

SCHOOL OF NURSING

**NURSING PRACTICE IN A REMOTE AREA:
AN ETHNOGRAPHIC STUDY**

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**“This thesis is presented as part of the requirements for
the award of the degree of Doctor of Philosophy**

of the

Curtin University of Technology”

APRIL 1998

DECLARATION

I certify that this thesis is my own work and no part of it has been submitted for a degree at this or any other university.

I certify that any assistance received in preparing this thesis, and all sources used, have been acknowledged in the thesis.

Jennifer Helen Cramer
APRIL 1998

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Instead of a Foreword

During the terrible years of Yezhovshchina (head of Stalin's secret police) I spent seventeen months in the prison queues in Leningrad.

One day someone recognised me. Then a woman with lips blue with cold who was standing behind me, and of course had never heard my name, came out of the numbness that affected us all and whispered in my ear - (we all spoke in whispers there):

'Can you describe this?'

I said, 'I can!'

Anna Akhmatova (1957)

ABSTRACT

The solitary position of nurses who practise in geographically isolated communities to provide direct health care to a predominantly Aboriginal population characterises nursing in remote areas. Munoz & Mann (1982) described this practice as *unique*. The uniqueness of this practice, however, has remained shrouded in superficial descriptions featuring service delivery at a one or two-nurse-post, the physical distance of nursing posts from hospital facilities and the autonomy with which nursing is performed. Only glimpses of the reality of nursing practice in a remote area have been revealed through the study of the educational needs of remote area nurses (Munoz & Mann 1982, Cameron-Traub 1987, Philp 1988, Kreger 1991a, Bell, Chang & Daly 1995). A key problem is the lack of a systematic description and detailed analysis of nursing as it is practised in a remote area.

The purpose of this study was to explore, describe and analyse nursing practice in a remote area. The research was undertaken at Warburton, an isolated community mainly inhabited by the Ngaanyatjarra people in the Central Desert of Western Australia. An ethnographic design was chosen for this exploratory inquiry into the social and cultural pattern of everyday nursing practice. In a pre-entry study a suitable setting and informants were found. Fieldwork was conducted at the Warburton nursing post by the researcher and involved living on site for a year. Data gathering techniques were participant observation together with interviewing, collection of pertinent documents and the daily chronological recording of fieldnotes, memos and a personal journal. Data analysis was performed concurrently with data gathering. The process followed the Developmental Research Sequence Method by Spradley (1980). Through a cyclical process of data collection and analysis the domains, taxonomies and componential variables in the culture of remote area nursing practice emerged.

Amorphous practice was the overall theme revealed in the underlying cultural patterns that shaped the practice of nursing in the remote area. The term *amorphous practice* is defined as the changeable nature of practice from nurse to nurse, from situation to situation, from time to time. This was observed in the recurrent differences between nurses in their knowledge, abilities and attitudes as well as in the variability between nurses in their management of client care. Contributors to the phenomenon of *amorphous practice* were found in three distinct, but inter-related, tributary themes termed *detachment*, *diffusion* and *beyond the nursing domain*. *Detachment* explained the nurses' feelings of separateness from the usual professional and organisational structures needed for the enactment of nursing. *Diffusion* encapsulated the broad spread of the nurses' role in remote area practice. *Beyond the nursing domain* described an unregulated practice considered to be outside the responsibilities of nursing care. The substantive theory of *amorphous practice* provided a detailed description of how nursing was practised in the remote area. It also explained why it was so different from nursing as it is generally understood by the profession.

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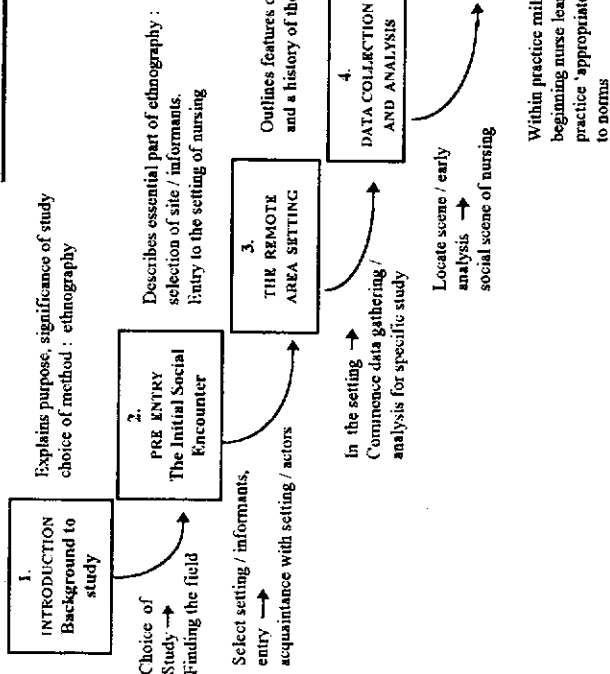
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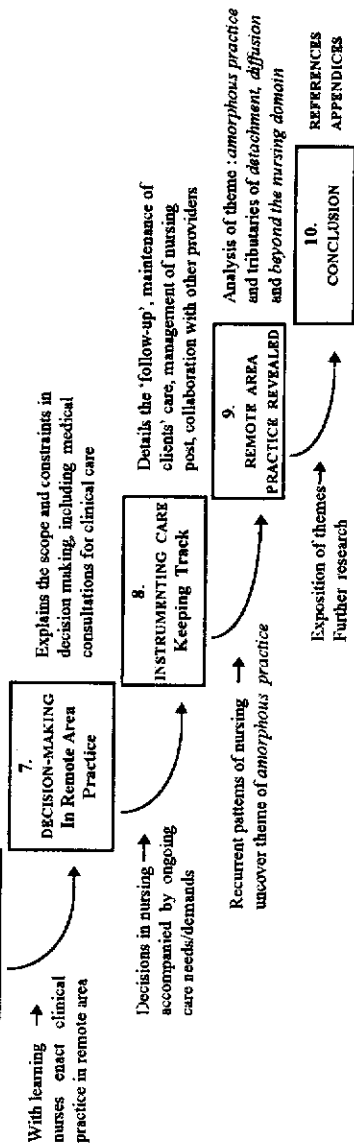
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Outline of chapters: sequence of narrative



CONTENT / RELEVANCE



LINKAGES

CHAPTER 1

INTRODUCTION: BACKGROUND TO THE STUDY

*The language that makes us invisible to history is
not coincidence but it is part of our real situation*

Sheila Rowbotham (1972)

Every piece of research begins with a puzzle

Elisabeth Noelle-Neumann (1993)

Introduction

The purpose of this study is to explore, describe and analyse nursing practice within a remote area community context. It aims to illuminate the day to day care given by nurses to the client in these communities. Nursing in this field was, and continues today, to be practised in virtual obscurity. Such practice also occurs in isolation from the nursing profession, health institutions and the organisations which employ remote area nurses.

This chapter provides a background to remote area nursing in Australia. A personal account explains how I came to an understanding of the need to portray remote area nursing as it is practised. An overview of the aims of the study and the ethnographic design chosen is then presented. Finally, the significance of the study for nursing knowledge is described.

An interest in remote area nursing

Ormiston (1983a, 1983b) coined the term 'remote area nurse' to differentiate these nurses from others. Since the beginning of this century, however, nurses have traditionally been relied upon to deliver health care in isolated and sparsely populated outback areas of Australia (Idriess 1948, International Nursing Review 1958, Department of Public Health 1959, Burchill 1964, Kettle 1969, 1991, McPherson

1971, Sisters of St John of God 1977, Inlander 1986, Spotlight 1986, Priestley 1986, Wilson 1992, Durdin 1994). The narratives of pioneer nursing in the Australian outback have aptly described the heroic efforts of nurses to provide care under deprived conditions. Most of these historical accounts have romanticised the adventurous and dedicated spirit of 'bush' nurses and were written in the vein of outback mythology (McGrath 1991). Could this view belie the reality? How did nurses practise nursing in a remote area context?

Nursing practice in remote areas has been described as *unique* (Munoz & Mann 1982). Some common features of the uniqueness of practice in remote areas refers to service delivery by a one or two-nurse-post, the physical distance of the nursing post from hospital facilities and the degree of autonomy by which nursing is practised in remote areas (Munoz & Mann 1982, Cameron-Traub 1987, Kreger 1991a, 1991b). The composition of the remote area nurses' client group also adds to the uniqueness of nursing practice. There is a mixture of Aboriginal and non-Aboriginal people (Australian Bureau of Statistics 1992). Approximately 80% of communities where remote area nurses are employed are mainly inhabited by Aboriginal people (Munoz & Mann 1982, Cramer 1993). The health needs of these groups require creative and resourceful strategies for their care by a remote area nurse. These general characteristics have been noted and documented in various reports (Munoz & Mann 1982, Cameron-Traub 1986, Philp 1987, Health Department Western Australia 1989, Kreger 1991a, 1991b, Buckley & Gray 1993, Cramer 1993). These studies, however, do not disclose the social world in which remote area nursing is practised. Accordingly, the nurses' perspective as witnesses to the everyday reality of practice performance remained untold.

The gaps in knowledge of the daily practice of remote area nurses has contributed to misunderstandings and assumptions about nursing as it is practised in the isolated environment (Kreger 1991b). The limitations of this knowledge disadvantages the practice discipline of nursing and the nurses themselves in that it appears to be a major constraint to the appropriate management of nursing services in remote areas and to

the development of educational programs relevant for the practice of remote area nurses (Munoz and Mann 1982, Cameron-Traub 1987, Kreger 1991a, Bell, Chang & Daly 1995, Fisher et al c. 1995). My personal beginnings in remote area nursing bear testimony to my unawareness and unpreparedness to practise nursing in remote areas.

The genesis of my thesis

I commenced nursing in 1966 with idealistic intentions of working amongst people who did not have access to health care. The next decade was spent gaining relevant education and experience in those areas of nursing that I believed were appropriate and necessary. For example, I undertook midwifery training and the management of home deliveries in England. I studied Community Health Nursing and Child Health and subsequently worked as a child health nurse.

My first exposure to nursing in remote areas was in Botswana from 1977 to 1979. I was employed as a public health tutor at the National Health Institute. One of my responsibilities was to organise student field experience in remote villages. During this time I met nurses who were stationed at isolated health posts. I then observed their self reliance, their use of nursing knowledge and skills and the difficulties for them in practising as a 24 hour care provider in isolation from hospital and medical services.

From 1979 to 1983 I worked with the Pitjantjatjara in the far north west of South Australia. In applying for a position as a remote area nurse I thought I was sufficiently equipped having additional qualifications and experience in midwifery, child health and community health nursing. Nevertheless, I found that I learned to practise in this unfamiliar setting by a process of adaptation of past experience, 'trial and error' and personal resourcefulness. The responsibilities of the nurse appeared to come about more by default than design. Nurses were left to determine for themselves how to deal with unreasonable community demands and service problems. For example, it was neither planned nor authorised that nurses take responsibility for medical functions.

The force of circumstances meant that the nurse was expected to perform these functions as needed.

The Pitjantjatjara Aboriginal people held different beliefs about illness, health, treatment and cure. I showed an interest to communicate in their language and they willingly taught me. I was also taught about their beliefs and customs. This was, however, according to their perceptions of my readiness and need to know. My language fluency was further developed because I was fortunate to begin work in this remote community with a nurse who had worked in the area for six years and who also spoke the Pitjantjatjara language. The Pitjantjatjara accepted nursing interventions and medical treatments by incorporating it into their way of life. A gradual trusting relationship with the Pitjantjatjara developed through client - nurse relationships. The intimacy of person, place and time shared between the nurse and clients in this isolated environment, however, also placed additional pressures on the role of the nurse.

I kept a journal during these years and recorded my thoughts and the events at the time. Entries in the journal reveal how I began questioning the implicit role expectations of a remote area nurse. Early in this experience I had concluded that education was the answer to the problems of nursing in the remote community. I was naive. Education of itself was not the answer. Organisational leadership, health service planning and an infrastructure that enabled a nurse to provide reasonable care in a remote area were also essential.

I then undertook a postgraduate diploma in public health as well as a master's degree in nursing management. Following these studies I worked for four years (1987 - 1991) as co-ordinator of nurses and Aboriginal health workers in an independent Aboriginal health service in the remote west Kimberley region of far north Western Australia. My opportunity to influence the conditions of practice for these staff was limited. Health service decision making was the prerogative of medical authority, not a middle management nurse.

Remote area nurses and the everyday care they provided in isolated communities were unseen and marginalised in the health system. Without nurses, however, health services in remote areas would flounder. Over time I engaged in dialogue with many nurses working in remote areas of various parts of Australia and overseas. This was in a quest to better manage our practice. The complex situations that we had in common, together with my efforts to write about and to research the subject, further aroused my desire to make visible the reality of remote area nursing practice (Cramer 1984, 1987a, 1987b, 1989, 1992a, 1992b, 1993, 1994). I also believed it was incumbent on nurses in remote areas to reflect upon and to question the quality of their practice and its implications for client care. A fundamental question of interest was what evidence was there of the day to day care given by these nurses? In my search for an answer I found a paucity of literature to substantiate the practice experience of remote area nurses.

The need to deepen the search

To date only glimpses of nursing practice had emerged when the educational needs of remote area nurses had been studied (Munoz and Mann 1982, Cameron-Traub 1987, Kreger 1991a, Kreger 1991b, Buckley & Gray 1993, Bell, Chang & Daly 1995). These authors recorded that nurses undertook a multi-faceted role within their practice settings. Nurses also utilised a wide range of knowledge and skills often under extremely problematic circumstances (Wilson & Najman 1982, Kreger 1991a, Cramer 1993, Armit 1995, Fisher et al. c. 1995). Kreger (1991a, p33) for example, found that,

Often singlehandedly (*sic*) the nurse will initiate first aid, life-saving and stabilising interventions as required. Concurrently, and when available, the remote area nurse will direct other health service staff, family or community members, bystanders, or police as to the type of assistance needed.

Nevertheless, these studies did not investigate how nursing was actually performed in such a practice context.

A further factor that was likely to impact on nursing practice was a lack of medical practitioners, allied health professionals and support services available in remote areas. Several studies have reported that this was a major factor in remote area nurses undertaking functions unusual to nursing practice (Wilson & Najman 1982, Kreger 1991a, Kreger 1991b, Cramer 1993, Keane 1993, 1994, Siegloff 1995). A serious concern noted by Wilson & Najman (1982) was the high rate of drugs, in particular antibiotics and sedatives, dispensed by nurses in isolated settings and without medical orders. These authors suggested that this practice warranted closer scrutiny in view of the lack of protection for nurses and for their clients.

As Kreger (1991b) pointed out, it was the context rather than the nature of care needed or the expertise of the on-site nursing staff available that influenced the delegation of professional responsibility. It appeared that this delegation occurred in an arbitrary fashion and with minimal administrative or educational support for nurses (Kreger 1991b, Cramer 1993, Armit 1995). Accountability was a fundamental concern, expressed by Kreger (1991b, p68), where practising in an isolated context and with a lack of guidelines 'leaves nursing practice open to abuse by the community, administrators, colleagues and nurses themselves'. This concern is pertinent and of central interest to this study of how nursing practice is enacted in a remote area.

According to Bell, Chang & Daly (1995, p46) the professional role of remote area nurses was 'poorly defined' and a constraint to effective nursing practice. Other authors attributed this basic problem to an unsatisfactory delineation of role relationships between nurses, medical practitioners and other health care workers in the management of health services (Kreger 1991b, Mills 1993, Kirkby 1994). A critical finding by Willis (1990, p20) was that a lack of role differentiation between health professionals served to subordinate the position of remote area nurses to the medical power base while leaving them to be primarily responsible for 'dispensing western medicine'. Furthermore, the routine practice of remote area nurses 'filling the

gaps' of absent health care providers and compensating for a lack of organisational infrastructure also contributed to a contraction of actual nursing practice (Kreger 1991a, p61).

Research reports and other official documents published over more than two decades have consistently reported a lack of educational preparation or orientation commensurate with the extraordinary role expected of nurses practising in remote areas (Committee of Enquiry into Health Services in South Australia 1973, Bentley 1974, Hospital and Health Services Commission 1976, House of Representatives Standing Committee on Aboriginal Affairs 1979, Munoz & Mann 1982, Percival 1986, Cameron-Traub 1987, Health Department Victoria 1987, Philp 1988, Sturmeay 1989, Health Department Western Australia 1990, Human Rights and Equal Opportunity Commission 1991, Sturmeay & Edwards 1991, Kreger 1991a, Buckley & Gray 1993, Cramer 1993, Armit 1995, Bell, Chang & Daly 1995, Fisher et al. c 1995). Munoz & Mann (1982), Cameron-Traub (1987) and Cramer (1993), for example, found that nurses had learned to practise mainly by 'trial and error' while often working unsupervised in the isolated setting. Cameron-Traub (1987) interpreted this manner of learning as nurses response to the demands placed upon them that exceeded their level of education and experience.

The practice skills informally acquired by nurses included prescribing medications, medical history taking and physical examination, suturing, initiation of intravenous drug therapy, performance of pap smears and counselling (Cameron-Traub 1987, Philp 1988, Kreger 1991a, Buckley & Gray 1993). Nurses were reported by these authors to also lack educational preparation for the management of common health problems and public health needs of remote area client groups. As Cameron-Traub (1987) had questioned, what are the risks and consequences of such *ad hoc* learning for nurses' professional integrity and confidence and for client care of a group already disadvantaged by their isolation? A further question deserving consideration is how nurses, deprived of an appropriate educational preparation and adequate management support, actually perform their day to day care interventions? What evidence is there

to corroborate remote area nursing practice? The lack of 'in-depth description' and 'little research evidence of how nurses practise in remote areas' remained a fundamental barrier to the advancement of remote area nursing practice (Kreger 1991a, p11, Siegloff 1995, p120).

A known fact of remote area nursing is a high staff turnover and occupational stress. How these factors impact on the practice of remote area nursing, however, has not been studied. In remote areas of the Northern Territory (1989-1990) and Western Australia (1985-1986), for example, turnover rates were in excess of 224% (Kreger 1991b, p17, Percival 1986, p18). As another example, in 1990 the turnover rate in some remote communities of far north Queensland was 145% (Brown 1991). In a national study, Kreger (1991b) reported that occupational stress was a major reason for resignation by remote area nurses. The experience of stress in remote area nursing has been attributed to persistent problems of unreasonable and often conflicting demands on nurses, and an unrealistic workload together with practising in an unfamiliar and unpredictable environment (Kreger 1991b, Willis 1991, Cramer 1993, Bell, Chang & Daly 1995). Stress in remote area nursing was also associated with verbal and physical harassment and threats to the nurse's personal safety (Kreger 1991a, Cramer 1993, Fisher et al. c. 1995). Fisher et al. (c. 1995, p38) concluded that the occurrence of these multiple stressors in 'both the working and private lives' of remote area nurses could explain the high nursing staff turnover in some remote areas. According to Willis (1990), another major source of stress for remote area nurses was their marginalised position in the structural hierarchy of rural health services. The effect of such distressful factors on actual nursing practice in remote areas has yet to be investigated.

A hallmark of remote area nursing is working with people of different cultures (Kettle 1969, McPherson 1971, Munoz & Mann 1982, Brown 1991, Kreger 1991a, Cramer 1987a, 1992a, 1993). Furthermore, as reported by Thomson (1984a, 1984b), National Aboriginal Health Strategy (1989) Bhatia & Anderson (1995) and Australian Bureau

of Statistics (1997), the health and socio-economic status of these people, who are usually indigenous Australians, is generally poor.

The Aboriginal people in remote areas mainly speak their own languages and their beliefs about well being often have strong spiritual connections (Hamilton 1972, 1981, Taylor 1978, Berndt 1982, Myers 1986, Hunter 1993). These beliefs are also in stark contrast to modern western perspectives of health and illness. At the same time, it needs to be remembered that behavioural factors and health values of any cultural group may also be influenced by the broader values and power relations of the society in which it is situated (Bruni 1988, Bigbee 1993, Buehler 1993, Whyte & van der Greef 1994, Airhihenbuwa 1995, Mulholland 1995, Swendson & Windsor 1996). A problem, particular to transcultural nursing practice in remote areas of Canada that Morin (1987) identified as worthy of further investigation, was how nursing interventions and the use of technology influenced the cultural values and beliefs of indigenous communities. This is also relevant to remote area nursing practice in Australia. Several researchers have noted that, with the introduction of western medical technology, Aboriginal people living in remote areas have incorporated aspects of this disease-cure model into their belief system according to their interpretation of its use for them, such as a value for pain relief tablets, 'needles' and X-rays (Tonkinson 1974, Nathan & Japanangka 1983, Brady 1992). This facet of remote area nursing practice has had minimal exploration. Nevertheless, as Kreger (1991a) found, the languages and cultural beliefs, values and behaviour of the remote area Aboriginal client group were often poorly understood by nurses. Curiously, in a survey of educational needs, 'cultural knowledge' was accorded lowest priority by remote area nurse participants in the study (Cameron-Traub 1987, p8).

The selective descriptions of nursing practice as recorded from the various vantage points have not conveyed a total picture of remote area nursing practice. All these diverse factors as touched upon in this literature, however, are germane to the need for a substantial inquiry to see first-hand what is the impact on everyday nursing

practice in remote areas. Alluding to the exceptional nature of remote area nursing Gray (1992, p102) stated,

The complexity is increased in [remote area practice] as a result of the isolation factor...the dearth of professional and system support has a significant impact on the way in which a nurse is able and required to practise.

A systematic description and detailed analysis of nursing practice from within the social and cultural context of remote area settings in Australia needs to be investigated, hence the following purpose of this ethnographic study.

Purpose of the study

The purpose of the researcher in this study is to explore, describe and analyse nursing practice within the social and cultural context of a remote area community in Western Australia. Guided by this purpose, the study aims to disclose the social world of nursing practice in an intercultural remote area environment. This study will explore and describe the delivery of nursing care from the perspectives of nurses, clients and other groups within a remote area setting. Factors in the remote area setting that influence nursing practice will also be described.

Research design

Ethnography was chosen as an appropriate method for inquiry into the unexplored area of the human and social phenomenon of nursing practice in a remote area (Spradley 1980, Germain 1986, Hammersley & Atkinson 1995). At an exploratory level of naturalistic inquiry ethnography provided flexibility to explore and to describe the culture of nursing practice from within the social context of nurses' daily life (Fetterman 1989, Germain 1986, Shaffir & Stebbins 1991, Mackenzie 1994, Streubert & Carpenter 1995).

The focus of interest for this study is nursing practice in a remote area of Western Australia. The study was conducted in the setting of Warburton, a remote community situated in the Central Desert of Western Australia mainly inhabited by the Ngaanyatjarra people and where nurses were employed as the main providers of health care. A two-stage pre-entry study was used in the selection of the setting. This first stage involved a search for a potential site for fieldwork and the acquisition of background information pertinent to the study. In the second stage I entered the community of Warburton for a three month period in order to ascertain if the social setting of nursing practice would yield sufficient data and to gain acceptance of my research proposal by community representatives and potential informants. Informants for the study were drawn from the Warburton social setting. These were the nurses, Aboriginal health workers, visiting medical practitioners and other health and allied service personnel as well as the clients who interacted with nurses in the community.

Fieldwork involved myself as the research instrument living in Warburton for one year. Participant observation was the main technique for data gathering. Additional data were obtained by interviewing informants and by collection of material documents to substantiate observations and to gain further insights into remote area nursing practice. Fieldwork was recorded daily in separate volumes of field notes, memos and a personal journal. Data analysis was concurrent with data gathering in the field. The Developmental Research Sequence Method (Spradley 1980), a systematic cyclical process of observation and analysis, was used as a guide to channel my inquiry toward the conceptual themes pertinent to the research. The themes that emerged from the data analysed formed the basis of this ethnographic study of nursing practice in a remote area.

