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Title Page

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Comment [JM1]: We acknowledge that the names of the methods used in this analysis might not be familiar to all readers of JNM. However, they are well referenced in the article so that readers are able to access more information if they wish. The focus of the article itself is the literature rather than the methods used. Because of this we have left the abstract unchanged.

Comment [JM2]: In the original manuscript there was a comma missing – sorry about that. However having received some feedback from Adele Clarke on another more methodological paper we have altered the collective groups to four. The participants are no longer grouped as a collective, rather their voices are addressed in the study using Goffman's theory of Frame Analysis which discusses how individual's construct their realities. We have also changed this article from aspiring to be a discourse analysis to being an analysis of the literature as a secondary source of data. The changes that we have made in relation to Clarke's feedback to the other paper are highlighted in aqua. The changes made in response to the JNM reviewers are track changed.

SUMMARY

What is already known about this topic?

- Workforce shortages of nurses are a global issue.

- Mentoring has been proposed as a solution to the problem of workforce.

What this paper adds

- Identifies collective actors who influence policy and action around the problem of workforce.

- Identifies the repercussions that perceptions of the effects of globalisation on the nursing workforce might have on the future of mentoring and personnel planning.

- Demonstrates collective action framing as a useful method to analyse the context of issues in nursing practice.

INTRODUCTION

The nursing workforce is experiencing chronic shortages in all practice areas. This is particularly so in the social world of Australian rural nursing, where mentoring has been adopted as a potential panacea for poor retention rates (McCloughen & O'Brien, 2005; Mills *et al.*, 2006). As a part of a constructivist grounded theory study that examined rural nurses' experiences of mentoring, this paper aims to identify the voices and actions apparent in texts about the problem of workforce and mentoring in Australian rural nursing between 2000-2005. Analysing who has produced these texts and questioning how, when and why mentoring entered the literature is of international interest, because it identifies influential actors in the eternal quest to bridge the gap between theory and practice in workforce recruitment and retention.

Collective action framing is the heuristic device that will be used to cluster and unpack texts produced about nursing workforce, particularly those concerning Australian rural nurses, between 2000 and 2005. In the first instance, we will briefly explain collective action framing and how it can contribute to the method of undertaking a constructivist grounded theory study. This will include our experience of using situational analysis mapping and our map of the Social World of Australian Rural Nurses (**Figure 1**). We will subsequently outline the search strategy used to locate the texts produced by the actors within this social world. Australian rural nursing workforce texts will then be examined to trace constructions of diagnosis, prognosis and motivation for change or action. Part of the analysis of such constructions will be to identify how voices, events and experiences were articulated

Comment [JM3]: We would argue that bridging the gap between theory and practice in workforce recruitment and retention is of international significance.

Comment [JM4]: Removed Constructivist discourse analysis

for the literature to change, and how these new collective framings were amplified and disseminated (Benford & Snow 2000).

COLLECTIVE ACTION FRAMING AND CONSTRUCTIVIST GROUNDED THEORY

The collective action framing of the rural nursing workforce discussed is part of a constructivist grounded theory study that sought to examine the mentoring experiences of Australian rural nurses. During data collection and concurrent analysis, it became apparent that prior to the language of mentoring entering the literature about rural nursing workforce, participants had no name for the supportive relationships that had been integral to their practice. As such, the importance of a name emerged as a significant category, while at the same time raising more questions. Now we wanted answers to two main questions. Who were the actors who had influenced this emerging cultural change in the social world of Australian rural nurses? And how had they done it?

To answer the first of these questions we used situational analysis mapping techniques to construct a map we call the Social World of Australian Rural Nursing (Clarke 2005). Crafting a grounded theory methodology that is explicitly underpinned by a postmodern epistemology and ontology, Clarke built on the work of Strauss that spoke to the sociological theory of social worlds and arenas (Strauss 1993). (For a more extensive discussion about situational analysis mapping see Adele Clarke's *Situational Analysis* [2005]. For the purposes of this paper we will refer to only one of Clarke's maps, social world mapping, but we used all three types of maps (situational, social and positional) extensively during the concurrent data collection and analysis

Comment [R5]: JANE – I pinched this from JAN paper.

