



ORIGINAL RESEARCH

Examining dual roles in long-term-care homes in rural Alberta: a qualitative study

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ABSTRACT:

Introduction: In rural settings, many healthcare professionals experience intersections of professional and personal relationships, often known as dual roles. Dual roles are traditionally studied in terms of their potential for ethical conflicts or negative effects on care. In the existing scholarship, there is little discussion of dual roles in long-term care (LTC) settings, which present distinct conditions for care. Unlike other forms of health care, LTC work is provided daily, over longer periods, in care recipients' home environments. This article outlines results from a case study of LTC in rural Alberta, Canada and provides evidence of some of the challenges and, more notably, the considerable benefits of dual roles in these settings.

Methods: The qualitative data discussed in this article come from a multi-site comparative case study of rural LTC that, among other questions, asked, 'How do personal and professional lives intersect in rural LTC settings across the province?' These data were collected through the use of rapid ethnographies at three rural LTC homes across the province of Alberta. The research team conducted semi-structured, in-depth interviews ($n=90$) and field observations (~200 hours). Participants were asked about care team dynamics, the organization of care work, the role of the LTC home in the community, and the intersections of public and private lives. The results were coded and critically analyzed using thematic analysis.

Results: Dual roles were primarily described as beneficial for care provision. In many cases, dual roles provided participants with opportunities for reciprocity, enhanced person-centered care, and increased perceptions of trust and community accountability. Similar to what has been documented in the extant literature, dual roles also presented some challenges regarding personal and professional boundaries for those in leadership. However, the negative examples were outweighed by positive accounts of how dual roles can serve as a potential asset of rural LTC.

Conclusion: There is a need for more nuanced conversations around the implications of dual roles. Policies and care approaches
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Alberta, Canada, dual relationships, dual roles, long-term care, multiple relationships, nursing.

FULL ARTICLE:

Introduction

In rural settings, many healthcare professionals experience what are known as dual roles. This refers to the intersection of professional and personal relationships; for instance, being someone's healthcare provider as well as their neighbor. In communities with small populations, these intersections of professional and personal lives are often inevitable¹. The concept of dual roles is well documented in literature from social work, nursing, and psychotherapy¹⁻⁴. Because of the intimate and confidential nature of healthcare provision, dual roles are often studied in terms of their potential for ethical conflicts or negative outcomes (eg conflicts of interest, privacy violations, or violations of professional boundaries)⁴⁻⁶.

Dual roles can be challenging for rural health professionals for several reasons. For instance, these professionals may be the only provider of a particular type of care in their region and be unable to refer clients with whom they have a dual role to another provider. They may lack privacy about their personal lives, have limited professional support or mentorship in the region, and/or struggle to integrate into a new rural community given their privileged access to intimate and confidential information about community members^{2,7}.

Dual roles can also create challenges when health professionals are longstanding community members. Their proximity to the lives of their clients or their shared history can complicate healthcare decision-making⁵. The implications of particular healthcare decisions can be seen and felt outside of the professional setting. For instance, if a physician determines a course of treatment to be medically futile, they may hear opposition to this decision from the patient's relatives in the grocery store. Likewise, if a physician decides to offer assessments for medical assistance in dying eligibility in a community that largely opposes the practice, then they may experience stigma and social marginalization from their community⁸. The politics of the rural locale can thus create dilemmas for healthcare decision-making and influence health professionals' job satisfaction, their ability to take action, and their commitment to the community⁵.

Although dual roles are typically framed as potential challenges or

need to emphasize and support the use of good judgment and the responsible navigation of dual roles, rather than taking either a permissive or prohibitive approach. Leaders in rural LTC can promote conversations among care providers, with an emphasis on the cultural context of care provision and how dual roles play out in their specific professional practice. Blanket policies or educational approaches that frame dual roles as necessarily problematic are not only insensitive to the unique nature of rural LTC, but prohibitive of relational elements that these results suggest are highly supportive of person-centered care.