Ethnography: the rationale

The ethnography is a process of interpretive inquiry into the shared meanings of the nurses' lived experience in order to discover cultural understandings that shaped nursing practice within the remote area. The assumptions underlying this interpretive

inquiry guided the strategy and design of this research and are based on the social theory of symbolic interactionism (Denzin 1989, 1992, Lowenburg 1993). Meaning in the symbolic interactionist's sense is perceived as social products in the remote area nursing setting created and formed in and through defining activities of people as they interact (Blumer 1969). This approach required a respect for the empirical world of remote area nurses and a close familiarity with the practice of remote area nursing being studied (Schwandt 1994).

The rationale of the ethnography was that by entering into close and prolonged contact with the everyday lives of people involved in the remote area social setting, nursing practice could be more fully understood and explained for another audience (Goffman 1961, Valentine 1968, Agar 1986, Lofland & Lofland 1984, Hammersley 1992, Mackenzie 1994). Extensive engagement of myself as research instrument with nurses within their actual practice environment was essential to revealing their social reality (Morse & Field 1995). According to Hughes (1992, p444), use of the senses as primary data gathering tools depended on 'being there'.

To learn first-hand the nurses point of view and their multiple realities I needed to situate myself as researcher in the position of the other and to find out what it was like for 'insiders' in this particular situation (Denzin 1989, Spradley 1980, Shaffir & Stebbins 1991, Morse & Field 1995, Burns 1997). The task, however, for an outsider:

becomes a struggle to see more than mere perception allows, to see deeply within the veil with which the empirical world supposedly hides itself (Clough 1992, p41).

As a cultural study, ethnography is ideational and based on the assumption that human beings are socialised into a cultural framework (Spradley 1980, Aarmodt 1982, Geertz 1988, Fetterman 1989, Denzin 1992). The concern of this study was to learn how nurses used knowledge together with the events that made sense for them in their ordinary everyday life (Geertz 1973, Spradley 1979, 1980).

The intelligibility of nursing as it is practised in a remote area together with the meanings ascribed by nurses to their practice, depends on the social context in which it occurs (Laing 1968, Goffman 1971, Denzin 1972, Geertz 1973, Benner 1984). Accordingly, as emphasised by Mulholland (1995) and Swendson and Windsor (1996), the social context is a fundamental concept that is pertinent to understanding nursing practice in a remote area cross-cultural setting. It accounts for the way in which the culture of nursing practice is produced and reproduced within the social, economic and political variables that prevail (Bruni 1988, Bourdieu & Passeron 1990, Purkis 1994, Mulholland 1995)

Nursing practice, however, is not only what 'meets the eye'. It is also shaped by elements beyond the local context. From an etic perspective, ethnography takes into account the larger sociocultural landscape that impacts on the local situation of nursing practice (Burns 1997). The focus of this research was the location of nursing practice. Marcus (1986, p172) clarified the practical necessity for selection of an ethnographic subject while retaining sensitivity to the broader background sphere:

One is obliged to be self-consciously justifying (or strategic) in the placement of ethnography because of sensitivity to the broader system of representation that is at stake, foreshortened by the practical advantage of ethnography fixed in a single locale.

The finiteness of a micro-field study of the human experience of nursing in a remote area can only allude to the more global forces that impact on the local setting of nursing practice. Spradley and McCurdy (1972) noted that a written ethnography was always incomplete in that it lacked a precise equation for the translation of culture. Similarly, as Geertz (1973, p29) and Clifford (1986, p6) explained, the predicament of an ethnographic study is its 'partiality' or 'incompleteness'. The trustworthiness and authority of the ethnographic text, however, ultimately depends on the testimony of what I, as the writer, have witnessed (Eipper 1996).

Ethical considerations

Initial approval for this research proposal was obtained from the Human Research Ethics Committee at Curtin University of Technology (Appendix 1). The proposal was then submitted to the Ngaanyatjarra Council (Aboriginal Corporation) and Warburton community representatives for their agreement and permission to conduct the study (Appendix 2).

Each health care worker informant was approached for their consent to participate in the study (Appendix 3). The study purpose was explained to potential informants individually. Each participant was advised that they could withdraw at any time or retract any information given to the researcher without any disadvantage. The protection of privacy, anonymity and confidentiality of informants was assured. Pseudonyms were substituted for personal names. No identifiable details of informants were recorded in field notes or in the ethnography, nor will they be recorded in any resulting reports or publications. All data collected will be safely held by the researcher until the completion of the study and for the following five years.

Preliminary research

In a preliminary study I visited nurses where they lived and worked in some of the most isolated communities in Australia (Cramer 1993). The findings of this research reinforced the need for a more detailed study of remote area nursing practice in its natural setting. To gain an understanding of this world of nursing it was necessary to learn it from the nurses perspective and within a remote area community.

From this study I acquired experience in the techniques of qualitative research. This had prepared me to undertake a further more substantial inquiry into the world of remote area nursing. I then felt ready to attempt an ethnography of nursing practice in a remote area community.

Understanding remote area nursing practice

As a first field based study of nursing within a transcultural remote area community setting of Australia it was important to understand both the explicit and tacit meanings that impinged on and shaped this practice (Leininger 1985). Nursing practice according to Reilly and Oermann (1992, pp13-15) encompasses theories of action, centred in and concerned with clients' health and illness responses within a 'practice milieu'. In other words it is shaped by the environment or society in which nurses practice (Weinert & Long 1991). This notion is well established and well accepted within the nursing community and led to a serious questioning of how nursing is practised in a remote area of the Australian outback. As nurses are the main care providers in this setting it is important to understand how care is provided and received in remote areas. Holden and Littlewood (1991, p6) maintained that the nurse's universal role of caring is restated within a society's cultural values. An important question is, therefore, how the cross-cultural setting of remote area communities impacts on the delivery of nursing care. Another pertinent question posed by Holden and Littlewood's remark, is how the dominant values of Australian society 'restate' the mode of caring by nurses for indigenous people living in an isolated context.

Braidotti (1994, p25) offered further insight into the importance of uncovering the nature of nursing practice within a remote area setting. The researcher stated that visibility and truth are not synonymous as 'there is always more to things than meets the eye'. Moreover, as Bartky (1990, p17) astutely commented, the nature of social reality also has a deceptive aspect 'since many things are not what they seem to be'. Similarly, this study was a search for the less visible and for the reasons not always apparent or taken for granted. Exposing the meanings that constructed nurses' reality challenged this research and it was a constant quest.

The importance of describing unknown aspects of nursing from within the context of practice was also supported by other nurse scholars. Benner (1984), for example,

noted that understanding nursing from within its context of practice was basic to the development of nursing knowledge and improved client care. Melia (1979), Aarmodt (1982) and Purkis (1994) also argued that nursing practice could only be more fully understood from a knowledge and analysis of the socio-cultural concepts and constructs relevant to nurses and others who inter-relate with the nurse within the social setting.

Melia (1982), Chapman (1983), Aarmodt (1989) and Reid (1991) each conducted qualitative studies of relatively unexplored facets of nursing practice. These authors concluded that describing nursing as it ordinarily occurred was a way to generate a rationale for nursing practice and to benefit nursing knowledge. As noted by Reid (1991), such a description necessitated a choice for a research method that was sensitive to the complexity of human experience. Accordingly, I selected the ethnography approach as a method of discovering the 'unmapped situation' of everyday nursing practice in a remote area community (Hughes 1992, p444).

Significance of the study

Current literature of nursing practice in remote areas of Australia provides a general superficial description of the phenomenon of remote area nursing. Glimpses of this phenomenon have come from the various viewpoints taken by a few authors (Munoz & Mann 1982, Cameron-Traub 1987, Kreger 1991a, Kreger 1991b, Cramer 1993). As a result of this ethnographic study, information can be organised and utilised to provide a more in-depth encompassing account of what is perceived and what is practised in the nursing care of a remote Aboriginal community. That is, from the perspectives of nurses, other care providers and informants, and recipients of care.

The importance of this study is that for the first time a wholistic exploration against a background of premises, interests and values concerning what it means to practise nursing in a remote area of Australia is provided. This ethnographic study of nursing assists in uncovering the complexities of practice that confront nurses in remote areas

as well as to inform the non-remote area nurse, health professionals, educationists and service planners.

To date there has been no detailed account of what is involved in the everyday practice of remote area nursing. The impact of environmental, political, social and cultural factors that shape nursing as it is practised within this unique context also remained unknown. Nevertheless, these circumstances are likely to have a profound effect on the nature of practice for nurses and, concomitantly, on the health care of clients.

This ethnographic study is significant in that it provides nurses in this country and overseas an opportunity to comprehend the work world and practice domain of remote area nurses who work and live by different meaning systems. Such an exposition illuminates the reality of what it means for nurses to practise nursing within an isolated geographic and socio-cultural environment.

The significance to the nursing profession of studying nursing as it is practised in a remote area from the nurses point of view, is based on the following three premises:

1. The nursing profession in Australia has an obligation to know the practice requirements of registered nurses in various settings (Appendix 27). This knowledge is pertinent to policy development, the legitimacy of practice by nurses, formulation of nursing practice standards and the development of educational programs for nurses (Gordon 1985, Affara 1992, Percival 1992, Shorten & Wallace 1996, Wallace, Shorten & Russell 1997). Furthermore, it is essential for an informed professional representation of this particular modality of nursing to health authorities and other organisations.
2. Nursing practice is enacted and shaped by a social and cultural context. There is a critical relationship between nursing as it is practised and the 'practice milieu'. (Reilly & Oermann 1992, Boyd 1993). Understanding this relationship is basic to knowledge of how nursing practice is performed in remote area settings.

3. The practice of remote area nurses has a major significance for health care in isolated communities. It is essential, therefore, to know how social and cultural meanings pertinent to the quality of nursing care are formed in this context and to apprehend the nurses' world.

Contemplating these premises and the problem of obscurity for nurses practising in remote areas it was clear that fundamental questions needed to be asked. Why is this nursing undervalued? What is known by the profession about the everyday practice performance of nurses within the remote area setting? How is nursing being shaped in this context? Is there a distinguishing culture of remote area nursing? What is the nurses' reality? These persistent questions and their significance for nursing practice were an impetus for embarking on this research.

Summary

Nursing in remote areas of Australia, mainly for an Aboriginal population, has been hidden by its isolation from the nursing profession and the health care system. It is also obscured by a lack of knowledge of the day to day care provided by nurses in this context. My personal experiences in remote area nursing and education, together with consultation with many other remote area nurses, led me to question the role expected of them and how their practice is performed. Authors of the research literature and official documents available have provided only glimpses of remote area nursing practice. These authors have also alluded to the intractable problems for practice that nurses commonly encounter in remote areas. A more wholistic portrayal of nursing as it is practised and from the world-view of nurses in a remote area was needed

The importance of this study for nursing is to make visible the nurses' reality through a systematic description and detailed analysis of practice in a remote area. Hence the purpose of this study was to explore, describe and analyse nursing practice within the social and cultural context of a remote Aboriginal community. An ethnographic

design was chosen. Ethical approval was obtained prior to commencement of the study.

The ethnography as an interpretive inquiry was appropriate for an exploration of this little known phenomenon and was based on the social theory of symbolic interactionism. Potential limitations of an ethnographic study are to be found in its local scope and in the author's representation of the culture of remote area nursing to another audience. These background ideas and concepts provided a point for beginning this research. I then entered the pre-entry phase of fieldwork.

CHAPTER 2

PRE-ENTRY: THE INITIAL SOCIAL ENCOUNTER

*You road I enter upon and look around, I believe you are
not all that is here, I believe that much unseen is also here*
Walt Whitman (1881)

Introduction

In keeping with ethnography the key phase in the research process is that of 'pre-entry'. The importance of this phase of negotiation is that it involves gaining access to the research site as well as influencing subsequent phases of the inquiry. This includes the design of the study, collection of data and eventually the dissemination of the completed work (Burgess 1991). In this chapter I explain the importance of the pre-entry phase to the purpose of my study. I then describe the way in which I obtained permission for entry into a remote area community.

Considerations for pre-entry

The pre-entry phase is essential because the ethnographic research depends on firstly, finding people who are not only willing but also able to communicate with the researcher (Shaffir 1991). Secondly, the research depends on selecting a setting that is relevant to the purpose of the study (Spradley 1979, Germain 1986, Wilson 1989, Glesne and Peshkin 1992, Morse 1994, Hammersley and Atkinson 1995, Burns 1997). According to Kirk and Miller (1986, p63) the pre-entry phase marks the period from the initial steps in 'finding the field' to the formal commencement of fieldwork.

Within such a context the pre-entry stage of my study was not too difficult. I am an experienced remote area nurse who had spent eight years working in remote areas of South and Western Australia. Furthermore, I had recently (Cramer 1993) completed a study on support for remote area nurses. Through this I renewed my personal

networks with people working in remote areas. My selection, however, centred on finding a remote area in which nurses were employed. More importantly my choice was based on whether the community would yield sufficient data relevant to the study of nursing practice in the remote area setting.

The selection of a potential location for this study was influenced by several preliminary considerations. Firstly, the community was reasonably typical of remote isolated communities. It was sparsely populated and nurses were employed as the main providers of health care on a 24 hour basis. Secondly, my preference was to undertake fieldwork in a community where Pitjantjatjara or a related language was spoken. This was because I already spoke the Pitjantjatjara language with a degree of proficiency. The advantage of this ability was evident in subsequent interactions with the Ngaanyatjarra people. Initial rapport was enhanced by knowing and talking with them about their Pitjantjatjara relatives and acquaintances. Familiarity with the colloquial language and sensitivity to customs of approved inter-personal behaviour was also a key for acceptance into the lives of these people. Speaking a kin language was important to learning the Aboriginal people's perspectives of nursing care in remote areas.

Thirdly, obtaining permission from health service officials and key leaders which was essential to my entry into the community was in my favour. I was previously acquainted with the health service manager and was already known to several community members. Entry also depended on agreement by nurses and Aboriginal health workers to participate in the study and for my residence at the nursing post.

The opportunity to live continuously in the remote community where nurses practised was significant to the extent of the inquiry and for the validation of collected data (Valentine 1968, Fetterman 1989, Kirk and Miller 1986). Consequently a further practical consideration was the availability of accommodation for the duration of fieldwork that was non-intrusive on the privacy of nurses. Warburton nursing

post which had single room accommodation in the nurses' quarters offered such an opportunity.

Finally, I was interested in undertaking the study in an independent Aboriginal community health service. This was in view of the trend in federal government policies of Aboriginal self-determination to establish this type of service in remote Aboriginal communities (House of Representatives Standing Committee on Aboriginal Affairs 1990, Rowse 1992, Anderson 1994, Aboriginal & Torres Strait Islander Commission 1994, Central Australian Aboriginal Congress 1995).

The pre-entry process

As a way of searching out suitable locations I reflected on my knowledge of remote area communities and the likelihood of access for my research. I spoke with several health service administrators and with remote area nurses from within Western Australia and from interstate. This was to gauge their interest in the research and to ascertain possible sites for the field study. Warburton, a remote central desert community which I had visited during my previous research (Cramer 1993) met my criteria. It was, therefore, tentatively selected.

Negotiations for entry to the community were commenced by a telephone inquiry on 9th December 1994 to the Manager of the Ngaanyatjarra Health Service based in Alice Springs. In this initial inquiry I outlined the nature of my study and sought a response as to the possibility of conducting the fieldwork at Warburton. I then forwarded a summary of the research proposal (Appendix 4) together with a letter and statement outlining my personal background, the method of fieldwork to be used and the benefits of the study for nursing practice and for the community (Appendix 5).

Subsequently, on 17th March 1995, the Manager advised me that the proposed study was acceptable. This was, however, subject to a review by the Ngaanyatjarra Council's resident senior anthropologist of the merit of the proposal and the value of

the research to the Ngaanyatjarra people. If these conditions were satisfied the proposal would then be presented for the approval and consent of the Ngaanyatjarra Council, the representative body of the Warburton community. This review of the research proposal was expected. As Lincoln and Guba (1985, p253) predicted:

In most cases those gatekeepers, before giving assent, will want to be informed about the inquiry in ways that will permit them to assess the costs and the risks that it will pose, both for themselves and for the groups to which they control access.

The anthropologist became the main contact person and played a vital liaison role in negotiations with the Ngaanyatjarra Council and Warburton community representatives for my entry to the remote community. Ultimately she was my ongoing support for the duration of the study. Germain (1986) and Hammersley and Atkinson (1995) have noted these important characteristics of a key contact person.

Initial acceptance of the proposal was assisted by my prior acquaintance with the manager. This came about from previous meetings during my term of employment with another Aboriginal health service in the Kimberley region. Also in my previous research the manager had agreed for me to interview nurses working with the Ngaanyatjarra Health Service. I was known to several Ngaanyatjarra people whom I had met when I worked with a neighbouring Pitjantjatjara community. Another advantage was being a nurse who was already acquainted with a lifestyle similar to Warburton community. Thus, these previous associations with the people and their setting enhanced acceptance of myself as a researcher.

Establishing ties

The relationship formed with the anthropologist through discussions via the telephone enabled clarification of relevant issues pertinent to the conduct of the study. These issues included a mutually acceptable trial period, the manner of regular

progress reports to community representatives and the options for my accommodation.

The opportunity to gain entrance was increased by the fact that my research interest and the interest of the key person representing the Ngaanyatjarra Council had 'coincided' (Shaffir & Stebbins 1991, p26). The anthropologist being in favour of the proposal stated:

Although researchers are generally not welcome [in the Ngaanyatjarra Lands], I support the need for research. The proposal is very timely. I can see the pressure on nurses in the community (Personal Journal 8.3.96).

Subsequently, the conditions proposed jointly by the anthropologist and the health service manager were that:

1. I undertake a pre-entry period of three months in the community. During this time the members of the community, nurses and other health care workers and myself as researcher could become acquainted and then evaluate the feasibility of the study to proceed.
2. A committee of community representatives, the senior registered nurse, the anthropologist and myself be formed to report progress of the study, seek advice and obtain consent for the parameters of the fieldwork. (This condition was followed through in consultations with community leaders which occurred on a needs basis. I also made written progress reports to the Ngaanyatjarra Council each six months for the duration of the research).
3. I would accept accommodation within the Warburton nursing post compound.

The recommendation was to be presented by the anthropologist at the monthly Ngaanyatjarra Council meeting. The presentation of the proposal to the Council was delayed for four months because of their other priorities. I was assured, however, that the proposal would proceed. The delay served to benefit fieldwork in the long term. The relationships established with key figures in that time enhanced feelings of co-operation and the acceptance and trust in myself as researcher. These factors, also

noted by Germain (1986) and Wilson (1989) for example, were essential to my entry to the community.

My strategies for gaining trust were to adopt an open stance about the nature of my study and to heed the specific instructions of my prospective hosts. To this end I informed the key figures of my activities and abided by the advice of the health service manager. For example, I had wanted to make contact with nursing staff at the community. The manager advised me, however, to await the outcome of the Ngaanyatjarra Council decision. I was informed that the manager would make first contact with the nurses and Aboriginal health workers. At this contact the manager would establish their interest in participating in the research and their willingness to accommodate me at the nursing post. I adhered to this advice.

Sensitisation to the setting

Throughout the pre-entry phase I kept a personal journal. In it I recorded my personal responses to events and the sequence of activities and communications in negotiating my entry to the field.

I began to assemble a background picture of Warburton and its history. This included formal interviews with two nurses who had previously each worked for two years at Warburton. Correspondence was also commenced with a nurse who had spent nine years at Warburton in the early years of the Warburton 'hospital', as it was then called.

Other bodies who had been involved in policy and decision making affecting the Warburton nursing post were also consulted. These were the former head of Frontier Services (who operated the health service from 1970 to 1979), the State Manager of the Aboriginal and Torres Strait Islander Commission (ATSIC) and the Regional Manager (ATSIC).

Specific senior managers at the Health Department of Western Australia declined my request for an interview. I was permitted by them, however, to view Health Department archival material relating to Warburton. I also undertook literature searches in the State library archives and in other libraries for material pertinent to my research.

Similar to Janesick (1994), I found that the insights gleaned from these investigations aided my understanding of the origins and historical influences on Warburton nursing post. The background information obtained was a way to becoming sensitised to the life of Warburton nursing post.

Being Accepted

Six months after my initial inquiry I received formal written approval from the manager representing the Ngaanyatjarra Health Service stating that permission from the Ngaanyatjarra Council to enter Warburton community had been granted (Appendix 6). An initial period of three months entry was nominated to assess progress before giving consent to the study. Accommodation was allocated for me at the nurses' quarters.

I then notified the manager of the Ngaanyatjarra Health Service, the Warburton community chairman and the nurse-in-charge at the nursing post of my date, and the route, of arrival. Six weeks later on Friday June 24, 1995, I arrived at Warburton.

Arrival at Warburton

I returned to the Central Desert by a Ngaanyatjarra Air passenger aircraft. Gazing down from the window I was awed again by the sheer magnitude of the uninhabited and sparsely vegetated expanse of earth that stretched out to the distant curve of the horizon. Finally, after the three hour journey north east from Kalgoorlie, a small

cluster of buildings in the midst of the desert's red sand became visible. I had arrived at Warburton Ranges (Plate 1, overleaf).

At the airstrip I was met by the Facilities Co-ordinator (clerical position at the nursing post) and was subsequently introduced to the staff at the nursing post. In the first few weeks I met community leaders including the chairman. I also met the anthropologist whose acquaintance until then was via the telephone.

Assigning my role

In these early days I focused on forming relationships with nurses and Aboriginal health workers. This included explaining the purpose of the study's fieldwork and making known to them the primacy of my role as researcher (Germain 1986). The importance of clarifying my study purpose and role position from the outset was reaffirmed in this disclosure made three months following my entry:

Before you arrived, we [nurses] had discussed whether you would see things from our point of view or just listen to management.

The nurse in charge introduced me to other members of the community as 'a nurse who is writing a story about nurses in the community'. This explanation was well accepted. Telling stories was a familiar concept to the Ngaanyatjarra people. For them it was a way of communicating important information.

Being a mature woman and a nurse with past connections to others known to the Ngaanyatjarra people was an advantage in respect to the people's perceptions of me and of my role. In their view a person acquired wisdom with age. As Warren (1988) noted, the role assumed by the researcher is more often subsumed by an interactive process whereby the researcher is assigned a role appropriate to the social order. Thus, gender and age influenced community perceptions of my place in this social setting. For example, in time when people came to know me I was invited by senior women to attend their sacred ceremonies. Familiarity with the social setting was basic to fulfilling my adopted role.