Comment [JM6]: Took out the references to our other submitted manuscript here. I understand Reviewer 2's comments here about wanting more about situational analysis. However, I think it would detract from the purpose of the paper which is to analyse the literature. We made reference to situational analysis so that the reader is able to make the methodological link and follow it up if they so choose. Summarising situational analysis is pretty impossible to do.

phase of this grounded theory study.) The maps enable the researcher to examine the broader social world of research participants. In particular, we examine how Australian rural nurses had changed the cultural world of workforce; using situational analysis in concert with collective action framing enabled us to examine the texts produced by the participants (actors) in the social world of rural nursing.

Constructivist grounded theorists seek to discover, explain and theorise peoples' experiences of issues of importance, in relation to context and influences – believing that individuals construct their own truths relative to history (Crowe 2005). This meets the challenge of locating participants' stories in the wider context, and in doing so 'making the broader *situation* of the phenomenon under research the analytic ground' (Clarke 2005, p. 21). The act of situating decentres the participant from being a repository of emergent truth as in traditional grounded theory, to expose the wider social world in which they practice as, in our case, Australian rural nurses.

The analytical device that allowed us to unpack texts constitutive of the literature of workforce in the social world of rural nursing is collective action framing. Put simply, this comprises three main tasks: diagnosing a problem, articulating a proposed solution, and motivating change through action (Benford & Snow 2000, p. 11). It therefore allows us to look at how collectives of people or actors interact to identify problems in their world, discuss solutions while deciding on plans of action, and subsequently act out these solutions. Implicit in this is the recognition of values and beliefs that allow such social movements to foster collective identities and change processes (Martin 2003).

AUSTRALIAN RURAL NURSES: A SOCIAL WORLD

The concept of social worlds as a way in which people organise their lives stems from symbolic interactionism (Strauss 1993). Each of us has multiple social worlds within which we exist, premised upon our interactions with others who have similar concerns. Clarke defines social worlds as being the 'principle *affiliative mechanisms* through which people organise social life. Insofar as it meaningfully exists, society as a whole, then, can be conceptualised as consisting of layered mosaics of social worlds' (Clarke 2005, p. 46; emphasis added).

The social world of Australian rural nursing, as we perceive it, consists of four collectives: community, advocates, academics and government, as well as the individual rural nurses who participated in this study. Charting this terrain involved making value judgements as researchers about who were the most important and influential players, and how and to what degree the boundaries between each group overlapped. Two of us have been very involved in this social world and can locate ourselves as actors representative of rural nurses (clinician), nursing organisations (president of the Association of Australian Rural Nurses, mentor development and support project officer), state government (rural nurse advisor) and tertiary education (research fellow, rural and remote health, head of school and professor of rural nursing) at various stages during the five-year period that we analysed.

Part of undertaking a constructivist study means living out a reflexive position as researchers and ultimately the final authors of an ongoing theorisation about the phenomena of interest (Cunliffe 2003). Mapping the Social World of Australian Rural Nursing (**Figure 1**) has enabled us to place ourselves on this map and in doing so acknowledge the partialities that come with our histories. Large circles in the figure

represent each of the four collectives, each intersecting and overlapping with others. From our experience, we know that the individual actors within each collective can wear a variety of 'hats' in the way in which they communicate with others, although one usually predominates, and that in the case of organisations this may be influenced by their charter or core business. As we 'lay … out the segments of a world [we] frame … the key interior differences' (Clarke 2005, p. 112), as well as their interdependence and interaction. Each interior circle represents actors who have a similar core business. For example, nursing organisations represent nurses, while the National Rural Health Alliance represents rural health organisations.

The Australian government intersects with the majority of the circles because it is the funding source for rural health under the rubric of universal health care. It is also responsible for funding the tertiary education of nurses. Many of these resources are managed through a second tier of state and territory governments. As well, numerous advocacy and community groups receive ongoing direct funding to manage secretariats. Increasingly the Australian government is also becoming directly responsible for funding workforce strategies such as undergraduate and re-entry scholarship schemes for nursing and allied health including medicine (Dakin et al. 2004).