ethical dilemmas, some scholars have noted their potential benefits. In some rural communities, clients are more likely to trust health professionals if they know them outside of the healthcare context and view them as relatable^{7,9}. In fact, 'traditional approaches to dual and multiple relationships and to professional boundaries more generally, are implicitly urban-centric based on an assumption that care relationships are primarily between strangers'⁶. Clients may also be more willing to engage in a therapeutic relationship with a known member of the community if they perceive that the health professional understands their values and their life context⁴. In this respect, dual roles can potentially enhance the depth and provision of person-centered care. Person-centered care is a model that emphasizes respect for a care recipient's preferences and life history, and foregrounds relationships and collaboration^{6,10}. Increasing person-centered care is considered to be essential to both the quality of care and life of people residing in LTC homes, especially those living with Alzheimer's disease or a related dementia¹¹. Thus, accounts demonstrating that dual roles may improve person-centered care provision challenge the pervasive rural deficit discourse that depicts rural areas as 'problematic, inferior and undesirable compared to its urban counterpart'¹². Although the challenges associated with dual roles are legitimate and warrant discussion, the notion of dual roles as a potential *asset* of rural communities remains underdeveloped.

In the interdisciplinary dual roles literature, there is little discussion of dual roles in rural long-term care (LTC) settings. The nature of LTC work can create distinct dynamics for dual roles. Unlike some other forms of health care, LTC work is provided daily, over longer periods, in care recipients' home environments. This article outlines findings from a case study of LTC in rural Alberta, Canada and provides empirical evidence of some of the benefits and challenges of dual roles in these settings.

Methods

The data discussed in this article come from a broader multi-site comparative case study¹³ conducted in the province of Alberta. This study focussed on better understanding the organization of care work in rural settings and the role of rural LTC homes in their communities¹⁴. A comparative case study supported the

examination of rural LTC at multiple sites and provided a rich understanding of the heterogeneity of Alberta's rural communities. At the macro level, this approach facilitated an analysis of funding structures, community resources, local health responses, and other structural features that influence LTC provision¹⁴. Specific to this paper, a comparative case study offered insight into micro-level care work and community dynamics in the rural context. One of the study's research questions was 'How do personal and professional lives intersect in rural LTC settings across the province?' The present article responds to that question and speaks to such intersections. Although the sites were quite different from one another, the benefits and challenges associated with dual roles were very similar.

The researchers employed a rapid ethnography design^{15,16}, and data were collected in week-long site visits to three rural LTC homes across the province between May 2017 and May 2018. The sample included sites in Southern, Central, and Northern Alberta. To maintain confidentiality, these sites will not be identified. In order to meet eligibility, the sites had to self-identify as rural and meet the Statistics Canada¹⁷ definition for 'rural and small town'. These sites were selected because of their variation in geography, local industry, and health zone within the provincial health authority.

Two types of data were collected: in-depth interviews ($n=90$) and field observations (approximately 200 hours). For field observations, rotating shifts of research team members observed the day-to-day workings of the LTC home. Observations took place between 7 am and 11 pm in public areas of the home that were accessible to visitors. The observations were written and digitally recorded as field notes. Participants were recruited using purposive sampling, with an aim of securing approximately 30 participants at each site. This sample size was determined based on practical feasibility, consistency with sampling practice in similar qualitative health services research¹⁶, provision of a range of perspectives and experiences related to rural LTC, and allowance for the team to answer the research questions. Sample size was also influenced by the number of care providers at each site who were working or visiting during the week-long site visit. The interviews were conducted with anyone who provided care in the LTC home. This included regulated nursing staff (registered nurses and licensed practical nurses), healthcare aides (unregulated care staff who provide the majority of direct care to residents), allied health professionals (occupational therapists, physiotherapists, recreation therapists), volunteers, and family members. These individuals were informed about the study and recruited to participate through prior discussions with site management, posters in the care home during the week of field research, brochures, and word of mouth. The interviews were conducted in private spaces at the LTC homes, digitally recorded, and 30–60 minutes in duration. Participants were asked about care team dynamics, the organization of care work, the role of the LTC home in the community, and the intersections of public and private lives. Concurrent member checking was used with participants at each site in order to ensure that observations were accurate and developing themes had resonance.

