縄県)：離島に診療所がありますが、そこには県立病院の看護師が約3年派遣されています。

(岐阜県)：私の県も高齢化が進んでいます。看護師を経費的に駐在させられない。どうしたらいいかと思っています。

(Kathryn Crooks)：3年の契約しかできない。しかし、看護師はずーとやっていたい。看護師のストライキがあります。看護師はひとつのところに留まりたいのです。カナダの北部では期間がもっと短く、3週間の契約で行っています。

(栃木県)：カナダの看護師の活動状況を教えてください。

(Kathryn Crooks)：290㎞離れた地域がカルガリーです。ここは人口が増加しているところです。北カナダのAcadia Valleyは学校がなくなっている。子供が小さいときは、家族がそこにいるのですが、大きくなると出て行ってしまう。手術や薬の使い方も地域によって異なっています。薬物の使用など、場所によってシステムが違っています。本当は平等にすべきですが、できない状況です。このようなことについて、中央病院が地域のことをよく理解しています。Bow Island、Bassanoの2機関の看護師がホームケアを行っており、ホームケアは老人と契約しています。費用は行政が支払います。カナダの保健活動の話ですが、伝染病は保健所の担当です。あとは、予防注射。また、出産の時は育児教育を保健師が行います。出産後は検診があります。また、出産の時には一度は保健師が訪問します。しかし、母親がそれを望まないなら、断ることもできます。しかし、子供の虐待は、話が別です。虚弱老人や閉じこもり老人についても、医師、看護師に連絡があれば訪問します。昔は、精神科の患者は病院に入れてしまっていました。20年前からは、病院へ入れることは控え、地域で生活するようにしています。精神科の患者はかなり地域に住んでいるので、それをサポートするシステムが必要です。地域によって、メンタルヘルスという部門があり、そこの診療所に通院するようになります。入院が必要ならば、精神科の救急病院に入院させます。危険がある場合には、警察に収容させます。地域にも精神科の看護師がいますが、精神科の病院の看護師が地域に出か

けて行くこともあります。教育の実施については、医療従事者との遠隔通信により行っています。たまに地域から出かけてきて、病院で学ぶことがあります。教育にお金をかけてもらえない。たとえば、地域では出産が少ないので、技術を維持するため、病院で研修させる必要がありますが、この費用は看護師が負担します。

（栃木県）：地域で慢性的な病気をもった子どもの特別なケアはどうなっているのですか。

（Kathryn Crooks）：ひとつは、親の選択もありますが、医師、保健師に病院を紹介してもらいます。中央の病院には小児科があるが地域にはありません。さらに、重度であると、飛行機で1時間はかかりますが、カルガリーの病院に行くことになります。地域のケアには、日常的サポートのホームケアがあります。このことから、地域の看護師は小児から老人まですべて対象にしています。そして、それだけでなく、地域によっても対応しなければなりません。

（司会）：最後に、へき地における看護実践に関する学士課程教育についてお聞きします。

（Kathryn Crooks）：へき地の看護は、スペシャリストではなく、ジェネラリストでなければならない。そして、さらにエキスパート・ジェネラリストでなければならない。地域のジェネラリストというのは、出産、老人、子ども、手術後のケア、救急疾患の対応、・・・など。こういうことができるということを人々は理解していないですね。地域看護というのは、老人を診て、次にお産を診て・・ということがあります。したがって、役割が特定されないのです。1つの役割ではなく、すべての役割が融合して、1つになる。また、看護の領域を越えて対処しなければならない。そして24時間、看護から離れるわけにはいかないのです。大学を卒業してすぐは難しいですが、やらせなければならないのです。自分で考えて解決しなければならないのです。卒業生を地域に送り出す時はできるだけそういった問題について教育をして送り出します。たとえば、アセスメントの普及、メンタルヘルス、循環器問題（心疾患）の生活支援、管理やリーダーシップ、リレーションシップなどです。カナダでは、仕上げの実習をしたところに就職します。それを地域でやることもあります。地域に送り出す前に13週間（4ヶ月間に及ぶ）リーダーナースのところで実習します。ここで、コンサルテーションなど、学校で学んだことを定着させるのです。学士課程教育ですが、Medicine Hat Collegeは、1学年は3学期制、2学年は2学期制、3学年は3学期制、4学年は1学期制で授業を進めています。

1学年　1学期　基礎となるもの
　　2学期　ヘルスアセスメント
　　3学期　老年医学
2学年　1学期　薬理学、病理学、医学/外科学
　　2学期　メンタルヘルス
3学年　1学期　コミュニティ
　　2学期　経験内容の整理統合
　　3学期　ルーラル看護理論と実習
4学年
　　1学期　統合、管理、同行と理論