Laying out the segments of the social world meant that we had to choose how to place each circle in the greater schemata. Although the shape we chose should have helped to negate a laid-out hierarchy, it was very difficult (as in life) to avoid creating one. As researchers our main concern was with rural nurses and as such they are placed at the top of our map. The arrow intersecting a broad cross-section of the

circles represents the Australian government's power as the major funding body for

rural health.

Figure 1

Figure 1: The Social World of Australian Rural Nurses

Abbreviations
AARN – Association for Australian Rural Nurses

RCNA – Royal College of Nursing, Australia

CRANA – Council of Remote Area Nurses

ANF – Australian Nursing Federation

SEARCH METHODS

Defining the criteria for such a retrospective was straightforward in that we were only interested in texts about Australia, the nursing workforce, and recruitment and retention. Texts that focused on rural nursing in addition to the above terms were considered a subgroup of the key search terms. We limited the years searched from 2000 to 2005. In 2000 the Australian government released a key report entitled *Rethinking Nursing* (National Nursing Workforce Forum 2000). Prior to the forum reported on in this document, the federal government in Australia had abrogated responsibility for nursing to individual state governments. However, by 2000 the shortage of nurses had forced the Australian Health Ministers' Advisory Council (AHMAC) to consider the issue from a countrywide perspective. This attitudinal watershed marked the entry of the Australian government into the discourse of nursing workforce. This is a key moment and as such is a worthy one from which to begin our analysis.

Comment [R9]: JANE - Excellent

The major journal databases for nursing, CINHAL and Medline, were searched using the key terms 'nursing manpower', 'nursing shortage', 'rural health nursing', 'nursing administration research', 'organisational administration/trends', 'nursing evaluation research', 'manpower/trends', as well as more generic terms such as 'nursing shortage', 'recruitment and retention, Australia'. These searches were limited to English and to between 2000 and 2005.

Other sources of texts were *Rural Nurse,* newsletter of the Association for Australian Rural Nurses (AARN), and *Nursing Review,* a national nursing newspaper, both of which were hand searched. The *National Rural Health Alliance Rural and*

Remote Papers 1991–2005, a CD-ROM produced by the National Rural Health Alliance, includes conference proceedings, newsletters, policy documents, annual reports and the *Australian Journal of Rural Health*. A search engine for most major daily Australian newspapers, Newstext, was examined. The Australian Nursing Federation's *Australian Nursing Journal*, the websites of the Royal College of Nursing, Australia, Country Women's Association, Australia and the National Farmers' Federation provided articles and media releases. Texts accessed numbered 118 in total, of which 52 were included in the analysis that follows. Those that were excluded where…. Because……The majority of the texts analysed were referred journal articles.

DIAGNOSING THE PROBLEM OF WORKFORCE

'*Reality is nothing but a collective hunch*' –   Lily Tomlin (1939–).

Collective voices that speak loudly and with authority about their collective hunches can make changes within their social worlds and in doing so create handles of 'reality' for others to grasp. The voices of Australian rural nurses that were located in the texts diagnosing the problem of workforce constructed their issues in the first person. These constructions centred on their individual realities and experiences of a changing workplace culture suffering from a shortage of nursing staff. They used the language of victimisation, in which their workplace was 'hell on wheels' and where more experienced nurses 'eat their young' (Nicol 2005).

Each of the other collectives constructed their diagnoses of the problem of workforce for Australian rural nurses in the third person, lending a sense of disembodied expertise to the texts (Wolcott 1990). Use of the third person effectively

added a layer of objectivity to the words used to describe characteristics of problematic workplaces and the expected outcomes of a continued shortage of nurses.

Two of the collective groups – academics and advocates – were 'embroiled in the politics of signification' (Benford & Snow 2000), which involved using a common language of objectivity to create a level playing field, reduce emotiveness and make their arguments more 'rationally' acceptable – generally furthering their cause with the government collective. Motivated by their own *raison d'être*, a contestation emerged as the process of reality construction began:

> Thus far little consensus has been reached about what the problems are, or how best to address them. Currently it would seem that those responsible for the preparatory education of nurses have a tendency to look to the clinical area as the site of the major problems, while those in industry cast a critical gaze toward the educational institutions and frequently complain that nurses are not adequately prepared for the realities of clinical nursing (Jackson et al. 2001, p. 165).