After each week-long site visit, the field notes and transcribed interviews were coded and analyzed using Braun and Clarke's approach to thematic analysis¹⁸. Multiple codes were identified, one of which was 'intersections of personal and private lives'. Across the codes, themes and patterns were identified. Key themes were identified for each site and those themes were used to revise the interview and observation guides for the subsequent site visit(s). When data collection and analysis were completed for all three sites, a cross-case analysis was performed and overarching themes were identified¹³. The cross-case analysis involved mapping out the key themes identified for each of the three sites and then identifying overarching themes that spanned all cases – inclusive of similarities and differences between them¹³.

Ethics approval

Ethics approval was received from the University of Alberta Health Research Ethics Board (Pro00067720) and operational approvals were granted by Alberta Health Services in each of the participating health zones. All consent to participation was informed and voluntary.

Results

Site 1 had a tightknit staff with strong and healthy community relationships¹⁴. Dual roles were abundant at this site, with staff members bringing their children in to visit with residents on their days off, a former nurse moving into LTC as a resident, plentiful volunteers, and more. The intersection of personal and private lives was consistently praised as a highlight of living and working at this home – one that made it more homelike and welcoming. The community relationships at site 2 were more strained. There were some unresolved tensions between staff members, complicated histories with particular residents' families, and indications of moral distress amongst care providers¹⁴. There was also limited engagement with the broader community outside of the home, and few volunteers coming in. However, participants at site 2 still touted the benefits of dual roles in rural LTC, claiming that they created senses of accountability and reciprocity, and made care more personal. Site 3 was the most geographically remote of the sites and, as such, had a harder time retaining staff and connecting with external health service providers¹⁴. As a result, there were fewer longstanding relationships than at the other sites. However, several site 3 staff members spoke about how caring for friends' grandparents was a pleasure and how their small town created rich opportunities for therapeutic recreation activities with local organizations they knew well.

Although each site was different and presented distinct conditions for care¹⁴, the benefits and challenges of dual roles were described similarly across all three care homes. In what follows, the benefits of dual roles in rural LTC are highlighted. These include that rural LTC can provide opportunities for reciprocity, enhance person-centered care, and create a sense of increased trust and accountability in rural LTC. The section concludes with discussion of several challenges associated with dual roles in LTC.

Rural long-term care can provide opportunities for reciprocity

At all three LTC homes, healthcare professionals indicated that they knew some of their colleagues outside of work and had known some of the residents outside of the LTC context. Several participants indicated that they provided care for people who had been their neighbors, teachers, and/or friends and acquaintances in the community. Many of these participants claimed that caring for residents that they knew in a personal capacity enhanced their lives and their perceptions about the value of their work. In other words, providing LTC within the context of intersecting roles was described as having reciprocal benefits for residents and care staff. When asked about the most meaningful part of her work, one participant said:

I think that our elderly population have more to give us than we have to give them. I mean, I'm lucky because I know most of our long-term care people from living here. We enhance their lives, but they enhance mine more. (Unit clerk, site 1)

Similarly, another participant described her work in rural LTC as an opportunity to give back to older members of her community:

I just think [residents] are at a time in their lives when we can give back to them. You have to be very passionate and very understanding because you knew them as vibrant adults, right? So, [I know them] from when I was a child, but now they're older and they have dementia and multiple co-morbidities so ... they need us. (Licensed practical nurse, site 2)

These participants suggested that providing care for residents they had known prior to their admission to LTC was rewarding and strengthened their sense of community. During the first site visit, a new resident moved into the LTC home. This resident had worked as a nurse at the LTC home for much of her working life. Several staff members described her transition into LTC as a 'success story' (registered nurse, site 1) because this resident was familiar with the building and comfortable with the staff. Further, the staff now felt privileged to care for someone who had cared for so many members of their community in decades past. Rural LTC homes can thus provide opportunities for care staff to maintain and deepen relationships with residents they had previously known in another capacity.