（司会）：もっともっとお話を伺いたかったのですが、時間になってしまいました。これで「へき地における看護実践と看護教育」を終わりにします。Kathryn Crooks先生、菊池睦子看護部長さん、どうもありがとうございました。（拍手）

分科会2「へき地におけるネットワーク作りと研究」報告

ファシリテーター　松田たみ子（自治医科大学看護学部）

国際研究集会2日目に行われた分科会2は、「へき地におけるネットワーク作りと研究」と題して、下記の3点の内容を討議した。

1）へき地に住む人々への保健医療福祉サービスの提供における課題について
2）へき地に住む人々への看護支援のためのネットワーク作り
3）遠隔地域への看護技術支援システム開発のための研究の課題と進め方について

本分科会は、1日目の「Elderly People Living Independently at Home Using Home Telecare and Regional Seamless Services」の講演者のHelli Kitinoja氏と、「沖縄県の一離島における高齢者の地域ケアシステム構築」の講演者の大湾明美氏の参加を得て行われた。

討論内容は、上記3つの視点を織りまぜながら進行した。1日目のKitinoja氏の講演に基づくフィンランドの保健医療福祉サービスの提供システムの現状についての紹介をしていただきながら、日本の超高齢化社会でのヘルスケア提供の課題と今後の提供システム作りについての可能性や方向性への示唆を得た。

討論の焦点は、高齢者あるいは地域で生活する人々へのケア提供システムであった。特にホームナースへの患者からの連絡、さらに他の医療職者との連携システム、そしてそれにおける情報技術の活用の視点が中心となった。

フィンランドでは、高齢者の急速な増加に伴って高齢者の自立支援という視点から個々のニーズに合わせて提供するという考え方にたって、多職種間のネットワーク作りということが課題となっている。また、高齢者ばかりでなく、地域住民への医療提供ならびにヘルスケアの提供へのインターネット等の情報技術の活用が行われている。

このシステムでは、病気になると住民は地域の保健センターに連絡をする。地域の保健センターでは、一般的な診療とケアの提供が行われ、重症であるなど、高度の医療が必要な場合はセントラルホスピタルで医療を受けることになる。退院後のケアは、ホームナースとホームアシスタントによって提供される。また、インターネットを用いてのモニタリングシステムの活用も、在宅療養の患者の身体状態のチェックにため試験的に行われている。

これらのシステムは、高齢者のヘルスケアだけでなく、若年層の方々もこのシステムを活用することによって、自らの健康への関心を高めることにも効果がある。多職種間の連携も課題であるが、これらのシステムに関与する職種は、ホームナース、一般医、ソーシャルワーカー、ホームアシスタントなどである。

フィンランドでも、地域により住民の年齢層に偏りが生じており、これは日本も同様である。しかし、近隣社会のあり方については、かなり様相の違う地域もある。この点については、沖縄のように高齢者人口20%以上という島でのネットワーク作りの例などにもあるように、日本では近隣の人々の支援なども活用することも現実的に行われている。地域住民に密着した役場の職員の意識の向上もネットワーク作りで重要な意味をもつ。

また、ネットワークの連携で情報を密に交換し合えるシステムと、医療的な介入が必要な場合の患者運搬体制についても合わせて整備する必要があり、地域状況や患者状況に応じてタクシー、救急車、ヘリコプター等の整備もネットワークのなかに組み込んでいくことの必要性も確認できた。これらの点は、フィンランドも日本も共通の課題であると考えられた。

分科会での討論を通して、フィンランドの高齢者医療の実際、沖縄の研究的取り組みからの実践例から、へき地（または医療過疎地域）の高齢者を自立させる組織作りとしては、

・地域住民で支援しあう組織作りが基盤となるネットワーク作り
・情報技術を活用して多職種間を結ぶヘルスケアネットワーク作り

・情報技術を活用した遠隔地へのケア提供システムのためのネットワーク作り

が考えられるのではないかということであった。

また、これらの組織作りを実施しながら、さらに有効な組織作りを構築していくことが重要であることから、アクションリサーチとしての研究を並行して進めることが大きな意味をもつ。このことは、研究を実施する過程のなかで、地域住民に働きかけたり協力をいただいたりすることが、地域住民への情報提供やこれらのヘルスケアシステムに関して考えるきっかけともなっている。研究成果はもちろんであるが、研究への取り組みそのものが、専門職種のみならず住民の意識も高めることへの効果をもたすことも大きな成果であることを認識した。

高齢化、入院期間の短縮化が進むなかで、日本におけるヘルスケア提供のネットワーク作りにおいて、高齢者が自宅で暮らすことが一般的なフィンランドのヘルスケア提供システムの考え方はとても参考になるものと思われた。また、地理的状況は異なっても、都市部と山間・離島という条件を考慮すると、広大な国土に少ない人口密度のフィンランドにも日本と同様の状況があり、現在そして将来的視点に立って有効なヘルスケアシステムを確立していくことが、実際に住民の生活のなかでどのような成果をあげているかを合わせて研究していくことが重要である。その研究成果をフィンランドと共同活用していくことで、互いに今後の発展の鍵となるかもしれないという印象を残し、分科会を終了した。