Part of the process of diagnostic framing is arguing over the source of the problem, in this case workforce shortages, an action often attended by conflict and focusing blame or responsibility on other actors (Benford & Snow 2000). The advocacy collective framed the diagnosis of workforce issues using the language of crisis and chaos ('Nursing crisis ignored', *Australian*, 26 July 2001), shifting blame between academics, for poorly preparing new nurses for practice, and government, for not attending sufficiently to workforce planning:

> Inflexible working conditions, long shifts with unpaid overtime, ever-increasing workloads and poor recognition of skills and qualifications are some of the issue facing nurses in the current health system. Many of the nation's nurses are ageing, and will retire in the next 10 to

> 15 years … The current Federal Government has consistently ignored ANF calls for urgent
> national action about Australia's nursing shortage … For some time it has been a concern of
> the ANF that the planning of nurses' education in Australia has failed to consider workforce
> requirements, leading to grave shortages in specialist areas (Armstrong 2001, p. 30).

Academics counter-framed this argument by underpinning the problem of workforce with a lack of educational opportunities and support for students and new graduates, while at the same time aligning themselves with advocates on the issue of workplace conditions (Duffield & O'Brien-Pallas 2003, McCloughen & O'Brien 2003, Nugent et al. 2004).

> Lack of understanding of the role, poor accommodation, the lack of a career pathway, little to
> no child-minding facilities, the lack of access to affordable and relevant education and
> training, lack of employer support, the level of work related stress, legal aspects of role,
> relationships with medical officers, inadequate locum relief, lack of promotion of rural nursing
> as a desirable career option, the low number of clinical placements that are available for pre-
> registration undergraduate nursing students, and the lack of graduate year placements (Hegney
> 2000, p.190).

The amount of text generated by the academic collective was vast in comparison to any of the others. Their arguments, with a continuing thread about the importance of education, achieved a high level of saturation. This constant textual presence, as this analysis will show when it moves on to analyse potential solutions to the problem, was ultimately effective in motivating action reflective of their core values.

There is strong evidence of alignment between the advocacy and academic collectives as they moved to frame the Australian government's actions to remedy the shortage of medical staff in rural areas as unbalanced in comparison to their actions to remedy the shortage of nurses:

Nurses presently provide 90% of the health care in remote areas, and form 87% of the rural

health care workforce, yet annually received less than 1% of rural health workforce support

funding (Hanna 2001, p. 43).

These arguments use the language of access, equity and a 'fair go' for rural

Australians – including all rural health professionals. Advocates and academics make

a case that 'there are many similarities in the practice characteristics of the main

health professional groups, particularly those who work in smaller rural settings, and

they clearly differ from urban practice' (Blue 2002, p. 199), and that workforce

support funding should also be similar. Running through these arguments was a

thread that identified rurality itself as a major contributor to the problem of workforce

for all Australian rural health professionals, in particular issues of: 'Lack of

professional development, support, orientation, locum relief and spouse employments:

and professional isolation, on-call demands and family and schooling reasons once

their children reach a certain age' (Dade Smith 2004, p. 127).

Community collectives demonstrated a shift from framing a crisis in rural health as

concomitant with a shortage of doctors, to more recently include the problem of

workforce for rural nurses (Pincott 2005). However, as with rural nurses themselves,

this group were relatively silent in the small number of texts produced which were

mainly confined to press releases in support of government initiatives (National

Farmers Federation 2006).

Aligning the collectives of advocates, academics and government was the framing

of workforce problems as stemming from an international shortage of nurses (Hegney

& McCarthy 2000, Iliffe 2000, National Nursing Workforce Forum 2000). In

globalising the problem of workforce, each works to mitigate their individual

responsibilities towards finding a solution. Conley (2004, p. 186) argues that 'political rhetoric and policy decisions throughout the developed world in recent years have worked together to lower expectations about what is politically possible in a globalising world economy'.

There is a sense of fatalism in the way in which each of the collectives has amplified globalisation as a 'conceptual handle or peg' (Benford & Snow 2000, p. 623) to explain the underlying cause of workforce issues in a way that constructs it as something beyond their control. This adoption of a predominantly fatalistic – rather than a more self-reflexive – approach is the easier behavioural choice when dealing with issues concerning globalisation (Backhaus 2003), and in some way explains the small number of actions that have been implemented to solve the problem of workforce for Australian rural nurses.