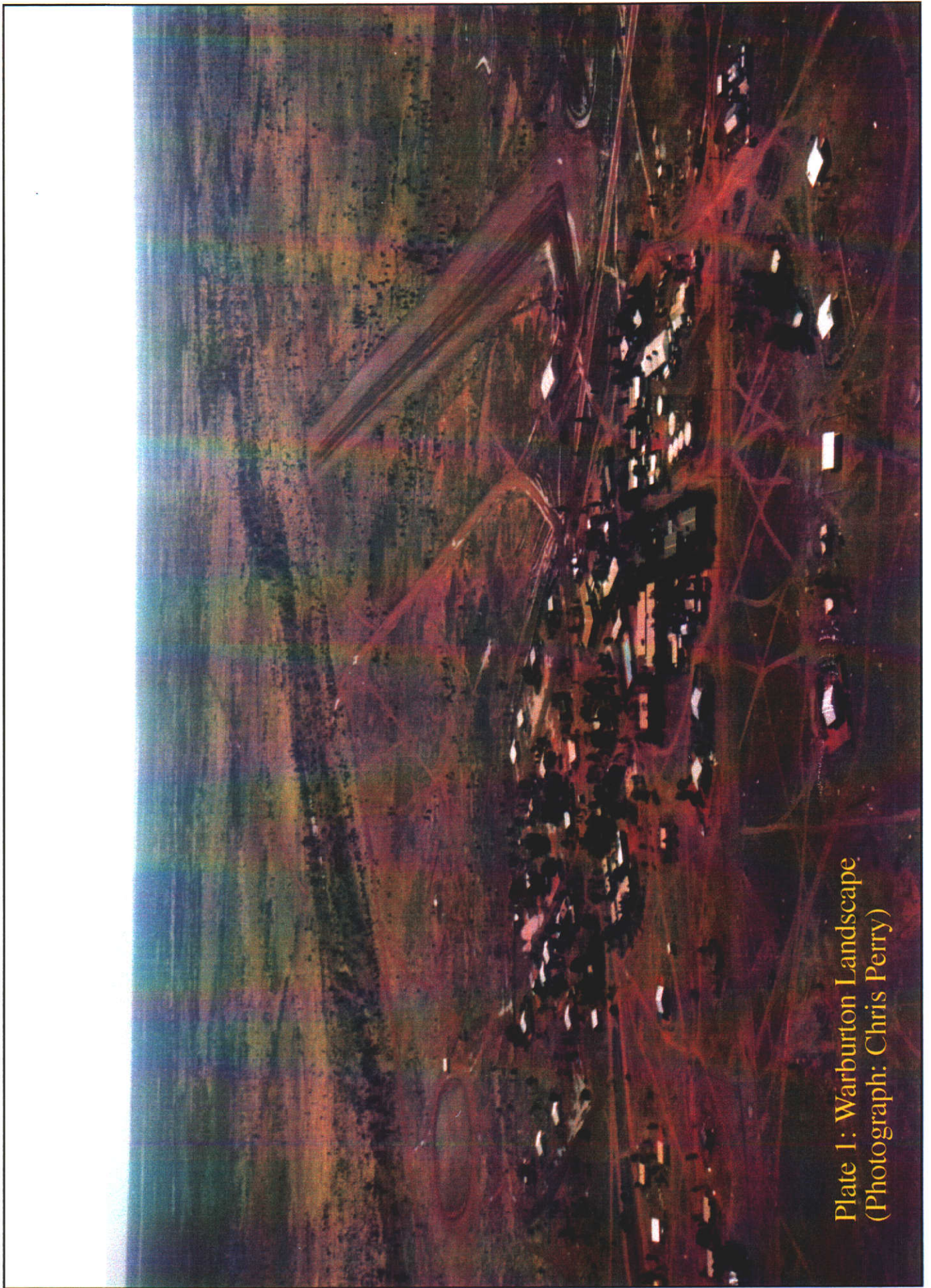


Plate 1: Warburton Landscape
(Photograph: Chris Perry)

Taking in the social situation

Initially I remained in the background and apart from clinic activities to familiarise myself to the 'relatively strange surroundings' (Hammersley and Atkinson 1995, p99). I made broad observations and asked general questions about the physical environment. For example, inquiring about the names of the nearby ranges, and the ways of obtaining general stores in the community. I observed the various daily activities and gatherings of people. These aspects took in the three primary elements identified by Spradley (1980) that were applicable to describing the social setting, that is, place, persons and activities.

In addition, I obtained permission from the nurse in charge to read documents pertinent to nursing practice and the records kept by nurses at the nursing post. Through this process I began to learn about the structural and cultural characteristics that shaped nursing practice within this context. For example, the monthly reports submitted on a form by nurses that placed importance on the aggregate numbers of clients seen and evacuated to hospital, but there was no record of the hours this involved for nurses.

When I perceived that the nurses and health workers were at ease with my presence I sought their consent to undertake periods of direct observation in the clinic. Accordingly, an agreement was negotiated between myself and individual staff on the mode of participant observation.

I would begin periods of observation by being introduced to the client by the nurse. The nurse would negotiate with the client for their consent to my presence during a consultation for the purpose of making observations. In the clinic I took an inconspicuous vantage point, usually seated out of the way in corner of the room, from where I could hear, observe and record in note form the interactions between nurses and clients.

These general observations and my preliminary data analysis prepared me for a more focused ethnographic inquiry. Pursuit of the inquiry at this stage, however, had depended on the decision of the Ngaanyatjarra Council.

Formal agreement

At the end of the three month period, I met with the community chairman and the anthropologist to discuss the progress of fieldwork. At this meeting their approval and support were given for the continuation of the study. I was offered a formal written contract specifying the conditions of the research and giving formal consent to the study being carried out. This contract, drawn up by a lawyer representing the Ngaanyatjarra Council, specified the agreement between myself and the Ngaanyatjarra Council and the Warburton community (Appendix 2).

The contract spelled out restrictions to reporting on community information and gave community consent. It did not, however, specify the consent and reassurance of confidentiality for nurses or Aboriginal health workers. Individual consent forms were completed separately by nurses and health worker informants (Appendix 3).

This moment of formal agreement heralded in a more permanent relationship. It was the beginning of a mutual commitment to completion of the thesis on the phenomenon of nursing practice in a remote area community.

Summary

The pre-entry phase entailed consideration of factors that were essential to the ethnographic research process. Primarily these considerations pertained to the selection of a suitable setting and the willingness and ability of the potential participants to communicate. The pre-entry process was facilitated by my

relationships previously established with people involved with remote area communities.

I entered negotiations with key personnel at Warburton and, after several months delay, obtained permission to stay at the nursing post for a three month trial period. Following the successful conclusion of this period a formal written contract of agreement was made between representatives of the Ngaanyatjarra Council and the Warburton Community and myself. With this consent I set out to make broad observations of the geographic, physical and social features of the Warburton community setting in which remote area nurses were employed.

CHAPTER 3

THE REMOTE AREA SETTING

Ah how my life runs on into the real back roads to far places

The door to the invisible is visible

Lawrence Ferlinghetti (1970)

The land is here, the land, the land with stories

Tommy Simms (1993)

Introduction

A view of the remote area setting sets the broad scene in which nurses lived and worked. The Warburton setting is described in a composite of its geographic, physical and social features that influence the lives of its inhabitants. These features highlight the environmental differences of a sparse population, isolation and the Ngaanyatjarra culture that impact on nursing practice in the remote area. It also reveals elements of the attraction of living in a remote area community. A brief history of Warburton, in particular health services, is pertinent to comprehend the nature of remote area nursing and to provide a background to the contemporary setting.

The Warburton Ranges, from which Warburton derives its name, were named by the explorer Ernest Giles in 1873. The history of Warburton was marked by missionary enterprise, government control and threats to the existence of the Aboriginal people who lived there. Entwined into this history was the introduction of nursing and medical services. The patterns established in this setting over time have had an enduring influence on the practice of nursing.

This chapter begins with a brief history of the Aboriginal reserve. It then portrays the landscape in which Warburton is located. Population characteristics, Ngaanyatjarra organisations and the social and cultural environment are also described. Finally, an outline of the history of the health services and its relationship to the current nursing practice setting at Warburton is presented.

Warburton: a preliminary introduction

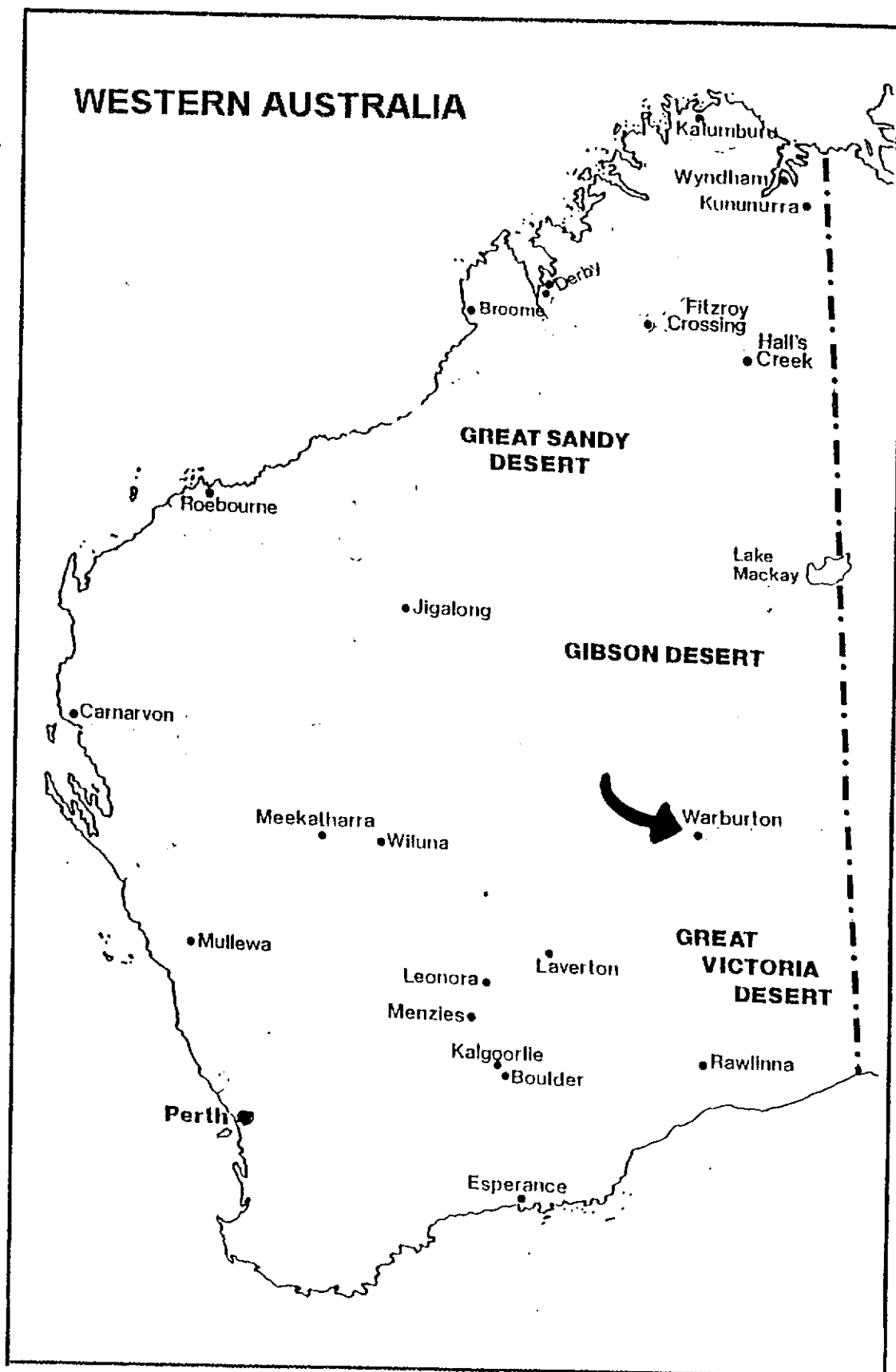
Warburton lies inland in the Western Desert area of Western Australia locally known as 'Ngaanyatjarra Lands', or 'the Lands' (Map 3.1, overleaf). These Lands occupy one of the most isolated and arid interior regions of the Australian continent. The region is mainly inhabited by the Ngaanyatjarra Aboriginal people. The dominant language spoken is Ngaanyatjarra. English is a second language. The population is also composed of non-Aboriginal people, mainly of European descent, who are employed in each community. The total population of the Ngaanyatjarra Lands is approximately 2000.

The region of the Central-Western desert, where Warburton is located, was originally established in 1918 by the government as a reserve for the Aboriginal inhabitants. It was known as the Central Aboriginal Reserve and was managed by the Native Welfare Department (Western Australian Department of Native Welfare 1965). The Central Reserves covered an area of more than 30,000 square miles.

Reserves were established earlier this century in line with federal government policy to 'preserve' Aborigines living in their tribal state. Each State and Territory independently determined the activities and conduct of missions on these reserves (Rowley 1972a). In this era Aboriginal people were treated by the government as a conquered people and subjected to protective legislation (Rowley 1972b, McLeod 1984).

The federal government believed that ultimately Aborigines of mixed racial descent would assimilate into the 'white community'. 'Full blood' Aborigines were, in the government's view, doomed to extinction (Neville 1937, pp9 & 16). Cleland (1933), a medical member of an anthropological expedition from the University of Adelaide, was in agreement with this view. He added that the Central Australian Reserves should be kept separate because, 'contact with civilisation spells disaster to the Australian native' (Cleland 1933, p322). Until 1934 it appeared that Aboriginal people living in the Central Reserve had only transient contact with a few Europeans.

Map 3.1. Location of Warburton



In 1927 two missionaries named William Wade and Reginald Williams from the United Aborigines Mission in Oodnadatta, South Australia, made their first expedition by camel to the Central Reserve (Douglas 1971, Morgan 1986). Their purpose was to reach the 'natives' far beyond the settled areas and to ascertain if mission work of a permanent nature could be undertaken so far afield (Riches, undated). Wade later joined with Rudolphe Schenk, the superintendent of Mt Margaret United Aborigines Mission, situated south of Laverton in Western Australia. Schenk also wanted to establish a mission in the Central Reserve (Morgan 1986).

Schenk sought official permission from the Protector of Aborigines, Commissioner A.O. Neville at the Western Australian Department of Native Affairs in Perth, to acquire land and to build a settlement in the Warburton Ranges Area (Morgan 1986). The Protector was opposed to this proposal. Nevertheless, in 1933 Wade and a small party travelled from Mt Margaret by camel and found a suitable place to settle. The following year, still without government approval, he returned and founded the Warburton Ranges Native Mission immediately outside the boundary of the Central Aboriginal Reserve (Morgan 1986).

Elderly Ngaanyatjarra people, still living in the Warburton area, remembered the arrival of 'Mr Wade' and expressed affection for him. They also remembered other 'white' men who came before Wade's arrival and who had terrorised them and fired at them with guns. The camel remains a beast of special significance as it had carried Wade and his party to Warburton. The Ngaanyatjarra believe that bad luck will befall anyone who kills a camel.

Subsequent decades had seen major changes in the administration and policies affecting Warburton and the Aboriginal people who lived there. In 1973 the United Aborigines Mission withdrew and the Warburton Community Council (Inc) was formed under the jurisdiction of the government (Douglas 1978). Eight years later the Ngaanyatjarra Council, an independent co-operative body involving the eleven communities that had been established in the Lands took over the management of Ngaanyatjarra affairs.

Geographic features

As a modern traveller, viewing the terrain of the Central-Western Desert area from an aircraft, I marvelled at the vast expanse of bare country stretching out to the distant horizons below. This country has defied pastoral development and agricultural cultivation (Beard 1974). Mining companies, however, have seen the economic potential for mineral exploration (Gould 1968a, Duffy 1995).

On the immense landscape the plains are dotted with small trees and shrubs that survive on the parched red earth and rocky ground. The vegetation as seen from the air forms gigantic grey-green patterns on the bare earth. These patterns of vegetation are distributed in branches, strips or clusters as they follow the myriad of water courses that lie across the flat open plain or in the shallow sheltered valleys. Strips of dense tall vegetation that meander across the plain from the hills indicate a dry creek bed. Water only flows in the creek in the rare event of torrential rains. Occasionally a dirt road is visible, stretched out like a narrow ribbon on the earth below to connect distant destinations. The land that seems flat in the distance, brings surprise on a closer view. Suddenly long sand ridges or a rocky escarpment become visible. The majestic stretch of ranges, hills and escarpments are a visual relief on the vast arid plains.

In the far distance the patterns of vegetation and the colours of the earth merge to a dark grey brown mass. The horizon of this ancient land extends as a straight line in the full circle of my view to separate the sky from the earth. Immediately above the horizon a white haze band softens the deep blue colour of the clear sky. There is nothing else out here. Nothing, that is, of human cultivation. Within this awesome and immense semi-desert landscape lies the small town of Warburton (Plate 1. p28). Local inhabitants usually spoke of 'Ranges' to refer to Warburton. Owing to a death, the name Warburton was not used by some people (Douglas, W. 1996, pers. comm., 24 Sept.).

Warburton: a physical description

Warburton township is situated in a wide valley between the rocky outcrops of the Brown Range and the Warburton Ranges. North west of Warburton is the Gibson Desert and to the south west is the Great Victoria Desert (Map 3.1, p34). The intersection of the South Australian, Northern Territory and Western Australian borders (referred to by airline pilots as 'the surveyors' general corner') is approximately 220 kilometres east of Warburton.

Warburton has been described in some tourist maps as one of the most isolated destinations in Australia.

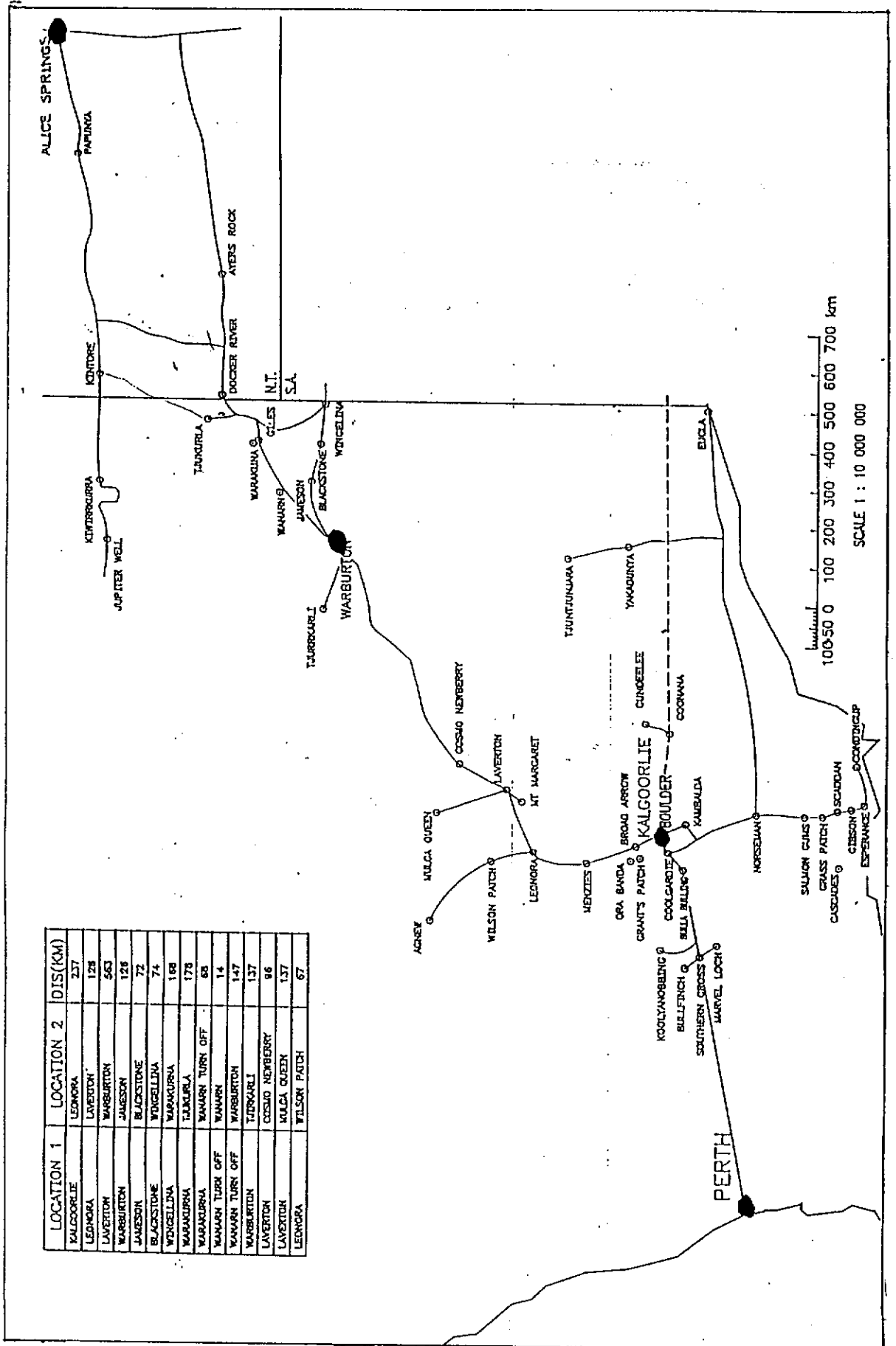
The geographic remoteness of Warburton is indicated by the distances from the urban centres. The city of Kalgoorlie, Western Australia, is situated 935 kilometres to the far south-west of Warburton and is the nearest major urban centre for medical and hospital services and for connecting services to the rest of the state. The main road to Kalgoorlie is unsealed between Warburton and Laverton, a distance of 563 kilometres. The other nearest major urban centre is Alice Springs to the north east in the Northern Territory and is 1050 kilometres away by air transport (Map 3.2, overleaf). (The head office of Ngaanyatjarra Council and the Ngaanyatjarra Health Service are based in Alice Springs.)

The terrain of Warburton is undulating and interspersed with rocky escarpments, mulga scrub belts, spinifex flats, red sand ridges and creek beds lined with river gum trees. The surface soil is mainly sand or coarse stone pebbles with granite rock outcrops at the base of the ranges.

The average annual rainfall is between 125 mm and 400 mm. with a high evaporation rate ('ninety six inches'). Rainfall is sporadic with long periods of dry weather. Seasonal temperatures are extreme and vary between 50 degrees Celsius during mid summer to below zero at night in the winter months (Bureau of Meteorology 1995). Rain and the onset of cooler weather are a welcome relief from the fierce heat of the desert summer. In the warmth of early spring and following good rainfall the desert landscape comes to life.

Map 3.2 Warburton and regional localities.

(Source: Water Authority of Western Australia, Perth)



The carpet of vegetation is transformed by a blaze of brilliantly colored wild flowers and by the rich hues of the foliage.

Wildlife found in the area include kangaroos of various species, bush turkeys, emus, goannas, other reptiles and birdlife. Many other small creatures also inhabit the environment. Camels, introduced from earlier times, roam freely in small herds around the region. Native animals, some insects, such as honey ants and witchetty grubs, the edible grains of native grasses and fruit bearing vegetation provide a source of food for the Ngaanyatjarra people. Many Ngaanyatjarra stories, both sacred and popular, include the wildlife, such as the kangaroo, the honey ant, the crow and the cockatoo and also describe the people's search for food. Strict cultural codes control how native foods are collected, prepared, distributed and eaten.

Lack of surface water and disturbances to the fragile environment, however, have depleted native flora and fauna in the vicinity of Warburton. The introduction of foxes and rabbits and intensive use of the nearby land by the large sedentary community has also contributed to the reduction of wildlife and of surrounding vegetation.

The scarcity of traditional foods and the availability of commercial food at the community has changed the dietary patterns of the Ngaanyatjarra people. Diet from locally gathered foods is now largely supplanted by foods purchased at the local roadhouse or the Milyirrtjarra store. Food bought from these local stores, however, is expensive. Basic items are approximately double the prices paid in metropolitan supermarkets.

Essential services

Essential services to Warburton involves a communication system and the availability of water, power and sewerage disposal. Roads, transport and the telephone are relied upon for communications. Telephone lines were first installed at Warburton in 1992.

Roads within the Ngaanyatjarra Lands are unsealed graded dirt roads or sometimes two wheel tracks that link Warburton to other distant communities and outlying stations. The

main direct road route from Western Australia to Ayers Rock in the Northern Territory and frequented by tourists, passes nearby to Warburton.

An unsealed all weather airstrip, 1610 metres long and compacted to a 30 metre width (Airfield Directory 1996), is used regularly by the locally owned Ngaanyatjarra Air service. Twice each week this service linked the major centres of Kalgoorlie and Alice Springs with Warburton and other Ngaanyatjarra communities, in each direction. The air service provided transport for passengers and freighted mail and goods between local communities and into and out from the Lands. Other private or government air services regularly utilising the airstrip included Goldfields Air Service, the Royal Flying Doctor Service and Police Airwing. Most official visitors to the community travelled by aircraft.

In this desert environment there is minimal permanent surface water. At Warburton artesian bore water is obtained with underground pumps. This water, high in mineral content, was used for human consumption. The few rain water tanks in the community were found at the nursing post and at several staff houses.