分科会３「へき地における看護実践と研究」報告

ファシリテーター　成田　伸（自治医科大学看護学部）

本分科会は、へき地における看護実践と研究的取り組みについての討議を目的に開催した。オーストラリアモナッシュ大学看護学部教授のKaren Francis先生を囲み、ファシリテーター１名、他12名の参加者を得て開催した。参加者は、地域看護学を専門とする者、実際にへき地で働いている者、働いていた者、JICA経験者、へき地看護に興味のある者等であった。

Karen Francis先生からは、１日目の講演で、医療資源や医療専門職者が限られた地域での独自の自立した看護実践としてのルーラルナーシングの特殊性についての話があった。日本のへき地での看護においても、実践における孤立性や雇用の確保の困難さ等で同様の課題をもっている。この課題をさらに探求し、またその解決に向けて考えていくためには、どのように研究的に取り組むべきかについて、またさらにせっかく広く多様な地域から集まった参加者の間での共同研究の可能性についても検討したいと思い、討議を進めた。

はじめに、Francis先生より日本のルーラルナーシングについて説明して欲しいとの要望があり、参加者の１人がへき地看護について実態調査の結果から下記のように紹介した。

・へき地での看護実践は、病院が近くになく、診療所を中心に行われている。
・へき地の個人の診療所では、看護職の仕事は診療の補助が主で、健康教育等は行われていなかった。
・へき地看護を実践している看護職の抱える問題としては、サポートがないことがあげられる。

そこで、地域看護とへき地看護の区分けなどの話題となり、Francis先生に対して、参加者側からルーラルナーシングをどう定義するのかについての質問があった。Francis先生がその際に板書された図を図１に示した。図にもあるように、ルーラルナーシングを考える上でのキーワードとして、「中心地からの距離」、「人口規模」、「健康、教育、経済、病院、店舗、専門家・医師等の資源」があげられた。たとえば、メルボルンは200万人の人口を抱え、大学、1,000床規模の病院（専門医、専門看護師がいる）、学校、店舗がある。Francis先生が住まれているのはメルボルンから200キロ離れた場所で、人口規模５千人から１万人、病床は200床で、いくつかの専門のサービス（心臓疾患、救急、外科、小児等）がある。そこから100キロ離れるといわゆるルーラル（へき地）で、人口規模は2,000人、病床は16床、専門スタッフはおらず、ナースプラクティショナー（NP）がいるだけとなり、NPが第一次医療を担っているそうである。しかし、大都市の医療とルーラルの医療は繋がっており、大都市の専門医が地域の医療を遠隔に支えているということであった。

そこで、同様に日本の現状の紹介があった。栃木県内のへき地の例は、自治医大から100キロ離れた地域で、110床に看護師61人、各診療科に医師１名の構成ということである。そこからまた離れた場所に診療所があり、看護師３人体制で、そこの診療所で対応できない場合は110床の病院に入院、あるいはヘリコプターで自治医大に入院している現状である。

このようにオーストラリアの状況と日本の状況を比較してみると、ほぼ同様の状況にあることがわかった。

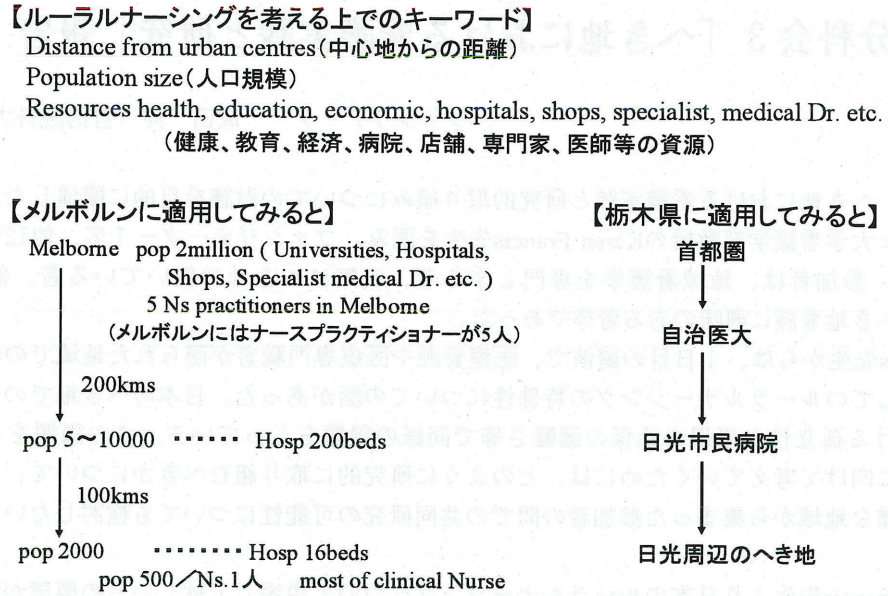


図１　ルーラルナーシングをどう定義するか

Francis先生は、このような概念図を説明された後、定義は自分たちで作ればいい、定義を作ってしまえば、実践や研究がそのなかから作り上げられるとアドバイスされた。