PROPOSING SOLUTIONS TO THE PROBLEM OF WORKFORCE

Literature about solutions to the problem of workforce for Australian rural nurses ranges over five main areas: working conditions, workforce planning, workforce support, workforce education and scope of nursing practice. For the purpose of this study we will examine only proposed solutions to the problem of workforce support for Australian rural nurses, and in doing so scrutinise how the concept of mentoring entered the literature and who its protagonists were.

Formal mentoring programs for nurses, and subsequently research about nurse mentoring, began in the 1970s, mainly in the United States. The mentoring movement was inspired by an emerging corporate culture that used it as a means of advancing the careers of women (Stewart & Krueger 1996). In nursing literature it is now often

cited as necessary for 'career socialization, advancement and success' (Morton-Cooper & Palmer 2000, p. 35), reflecting a diffusion of mentoring from the social world of business, and a strategic fitting of the concept as a possible solution to the problem of workforce generally (Benford & Snow 2000).

The literature about nurse mentoring is extensive, with a strong emphasis on the roles of the mentor and mentee, and on the mentoring process (Glass & Walter 2000, McIntyre et al. 2005). Two contexts for mentoring relationships are usually discussed: formal and informal (Lacey 1999). Formal mentoring relationships exist within a clearly identifiable structure originating from within an organisation or discipline. For example, the Institute of Nursing Executives in New South Wales uses a formal mentoring program to assist with the development of nurse managers, some of whom are rurally based (Waters et al. 2003). Although a distinction is made between formal and informal mentoring by those who write about the former, there is little discussion about informal mentoring in the literature, because it appears to arise spontaneously between a mentor and mentee. The relationships Florence Nightingale developed with many of the nurses she had trained are cited as examples of informal mentoring (Lorentzon 2003).

Irrespective of the structure of the mentoring partnership, mentoring experiences are constructed as providing opportunities for self-development and growth for mentor and mentee, and are framed positively by three of the collectives in the social world of Australian rural nursing, the community collective making no specific comment. This demonstrates a strong alignment on mentoring as a solution to the problem of workforce (Jackson *et al.* 2001, Francis *et al.* 2002, Hegney *et al.* 2002).

One clinician stated that to stop the exodus of nurses from the profession we needed to 'decrease the patient/nurse ratio, increase time for handover periods and provide mentors for newly registered or re-registered staff' (Elgar 2001, p. 12).

The national *Rural and Remote Area Nursing Project 2002–04*, which included representatives from each collective, identified mentoring in its priorities for action (Lindsay et al. 2002). Mentoring as a means of supporting undergraduates and leaders also appeared in the recommendations of two major reviews of nursing undertaken by the Australian government, the *National Review of Nursing Education 2002: Our Duty of Care* (National Review of Nursing Education (Australia) 2002), and *The Patient Profession* (Senate Community Affairs Reference Committee 2002).

McCloughen and O'Brien captured the prospective hopes of all collectives:

> As a constructive model of integration mentorship is a valuable approach to supporting novice nurses in periods of change and transition to practice … Undoubtedly mentorship ameliorates the traditional sink or swim phenomenon. Utilising the supportive framework of a mentoring relationship, the trained registered nurse is able to be more than a life raft to the new graduate. Rather than jumping in to assist at times of crisis, the registered nurse mentor provides the new graduate ongoing and progressive support, assistance and commitment (2003, p. 30).

MOVING FROM RHETORIC TO ACTION

In 1991, Hegney and a group of nursing academics formed the Association for Australian Rural Nurses (AARN, which is included here as an advocacy group, although its membership continues to have a large number of academics with an interest in rural nursing) (Francis et al. 2002). AARN's membership grew quickly to include also a significant number of clinicians. Members of AARN were responsible, from the mid-1990s until the time we are now analysing, for a large number of

research studies about Australian rural nurses, including two seminal literature reviews (Hegney 1996, Francis *et al.* 2002; see also Stephenson *et al.* 1999).