Dual roles can support person-centered care in rural long-term care

Person-centered care is an approach that diverges from illness-centered care models and recognizes care recipients as whole persons¹⁹. Alberta Health Services has adopted a person-centered care philosophy and implemented it in the provision of continuing care services²⁰. In the rural LTC context, dual roles can enable and enhance person-centered care because a resident's life history, family members, preferences, and 'whole personhood' are often already known to care staff. At one of the sites, a recreation therapist made an explicit connection between person-centered care and dual roles:

I think the majority of the staff care about person-centred care – it really is all about the clients. I see that with nursing and I

think because it's a small community and we have someone who's coming to take their blood who used to be their neighbour, or you know, that person isn't just a resident here, they're actually a person. (Recreation therapist, site 1)

A healthcare aide at another site echoed this sentiment, claiming, '[a] lot of residents here, they're not just a resident; that's my friend's grandma' (healthcare aide, site 3). These comments illustrate that prior knowledge about residents meant that they were already viewed holistically, as people with rich life histories and connections to the community. A registered nurse made similar remarks, emphasizing that dual roles were seen as beneficial and conducive to personalized care practices:

The care is more personal simply because we're familiar with those in [the] community. We have those external relationships that bleed over into the institution itself, and I think that's a strength, it really is. (Registered nurse, site 2)

An important component of person-centered care is understanding who the person is and was throughout their lifetime. In the instances previously quoted, being from the same community was not described as creating potential conflicts of interest or blurred boundaries. It was described as a shared history and connection that can facilitate high quality care. In the field notes, one research team member noted that this familiarity with residents' life stories and personal interests was used by staff members to facilitate engagement and connection:

The engagement is often centred around the stories of the residents. The LPN [licensed practical nurse] who is passing meds is talking at length with a resident about him breaking and riding horses in the past. Since she knows the other residents, she tells this man that he should talk to [resident's name] because he used to break horses too. (Researcher, site 1)

The findings from this study indicate that dual roles have the potential to enhance person-centered care in rural LTC. Possessing knowledge of residents as community members, having ongoing relationships with their family members, and being aware of shared histories can all contribute to a care provider's attention to residents' individual interests and add depth to caring relationships. Efforts to avoid dual roles in this context may thus have unintended negative consequences for relational elements of care⁶.

Dual roles can enhance trust and accountability in rural long-term care

Several participants suggested that knowing residents and their family members outside of the LTC home created a greater sense of accountability within their communities. In a small community where people know one another, there is limited anonymity and increased visibility. Several participants spoke about this phenomenon and noted that the lack of anonymity creates a greater sense of accountability for healthcare providers, as well as for residents and their family members. For instance, a nurse at site 1 described this as being a part of 'rural culture':

I think there is a difference to rural culture and maybe it's the accountability. We hold each other accountable because, 'if you're going to treat me nasty in the hospital, I'm sorry, but I'm in this community with you ...' So maybe there is a little bit of that on both sides. I've had to kind of turn my brain off in some situations – running into people in the grocery store and thinking, 'okay, what you found out at work is work. You just need to turn off your brain and say hello to this person.' So it goes both ways. (Registered nurse, site 1)

This sense of 'I'm in this community with you' meant that disrespectful or inappropriate behavior within the walls of the LTC home would have implications in the outside world. This was generally described as an asset. A family member at another site indicated that the dual roles experienced in rural LTC create 'a natural balance' in the community:

I've always said that in a small town there's a natural balance because I know a lot of the people that work here outside of here. I'll see them in other social settings and I'll know their husbands, or wives, or children, or things like that. And so there's this balance, right? Because there's no anonymity in small towns. You can't be a terrible care worker or a terrible patient. It just gets out and the people know it ... so you're cognizant that what you do to other people is going to be known by a lot of people. So I think you're more cognizant of that than if there was anonymity. (Family member, site 2)

Some healthcare providers, particularly those new to rural settings, may feel vulnerable because of the increased visibility and scrutiny they may experience in rural practice²¹. However, as Simpson and McDonald have noted, dual role relationships may level a presumed power imbalance in the care provider–recipient relationship⁶. This leveling of power dynamics may be beneficial for empowering LTC residents and their family members. In sum, the leveling power of dual roles may enable this 'natural balance' by fostering care provider–recipient relationships that are grounded in reciprocity and accountability.