Electricity is supplied to Warburton by two central diesel generators. Fluctuation in power supply and power failure occur occasionally, but is usually of limited duration. At the time of this study, an essential services' officer was employed for the maintenance of power and water supply and sewerage disposal.

Three different systems are used for sewerage collection. The main pipework system, operating for approximately half the houses in the community, gravitates to a pump station then flows on to a treatment plant of three open ponds. A second pump station services another group of houses and discharges into the main pipework system. Houses that are not connected to deep sewerage utilise septic systems. Under the Health Infrastructure Priority Projects funds have been allocated by the Aboriginal and Torres Strait Islander Commission for upgrading the sewerage infrastructure at Warburton (State Manager, Aboriginal and Torres Strait Islander Commission, Perth 1995, pers. comm., 2 June). During the time of the study, however, this had not been commenced.

Other services

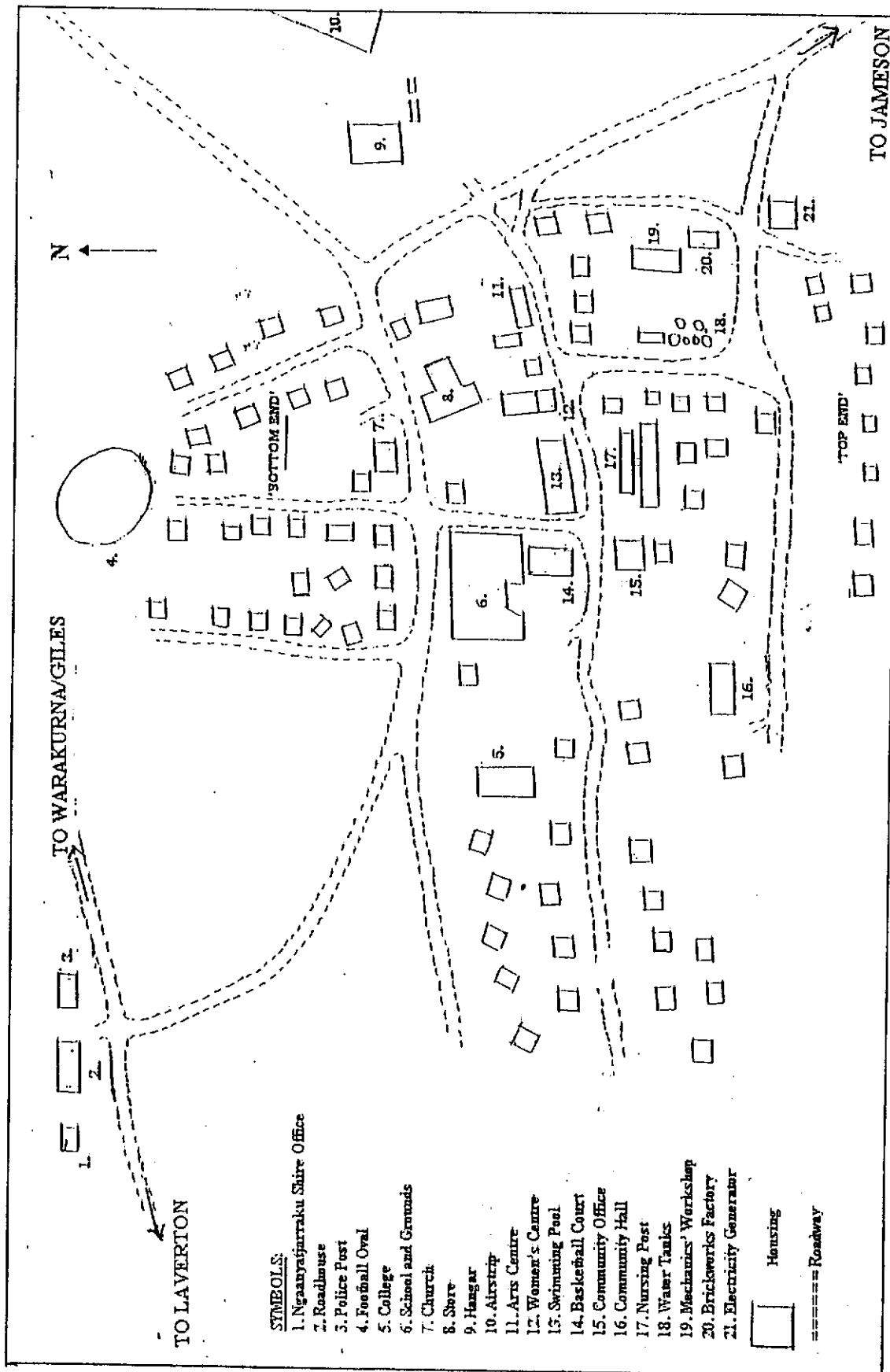
The site of services and facilities at Warburton as described below are represented in Figure 3.1 (overleaf). The community office is the main centre and has responsibility for the day to day administration of local affairs. For example, weekly pays for community employees, management of social security payments and communication with the Ngaanyatjarra Council head office. A postal service and a Westpac bank agency are also operated from the office. A week day 'meals on wheels' service, funded by the community office, supplies midday lunch for pensioners in their home.

Primary and secondary school education are provided from pre-primary up to year 11 level. The school buildings and playground occupy a large area in the centre of the community. Approximately 60 students attend the school. Six teachers, including the principal and five Aboriginal education workers are employed by the State Education Department. In 1995 a Teaching and Further Education college had been built as an annexe to Pundulmura College in Port Hedland (Pilbara region, Western Australia). Here it is intended to offer adult technical education courses to local Aboriginal people.

The Warburton nursing post is situated adjacent to the community office. A 24 hour on call nursing service is provided. (This feature is described in chapter 5). A fortnightly medical clinic in the community and access by telephone for medical consultations is provided by the Royal Flying Doctor Service based in Kalgoorlie (Appendix 7).

A police post is situated on the main road that by-passes Warburton. It has an office and accommodation for itinerant police officers who regularly travel by road to the Ngaanyatjarra Lands from Laverton. At the rear of the police post is a fenced yard and two holding cells used to detain Aboriginal people held in custody prior to a court hearing or transfer to a prison. A plaque displayed beside the front door announces: 'The Warburton Holding Centre for the use of the Ngaanyatjarra people'. Local court hearings for offenders are held fortnightly. Either a magistrate from Kalgoorlie or local justices of the peace presides over the court. This depends on the seriousness of the offence.

Figure 3.1: Site plan of Warburton (not to scale)



The presence of the police often arouses feelings of trepidation amongst Aboriginal people. When the police vehicle is sighted, for example, women and children were observed to silently signal the police presence to one another by putting their wrists together, as if handcuffed. The expression, 'I'll go to a court' is sometimes used as a threat by someone who feels frustrated as well as unfairly physically attacked by another person.

Housing

Most people occupy houses and the tenants pay a nominal fee which is deducted from their weekly pay. A waiting list exists for housing for individual families. Meanwhile Ngaanyatjarra people often share their houses with relatives. A few people occasionally build temporary *wiltjas* (shelters) for their family in preference to sharing a house. Areas of housing have been allocated according to the main family groups. Groups of homes and where a person lives are described by their location. 'Top end' refers to the homes situated on the side of the upper ground slope of the community. 'Bottom end' is the location of homes on the low lying aspect of the community (Figure 3.1, p42).

The earliest houses built for local residents in 1976 were called 'nomads' and were a basic aluminium construction. Few of these houses remain as most had been demolished to make way for more durable brick housing. The more recently built 2 bedroom houses, each similar in design, are constructed from locally made cement blocks and are unfurnished for the local residents.

Staff housing for non Aboriginal residents is centrally located in the town. It is visibly distinct from Aboriginal housing in that staff houses generally appear to be more established. They often have neater surroundings and are fully equipped with furnishings and built-in cupboards. Staff pay minimal rent and some occupy houses rent free.

At the time of the study, a total of 48 houses in Warburton accommodated the total population of 513 people (Table 3.1, p48). This indicates overcrowding with an average of approximately 11 occupants per household. In addition, households are further

increased to accommodate visiting relatives. Most Aboriginal people often live, eat and sleep outdoors especially in fine weather, either under the verandah or in the open yard of their residence.

Employment

Ngaanyatjarra adults who live at Warburton are employed under the Community Development Employment Projects (CDEP) scheme. The CDEP scheme operates within the Aboriginal Employment and Development Policy. It was introduced by the Federal Department of Aboriginal Affairs in 1976 as an alternative to Social Security Unemployment Benefit entitlements and was to be administered by the local community (Sanders 1988, Aboriginal and Torres Strait Islander Commission 1995, Altman & Sanders 1995, Bernardi 1997). Aboriginal and Torres Strait Islander people are the only Australians who fore-go unemployment benefits in order to fund their work for community essential services and community projects (Committee of Review 1985, Aboriginal and Torres Strait Islander Commission 1994, Land Rights News 1996). Aboriginal people term it a 'work-for-the-dole' scheme (Land Rights News 1996).

The CDEP scheme was originally introduced at Warburton in 1977 (Coombs 1977). In 1995 local Aboriginal adults were paid a base rate of \$60 per week, referred to by them as 'sit down' money. An additional six dollars per hour of work was paid up to an amount equivalent to the Unemployment Benefit. Personal incomes are generally low. Debts accumulated at the local Milyirrtjarra store as well as a weekly fixed amount for expenses such as rent, essential services and pharmacy (see pp260-61) are automatically deducted prior to pays being received. In the Ngaanyatjarra communities the recipients of CDEP also contribute a portion of their earnings to a 'chuck in' system for funding community enterprises such as road construction, a swimming pool and other community recreational facilities (Local Government Boundaries Commission 1992, p22).

Local Warburton residents are engaged intermittently in various occupations, such as brickmaking; maintenance and construction workers; garage mechanics; store and office

assistants; cleaners; garbage collectors; craft workers and artists. Hand made artefacts are made by both craftsmen and craftswomen and often sold privately. The Women's Centre employs about eight women who are paid by CDEP. The Centre is also utilised daily by women as a meeting place. The women learn sewing, fabric painting and other crafts. They also produce garments and items for their personal and household use or for sale to others.

The Aboriginal health workers at the nursing post are employed by the Ngaanyatjarra Health Service under a State Award (Appendix 8). Aboriginal health worker trainees, however, are initially employed under the CDEP scheme for a probation period of three months. Aboriginal education workers employed at the local school are paid a wage by the State Education Department.

Aboriginal people who do not work in some capacity and who do not receive other Social Security benefits, such as a pension, mainly rely on additional financial support from their relatives. Recipients of aged pensions refer to it as '*ration money*'. Child endowment is called '*tjitji money*' (child money). Local people differentiate weeks of the year according to whether it is 'pension week' or not. Income from pays or pensions are often lost or supplemented by gambling in card games, depending on wins and losses. This form of gambling is a popular past-time for many people and invariably takes place in small groups following the receipt of pays or pensions.

A few Ngaanyatjarra men occupying positions of office in the Ngaanyatjarra Council are paid a salary. Income is also received by Aboriginal people for work in guiding mining exploration. Senior Ngaanyatjarra people who are knowledgeable about sacred lands are paid for traditional knowledge of the country, such as provided to the Department of Conservation and Land Management (CALM).

In Warburton the term 'community' is generally used collectively to refer to the local Aboriginal residents and excludes the non Aboriginal residents. Non-local staff living at Warburton are employed either by the Ngaanyatjarra Council, Warburton Community

Inc., Ngaanyatjarra Health Service or government education departments. These staff generally regard themselves as a resource to the Aboriginal community. Similarly, the Aboriginal people often consider non-Aboriginal staff as working for them as a service provider and not as an equal member of the community. For example, at a large community meeting a senior Ngaanyatjarra man defended the employment of 'white people' in the Ngaanyatjarra Lands and declared, 'They [non-Aboriginal staff] are here to help us'.

The positions held by non-Aboriginal employees includes school teachers; Department of Employment, Education and Training (DEET) educators; a community development advisor; a shire clerk; roadhouse managers; store-keepers; office administrators; registered nurses; a resident anthropologist; essential services maintenance workers; a grader driver; workshop mechanics; building contractors; linguists and two arts advisers. In proportion to the total Warburton population, the non-Aboriginal staff, who were resident because of this employment, comprise approximately 14 percent.

Population

The 1991 population census showed the total population at Warburton as 345; 170 males and 175 females. There was doubt, however, about the reliability of these population figures. For example, at the time of the 1991 census there was a women's meeting at another community. None of the Warburton women attending this meeting had been included in the census survey (Turner, J. 1996, pers. comm. 21 Oct.).

More recent statistics obtained in January 1996 numbered the total population at 513. This population was comprised of 442 Aboriginal people and 70 non-Aboriginal staff and their families. Over half the Aboriginal population (n244) were aged less than 26 years. (Table 3.1 p48).

Itinerant regular service providers to Warburton who stay overnight, included police officers, medical officers, a paediatrician, a dentist and welfare officers. Occasionally government and other administrative officials visit the community.

Warburton had, in the past, attracted many tourists. During 1987, for example, 15,000 tourists were reported to have visited Warburton (Warburton Nursing Post Annual Report, 1989). Today, however, most tourists pass nearby Warburton on the main road between Laverton and Ayers Rock. Tourists are usually not permitted to enter the Warburton township.

It is a requirement of the State Aboriginal Affairs Planning Authority Act regulations under Section 31 that travellers using this route obtain a permit specifying the conditions and duration of their transit through the Central Reserve (Local Government Boundaries Commission 1992). Visitors and non-Aboriginal employees require a permit from the Ngaanyatjarra Council prior to their entry into Warburton community.

The local population fluctuates with the semi-permanent movement of Ngaanyatjarra people between outstations and other regional towns and community centres. During ceremonial gatherings or funerals at Warburton large numbers of people from across the Western Desert area temporarily congregate in the vicinity of the community. Conversely, the community becomes almost deserted as people move away for traditional ceremonies in other areas or for periods of mourning. Ngaanyatjarra Council meetings, church gatherings and meetings for recreational activity, in particular men's football, result in many people travelling to Warburton, or from Warburton to other communities in the region for short periods of time.

The establishment of other communities over the past 10 years and the mobility of groups between these communities in the Central-Western Desert area has contributed to variations in the Warburton population. Warburton, however, remains the largest community and is the operational centre for the Ngaanyatjarra Lands.

Table 3.1: Warburton community population (1996)
 (Source: Warburton CDEP, Medicare records)

WARBURTON COMMUNITY			
POPULATION			
JANUARY 1996			
	FEMALE	MALE	TOTAL
AGE GROUP (years)	n	n	n
<u>ABORIGINAL</u>			
0 - 5	28	26	54
6 - 15	46	39	84
16 - 25	49	57	106
26 - 35	49	35	84
36 - 45	29	28	57
46 - 55	13	10	23
56 - 65	11	8	19
66 - 75	6	4	10
76 and above	2	1	3
SUB-TOTAL	233	208	441
<u>NON-ABORIGINAL</u>			
Adults	19	46	65
Children (< 15)	3	2	5
TOTAL	225	256	511

The Ngaanyatjarra Lands

The Ngaanyatjarra Lands refers to the vast Central Reserves region west of the Western Australian border (Appendix 9). Leasehold land title to 13.1 million hectares was granted

in 1988 and is held by the Ngaanyatjarra Land Council (Aboriginal Corporation) under two different categories from the Aboriginal Lands Trust. The first are 'A' class reserves for 'the use and benefit of Aboriginal people'. The second are special purpose leases (Turner, J. 1996, pers. comm., 21 Oct.).

Under the 50 year special purpose leases, 3.4 million hectares is leased from the West Australian State government Minister for Lands. Vacant crown land west of the Central Reserves was also seen by the Ngaanyatjarra Land Council to be under its operational responsibility.

The Gibson Desert Native Reserve, adjoining the Central Reserves, is listed by the Australian Heritage Commission in the Register of National Estate. This Reserve is also viewed as the responsibility of the Ngaanyatjarra Land Council. The total land area, including the Gibson Desert Native Reserve, is estimated to be 20 million hectares (Ngaanyatjarra Council (Aboriginal Corporation) 1993). The Ngaanyatjarra Land Council holds the leases for land in trust from the State. A separate entity, the Ngaanyatjarra Council, has responsibility for services to the communities on the Lands.

The Ngaanyatjarra Council

The Ngaanyatjarra Council (Aboriginal Corporation), formed as a co-operative in 1981 has representatives from the eleven established communities within the Ngaanyatjarra Lands (Appendix 10). The Council members meet each month at a different community and have oversight of Ngaanyatjarra affairs including land management and tenure, mineral exploration, social welfare and dealt with State and Commonwealth government agencies. It also provides essential services to the communities.

Since 1981 a range of services have been developed and managed through the Ngaanyatjarra Council. These service based enterprises, owned by the Ngaanyatjarra people are regarded by a community leader as important to develop the people's standard of living and quality of life.

Services include road transport for supplies, building and housing construction, maintenance, an air service (Ngaanyatjarra Air) and a health service (Ngaanyatjarra Health Service). The Ngaanyatjarra Agency Transport Service (NATS) based in Perth, transports material and bulk food supplies to communities in the Ngaanyatjarra Lands. Business enterprises of the Ngaanyatjarra Council (Aboriginal Corporation) are two roadhouses (at Warburton and at Warakurna/Giles), and two Ampol distribution depots in the Northern Territory.

The Ngaanyatjarra Health Service forms an organisational division under the authority and direction of the Ngaanyatjarra Council. The health service is responsible for initiating and delivering health care programs to communities in the Ngaanyatjarra Lands (Ngaanyatjarra Council (Aboriginal Corporation) c. 1991). In addition to representation on the Ngaanyatjarra Council, the local Warburton community council meets weekly. The Shire of Ngaanyatjarraku is the office of local government and is based at Warburton.

Shire of Ngaanyatjarraku

On 1st July 1993 the Shire of Ngaanyatjarraku was officially formed. Previously the Central Reserves were the eastern region of the Wiluna Shire. (The suffix '*ku*' means 'for', that is, for the Ngaanyatjarra.) In 1992 Ngaanyatjarra Council petitioned the Local Government Boundaries Commission to establish a separate shire with the purpose of ensuring better access to local government services in the Ngaanyatjarra Lands (Local Government Boundaries Commission 1992).

The Ngaanyatjarraku Shire office and Shire Clerk are based at Warburton. The responsibilities of the Shire of Ngaanyatjarraku relate to road building and maintenance and public health matters such as sewerage disposal and water supply. Elected Ngaanyatjarraku shire councillors meet regularly. Each month the essential services officer and the environmental health officer are required to make inspections and to report to the Shire office.

The Ngaanyatjarra people

The Ngaanyatjarra have inhabited the Central-Western Desert area from a time long before European contact. The majority of residents at Warburton are Ngaanyatjarra people. These people regard living at Warburton and in the neighbouring areas as their permanent home. They feel that they belong to the Ngaanyatjarra Lands.

The Ngaanyatjara language forms one of the related dialects of the Western Desert group (Douglas 1988, Glass 1990). These dialects also include Pintubi, Pitjantjatjara, Kukatja, Yankuntjatjara, Ngaatjatjara and Mantjiltjara. The suffix *tjara* means 'having'. *Ngaanya* means 'this (near) one' and distinguishes the language speaker as Ngaanyatjarra (Douglas 1988). English is spoken as a second language. Native speakers of the Western Desert languages spoken at Warburton and further west are referred to as *Wangkatja*, a term meaning 'one who speaks our way'. According to Douglas (1988) the often heard term *Wangkayi* was a nickname first used by outsiders for the people and language of the Warburton Ranges area.

The Ngaanyatjarra people were traditionally hunter-gatherers (Gould 1968b). Hunting and food gathering activities continue to some extent with the aid of modern technology such as vehicles, crow bars, axes and rifles. These activities, however, are no longer depended upon for survival. People have settled in larger groups. This is in the wake of government policies of settlement and assimilation (Rowley, 1972a), the establishment of Warburton Ranges Mission and the scarcity of naturally occurring food and water supplies.

Traditional relationships

Traditional relationships of social organisation between Ngaanyatjarra people are of great importance. Douglas (1990) described six relationship groups, each with a distinct kin term. Each kinship group defines an individual's relationship to everyone else in the whole Ngaanyatjarra group. The particular group into which a person is born determines the

individual's obligatory social responsibilities, avoidance rules, choice of marriage partners and ceremonial behaviour.

Polygamy is not uncommon. Older men often marry a second younger woman who is sometimes a younger sister of his first wife. One woman informed me that she was unhappy when her husband had taken a second wife. This woman then no longer slept with him although she retained her status as the first wife.

Men's sacred ceremonies in which male youths are initiated into manhood are regularly practised. These ceremonies are held at special sites and secluded from any outsiders. No-one else is allowed to venture into these areas. The actual practises used in these ceremonies are 'taboo words' (Douglas, W.H. 1997, pers. comm. February 12). Various ceremonial lacerations to the body sometimes became infected. Occasionally these men are brought to a nurse, or a nurse is requested to go with a male informer, for example, to give an antibiotic treatment when someone becomes ill with a wound infection.

Women also hold their own ceremonies, completely separate from 'men's business' (Davies 1993). Their ceremonial dances, usually performed in bushland that is set apart for women's use, often involve story telling and rituals that are passed on by senior women to younger mature women. Women also dance for pleasure as a way of recreation. Sacred ceremonies are believed to be powerful. I was invited to attend one ceremony for mature women where rituals were performed with a woman whose marriage partner had deserted her for another woman. The belief was that this ceremony had power to reunite the couple.

Customs and taboos

Customs and taboos are respected. This includes the acceptable choice of language used for communication under various circumstances and the appropriate manner of interpersonal and group behaviour. For example, it is polite to use indirect speech whenever criticising another person or persons. Ngaanyatjarra people generally interpret a

disregard for these customs as a lack of respect and as a source of humiliation and embarrassment.

Retribution and punishment ('pay back') for serious contraventions of approved behaviour, such as being held responsible for the death or serious injury of another or for resolution of interpersonal conflicts are usual. For instance, spearing a man in the thigh who was the driver in a vehicle accident in which another person was critically injured. A woman may be ritually beaten for allegedly having an illicit sexual relationship. Often the recipients of these retributions later come to a nurse to be treated, such as dressings or pain relief, for their physical injuries.

Names

The Ngaanyatjarra regard names of places and of people as sacred. Place names hold significance for mythological events as well as for their association with food and water sources that were vital for survival. English personal names are mainly used. Adults have also been given a Ngaanyatjarra name, and most of these have at least two other names. Several women I spoke with did not use this name publicly although it was well known to other Ngaanyatjarra people. In the Ngaanyatjarra language possessive pronouns are not used for personal names (or parts of the body). An observation of the names recorded on clinic files revealed an absence of Ngaanyatjarra names, except for older clients. Generally people were named with familiar English Christian names and surnames. Large family groups used the same surname. In recent years, however, infants are being given more inventive names that are uncommon in English and in Ngaanyatjarra.

The name of a deceased person is not to be spoken, especially in the hearing of a relative. Any person with the same or similar name to the deceased is subsequently called *Kunmarnarranya* or *Kunmarmunya*. This is a substitute name meaning a person whose name was taboo or *maal-maalpa* (Glass 1990). It is used out of deference for the deceased (Douglas 1988). At some later time that person is given a new name. All personal possessions and images of the deceased are incinerated or destroyed in some

other way. The dwelling where a person had died is abandoned out of respect for the deceased and their grieving relatives and for fear of the spirits who may abide there. In time, however, if someone knew a non-Aboriginal person who possessed a photograph of a deceased relative they may secretly ask to view it in private.

The spirits

Each living person has a spirit or *kurrurnpa*. The *kurrurnpa* is sacred and central to personal feelings of physical and mental well-being. Taboos are also related to spiritual beliefs.