AARN has provided an alternative platform for members of the academy to legitimise their actions as advocates. The organisation initially undertook activities that were research based, promoted by academic members who recognised a dearth of information about rural nursing as a speciality. Clinician members of AARN were an effective member check for these activities, as well as opening the gates into rural nursing as a research arena.

As time went by the activities of AARN shifted to outcomes-based projects on topics such as mental health emergencies, falls prevention and mentor development (AARN 2004). These projects were informed by AARN's earlier research and the publication of a monograph series that profiled rural nurses, gave some insight into the nature of their work, and identified their education, training and support needs (Handley 1998, Stephenson et al. 1999). Interestingly, the educational basis of all of AARN's later projects indicates how the academic collective's prolific diagnostic framing of workforce as a problem underpinned by inadequate educational opportunities influenced the genre of action that was seen as valuable enough to be funded by the government collective and subsequently implemented by the advocacy collective.

In March 2003 AARN, in partnership with the Royal College of Nursing, Australia (RCNA), implemented a two-year Mentor Development and Support Project that aimed to improve the recruitment of graduate nurses to, and their retention in, rural and remote practice settings. It was a direct response to the call for mentoring to be

implemented as a solution to the problem of workforce for Australian rural nurses (Mills et al. 2006). The AARN project was funded through the Australian Government Rural and Remote Nurse Scholarship Program: Undergraduate Scheme, which is administered by the RCNA.[1] The project resonated strongly with Australian rural nurse clinicians, enabling them to reframe how they thought about concepts such as mentoring and promoting a cultural change in the ways in which they interacted with others in their workplaces. Collective group members, such as AARN, can only achieve cultural change in this way if the potential frame they are offering is perceived as being credible and salient (Benford & Snow 2000).

> **Comment [JM12]:** This is a large footnote, however the information is useful in explaining the origins of the analysis. It might be a distraction though in the text. Am happy to change it if required.

Working together, these members of the advocacy collective were first able to transform the existing frame of mentoring from being a concept associated with leadership and corporations into a frame of possibility for Australian rural nurses

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[1] The Australian Government Rural and Remote Nurse Scholarship Program: Undergraduate Scheme was an action initiated by the government collective to answer the question of workforce support inequity between medicine and nursing, as framed by academics and advocates. The amount and the type of funding for nursing, though, falls far short of that allocated to medicine (Hanna 2001). The Australian government shares responsibility for nursing with state and territory governments (Dakin et al. 2004), a situation that lends itself to ongoing contestation over provision of concrete solutions to the ongoing problem of workforce generally. The National Nursing and Nursing Education Taskforce was established in 2003, by the Australian government with state and territory health ministers, to implement recommendations from the two national reviews of nursing and nursing education (Chair, Australian Health Ministers' Conference, 2003). Rural nursing is subsumed under nursing generally in their strategic plan, none of which has yet translated into any on-the-ground action on the problem of workforce for Australian rural nurses.

generally. This was achieved through media releases, newsletter articles, journal papers, conference presentations and, most importantly, a series of two-day workshops for rural nurses interested in mentoring. In the texts produced as a result of these workshops, project participants' words were often used in a positive way to create a sense of self-identification in the reader – aiming at leading them to think 'yes I could do that' or, more importantly, 'I do that already'.

> I have just finished applying for my graduate year jobs. It was pretty stressful sifting through all the piles of information each hospital gave out and trying to decide where to apply. My mentor was fantastic during this time. He helped me put together a great resume and application for each hospital. Today he helped me with interview techniques. I must admit that I was a bit sceptical about this mentor program to start with, but it has been such a great help to me over the last few weeks. I hope the rest of you guys are benefiting as much as I am from this program. (Johnson 2003, p. 25).

As the project progressed, this frame transformation was then amplified by drawing upon the outcomes for Australian rural nurses who had participated in the workshops. Characteristics of rurality such as professional isolation, distance to travel, limited backfill and restricted face-to-face continuing education opportunities had been addressed in the design and implementation of AARN's Mentor Development Workshops, which were fully funded, face-to-face and run over a Friday and Saturday. Outcomes amplified from the workshops were clearly linked to the characteristics of rurality that were problematic as advocates framed mentoring as a solution to the problem of workforce.