Accountability is intimately connected to trust. At the rural LTC homes included in this study, several participants indicated that alongside the accountability associated with dual roles was increased trust. Family members indicated that they felt reassured when they had a personal connection to the people providing care for their loved one. At one site, a healthcare aide stated:

I think we need more rural type long-term care facilities because here I know a lot of the people. They're from my community and I've known them all my life, a lot of them. I think that helps the families too. They feel much better about the care when they know us personally. (Healthcare aide, site 1)

A licensed practical nurse shared a story in which she was both a staff member at the LTC home and a resident's family member. She said that she was reassured by the fact that the other staff members knew her and her mother personally, and she expressed gratitude for the rural context that made this dual role possible:

My mother was here when she passed away and I didn't worry about her. I felt like she was very well cared for. I knew the girls who were taking care of her, and that they cared. They knew who she was and cared about her. Whereas I feel that in an urban setting, not that they don't care, but it's different when you don't personally know someone, right? (Licensed practical nurse, site 1)

In this instance, the participant alluded to a distinction between caring *for* and caring *about* someone. She suggested that dual roles, and caring *about* a resident in one's personal life can increase trust and accountability in caring *for* them in one's professional life.

The findings of this study suggest that dual roles in rural LTC can improve trust and accountability. Study participants suggested that being part of the same community and having increased visibility was an asset that supported a 'natural balance' and reflected a 'rural culture' that encouraged good care on the part of care providers, and respectful behavior on the part of family members and residents.

Dual roles can also pose challenges

Although this article primarily focuses on the benefits of dual roles, this does not mean that they do not also introduce challenges. Dual relationships can potentially lead to making false assumptions, acting on biases, and can sometimes cloud judgments. This research did reveal several instances in which dual roles posed challenges, particularly for management:

I was born and raised here and people see me as the face of long-term care. They see my family and, that's the one challenge. If something goes wrong, they're talking to my mom about it and my mom's like, 'I don't know who died or when your mom's going to get into the facility.' It's hard for people to understand that I go home and I don't want to talk about work. (Manager, site 3)

When asked more about the blurred boundary between the personal and professional, this manager said:

Oh yeah, totally. Even with my staff. Like if I'm out, staff will think nothing of coming up to me and saying [work-related] stuff, and I'll say, 'You know what? I'm drinking and I don't want to talk about this'... You try to shut it down. Also, I don't go out much in [town]. I do all my grocery shopping in [other town]. I'm very home and family-oriented. People say 'you know, you'd never think that you lived in [town]'. (Manager, site 3)

In addition, participants at site 2 also described a scenario that revealed a risk associated with dual roles. There was a traumatic conflict in site 2's community that went unaddressed in the care home and translated into a workplace conflict among several LTC staff. This conflict had negative effects on staff morale and led to numerous absences because several staff members refused to accept shifts with one another. When asked explicitly about dual roles, a participant from site 2 mentioned that dual roles can

occasionally lead to expectations of special treatment:

So I'm going to [tell you about] what might occur and has occurred – though not very often. There may be times that when you have that previous relationship or knowledge of the individual before that person moves into the facility, in association with the family being there as well, sometimes there's higher expectations from the resident and the family placed on individuals who might know them. And they may ask for special favours or whatever. So there's always a learning point of professional boundaries. (Manager, site 2)

The results of this study suggest that dual roles can indeed pose challenges for LTC staff, primarily related to perceived boundary violations. These challenges can have implications for job satisfaction and staff retention. However, the negative examples that surfaced in these data were notably outweighed by positive examples of how the intersection of personal and professional roles in rural LTC served to enhance person-centered care, and contribute to trust, reciprocity, and accountability in care relationships.

Discussion

The aim of this research was to glean insight into how personal and professional lives intersect in rural LTC homes. These intersections manifested primarily through what are known as dual roles or dual relationships. Contrary to a number of existing studies, which generally emphasize the negative aspects of dual relationships^{2,5,7,8}, this research is consistent with that of others who have revealed that dual roles can also be quite beneficial^{6,7,9}. Specifically, dual roles provided participants with opportunities for reciprocity, enhanced person-centered care, and increased perceptions of trust and community accountability. Across three very different sites¹⁴, the majority of participants described dual roles as a strength of rural LTC provision, one that made rural LTC seem more desirable than care in a larger urban center. This suggests that dual roles may be an asset in a variety of rural LTC settings and do not rely solely upon the dynamics of a particular community.