Beliefs in the spirit or *mamu* were often used in expressions of fear of the unknown. Explanations for ill health, including mental ill health, were often associated with sorcery occurring at a certain place or with the supernatural powers of the *mamu*. The causes of illness may be described as holes or foreign objects located within the human body at the site of the disease. Breaches in sacred laws or inadvertent sighting of sacred objects may also result in illness.

Mamu may assume various forms. For example, the apparition of a young girl, a stranger, who had been 'seen' by only a few people as a passenger on the local aeroplane, was suspected of being a *mamu* since no-one could explain where she came from or where she went.

Healing

Maparntjarra or *ngangkari* are traditional healers. They are highly regarded for their psychic and physic powers in healing the body and mind and in restoring the spirit, *kurrurnpa*, of an afflicted person. Traditional healers are sought out by the Ngaanyatjarra to explain the causes of an illness and to cure any significant mental or physical illness or injury (Glass 1992).

Traditional medicinal remedies extracted from specific native plants or other sources are widely known among adults for their healing properties. For example, a particular web from a spider's nest found on the branches of an acacia tree or the cocoon silk of the spitfire caterpillars were mixed with breast milk for application to heal skin burns.

First encounters with the alien hospital environment, and its association with death, had brought fear and anxiety to the Ngaanyatjarra people (Douglas n.d). Moreover, it was paramount for people not to be separated from family and to die 'on the country' of one's birth (Woenne-Green 1995, p59). The advent of the mission and ministering of western medicine to the Ngaanyatjarra people over time, however, had also led to a desire for care and alleviation of illness and/or cure from nurses and doctors. Nevertheless, the role of nurses, Aboriginal health workers or medical officers at the clinic is still regarded as totally different from the traditional healer.

Nurses are not expected to intervene in matters relating to traditional beliefs, such as a cure for ill health that was attributed to the spirits. Nurses, however, are expected to provide symptomatic relief, for example, a medication as requested. Ngaanyatjarra people also perceive western medical tools as a useful adjunct to traditional healers and their remedies. This was seen in the following observation:

A young woman who suffered from frequent headaches was attended by a *ngangkari* who she also called in English a 'magic man'. The woman recounted to me that the *ngangkari* had touched and stroked her scalp then told her that there was a hole inside, but it was now half closed. She indicated, with her hand, a strip along the top of her head. The hole was caused by a *mamu* (spirit). When the sun was very hot the headache became much worse. Now the woman wanted to go to Kalgoorlie for an Xray of her head to 'see if there is anything inside'.

Christian prayer is also important to many of the people for an ill person's recovery and safety, especially while they are away from the community in a hospital. At the bedside of an ill or injured person, or at the RFDS aircraft prior to a medical evacuation to hospital, prayers are sometimes offered with solemn intonation by a devout mature person.

The nursing post is always referred to as 'the clinic' or 'the hospital'. To the Ngaanyatjarra people it appears that the English words 'clinic' and 'hospital' are synonymous. The following field note illustrated this perception and the use of prayer for a person's safety:

Late one night an ill young woman was being evacuated by air to the regional hospital. As the flight nurse secured the safety straps around her in the aircraft, a Ngaanyatjarra man stood almost in the darkness with one hand resting on the 'plane and the other raised in prayer. In Ngaanyatjarra he prayed to God to care for the young woman '*clinic pulkangka Kalgoorliela*' and to return her safely.

In English translation this literally means, 'at the big clinic in Kalgoorlie'. This spontaneous expression is not isolated. It gives a sense of how Ngaanyatjarra people perceive the health care and healing establishments of modern western medicine. A history of the Ngaanyatjarra people's contact with the dominant western health care ideology offers clues to the origins of these perceptions. In this history there are also clues to learning the underlying reasons for the people's expectations of nursing care.

A brief history of health services at Warburton

Health services at Warburton Ranges were commenced in 1954 by the United Aborigines Mission. In the intervening years there have been several changes in the management and policies of these services that involved missions, government and, most recently, an independent health service. Throughout this period of over 40 years, however, nurses who lived on-site had always been the providers of care to the people at Warburton and nearby areas.

Prior to 1954 medical interest in the population living in Warburton and Central Reserves area was mainly for scientific studies. It was associated with anthropological expeditions to survey anthropometric measurements and medical conditions of the Aborigines (Cleland 1933a, Cleland 1933b, Tindale 1936). According to the reports available, missionaries at the Warburton Ranges Aboriginal Mission were the first to perceive that there was a need for a locally based health care service.

Warburton Ranges Mission: the beginning

Initially the Warburton Ranges Mission took in orphaned Aboriginal children. The missionaries, William and Iris Wade, also offered to care for children (Davies 1993). Children were then brought to them by Aboriginal people for care at the mission while the parents went away on journeys. The agreement was that the parent could claim their child at any time (Riches n.d.).

In 1935 a school was commenced. A children's home was built with separate dormitories for boys and girls. By 1951 a total of 87 children were in the care of the mission (Riches n.d.). The Education Department of Western Australia appointed teachers to the mission school in 1956. In 1961 the children's dormitories, where they were accommodated during the school year, were closed down to become the new school under the control of the Education Department (Harman 1962, Green 1992).

At that time more Aboriginal people had settled in Warburton and wanted to care for their own children. A dietary programme was continued until about 1973 with three meals served daily to approximately 80 school children in the mission dining room (Douglas 1978). As an inducement to attend school only those children who attended were given meals (Green 1992). Week-end food rations were supplied to parents for their children and funded by the Native Welfare Department (Harman 1962, Stockwell 1972).

As well as education, the missionaries also attended people with various illnesses or injuries and provided treatment using minor remedies. As the demand for this care increased they perceived that 'there was an urgent need for a nurse' and that many Aboriginal people needed 'medical treatment' (Riches n.d. pp13 & 24). The missionaries considered it a priority to establish a 'hospital' and to appoint a qualified nurse.

Warburton hospital

A small 'hospital', funded by the Western Australian State government, was built by the missionaries in 1954 (Graydon 1956). Olive Graham was the one nurse appointed and had the title of Matron. In one year over 100 admissions to the hospital were recorded plus 40 - 90 out-patients seen per day (Richards n.d.). Other missionaries assisted in the hospital when there were many patients (Douglas 1967).

Frequent health problems of the Aboriginal people were described as wounds from interpersonal conflict, skin sores, trachoma, ear infections and the common cold (Riches n.d.). A difficulty for the nurse in providing treatment, such as for trachoma, was the transient stays of people at the mission. In a private letter dated May 1957 Graham, the nurse, stated that all children had received immunisations. The Public Health Department supplied drugs and equipment. Graham added, 'We are very well equipped to meet any emergency beyond which patients would be transferred to Kalgoorlie' (quoted in Riches n.d. p30).

Nevertheless, it also appears that the nurse's resources were sorely taxed at times. For example, in 1961 a 'severe measles epidemic' was reported (Douglas 1978, p110). At that time several hundred people became ill and were cared for at the mission. No deaths were recorded. An unoccupied school dormitory building was used as an emergency hospital and additional nursing staff were sent to Warburton from Kalgoorlie and Perth (Douglas 1978).

The Warburton controversy

In 1956 a public controversy erupted in the media over the report of a parliamentary inquiry titled, 'Native Welfare Conditions in the Laverton-Warburton Area'. Graydon (1956, 1957) who presented the report, described a severe state of ill-health and debility among the Aboriginal people at Warburton and attributed this to a lack of medical attention. Others disputed Graydon's claims and argued that the people he had seen were

strangers recently arrived in Warburton who had suffered from conditions of starvation (Berndt 1957, Douglas 1978).

Sensational reports in the Western Australian and interstate newspapers expressed sentiments of shock and appealed for action for the health and welfare of Aboriginal people in the Warburton area (for example, West Australian 1957, Cotterill 1957, Graydon 1957). Subsequently a medical party was sent out, headed by W.S. Davidson, the Deputy Commissioner of Public Health, to investigate the health of the Warburton people (Davidson 1957, Davis & Pitney 1957, Mann 1957). Clinical examinations were conducted on approximately 300 people. Davidson (1957) concluded that there was no indication of a lack of food, apart from a lack of suitable dietary supplements for children in the weaning period. At Warburton itself, however, nothing changed and the nurse continued her work as usual.

A daily routine

A nurse, who came to Warburton in 1965, stayed over nine years working either with one other nurse or alone. The nurse described the daily routine then as:

Outpatients clinics were held every morning, those needing further treatment returned in the evening, usually with others. Sunday work was kept to a minimum, though this could not be counted on. Mothers and children's care was important. Babies were weighed weekly, children's heights recorded, immunisations carried out, advice regarding hygiene and nourishment given. It was wonderful to see the severity, length and frequency of epidemics decrease due to this. Gastro-enteritis and respiratory infections were common. Eye care for trachoma was an important task, as well as treating ear infections. Patience, perseverance, plus constant teaching was needed and the parents appreciated what was done for them...there were admissions to the small hospital attached, if they were willing. The needs of the white staff were met too. (Dawson, P. 1995, pers. comm., 25 June)

The Warburton Hospital Admission and Discharge Record kept by the nurse during that time revealed that the length of stay for inpatients was usually between one to eight days

with a median stay of two days. Exceptional stays, however, ranged up to 31 days. Admissions covered all age groups. The reasons stated for admission were mainly respiratory infections, gastro intestinal infections, acute skin infections, trauma and for maternity confinements.

Three of the epidemics referred to by the nurse (above quote) involved large numbers of admissions to the hospital. The admissions record listed 40 cases of respiratory infections over a three week period in 1971, 26 cases of gastro enteritis over one week in March 1972, and 81 cases of viral influenza admitted over a four week period in September 1972. Only four of these cases were recorded as being transferred to Kalgoorlie Regional Hospital. In these time periods there were six deaths recorded in the Admission and Discharge Record at Warburton Hospital. These were one female adult, three children and two neonatal deaths. In 1972 the United Aborigines Mission relinquished its responsibility for the Warburton Hospital.

Warburton hospital changes hands

In 1972 the Australian Inland Mission Frontier Services succeeded the United Aboriginal Mission in managing Warburton Hospital. The United Aborigines Mission continued to manage all other services at Warburton until 1973 (Griffiths 1992). There was, however, government pressure on the United Aborigines Mission to upgrade services and to develop the economy of Warburton. In response the mission requested the government to take over these responsibilities. The government hired a consultant for advice. Subsequently, in 1973, the first community adviser to Warburton was appointed and Warburton Community (Incorporated) was formed (Douglas 1978).

In a report to the Senate in Canberra, Nicholls and Hinrichson (1973) described the Warburton hospital as a small tin shed with one bunk. (An admission that was subsequently 'corrected for the record', i.e. deleted, in response to the Chairman's objection. p573). In their view the two nurses at Warburton were 'most dedicated' and provided a good service 'to the limit of their ability' (Nicholls & Hinrichson 1973, p574).

They also recorded that nurses purchased food with their own money and gave it to some Aboriginal people who they perceived as starving. That the hospital building was small and dilapidated with one ceiling collapsed was confirmed by a nurse who worked during that time at Warburton (Green. J. 1995 pers. comm. 22 May).

The new hospital

In 1974 construction commenced on a new hospital building (still in use) costing \$1.12 million. It was built and fitted out with 13 beds for use as a hospital with a grant from the Federal Department of Aboriginal Affairs (Smith 1977, Warburton Nursing Post Annual Report 1987).

Disruption to the completion of the new hospital occurred in early 1975 when tradesmen blasted trenches for the sewerage system that cut across the sacred kangaroo track, *marlu tjina* (Douglas 1978). Anger, distress and threats of violence from the Aboriginal people led to the workmen abandoning the building site. Warburton was again featured in the news media (West Australian 1975, Daily News 1975).

A Director of the Medical Department in Perth sent out a truck and driver with instructions to immediately remove the nurses from Warburton 'for their safety'. The nurses were to close down the existing hospital and take with them all medical supplies. In a diary kept by nurses at Warburton a nurse recorded their resentment of this impulsive decision. There had been no prior consultation with them or any warning to the Warburton people about the closure of the hospital. A nurse had entered in the diary on 24th May, 1975, 'We just feel so helpless and resent all the organising of us without any explanations'. After staying away for one month in Perth the three nurses returned to Warburton. The new hospital building was finally completed and opened in August 1975.

Demands on nurses

Extreme demands were placed on the few nurses who were not rostered on shifts but worked on call and as needed in the care of inpatients after hours. A Royal Flying Doctor Service (RFDS) Medical Officer reported that he admitted many patients from the Central Reserve to the Warburton Ranges Hospital. This was in preference to the 'cost' and 'disruption', for example, of transferring patients to Kalgoorlie Regional Hospital (Thurley 1977).

The maximum number of registered nurses employed was four. Frequent staff shortages, however, contributed to a severe strain on the remaining nurses (Thurley 1977). In addition to their hospital nursing, nurses had been expected to coordinate patient treatment between RFDS medical officers as well as with other medical specialists who visited the area (Thurley 1977, Quadros 1977).

Monthly reports at that time, written in the form of personal 'newsy' letters from nurses to the head office of Frontier Services based in Sydney, revealed a recurrent pattern in their daily work including extensive domestic duties. 'Out patient' clinic included weekends and involved meeting clients' frequent demands for 'coughing' and 'rubbing medicine' and treating injuries sustained in inter-personal conflicts. Nurses repeatedly reported being subjected to the throwing of rocks and other forms of harassment as well as vandalism to the hospital building. One nurse sustained a fractured nose and facial lacerations. Frequent break-ins to the nurses' residence were also reported.

In these monthly reports nurses had also vividly described their long hours of work at day and night, their lack of sleep and their extreme fatigue. Nevertheless, nurses endeavoured to play down their problems. Many otherwise serious incidents were accompanied by a light-hearted comment as if to alleviate the stresses they faced or to appear uncomplaining. One nurse had left because of 'physical and emotional exhaustion'. Another nurse left because, as she wrote:

The work and the people in the area itself are full of interest, but there seems to be a limit to the time that people [nurses] can spend here and still function competently (5 October 1976).

The replies to the nurses' reports from the Superintendent and a business manager at Frontier Services generally praised them for their tolerance, commitment and courage and often said that they found their letters, 'vital, interesting and above all happy'. The Superintendent, however, did visit the nurses on several occasions and had intervened in some of the problems experienced by nurses in their relationships with the community and with external services.

Visiting services

In 1975 a separate community health building was erected adjacent to the hospital. The building had provision for a resident doctor, but this appointment never eventuated. The State Health Department Community Health Services, based in Kalgoorlie, provided a visiting nursing service in child health to Warburton. From 1980 until 1985 two community health nurses, separate to the hospital, were stationed at Warburton. The RFDS, based at Kalgoorlie, has provided regular medical clinics to Warburton. In the early 1970's these visits were conducted approximately every 8 weeks (Dawson, P. 1995, pers. comm., 25 June). Routine medical visits later increased from every six weeks to fortnightly visits (Quadros 1977).

Health care: from mission to government

The Australian Inland Mission Frontier Services withdrew the nurses from Warburton in 1979, because of harassment of the nursing staff (Griffiths 1992). Harassment took the form of recurrent break-ins to the nurses' accommodation and the rape of a female nurse. These nurses did not return.

On 5th December 1979 the Australian Inland Mission Frontier Services transferred control of Warburton hospital to the Administrator of Kalgoorlie Regional Hospital. The

Administrator acted as representative of the Department of Health and Medical Services, Western Australia (Memorandum issued by H.H. McGrath, deputy director of Hospital and Allied Health Services, 3 December, 1979). Nurses were then recruited to Warburton by the Kalgoorlie Regional Hospital on limited six month term contracts.

Possibility for an independent health service

At the time the Community Advisor at Warburton suggested to the Department of Health that the Pitjantjatjara/Ngaanyatjarra Homelands Health Service (P/NHHS) was an appropriate agency to provide health services in Warburton. Indeed, this seemed to be the preferred option of the State government as well. The Minister for Health had handwritten a succinct note at the foot of a communication from the Assistant Director of Hospital and Allied Service, dated 29 December, 1980. In it he had stated:

It is time we made this community face up to its shortcomings. The Pitjantjatjara Homelands Medical Service (sic) might like to keep them healthy and in check. I'll take the matter to Cabinet.

The P/NHHS was based across the border at Kalka in South Australia (Scrimgeour 1997). Robertson (1988) described how, as the only nurse in the area in 1984, she had single-handedly provided a regular visiting service to the Ngaanyatjarra outstation communities of Jameson, Blackstone, Wingellina and Giles on the eastern side of the Central Reserve; an area approximately the size of the state of Tasmania. In 1980 discussions had taken place between a medical representative of P/NHHS and the Director of Community Health Services, Western Australia .

Warburton community, however, desired to retain the existing health service, as was recorded in correspondence dated 14 January 1981 from the Administrator at Kalgoorlie Regional Hospital to the State Director of Hospital and Allied Services. This position was supported in statements made to me by several community staff members who had been present at that time. Amongst this group the view was that they did not want to inherit the staffing and financial problems of the P/NHHS. As a result the proposal was not pursued.

Other more immediate administrative problems continued to beset the Warburton Hospital.

A complaint

On January 8, 1981, the charge nurse wrote a report of complaint to the Administrator at Kalgoorlie Regional Hospital. In this report the nurse had outlined the extent of the community's expectations of nursing staff. The list covered the community's unrestricted use of the hospital facilities, access to hospital transport and a continuous 7 day week 24 hour nursing service. The nurse then listed the services provided by the three nurses available which included a daily clinic, health programs, home visits, dispensing of drugs, inpatient accommodation, medical evacuations, and regular visits to outstations in the area. In addition, these nurses provided domestic and hotel services in relation to the hospital and in the accommodation of visitors.

The Minister for Community Welfare had visited Warburton a few weeks later. He reported, in a letter dated 17 March, 1981, to the Minister for Health that nursing staff numbers were depleted and that nurses were subjected to 'bad' behaviour by some members of the community. The Minister believed that nurses were entitled to some privacy and relief from the constant community demands for their attention.

Subsequent to the nurse's complaint the community adviser informed the Administrator at Kalgoorlie Regional Hospital that this nurse was not wanted by the community. No reason was given. It appeared that the perception of a problem only occurred after the nurse's formal complaint. The Administrator found it difficult to respond. In a letter, dated 13 April 1981 and addressed to the Director of Hospital and Allied Services, he conceded that the nurse was diligent in implementing his policy decisions for the efficient conduct of the health service at Warburton. The policy had been introduced when a previous nurse, although popular with the community, had allegedly let the hospital fall into disarray. The nurse who had made the complaint, resigned.

By 1985 it was no longer considered viable to operate a hospital at Warburton. The final entry in the Warburton Hospital Admission and Discharges Record was on the 5th August, 1985.

Hospital to Nursing Post

In 1985 Warburton Hospital, incorporated under the Hospital Act, 1927, officially became a Nursing Post. Nurses were then employed by the Eastern Goldfields Community Health Region (Warburton Nursing Post Annual Report 1987).

At the time of this change, media attention again focused on Warburton. The media reported that a gun shot had been fired through the hospital door by a disgruntled person when he had been refused cough mixture. The bullet had narrowly missed a nurse (Magnus 1985). Nurses objected to this media report. In a letter to Western Australian Health Department officials, dated 23 July, 1985, they claimed that this was an isolated incident. These nurses also stated that they wanted to promote a positive image and feared that adverse reports would impair their credibility in the community.

The shooting precipitated a six month pilot project in mid 1985 by the Eastern Goldfields Health Service Executive (Baker et al. c.1986). The purpose of this project was to evaluate the transition from a hospital to a community health service at Warburton. It was believed that the hospital based model of care fostered community dependency and was ineffective in reaching others in the population who also needed care. The high cost of running the hospital was another factor (Baker et al c.1986). Nurses, it was assumed, were to continue to provide acute care and first aid to outpatients.

Warburton residents were informed of the change to a community health service. According to the report, the result of this trial was that the community generally accepted the change. The residents, however, still expected the hospital inpatient facility to be available. This was attributed to the community's long established experience with the hospital and to the continued presence of the hospital buildings. In addition, nursing staff

levels had been reduced and high levels of morbidity and major social problems in the community remained. The evaluation report noted that these factors had further limited nurses in taking the opportunity to extend nursing work into the community (Baker et al c.1986).

In 1987 discussions were resumed between the Health Department of Western Australia and the Ngaanyatjarra Health Service (Warburton Nursing Post Annual Report 1988). The Ngaanyatjarra Health Service was already responsible for health services in neighbouring Ngaanyatjarra communities.

Transition to an independent health service

From the 1st January 1989 the Ngaanyatjarra Health Service, an independent Aboriginal health service, took over responsibility for the management and provision of the health service and use of facilities at Warburton. Official notice of this transfer and the conditions were stated in correspondence from the Minister for Health to the Chairman of the Ngaanyatjarra Council and dated 29 December 1988. The nursing post buildings remained the property of the Health Department of Western Australia. A formal Warburton Health Services Agreement, signed by Health Department officials and Ngaanyatjarra Health Service representatives, described the terms of the agreement and the responsibilities of the signatories. In addition, an Annual Performance Agreement, based on objectives and strategies of the service, between the Ngaanyatjarra Health Service and the Commissioner for Health was signed on May 3rd 1989 with further agreements to be made in the financial year (Warburton Nursing Post Annual Report 1989, Holman and Coster 1990).

The organisational structure of this new health service was headed by the Minister for Health, with the Commissioner of Health appointed as the accountable authority over the Ngaanyatjarra Council (Incorporated). Staff at the nursing post were responsible to the manager of the Ngaanyatjarra Health Service who, in turn, was responsible to the Ngaanyatjarra Council (Warburton Nursing Post Annual Report 1989). Today the

Warburton nursing post is completely managed by the Ngaanyatjarra Health Service (Aboriginal Corporation).

Ngaanyatjarra Health Service (Aboriginal Corporation)

The Ngaanyatjarra Health Service was established in response to a need for health care to an extremely remote and sparse population who were scattered over a vast area. The movement of the Ngaanyatjarra population to outstations in their own country during the early 1980's meant that these isolated locations had great difficulty in obtaining health care (McLean, D. 1995. pers. comm. 28 July). Until 1982, the Warburton Hospital was the only on-site service in the region.

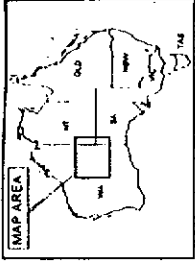
In 1985 the Ngaanyatjarra Health Service (Aboriginal Corporation) was formed and took over the health services from P/NHHS in the communities of Wingellina, Blackstone and Jameson. Over a further period of 4 years health clinics were established in another 5 communities. These were Warakurna, Tjukurla, Kiwirrkurra, Tjirrkali and Wannan. In each of these communities one registered nurse and an Aboriginal health worker were usually employed. In 1991 a clinic was also established at Cosmo Newberry and, in 1995, a new outstation clinic was built at Karilywarra (Patjarr) in the Gibson Desert (Map3.3, overleaf).

The Ngaanyatjarra Health Service is responsible to the Ngaanyatjarra Council. The organisation employs a manager, two office staff and a Staff Development Officer in the head office in Alice Springs, as well as an Aboriginal Liaison Officer who is based at Wanarn in the Ngaanyatjarra Lands. At the Warburton nursing post three nurses and three Aboriginal health workers are usually employed. A Facilities Co-ordinator (clerical position) and maintenance worker are also employed.