> Participants wrote about how attendance at a mentor development workshop had increased their sense of self worth as a rural or remote nurse, through sharing their experiences with

others – 'Some understanding that despite personal strengths and weaknesses my knowledge and experience is … useable in the mentor role' (Mills *et al.* 2006).

The efforts of advocates to transform and amplify mentoring as a frame for supportive relationships in the workplace (with a view to improving recruitment and retention) were credible and salient in the eyes of the Australian rural nurses who participated, as evidenced by the positive evaluations of the Mentor Development and Support Project and the Australian Government Rural and Remote Nurse Scholarship Program: Undergraduate Scheme.

Mentoring as a prevalent frame for action for Australian rural nurses was also identified in a recent action research study that investigated the culture of workplace learning in rural Australia. Investigators found 'it was clear that although all sites had some mentoring occurring serrundipitously [*sic*], some had more effective mentoring arrangements than did others' (Gibb et al. 2004, p. 204). In this study, effective mentoring equated with a cultural shift in how health care workers related to one another, so that those who were once marginalised were now the focus of mentoring and took on the role of protégés. For their mentors there was a realisation that 'their own workplace learning opportunities increased through supporting others' (Gibb et al. 2006, p. 38).

All of the projects reported here resonated strongly with the Australian rural nurse clinicians involved because they were outcomes based. The workshops and the action cycles were about rethinking mentoring as something clinicians could 'do' to support and hopefully retain new and novice nurses in the workplace. Nurses have long constructed their work in dichotomous terms such as thinking and doing, assigning values to each depending on how they position and construct their own sense of self.

As Walker argues,

> clinicians – through their apprenticeship, with its focus on the work ethic, pragmatics and tasks
> – came unwittingly to privilege their bodies as the active agents in the business of 'doing'
> nursing and (again unwittingly) marginalise the intellectual work that informs 'doing' as
> peripheral rather than central to what 'real' nursing is all about (which is to say, 'getting things
> done') (1997, p. 8).

Australian rural nurses, like most nurses, unapologetically focus on getting things done, and thus value action, constructing themselves as doers. Mentoring is a conceptual handle that clinicians have grasped in an attempt to reframe and improve their working lives, and the lives of those they work with – be they clients or novice nurses – enabling them to 'do their bit' to ensure a stable workforce.

The result of implementing mentoring as a collective action frame for the problem of workforce for Australian rural nurses is yet to be seen, if ever. No evidence was found in the literature of a current or planned longitudinal study examining whether factors such as mentoring contribute to staff retention. There has been some research into the concept of magnet hospitals and retention factors, which found that developing supportive relationships was most frequently reported as important in staff retention (Naude & McCabe 2005). On the whole, though, government and academic collectives continue to focus on diagnosing the problem of workforce from the perspective of finding out why nurses are leaving rather than why they are staying (Dakin et al. 2004).

CONCLUSION

This analysis is limited in that it focuses on the experiences of Australian rural

nurses. There are however several key messages for nurses both internationally and across speciality areas.

Mentoring entered the discourse of Australian rural nursing because of a juxtaposition of political and academic will – or collective thinking – based on the idea that it might provide a solution to the problem of workforce. The importance of advocacy groups, such as professional nursing organisations, was shown to be paramount in transforming this collective thinking into action. These organisations successfully lobbied the federal government to fund the implementation of an effective mentor development program and continuing support project for novice and experienced clinicians.

There are now signs that both government and academic collective groups are changing their focus of attention to the globalisation of the problem of workforce, and so are losing the will to continue funding mentoring activities. This in turn has led to the advocacy collective constraining their workforce support activities. Mentoring therefore is moving to become the province of a core of Australian rural nurse clinicians who are living the legacy of a collective action frame that envisaged the possibility of supportive relationships as a solution for the problem of workforce.

Reading the political climate is part of managing workforce support strategies for all nurses. Identifying key players both locally and nationally is important in resourcing creative ways of recruiting and retaining nursing staff. Measuring the effectiveness of mentoring as a strategy for recruiting and retaining staff could provide the necessary leverage to return it to centre stage politically, enabling more action locally for clinicians.

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