引き続いて、ルーラルナーシングに関わる看護職の持つべき能力について討議した。Francis先生によるとメルボルンのモナシュ大学の２施設では、入院患者はほとんど高齢者であり、看護師の能力として老人看護が必要となっている。また、近くをハイウェイが通り、交通事故が多発しているため、救急にも対応できなければならない。ルーラルでは、週３回都会から医師が派遣され、医師は手術後の処置等を行っているが、後を担う看護師は住民500人に１人で、糖尿病・心疾患といった慢性疾患を持つ人も多く、花粉の多さから喘息も問題で、へき地の看護職は養護教諭の役割も担うし、老人の買い物などもする、喘息の継続ケア、糖尿病のインスリン投与、ヘルパーや理学療法士の役割も果たし、多様な役割を担っている状況にあるそうである。また、へき地の健康問題として若い世代の自殺があり、精神科看護が重要だそうである。へき地の住民が抱える健康問題については、日本とオーストラリアの間で土地柄による違いがあるようである。

日本のへき地の保健医療は、診療所の看護職と地域の保健師が二重で行っていること、へき地の診療所の看護職は准看護師が多いとの報告があった。

ここでFrancis先生から、オーストラリアの看護教育の制度について説明があった（図２）。オーストラリアでは、看護基礎教育は３年、Clinical Nurse（臨床看護師）として臨床で働き、Specialist Nurse（専門看護師）になり、スペシャリストのコースに入り、看護管理等を行うLNCというコースに入るか、NPになる。臨床で働く看護師は全体の80％ほどとのことである。

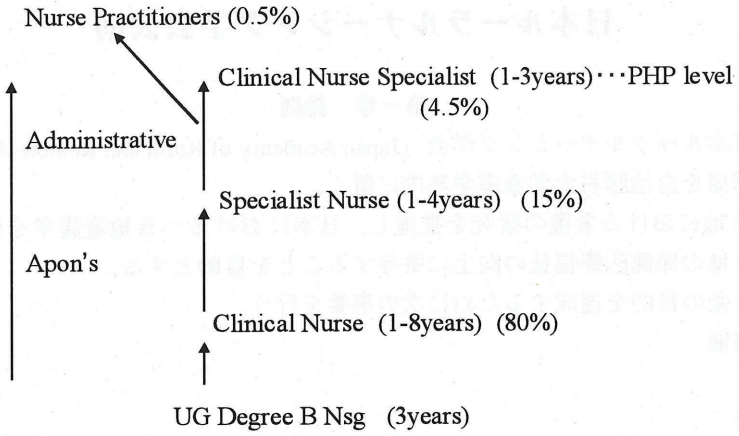


図2　オーストラリアにおけるキャリア・パス（Career Pathways）

日本と同様、オーストラリアでも、へき地では40％が准看護師（大都市では10％）であり、そのため少ない正看護師が准看護師の分も責任を負わなければならず、負担が重くなっているそうである。また、オーストラリアの看護師の高齢化も問題であり、若い看護師は都市部で働くことが多いそうである。看護師の高齢化は、特に精神科看護師において存在しているそうである。また、へき地で働く看護職をどう育成するのかという問題では、モナシュ大学では、へき地での実習を組み入れており、その実習体験により都会育ちの学生もへき地に興味を持つようになるそうである。また、州単位でスタッフを派遣するが、それでも長期間や遠隔地の場合は難しいそうである。また、へき地にいる看護職に対するオンライン教育も行っており、災害時にそのオンラインでも教育システムが役立ったという実績もあるそうである。

最後に、Francis先生から提示された今後の研究課題を示す（表1）。今回の分科会での話し合いは、残念ながら、共同研究の立ち上げのような直接行動に結びつくまでには至らなかった。しかし、ルーラルナーシングの領域は、これから発展する領域であり、自分たち自らが定義を作り、実践し、研究し、作り上げていくことが大切であるとの示唆が大きな学びとなった分科会であった。

表1　今後の研究課題

1．to define rural nursing（ルーラルナーシングを定義すること）
2．to establish “why” it is and/or is it different（ルーラルナーシングがなぜ困難さを持つのかを明らかにすること）