Warburton as the largest most established community was regarded as the main centre of the Ngaanyatjarra Lands. It was in the community of Warburton that this ethnographic study of nursing practice was undertaken

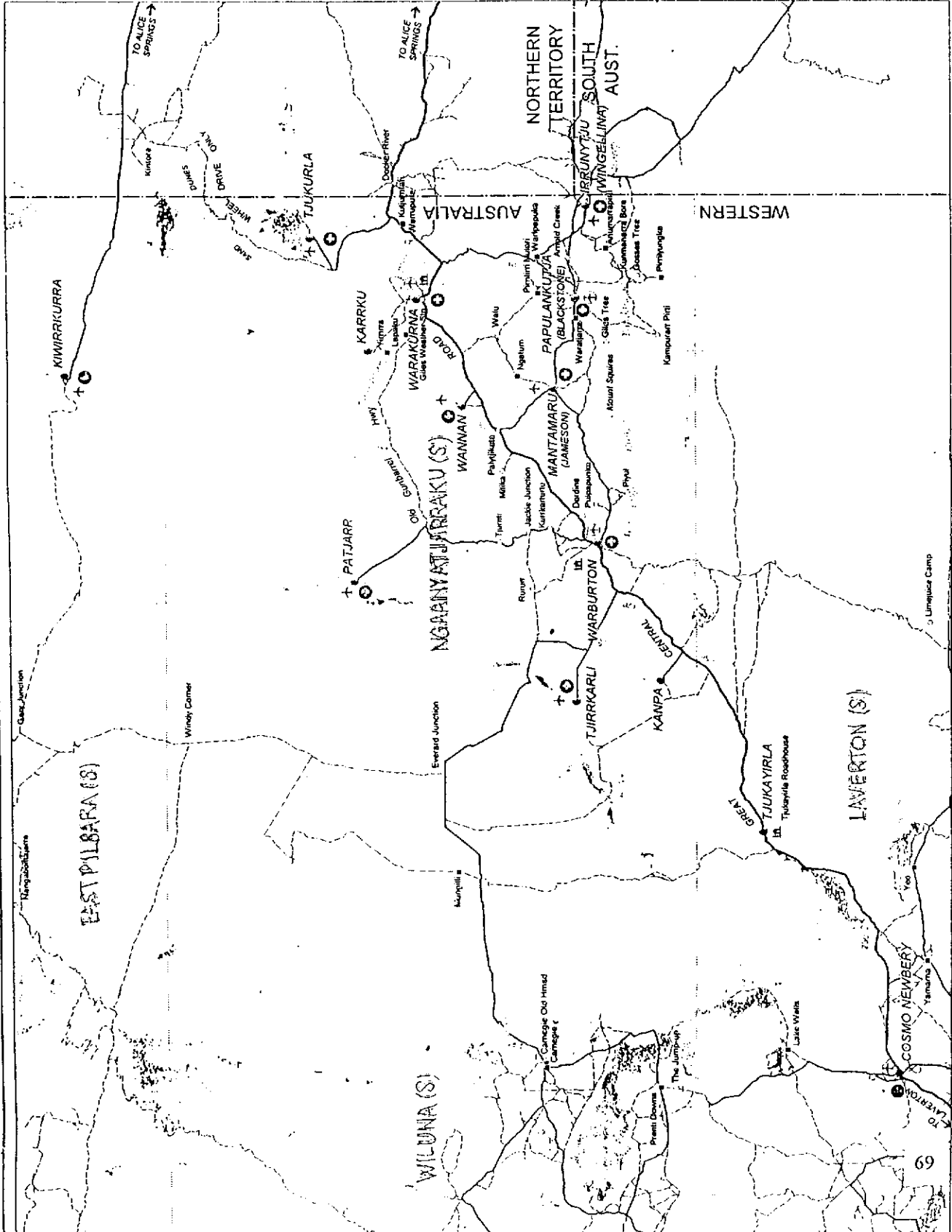
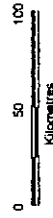
Map 3.3: Location of Ngaanyatjarra communities and health centres

LOCALITY DIAGRAM



LEGEND

- Aboriginal Community
- Homestead
- Locality
- ⊕ Health Clinic & Ambulance
- ⊖ Roadhouse/Fuel
- ⊕ Airstrip All Weather PAL Runway Light
- ⊕ Airstrip Daylight Ops/Night Emergency Ops
- Main Road
- - - Secondary Road
- ⋯ Tracks
- Distance in Kilometres
- - - State Boundary
- ⋯ Local Government Boundary
- (S) Shire



Map No. A3-G0270
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LOCATION OF NGAANYATJARRA COMMUNITIES

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Summary

The remote area setting of Warburton is situated in the midst of a vast semi-arid desert landscape between the rocky ranges of the Gibson Desert and the Great Victoria Desert of Western Australia. Recorded history of European contact with the Ngaanyatjarra people who live in this region dates back to the latter years of the 19th century. Early this century the Government policy was to retain these people in the Central Aboriginal Native Reserve.

In 1934 the Warburton Ranges Aboriginal Mission was established on the fringe of the reserve. Warburton had begun as a mission but is no longer that today. Today several Ngaanyatjarra Aboriginal Corporations have oversight of the affairs and services to the Ngaanyatjarra Lands, which includes Warburton. These are the Ngaanyatjarra Council, the Ngaanyatjarra Land Council and the Ngaanyatjarra Health Service. The Shire of Ngaanyatjarraku also provides local government services.

The total population of the Ngaanyatjarra Lands is approximately 2000. The majority of these people live at Warburton. A proportion of the Warburton population is mainly of European descent and reside in Warburton because of employment. At Warburton essential services are provided, such as communication systems, electricity and sewerage disposal. A general store, housing and limited forms of employment are also available.

The Ngaanyatjarra people retain their traditional beliefs and have incorporated the materials of western culture that are available to them into their everyday lives. This was also apparent in their attitudes to health care where the availability of western medicine was seen as an adjunct to traditional healing practices.

A history of the health service revealed that the first hospital was built in 1954 with one registered nurse to provide the service. In the ensuing years the health service changed hands from one mission to another then to government management. Most recently an independent health service has assumed this responsibility. Throughout these four decades

nurses have had primary responsibility for health care within the Warburton community and the surrounding area.

This history of health care delivery is notable for its recurrent problems and the shifts of administrative responsibility, as well as for the promises to nursing staff and for the Warburton community: problems that were smoothed over and promises that were unfulfilled. It is out of this legacy of upheaval and turmoil that nursing practice was and continues to be shaped within the remote area setting. This scene of contemporary Warburton and its history of health services provided the backdrop from which I commenced the gathering of data and data analysis for this inquiry into nursing practice in a remote area.

CHAPTER 4

METHOD OF DATA GATHERING AND ANALYSIS

*The ethnographic perspective develops an interplay
between making the familiar strange and the strange
familiar...and thus need an explanation*

Renato Rosaldo (1989)

Introduction

Ethnography is an inquiry into the meanings by which a cultural group make sense of the everyday patterns of life (Hammersley & Atkinson 1995). In this ethnographic inquiry I utilised the Developmental Research Sequence Method as the basic strategy for systematic data gathering and analysis (Spradley 1979, 1980). This sequence of ethnographic inquiry followed a cyclical pattern of recurrent question, observation and discovery (Figure 4.1, overleaf). The inquiry was guided by my research interest in nursing as it was practised in the remote area setting.

In this chapter the techniques used for data gathering are described. I also explain how the data were analysed using the Developmental Research Sequence Method. Illustrations of the method of data analysis are presented as examples.

Preliminary data gathering

The collection of data commenced prior to beginning fieldwork in the setting. At that time background information was obtained from library searches for historical information. I also conducted formal interviews with nurses who had formerly worked at Warburton and with various others who had involvement with the health service.

Early data gathering was a way to prepare myself for fieldwork and to obtain background information pertinent to the study. With the interview data I trialed the

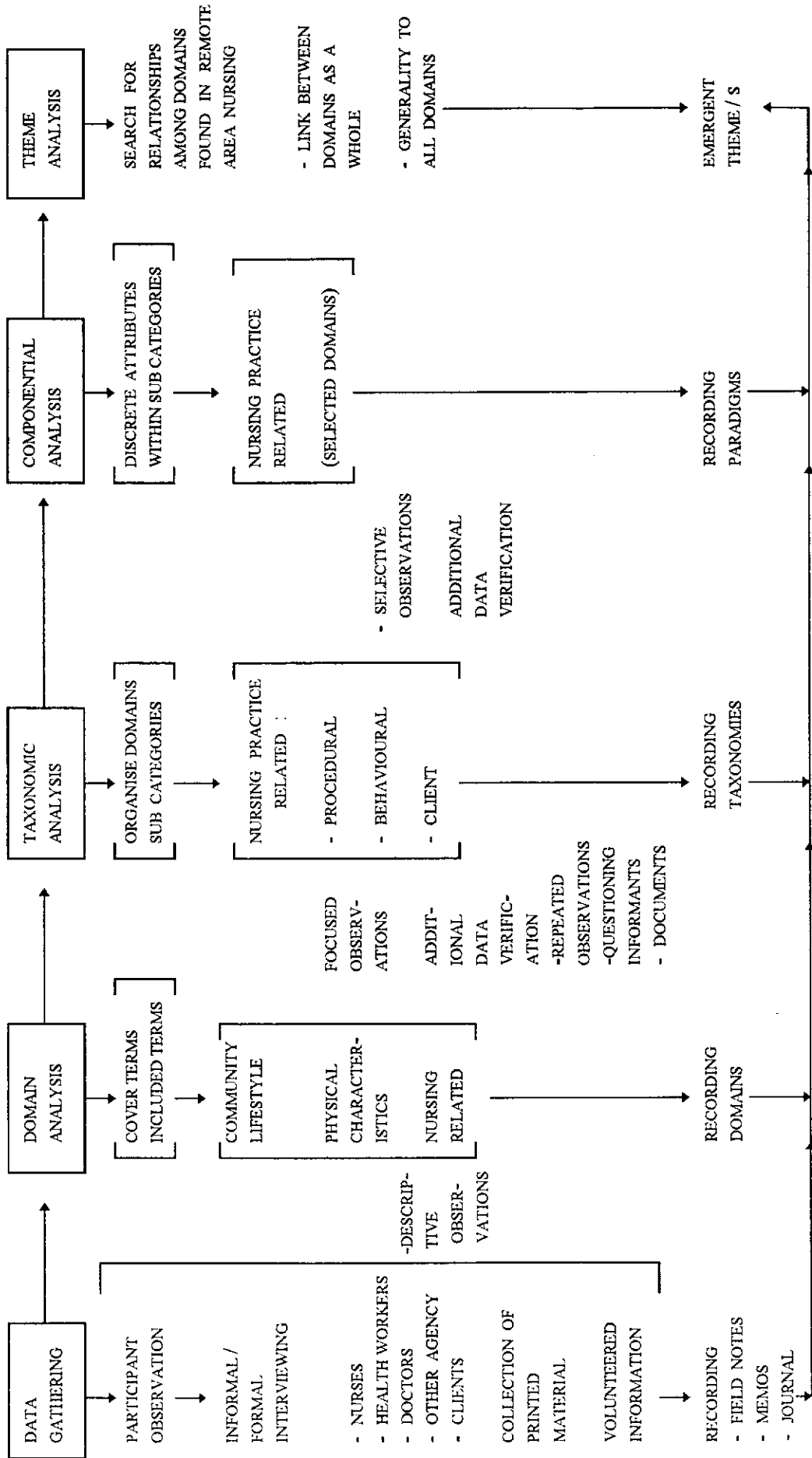


Figure 4.1: Process of data gathering and analysis
Developmental Research Sequence Method (Spradley 1980) as used in this study.

method of domain analysis to assess its suitability for this inquiry. Domain analysis of this preliminary data proved fruitful for uncovering in detail the terms used by informants that were relevant to this study.

I then commenced fieldwork which included participant observation, face-to-face interviews and document perusal in the remote area of Warburton. This was where nursing was practised and was the main source of data.

Fieldwork

Fieldwork for the gathering and analysis of data involved living for one year, from June 1995 to May 1996, at Warburton. I was accommodated at the nurses' quarters, next to the nursing post. Living at the nurses' quarters provided the opportunity to observe first-hand the everyday patterns of behaviour and what was involved for nurses in their practice. For example, at night I too heard the clients' knocks on the door or the ringing of the buzzer to call the nurse. Being there I was able to observe what it meant for a nurse to be on call and to deliver care at all odd hours of the night.

Sharing accommodation with nurses who stayed at the nurses' quarters also had the advantages of immediacy. Being there I was able to listen to nurses who volunteered information of what they felt I, as the researcher, needed to know about nursing as it was for them in this setting. Nurses in this informal situation were able to talk over their experiences and feelings as they occurred. These times were a valuable source of data that revealed what was salient for these nurses in a remote area. From this base I began my ethnographic journey and took the first step in the Developmental Research Sequence.

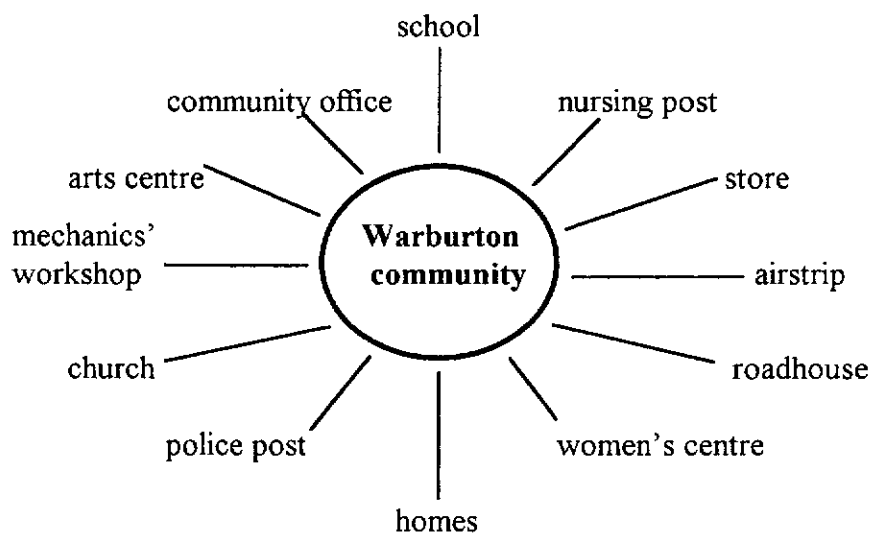
Locating the situation

The first step of fieldwork was to locate the social situation in which nursing was practised within the Warburton community. With broad descriptive questions in mind,

I sought to discover the actors, activities and places that made up the social situation of Warburton. These general descriptive questions were a way to net what was pertinent to my study. It provided a wide angle view of the social setting and what was important to the everyday life of community groups in Warburton.

Within the community, clusters of social situations were found. These pertained to all the places where groups of people routinely congregated for various purposes and activities. Each of these social situations were discovered to be part of the network in which nurses participated. The places discovered to make up community life are illustrated in Figure 4.2.

Figure 4.2: Network of social situations: Warburton community



Depiction of social situations found at Warburton where groups of people usually gathered for various purposes and activities.

From this overview of the Warburton social scene and taking into consideration the purpose of my study, I selected the nursing post as the focal social situation for inquiry. In this location nurses, Aboriginal health workers and visiting medical officers were found to be routinely engaged in health care activities with clients.

Locating the social situation was important for finding a focus for the study of nursing practice in its context and for directing the next step of participant observation.

Participant observation

Participant observation was the primary and constant method of data gathering throughout the fieldwork (Becker & Geer 1957). According to Spradley (1980), the position of the researcher is being both an insider and an outsider. As an insider I was part of the situation, to feel what it was like for participants. As a detached observer, however, I was separate from activities and viewed nursing practice and the self as objects for study.

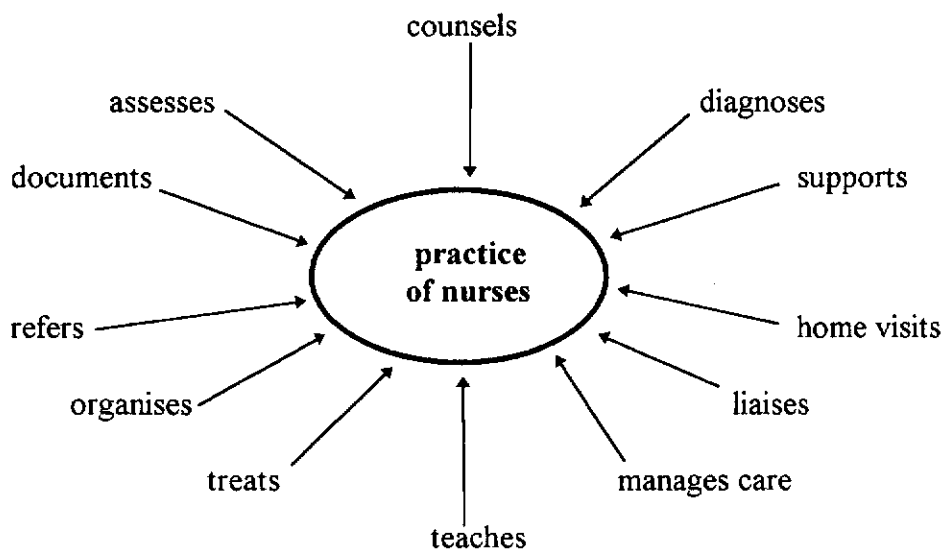
My role as researcher, therefore, was as an observer-as-participant (Wilson 1989). In this role I mainly acted as an observer with minimal participation in the activities under study. It also allowed me to remain less obtrusive in the setting. Agreement and permission was obtained from nurses, Aboriginal health workers and visiting medical officers for this level of participation.

I attended the nursing post at the start of each day, staying around in order to observe as fully as possible and to ask questions about the everyday life events as they occurred. I also perused documents and maps available to me in the clinic and engaged in conversations with staff, clients and official visitors to familiarise myself with the nursing setting.

In this initial period the readiness of the staff to accept a researcher was often shown. For example in situations where a nurse would remark, 'I'm glad you are here to see this,' such as the work involved for the nurse in 'doing paperwork', or in transporting a critically injured client. Or, 'Look at this (showing me a brown paper bag on which someone at a city hospital had written a client's medications, or a piece of malfunctioning equipment, or an incomplete client record)! I think you should know about this for your study.'

Initial data gathering involved the use of broad questions to discover the range of similar recurrent activities that involved nursing practice. These recurring activities were observed repeatedly over time in order to find the cultural patterns and rules for behaviour inherent in the nursing practice setting. The following diagram displays the similar activities of nurses in practice at the clinic that were discovered (Figure 4.3).

Figure 4.3: Recurrent activities in the practice of nurses



A representation of the observed range of activities routinely performed by nurses in their day to day practice.

In the role of detached observer, I arranged for periods of observation in the clinical setting with agreement from nurses and Aboriginal health workers. I informed clients of the reason for my presence and obtained their permission for me to remain in the room and to observe. These sessions of observation were conducted over three or four consecutive days and again at different time periods. There I made detailed observations of all the interactions and sequence of activities that occurred. Similarly, on four occasions I also observed in the RFDS fortnightly medical clinic. A small notepad, carried with me at all times, was used during these planned sessions and as needed to make jottings of my observations (Emerson, Fretz & Shaw 1995).

The insider role in which I assisted nurses in minor ways, enabled me to observe first-hand what was involved for nurses in the care of clients. Introspection on this experience of engagement in the practice situation provided added insight and raised further questions that were important for the study. For example, in an emergency situation how did a nurse manage the multiple care needs of the client, the needs of the relatives, the assembly of equipment and telephoning for a medical consultation when there was no telephone in the clinic area?

Interviews were secondary to observations for data gathering. Occasional interviews, however, were important to explore questions about an event or an activity I had observed and to obtain the informants' point of view. An advantage of the interview was that it provided a congenial time for informants to reflect upon and to explain their perceptions, such as a practice situation. Also, by the researcher being in the setting, there was opportunity for nurses to add to their first spontaneous responses. For example, when other ideas or additional information later came to mind that a nurse believed were pertinent to a question but had not thought about at an interview or during a discussion.

Another notable point in concurrent observation and interview data gathering was that the events or activities being discussed were in the present or recent past and were usually known to the researcher as well as to the nurse. This tended to limit the validity problems of memory distortion and the revisionist nature of accounts in an informant's recollection of events and their feelings at the time (Oeschle & Landry 1987, Sandelowski 1993). Furthermore, in this research the importance of observations of what is done as compared with what is said in a formal interview was also apparent. For example, a nurse who had stated in an interview situation that he preferred 'to give oral antibiotics wherever possible because of the risk of possible complications from administering intravenous antibiotics', was observed on several occasions to give antibiotics by intravenous cannula without a medical order.

The interviews were semi-structured in that I prepared areas for questions, based on the dimensions of the social situation I had observed. Questions were generally open-ended to allow the informant to express what was salient for them. Formal interviews in the field setting were conducted with nurses, Aboriginal health workers, RFDS medical officers and other community members.

Informants were advised of the kinds of questions I wanted to ask. A date and time was agreed for a formal interview. At the interview appointment the informant was firstly informed of the purpose of the study. Each informant was assured that their confidentiality and protection of privacy would be respected. No names identifying any person would be used in the study without their prior permission. I obtained consent for the interview to be recorded onto a microcassette recorder (Appendix 3). This was in order to retain their responses in full. I advised them that the taped interview would be transcribed and then returned to them for their approval. At the close of each interview I thanked the informants for their assistance. I also asked them if I could interview them again at a later date if needed to verify points made in the interview and as I collected further data.

Several of the Ngaanyatjarra informants volunteered 'story telling' as a way to communicate their ideas and for me to record. One of these informants was a senior woman whom I had asked to confirm an account of Ngaanyatjarra beliefs related to health. This woman had approached me about five months after I arrived in Warburton. She asked me to sit down with her in privacy. There the woman began to tell me, in Ngaanyatjarra, about aspects of the Ngaanyatjarra way of life that were important for her. She instructed me to write it down as she spoke. As I wrote, the woman asked me to read back to her what I had written. 'That's right!', she would exclaim, 'That's what I said.' She also reminded me of what I had omitted and corrected my inaccuracies of recording. This woman became my main Ngaanyatjarra informant.

Observational data gathered during the year of fieldwork in the community involved participant observation together with formal and informal interviewing and the perusal of documents and note taking. These observations and the questions that arose formed the basis of the ethnographic record.

Recording fieldwork

Fieldwork observations, questions and experiences were recorded in three separate volumes. These were fieldnotes, memos and a personal journal. Fieldnotes, the central fieldwork activity, were handwritten in 300 page quarto sized notebooks. Pages in each volume were numbered in sequence. The notes taken during observations were used as prompts for recording fieldnotes. These were completed in full detail each day and recorded in chronological order, with date, day and time entered. A six centimetre margin on each page allowed space for data analysis.

The style used for the fieldnotes followed the conventions suggested by Spradley (1980) and Kirk and Miller (1986). These were the principles of language identification (whether native or observer), verbatim and concrete recording. In verbatim recording the exact words of a speaker were used. Concrete recording was the documentation in specific detail of what was seen and heard (Straubert & Carpenter 1995). Diacritical conventions were used to distinguish these types of entries, that is, the consistent use of commas and brackets to differentiate between direct quotes from informants and personal notes (Kirk & Miller 1986).

Memos were a kind of 'thinking on paper' where I recorded questions, propositions and hypothesis to be tested in my observations and from the data as it was analysed. A fieldwork journal was kept to record personal perceptions and experiences. The journal was an adjunct to field notes and used for reflexive analysis (Aarmodt 1989, Hammersley & Atkinson 1995). The ethnographic record was basic to the ongoing process of data gathering and analysis. These records prompted further descriptive

questions and led to more observations and occasional interviews in the social situation being studied.

Descriptive questioning

Use of 'grand tour' descriptive questions for observation was a way to discover all the dimensions in the social situation of nursing practice (Spradley 1980, p77). From this data 'mini tour' questions were formulated as a guide to search for all the variables within each dimension. For example, what were all the actions involved in an assessment of a client? Who were all the people involved in an emergency evacuation? Informal discussions with nurse informants provided the opportunity to ask them these questions in various ways, such as, 'Can you tell me what it feels like to be on call?' 'Can you describe in detail the procedure you used for making this clinical decision?'