Notably, these findings challenge the rural deficit discourse¹³ and offer insights into one of the potential strengths of rural LTC. These positive accounts challenge normative, urban-centric ideas about dual roles as something inherently risky to be avoided, and recognize the distinct social realities of rural communities. Findings from the UK suggest that familiarity with a rural care home and its staff provides positive experiences with transitions into LTC²¹. As Bushy explains, in rural settings '[t]he patient-provider relationship is formed and cultivated in both the examining room and in the general store'²², reflecting cultural differences that are often overlooked in 'Westernized professional treatment culture'²³. Indeed, an analysis of rural palliative care found that 'knowing and being known' by care providers was the value most frequently cited by participants²⁴. Similarly, in community settings, close relationships between older adults and their healthcare professionals have been found to provide considerable benefits for patient health and wellbeing²⁵. Dual roles thus require context-

specific analyses that account for the realities of rural locales.

To date, dual roles have received little attention in the LTC context. It is worth exploring the intersection of personal and professional lives in these settings for a number of reasons. First is LTC care staff work in residents' home environments. This means that care staff see residents more often than they would in an acute care setting and within a caring relationship that is, most often, of a significantly longer duration. Acute or episodic healthcare service provision is more likely to be treatment or illness-focused. In LTC homes, however, care is focused on supporting people to have the highest quality of life possible while living with complex healthcare needs. This often entails assisting residents with the most private activities of daily living, which adds another dimension of intimacy to the dual role relationships. It is also common for LTC staff members to engage with residents' family members and get to know more about residents' personal histories and interests (eg through recreation therapy programming especially). These relationships are crucial to person-centered care, given that LTC residents have indicated that the quality of the relationship between themselves and their care providers exerts the single greatest influence on their perceived quality of care²⁶.

The findings of this study reveal important implications for rural LTC providers and policy leaders. First, it would seem that there is a need for more nuanced conversations around the implications of these intersecting roles, particularly as they relate to person-centered care. Blanket policies or educational approaches that frame dual roles as necessarily problematic are not only insensitive to the unique nature of rural LTC, but also prohibitive of relational elements that enhance person-centered care. The findings also reflect that there are indeed challenges with care providers occupying dual roles, consistent with literature in the area. However, policies and care approaches need to reflect the exercise of good judgment and responsible navigation of dual roles, rather than taking either a permissive or prohibitive approach. When conflicts from outside of work impact the workplace, additional leadership efforts are needed to ensure that tensions are addressed and are not permitted to fester.

Leaders in rural LTC can promote and support conversations among care providers, with an emphasis on the cultural context of care provision and how dual roles play out in their specific professional practice. Care providers need clarity on what supports are available to help them as they navigate dual roles and should be encouraged to bring their questions and concerns forward to their leadership. For example, care providers may have discomfort about providing intimate personal care to a relative, or they may have questions about how to appropriately share resident information with colleagues when that resident is a family member or friend. In terms of supports, care providers may pose questions that could be navigated with the help of a clinical ethicist or a practice consultant from their professional body to ensure ethical practice that does not cross inappropriate boundaries. The first step, however, is to create a supportive practice environment that enables care providers to engage in these conversations about dual roles.

Conclusion

This study was conducted in three publicly owned and operated rural LTC homes in one Western Canadian province and, therefore, the results may not be transferable to all rural LTC contexts. However, given that much of the literature on dual roles in rural healthcare spans Canada, the USW, the UK, and Australia^{1-7,9,12,21-23,25}, there is reason to think that the results of this study may have resonance in other Western jurisdictions. The potential for ethical conflicts associated with dual roles is

legitimate and warrants attention and mitigation. However, efforts to minimize or completely avoid dual roles could mean the loss of the considerable benefits and meaningful relationships described by participants in this study.

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