With the gathering of descriptive data, I simultaneously began a domain analysis. A personal computer, with a Microsoft Windows 6 word processing program, was used to sort the interview data into meaning units. This technique, described by Burnard (1994), was effective for the organisation and retrieval of interview data. The search for cultural domains in the remote area setting was basic to the use and sense of the data and to the direction of further questioning and observations.

Domain analysis

Domain analysis entailed a search for all the domains in the descriptive data to find cultural patterns in the remote area nursing setting. Each domain was comprised of three elements: a cover term, a semantic relationship and included terms (Spradley 1980). A domain was identified by examining the unit terms used by nurses, clients and others in the setting and by finding semantic relationships amongst those terms. The search for a domain cover term in the textual data was preceded by a question

using a single semantic relationship. For example, is this term a way to achieve something else? Is this term a kind of something? Or, as another example, which terms are a characteristic of something else?

Each cover term of a domain was recorded in bold letters at the top line of a separate file card (20.5 cm. x 12.5 cm. size). The semantic relationship was written directly beneath the cover term. Below the cover term and semantic relationship the included terms were listed. As further included terms were found these were recorded accordingly. At the bottom of each domain file card a structural question, using the cover term and the semantic relationship, acted as a prompt for focused observations (Spradley 1980). Structural questions were, for example, what are all the ways to learn remote area practice? What are all the steps in a medical consultation? What are all the kinds of organising activity? What are all the ways to build rapport? Such questioning was basic to learning all the parts of a cultural domain.

Cover terms were further distinguished by whether they were folk, analytic or mixed domains (Spradley 1980). Folk domains consisted of those terms found in the data as used routinely by people in the remote area cultural setting, such as 'fitting in', 'being on call', 'coping' and 'not knowing'. Analytic domains used cover terms I devised to represent the tacit cultural meaning that was inferred from behaviour or speech. For example, 'client expectation' and 'difficulty for decision making'. Mixed domains contained a combination of folk and analytic terms, such as in the cover domain terms 'back-up for nursing care' or 'medical evacuation'.

The following examples (Figure 4.4 and Figure 4.5, overleaf) illustrated domain analysis from a segment of textual data. This segment of data recorded, in direct speech, a nurse's explanation of how she had learned to practise in a remote community.

An alphabetical index was recorded in the inside covers of each volume of field notes to locate the domain terms in the text.. A list of each domain cover term was entered

on the personal computer word processor and updated as further domains were found. A total of 136 domains were discovered in the data analysed. The three major groups of domains that emerged were termed community lifestyle, physical description and nursing related.

Figure 4.4: Extract from field notes: Domain terms

TEXT	TERM
<p>“You <u>remember what you saw</u> someone else do, like the doctor...You <u>remember some basic principles of nursing</u> . And you <u>have a go</u>. <u>If you don’t do it, its not done</u>...I previously worked in the asthma ward at the children’s hospital. <u>My experience</u> with asthma gave me a <u>good grounding</u> in that. As <u>a regular thing</u> I <u>listened to kids chest</u>”.</p>	<p>recall procedure seen recall nursing principles have a go necessity to perform past experience grounding skill attained</p>

The cover term was found by searching the data with the question: Is this term, ‘remember what you saw’ or ‘have a go’ a way to do something else? That is, learn remote area nursing. As these terms were discovered they were noted in the margin of field notes.

Figure 4.5: Domain analysis (example)

COVER TERM: Learn remote area practice (mixed)	
SEMANTIC RELATIONSHIP: is a way to	
INCLUDED TERMS:	
<p>recall procedures seen have a go past experience skill attained</p>	<p>recall nursing principles necessity to perform grounding</p>
STRUCTURAL QUESTION: What are all the ways to learn remote area practice?	

The included terms found in the data as a way to learn remote area practice were added to the list on the appropriate domain card. As additional data was collected, the structural question, ‘what are all the ways to learn remote area practice?’ was used to discover other terms in this domain.

Domains were tested and verified by repeated observations and by consultation with informants. At this stage of the Developmental Research cycle focused questions were used to guide additional observations..

Focused observation

Focused observations used questions with a narrower scope of interest in a search for all the parts of each domain that were pertinent to my pre-selected ethnographic study. These observations were based on the structural questions formulated from the semantic relationship of a cover term. For example, ‘What are all the stages in a medical clinic?’ or, ‘What are all the steps in pharmacy supply?’

The domains selected for detailed investigation were those found to impact on the practice of nursing, that is, the nursing related domains. At the same time, parallel to this focus, broad observations taking in the whole scene continued to be recorded for surface analysis. The additional included terms found from the focused observations were added to the nursing related domains. Those domains in which multiple included terms were found were then chosen to begin a taxonomic analysis.

Taxonomic analysis

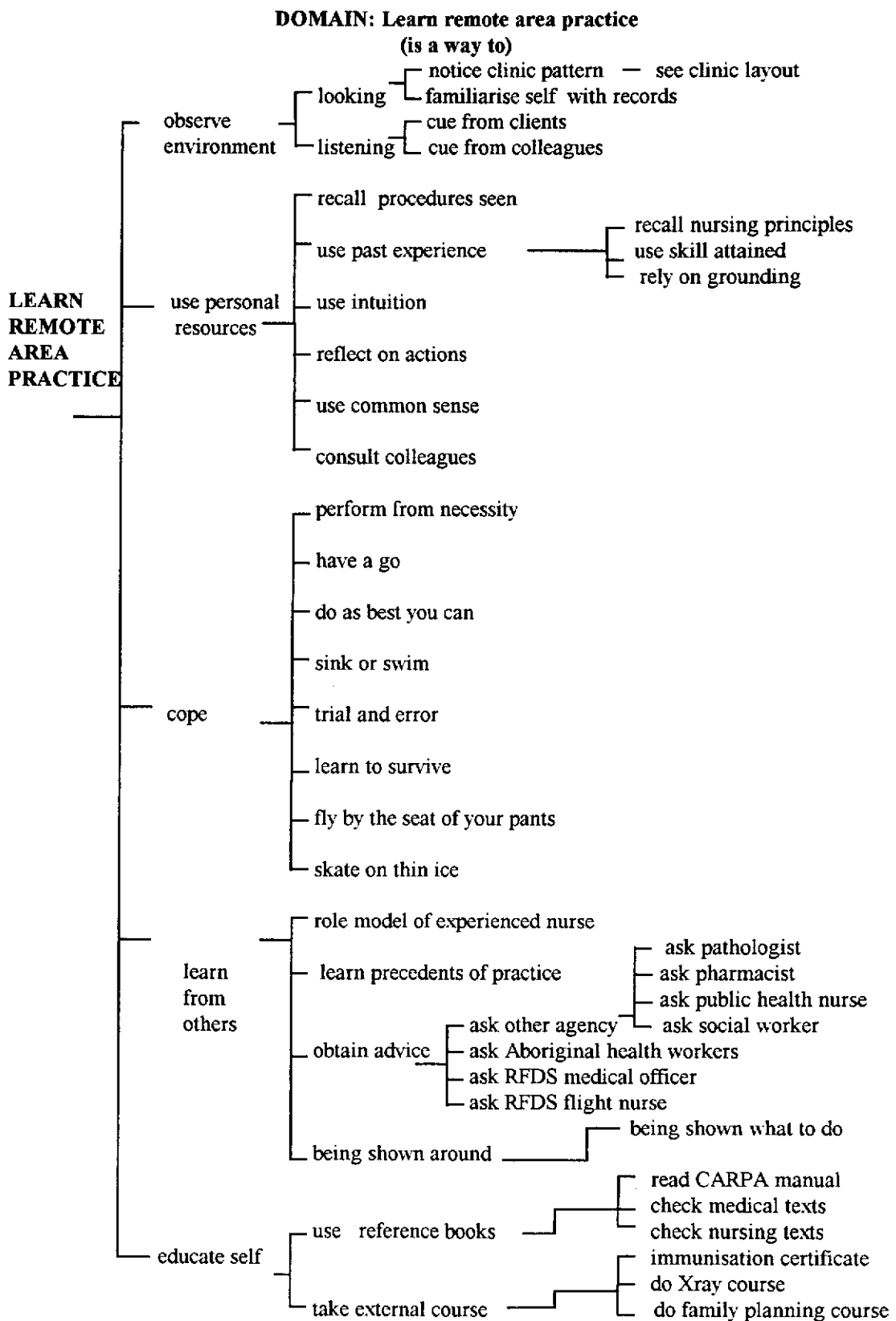
A taxonomy represented how all the domain terms were systematically organised (Figure 4.6, p86). This process involved a search for relationships among terms found in a domain. Domain terms were then sorted into subsets according to their similarities and variations in meaning. Each included term was examined for higher terms and subordinate terms. Subordinate terms were identified by using the same semantic relationship to a higher term. A separate sheet of A4 paper was used to record each taxonomy.

Taxonomic analysis exposed gaps in the data collected. A taxonomy generated further structural questions and the repeated observations needed to discover additional included terms in each subset. The process of taxonomic analysis was also used to explore domains for larger domains, such as the question, 'Is this domain a kind of something else?' Thus, for example, the domain 'medical consultation' was also found to be a step in 'clinical decision making for acute care'.

Nurse informants were each asked to view the taxonomies with me and to verify the domains. Terms I had included in the domains but not verified by more than one nurse informant were deleted. Very few terms were unconfirmed. Additional notes were also taken to document variations in the nurses perspectives and to record their additional insights that emerged from these sessions.

This resulted in new focused questions to revise the taxonomy and to find all the subcategories in a domain. The taxonomy was completed when no further subcategories could be found. The structure of a taxonomy is shown in Figure 4.6 (p88). As taxonomies were developed the next step in the ethnographic cycle was taken. Finding the differences as well as the similarities of cultural meaning among terms was essential to make sense of nursing as it was practised in this remote setting. The selected observations that followed were a search for these contrasts in meaning.

Figure 4.6: Structure of a taxonomy



Selected observations

Questions for selected observations were restricted to a search for the differences in meaning within the sub-categories of each domain. The domains chosen for selected observations were those found to be salient to the practice of remote area nursing. Contrast questions were used to find the different meanings between the cultural terms in the chosen domains (Spradley 1980). For example, 'In what way was 'have a go' different in meaning from 'trial and error' to learn remote area practice?' Contrast questions, as explained by Spradley (1980), examined pairs or triad groups of similar terms. These questions asked in what ways the meaning of one term differed from, or was similar to, others. For example, in the domain 'Consulting a medical practitioner' (is a reason for) a question was: What are the differences between the included terms 'ask advice', 'notify doctor' or 'clarify a problem? The differences in meaning that were discovered were termed dimensions of contrast. The dimensions of contrast found from selected observations formed the substance of a componential analysis.

Componential analysis

Componential analysis, as an abstract level of ethnographic inquiry, explored the contrasts in attributes of meaning for each domain. A worksheet with columns was drawn on A4 sized paper. The taxonomy of a domain was re-written down the left hand side of the sheet. Each column was headed with a discrete attribute of contrast, discovered from selected observation and that was significant to the domain. As further dimensions of contrast were discovered the attribute was added. The completed worksheet was termed a paradigm (Spradley (1980).

Further selected observations with new questions based on these dimensions of contrast were used to substantiate the attributes discovered and to find the data missing in the paradigm. For example, dimensions of contrast for the domain 'learn remote area practice' was found to include the meaning attributes, 'gained in formal

education', 'self taught', and 'risk taking'. As another example, attributes of contrast for the domain, 'fear of nurses', included 'unpredictability', 'reliability of back up' and 'lack of educational preparation'.

Componential analysis provided a tool to test propositions and hypotheses formulated during observations and data analysis. In this process exceptions and variations in the cultural patterns were detected. Such evidence was important to discover what factors circumscribed these patterns and to clarify meanings that could add to an understanding of the practice of nursing in the remote area (Fetterman 1989, Strauss and Corbin 1990).

The dimensions of contrast found in the componential analysis were discussed with nurse informants to establish their face validity for nurses. As the analysis cycle advanced, the search for patterns and recurrent themes in the domain relationships and the way domains fitted together as a whole were always in mind.

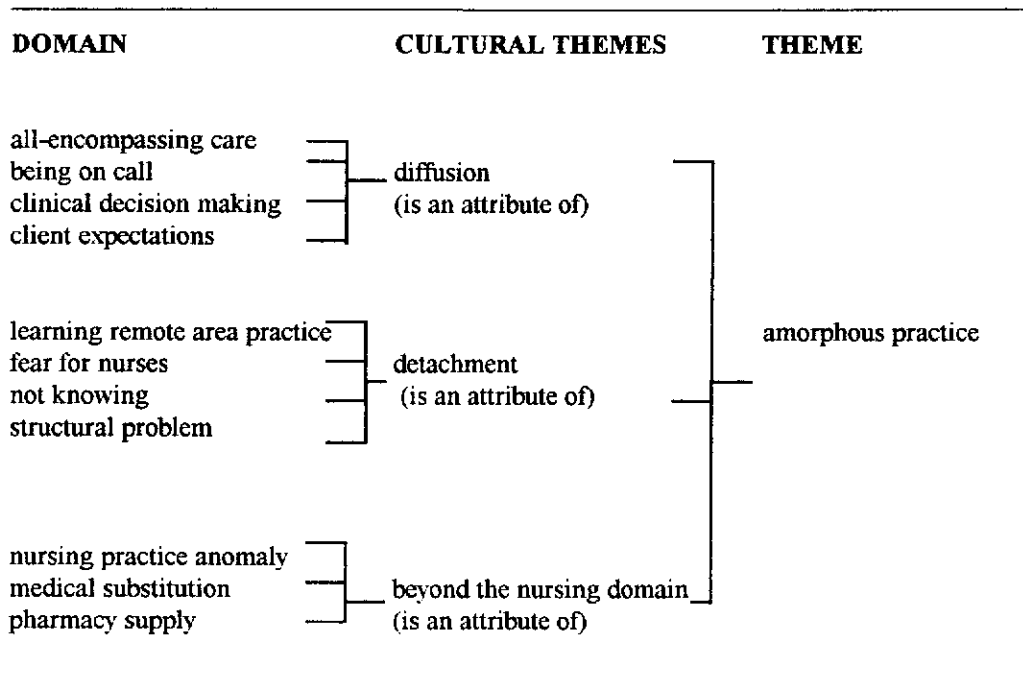
Finding cultural themes

Thematic analysis was the exploration of relationships among domains found in the practice of nursing in the remote setting and that connected these domains together as a whole. Cultural themes were identified as recurrent principles that appeared in several domains to form sub-systems of meaning (Spradley 1980, Fetterman 1989). The search for cultural themes involved linking domains together according to their similarities and differences. At this level of analysis, themes were revealed as higher domains that integrated the cultural domains pertinent to the practice of remote area nursing. An example illustrated the use of thematic analysis (Figure 4.7, below).

The overall theme that emerged from this analysis was *amorphous practice*. *Amorphous practice* was defined in this study as the changeable nature of practice from nurse to nurse and from situation to situation and from time to time. This theme had generality to all domains and was supported by a recurring assumption about

nursing as it was practiced in the remote community context. Cultural themes that were sub categories and seen as tributaries to *amorphous practice* were termed *detachment*, *diffusion* and *beyond the nursing domain*

Figure 4.7: Thematic analysis (excerpt)



By asking semantic relationship questions, the domains were found to form sub-categories as attributes of larger domains. These larger abstract domains were termed cultural themes. Further questioning of the relationship among these cultural themes and their link to domains as a whole revealed the overall theme of *amorphous practice*.

The underlying pattern that emerged in the vocabulary and actions of nurses as well as those with whom the nurse interacted, was the changeability of practice. Thus the overall theme, and climax of this Developmental Research Sequence Method (Spradley 1980), was revealed in the phenomenon of *amorphous practice*. The following chapters are an exposition of the findings of this analysis and the substantive theory that emerged. This written exposition was undertaken following the end of my fieldwork.

Departure from the field

Leaving the field marks the closure of fieldwork (Kirk & Miller 1986, Taylor 1991). Disengagement from Warburton community was a process whereby I gradually withdrew from participant observation in preparation for my departure. At this stage I had assessed the data gathered. I concluded that sufficient data had been obtained to answer the questions posed by the ethnographic study. (Shaffir & Stebbins 1991).

In respect to the informants I gave advance notice of the time I was intending to leave Warburton (Morse & Field 1995). Questions of staying in touch and revisiting Warburton in the future were frequently asked of me. As Gallmeier (1991) found, continued communication with informants with whom I had formed a relationship of trust was important. This was not only for personal reasons but also for the ongoing confirmation of analytic interpretations and representation of data. An association had been formed with nurse informants and others that was sustained until the finalisation of the research and beyond. My relationship with some members of the community and the Ngaanyatjarra Council also continued through regular reports and the submission for comment of draft chapters of my thesis as they were being written. A draft of the entire thesis was presented to the senior anthropologist for review and for approval by the Ngaanyatjarra Council and Warburton Community Representatives prior to its completion.

Summary

In this ethnographic inquiry the Developmental Research Sequence Method (Spradley 1980) was used for data gathering and analysis. This cyclical method involved the recurrent use of ethnographic questions, observations and discovery. On the one hand, the cycle consisted of increasing focus and refinement of questions and observations and on the other hand, maintaining a broad surface picture of the cultural scene. Field notes, memos and a personal journal were kept daily to record data and the research process.

Fieldwork for the gathering of data was undertaken for one year at the remote community of Warburton. Locating the social situation for study was the first step and involved a search for all the social situations present in the community and how these were linked together. The nursing post was found to be the main location for nursing activities and thus was selected for the focus of my study. The method of data gathering was primarily participant observation. Formal interviews and the perusal of documents were an adjunct to observation.

Initially data analysis involved a search for domains by asking broad descriptive questions in the nursing setting. Focused questions and observations were then used to complete the domain analysis. Taxonomies were constructed to organise the domains into sub-categories. In the selective observations that followed, dimensions of contrast in the meaning of domain terms were explored. Componential analysis was the search for attributes of meaning that distinguished the differences and similarities between these terms. At each stage of the Developmental Research Sequence nurse informants were consulted for verification of the data analysis.

Finally, themes were found in the analysed data that connected the domains as a whole and that had generality to all domains. Fieldwork was terminated at this point. The overall theme that emerged was termed *amorphous practice*. The domains found in remote area practice, and from which the theme was revealed, is the basis of the exposition that follows. Firstly, however, it is important to describe the practice milieu which had a fundamental influence on nursing in the remote area.

CHAPTER 5

THE PRACTICE MILIEU

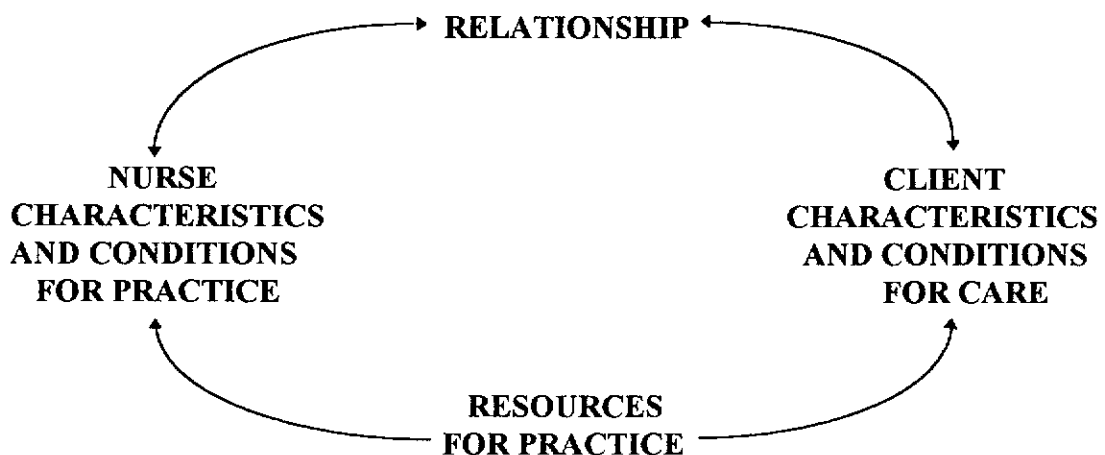
In nursing practice, the nursing situation refers to the nurse-client relationship and the broad context in which that relationship is lived through, inclusive of the institution/unit/community/societal milieus

Carolyn Oiler Boyd (1993)

Introduction

Irrespective of the setting in which nursing is practised, it remains an interactive process (Reilly and Oermann 1992). This requires the involvement of the nurse and the client in a supportive, facilitative milieu or environment. Such a milieu requires a caring, sharing relationship between the nurse and the client. This in turn depends on resources for practice together with nurse/client characteristics and conditions that facilitate or impede the practice of nursing. The idea of the practice milieu is portrayed in the following conceptual paradigm (Figure 5.1). This is further explained in terms of remote area nursing practice in this chapter.

Figure 5.1: The practice milieu



The characteristics and conditions of the nurse and client as well as the resulting relationships contribute to the practice milieu. Resources for practice is also a contributor as it impacts on the conditions for practice and care and on the nurse/client relationship.

The practice milieu of a remote area in this study begins with the characteristics and work conditions of the nurse as well as organisational expectations. It then describes features of the client population including their perceptions of care and carers. The nurse and client relationships are also explored. Finally this chapter describes the material resources available for nursing practice.

Remote area nurses

During the period of fieldwork at Warburton, the maximum number of full-time nursing staff was three registered nurses. This number of nurses was usually employed by the Ngaanyatjarra Health Service at Warburton nursing post. One of these nurses was appointed by the health service manager as a 'Sister-in-charge'.

In one year a total of 19 nurses were employed either on a permanent or a temporary basis (Appendix 11). The ages of these nurses ranged between 24 and 50 years. Ten nurses were aged between 30 and 38. Thirteen nurses were female and six were male. This age and gender distribution reflected a typical pattern when compared with other studies of remote area nurses that reported on these demographic characteristics (Philp 1988, Buckley and Gray 1993, Cramer 1993). The qualifications and experience of nurses also varied.

Qualifications and experience

The level and mix of qualifications and experience of nurses is a fundamental element of the practice milieu. These characteristics represent the nurses' professional abilities for the delivery of client care in the setting. At Warburton, of the 19 nurses employed during the year of observation, 12 nurses were registered in general nursing only. The remaining seven nurses had additional midwifery registration. Two nurses had an undergraduate degree in nursing. Other qualifications held by nurses were in paediatric nursing, theatre nursing and a diploma in health promotion (Table 5.1, overleaf).

Table 5.1: Qualifications of Nurses (June 1995 - May 1996)

WARBURTON NURSING POST	
QUALIFICATIONS OF NURSES EMPLOYED	
(June 1995 - May 1996)	
<u>Qualification</u>	<u>n</u>
General nursing certificate only	5
<u>Additional:</u>	
Midwifery	5
Undergraduate Degree (Nursing)	1
Midwifery and Undergraduate Diploma in Nursing	1
Midwifery and Undergraduate Degree (Nursing)	1
Midwifery and Paediatric Nursing Certificate	1
Paediatric Nursing Certificate	3
Theatre Nursing Certificate	1
Diploma in Health Promotion	1
	<hr/>
	19
	<hr/> <hr/>

Five nurses had previously nursed in other remote area regions either in the Northern Territory or in Western Australia. The length of this experience ranged between six weeks and one year. Two nurses had worked with international agencies and each of these nurses had more than two years experience nursing in rural areas of African countries.

The majority of nurses (11), prior to their employment at Warburton nursing post, had previously only worked in major public hospital settings. These were paediatric units (four), intensive care (three), theatre (two) and midwifery (two). Four nurses had trained at metropolitan children's hospitals in different States (two) or in England

(two). Three of these nurses had worked almost exclusively in paediatric nursing. Their only adult nursing experience had been during their basic nursing education. The length of nursing experience ranged from less than two years (three) to twenty five years (three). Nine nurses had at least eight years general nursing experience.

Only one nurse expressed a long term career interest in remote area nursing in Australia and had pursued his nursing education accordingly. The nurse's expectations derived from a remote area nursing course, however, had proved unrealistic in the practice setting. This was stated as follows:

You come out here expecting to do a lot of what you were taught remote area nursing is about...health promotion and health education and primary prevention and community development. The whole focus of the course is that. And then you get out here. You find that it really is dealing with tertiary stuff.

Nurses perceptions of the adequacy of their level of qualifications and experience were influenced by the manner in which they had been recruited to the remote area and the offer of employment.

Recruitment

There were various avenues by which nurses had been recruited. Most nurses had been accepted following an initial telephone call of inquiry to the health service followed by a submission of their curriculum vitae. A few had responded to an advertisement in the State newspaper (Appendix 12). Two nurses had previously worked with the health service and had accepted an offer from the manager to return to Warburton. Nursing agency services were the main means of recruitment for the employment of temporary and relief staff, especially when they were required at short notice.

The preferred requirements for the selection of nursing staff were stated by the health service manager as follows:

I prefer at least three years of nursing experience and acute nursing experience in accident and emergency nursing and intensive care nursing, for example.

The health service administrators, as well as several nurses, held the view that clinical experience in an acute care hospital was a sufficient pre-requisite to function effectively as a nurse in a remote area setting. In their view, as heard on repeated occasions, the essential skills were to 'insert IV. (intravenous), take bloods and suture'. A nurse described being given similar information in a response to her inquiry about nursing in the remote area:

I spoke to a manager [on the telephone] before coming to Warburton. She asked me only about four skills. Could I put in an IV (intravenous)? Could I suture? Could I diagnose and assess? I asked about cultural acceptance and information about the Aboriginal people. 'You will be alright', I was told, 'They'll let you know, throw rocks on your roof or call you out at night if they don't like you'. I felt that this was unacceptable and asked for information about the area, but was not sent anything to inform myself.

Another nurse had requested relevant reading materials and information on the skills required in the remote area from the head office of the health service. No reading material was supplied. Instead, the nurse had been advised by an administrator, who was not a nurse, that she 'would be alright' with her skills in acute care paediatric nursing.

Interviews for the recruitment of nurses were mainly conducted by telephone. In the view of most nurses, the interview consisted of questions about their clinical skills and their availability to commence employment. For example, in this nurse's account of her interview:

My telephone interview consisted of, 'Can you do IVs? 'How are you at assessment and diagnosis?' I haven't actually done any IVs or suturing, I said, but I thought I could. I have not been taught assessment and diagnosis. That was it. She said, 'When can you start?'

For several other nurses the interview at recruitment had seemed perfunctory. These nurses described their appointment in the following way:

- I was employed after a talk with the Staff Development Officer on the telephone and sending in my CV (Curriculum Vitae). They didn't know who I was. I think if any nurse applied they would get a job.
- I've never got a job so easily. 'When can you start?' I was asked. In other jobs I've always been asked things like, 'Define primary health care'.
- I didn't really have an interview. I rang up and was offered the job and just got a letter informing me that my ticket [for travel] was ready for me on such and such a day. I was surprised. In no other employment have I not had an interview.

Following their recruitment, most nurses expressed surprise at how promptly they had been accepted. The fact that they had been accepted seemed to persuade nurses that, with their present nursing skills, they were regarded by the health service as sufficiently qualified and able to assume the role and responsibilities of a remote area nurse. For example, this nurse who had previously only nursed for two years at a metropolitan public hospital:

I had telephoned to inquire about positions with the health service but was thinking I am not qualified or experienced enough. But I was offered a position and asked, 'When can you start?' It really surprised me and I thought then maybe I am qualified.

Communication gaps between the information given to a nurse by the employer and the nurse's interpretation of this information often occurred, such as when the information provided was later found by a nurse not to accurately reflect the situation. A nurse who had inquired about the availability of a medical practitioner in the setting is an example of the mismatch of information:

When I asked [at the interview] about the medical back-up, I was told that the flying doctor would be there in the community in two hours. I thought, 'Oh well, there will be a doctor flying in shortly'. It really shocked me when I found out that there wasn't a doctor to rescue me. It was a nurse who arrived on the RFDS 'plane.

Several nurses had been unaware of the location of employment. One of these nurses had not known where the health service head office was situated. This was what she had to say:

I didn't even know the head office was in Alice Springs. I thought it would be at Warburton. I rang up to find out about something and was told I'd need to get a permit [to enter Ngaanyatjarra Lands] and to call in and get it before going to Warburton. Only then did I realise the head office was in Alice Springs.

Few nurses had made their own separate inquiries about nursing and working conditions in a remote community prior to accepting a position or arriving in Warburton. Instead, most beginning nurses appeared to accept whatever they were told as being all they needed to know in making a decision to enter remote area nursing. This was despite their acknowledgment that they lacked a knowledge of remote area nursing, as shown in this example:

I had no idea of what I was coming to and I was not told anything about what to expect. I was naive perhaps but I should have been told.

Two nurses, however, who had been recruited later declined the offer and withdrew their applications. Their reasons were not given.

Not all nurses had contracts of employment, or any notice in writing of their appointment. Nurses who had received a written confirmation of their appointment and the level of pay, for example, had accepted this as a contract of employment (Appendix 13). These experiences, however, had not deterred nurses from accepting employment in the remote area. The attraction of remote area nursing for these nurses appeared to be based on how they could further their nursing and personal aspirations.

The attraction of remote area nursing

What attracted these nurses to come to work in a remote area community? Reasons given by nurses for the attraction of remote area nursing included a curiosity about

remote communities. Some stated that they were 'wanting to do something completely different'. This viewpoint was usually associated with a desire to leave the dissatisfactions and demands they had experienced in hospital nursing. Nursing in the hospital environment was seen by these nurses as too restrictive. The appeal of remote area nursing was in anticipation of a perceived contrast to hospital nursing, or as an alternative to working overseas, as this nurse stated:

I decided to work in a remote area because I wanted to get out of the hospital and do something different. I applied to several aid agencies overseas but I didn't hear from them. A ___ (name of nursing agency) offered me this job.

A few nurses made comparisons between the remote Aboriginal community and 'third world' situations as they had perceived them. This perception had influenced their decision to work in the remote area. A nurse expressed this view as follows:

I guess I wanted to work in a third world country and thought that nursing in a remote Aboriginal community would be a good experience.

Some nurses had envisaged that they would find remote area nursing more fulfilling by being able to practise independently. A nurse who realised this expectation remarked:

Working out here I just love it. I enjoy all the independence. But working in a hospital has no appeal for me whatsoever

Several other nurses had believed that with their clinical skills acquired in a hospital setting they could contribute to the health care of Aboriginal people in a remote community. Those nurses who had previous experience in remote area nursing saw a greater opportunity to develop and use their clinical skills in a remote area, for example:

I guess the independence of the job is very satisfying. You actually get to use a lot of your skills which nurses do have but are never granted for having in a hospital.

The opportunity to use initiative such as for health education also held appeal for several nurses. A nurse described this as a satisfaction in remote area nursing:

For me the satisfaction is the [health] education. Even going into the school or going into the women's centre or talking to kids... You might set out to do something that has gone on before, but that doesn't mean something cannot be re-done. It often needs to be done time and time again. Just going out there and finding that you've got people interested. Like with the teenage girls that I have been working with during the holidays, setting out an afternoon a couple times a week and giving information. If I had more time then I guess I'd be able to find out more of what they wanted to talk about and give them information on what they wanted to know. I think it is the most satisfying, particularly when you get some of them coming back and asking you more questions.

Another factor that had attracted some nurses was a perception of a freedom of lifestyle. Remote area nursing, they believed, would provide an opportunity to explore the outback. A few nurses expressed an interest in remote area nursing as a way to learn from Aboriginal people about their culture and a desire to learn the Ngaanyatjarra language. Interests and relationships apart from nursing were also an important motivating factor, as this nurse explained:

I'm not here for the health service *per se*. I'm here because I want to be and I know the potential of what can be out here. I want to be part of that. I've come out here for the lifestyle, the people and the landscape. I've got some good friends here too.

Other nurses had accepted an offer from a nurses agency for a short term contract of employment in the remote community. For several of these nurses, agency nursing had appeared to offer an opportunity to 'try out' remote area nursing or to take a 'working holiday'. A nurse on her first day in Warburton explained this perspective as follows:

I arrived in Australia two weeks ago and saw an agency advertisement in the newspaper. I applied for the position here. It was easy to get work and for me it's a working holiday. I'm here for ten weeks and it's good money, better than in ____ (name of a capital city). It also looks good on my CV (Curriculum Vitae).

Short term employment in a remote area through an agency was also seen as a way of 'filling in' between different jobs. This view was described by a nurse in the following quote:

I'm here for three months with _____ (name of agency). I'm filling in between finishing at the children's hospital and waiting for [nursing] registration to work in England.

One nurse felt that she had been misled by an agency to accept a short term relief position at Warburton. The agency had promised 'good pay' and claimed that 'it was more of an adventure than work'. In hindsight the nurse felt that she had been unprepared and naive. The nurse recounted her experience in this way:

This is real Indiana Jones stuff. I was told [by the agency], 'You are up there (raises her hand high above her head). You are queen of the desert'. I was told the pay was good. Then I find out the pay is less here for the hours of work and the on call than I could earn with an agency in the city. Free rent is offered in lieu of payment for overtime. The pay is not good, but you get free rent! You come out here and the reality hits you. If only you were prepared. You feel cheated.

Despite the attractions and the various motivations, most beginning nurses admitted that prior to their entry to the setting they had only a vague idea of what it would be like to nurse in a remote area. A few nurses conceded that they had been ignorant of the work required and naive in their expectations. These factors pertaining to their motivations together with their expectations for nursing practice in the remote area also influenced their intentions to stay.

Nursing Staff Turnover

One of the problems encountered by nurses in the practice setting was the rapid turnover of staff. As was previously stated (p93), in the 12 month period of fieldwork a total of 19 nurses worked at Warburton (Appendix 11). Of these nurses, six were employed on a permanent basis by the Ngaanyatjarra Health service. This included

three nurses who were usually employed at other communities in the Ngaanyatjarra Lands and who had worked temporarily at Warburton (one week to four weeks).

Three nurses were appointed on eight weeks 'probation' preceding permanent employment. One of these nurses resigned before completing the probation period. Another nurse, on probation, following conflict with a nurse-in-charge was dismissed within two weeks of her appointment by a Staff Development Officer on an allegation of 'unsafe care'.

Ten nurses were employed temporarily on a short term relief basis. Of these nurses five had been recruited from a nurses' agency either in Perth or in Darwin. Short term relief staff worked for periods ranging between one week to three months. A list of nurses, kept at the nursing post since 1987 revealed that this annual turnover was not an isolated phenomenon. In each year, from 1987 to 1995, there had been between six and sixteen different nurses employed at the Warburton nursing post.

The staff turnover was generally influenced by the level of satisfaction nurses experienced in remote area nursing. Or, more precisely, whether satisfaction outweighed dissatisfaction. This was expressed by a nurse in the following way:

I find relationships with the people very rewarding, but the problems of on-call and treating people when I don't really know what I am doing just wears me out. It is for this reason I've decided to leave.

The satisfaction some nurses found in forming relationships with various Aboriginal people was an important factor in their desire to remain at Warburton. Through these relationships these nurses had gained knowledge of people's customs and beliefs about health and ill health as well as established a rapport with clients.

Satisfaction for several nurses was seen as the opportunity to make independent decisions about client care. These nurses felt that there was less interference in their practice from supervisors or other bureaucratic structures. Enjoyment of the geographic environment and friendships with members of the community were other positive factors in a nurse's decisions to stay. A few nurses experienced satisfaction

from the different lifestyle and in the use of self-reliance. A nurse expressed this satisfaction as follows:

Well half the satisfaction for me is actually being here and with photography and things like that, the landscape and the total difference from the city which is something I wanted. For me remote area nursing is like the pinnacle of nursing. It is all the autonomy and responsibility. It is everything I thought I wanted. It is self-reliance and that's the fulfilling part I find about remote area nursing.

Some nurses experienced most work satisfaction in managing acute care situations. In contrast, the recurrent demands and similarity of minor or non-acute ailments of clients as seen repeatedly every day in the clinic were often described by nurses as 'tedious' and/or 'mundane work'. This perception seemed to relate to a low morale and thoughts of resignation, as revealed in this nurse's remark:

I guess I'm getting to the stage where I'm thinking of leaving. I look on all these things and sort of yearn for something dramatic because the every day wear and tear of scabies and boring things like that they [clients with those problems] don't really need to be walking through the door. But its never ending. Its almost easier to deal with an emergency where you are doing a good thing and you finish it and the person gets better.

Nurses who contemplated resigning often felt discouraged from the clinic workload and the lack of staff continuity. The stress of frequently being on call, together with the feelings of uncertainty where unpredictable problems could arise at any time and recurrent frustration from the barriers to effective nursing practice, were major sources of dissatisfaction. These problems were nominated by this nurse as a reason for her resignation:

One of the main reasons I've decided to resign is the on call. You just don't know what is going on out there, and especially at night when you are on your own. I mean it could be anybody going right off and you have got nobody there to help you. You are it, and that's what worries me. And it's such frustrating nursing.

In addition, being unpaid for the hours of overtime contributed to several nurses finding alternative employment where they believed they would be better paid and valued. As one of these nurses stated:

I've decided to resign. I did consider applying for a permanent position but I feel frustrated with the lack of communication. I also feel dissatisfied with the prospect of every second week on call and no overtime paid. I've contacted a friend in the Northern Territory who told me there is a position [available] at G_____ (name of community). Conditions are better there, pay-wise at least.

Nurses feelings of being devalued were associated with a lack of organisational acknowledgment of their workload or recognition of the problems for nursing practice. Furthermore, these feelings were reinforced by a lack of remuneration for all the hours and days of overtime they worked. Ultimately, however, several nurses concluded that the stress of on call and overtime work could not be compensated for by pay alone or mere acknowledgment of their conditions. These feelings were explained by a nurse as follows:

There doesn't seem to be any appreciation from the community or any understanding from the employer of the hours that you are doing that are on call. At least if you got paid for it you would feel that the employer is recognising the skill and recognising that you deserve to be paid for the health care that you are giving out. But here it is like you are just being taken for granted. Its like you are just a nurse. You should do this...So that's one thing, the pay. And the other thing, even if you are getting paid for the overtime there is still this constant overtime that gets you down. And in the end even the money is not enough. Nothing is enough to keep me here.

There was also a sense of futility in staying when nurses observed that colleagues had been criticised by others following their departure. The criticisms described were based on the individual personality or the supposed personal problems of a nurse. These nurses felt that they did not want to be maligned by such judgements. A nurse, explaining this aspect of staff relationships, added:

I remember feeling like a bad little girl when she [a manager] said to me, 'Most remote area nurses are negative. They've got a problem They must be running away from something'.

First impressions, as well as how each nurse viewed the sanctioning of practices not usual to nursing standards, appeared to be a factor in their decision to stay or to leave the position. For example, a nurse who had refused to compromise her practice and the rights of clients to safe care as she perceived it had promptly resigned within two days of her arrival. The nurse stated:

I'm told its different out here. Why is it different? I have my standards of nursing and I am not prepared to change that in order to stay here. With these people there is an even greater responsibility to give a proper standard of care because they don't know their rights.

Another nurse, two months after his appointment, decided to leave and reconsider whether to return to remote area nursing. The reason expressed was a lack of knowledge and abilities required to practise legitimately in a remote area. The nurse also believed that from a moral point of view a misrepresentation of self to clients could not continue. This was how the nurse described these feelings:

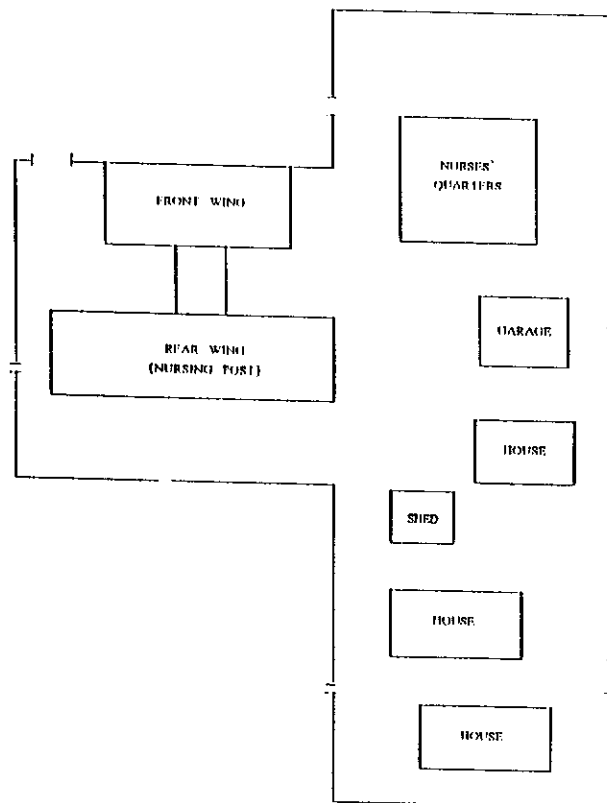
For me it is the moral responsibilities that make me question myself here. I know that I am not qualified to do these things, but I do them. It's not right that because people are unaware of their rights and of my lack of knowledge that this is allowed to happen. It is the moral, ethical and legal questions that have led me to decide I will go away and think about whether I will return. It will be better to do that when I am away from here.

The nursing staff turnover was influenced by factors pertaining to the nurses' experience at their entry into remote area nursing and to their subsequent job satisfaction. For a few nurses the moral dilemmas were the main factor contributing to their resignation. The conditions of nurses' employment within the remote area practice milieu were also an important factor in their job satisfaction and in the delivery of nursing care.

Conditions of work

An essential feature of the practice milieu is the organisational conditions of work for nurses. In the remote area this included the arrangement of nurses' accommodation as well as their place of work at the nursing post and the features of their work environment. The nurses' accommodation and the nursing post were located adjacent to each other to form a compound (Figure 5.2, below). The yard around this area was surrounded by a high cyclone wire fence with 3 strands of barbed wire at the top, apart from the front section of the nursing post that opened onto the roadway. Gates into the yard provided access for pedestrian and vehicle entry. The maintenance worker usually pad-locked the main gates overnight. I overheard a community staff member, who was escorting a group of visitors around the enclosure, state to them, 'This is the nurses' domain'

Figure 5.2: Warburton nursing post compound
(not to scale)



Layout of the Warburton nursing post and nurses' accommodation. The outer lines and gaps represent the fence and gateways surrounding the grounds of the nursing post compound.

The nurses' accommodation

The nurses' accommodation consisted of a six small single bedroom nurses' quarters and three houses. One house was occupied by the Facilities Co-ordinator. The accommodation was equipped with essential furniture and cooking utensils. The nurses' quarters had a large dining/living room, a small narrow kitchen, laundry and two bathrooms (showers only).

The nurses' quarters was also used to accommodate any visiting health personnel. The Facilities Co-ordinator was responsible for preparing their rooms and for providing meals. The health service charged \$50 per person per night for visitor's accommodation. The most regular overnight visitors were the RFDS pilots and medical practitioners who came to Warburton each fortnight. These visitors were usually well accepted by most nurses for their social support. For periods up to five days all rooms in the nurses' quarters were occupied. The presence of visitors, however, always intruded on the privacy and hospitality of the resident nurses. The nurses' quarters were often referred to as 'visitors quarters'.

A feature of the practice milieu was the immediate availability and accessibility of nurses at their place of residence. Each nurses' residence had an outside red light which was usually switched on after hours to indicate the location of the nurse on call. One group of nurses, however, detested the 'red light' and its connotations of advertising their availability and refused to use it. Instead, these nurses had used a notice at the front entrance to the nursing post to inform clients.

A buzzer button, located beside each gate nearest the residences, was switched on inside the premises by the nurse who was on call. In the nurses' quarters, a buzzer was installed on the ceiling above the head of each bed. A switchboard on the living room wall enabled the buzzer to be switched through to the bedroom. Often I observed nurses to jerk at the sudden penetration of quietness by the harsh grating ring of the buzzer. At such a time a nurse remarked, 'I hate that sound. I jump

whenever it rings over my bed'. Perhaps unaware of the impact of the buzzer to the occupant nurses (and sometimes their families), clients often continued to, or repeatedly, pressed the buzzer until a nurse appeared.

Nurses often experienced inconvenience in the lack of separation between work and private life. This problem appeared to be aggravated by the proximity of the nurses' residence to the nursing post. The repeated interruptions and invasions of private time by client demands contributed to nurses feeling frustrated from a perceived lack of freedom to move about unobserved even in their home-life. Several nurses likened these feelings to an imprisonment. This was illustrated in the following observation:

Wednesday 12.30 pm. It is lunchtime and the nurse, returning to the nurses' quarters, decides to sit out in the fresh air to relax. She takes out a cloth to sit on and a book to read. After 5 minutes a client calls out to her from the fence. The nurse looks up from her book, then explains to the client, 'It is lunchtime and the clinic will re-open at 2 pm'. The person leaves. A short while later another person walking along the roadway sees the nurse and comes over to her seeking attention. Again the nurse states when the clinic will be open. The client remains standing expectantly. The nurse stands up and, gathering up her book and the cloth without further comment, walks back into the nurses quarters. She throws the cloth on the couch. In a tone of exasperation the nurse states, 'I think I have made a mistake coming out here. I think I'll go fruit picking. I wanted to do some painting while I am here, but people don't leave you alone'. Then, beginning to walk across the room, the nurse declares, 'I'm going back to my cubicle. I feel like I am in prison'.

Sometimes nurses who were 'off duty' drew their window blinds during the day so that they were not visible to passers by. These nurses concluded that if they were unseen, then other people were less likely to call upon them for attention. The following is an example of the restraint experienced by nurses from feeling constantly observed:

A nurse's 13 year old son is staying with her in the nurses' quarters. On returning to the residence at lunchtime the nurse finds her son reading in his room with the blinds drawn. The nurse asks him why he has done this. Her son explains, 'People keep looking at me through the window'. In the evening the nurse further explains her feelings to me and states, 'It's a big adjustment putting up with these invasions of

your own private time and place when you are not used to it. Like people walking around the nurses' quarters and looking in the windows and being constantly watched.

The institutional arrangements for nurses' accommodation in the remote area also contributed to these nurses feeling that they were never completely off duty and that their time was not valued by others. This perception was portrayed by the nurses' comments below :

- February 1996, Monday 7.30 pm. A nurse describes her feelings about the relationship between accommodation and the clients use of the nurse's time. She explains, 'All the time you feel like you are actually on duty because there is always somebody asking you something. People even come to the nurses' quarters all the time, sometimes asking for things that are totally unreasonable like coming in on a Saturday afternoon and asking if you would mind driving them 300 kilometres up the road so that they can go to a football match and those sort of things'.
- November 1995, Wednesday 6 pm The nurse leaves the clinic and returns to the nurses' quarters. She changes her clothes then goes out saying, 'I'm off for a walk'. As she walks out the door the nurse notices two clients who have walked up to the front door of the nursing post. They immediately sight the nurse and call out, 'Sister!' and beckon for her to come over to them. The nurse calls back, 'The clinic is closed. I'm going for a walk and will be back in half an hour'. She then turns and continues on her way, not waiting for a reply. The clients then sit down on the front steps to await her return. As she returns from her walk the nurse sees that the couple are still there. They watch the nurse as she walks back towards the nurses' quarters. I asked the nurse to explain how she felt about this situation. The nurse's reply was, 'When you are just about to start off on your afternoon walk and you see someone waiting at the clinic and you know they will still be there when you get back you feel there isn't much understanding of the hours you do on call. Its like you are being taken-for-granted.

Personal security, especially at night, was a recurrent problem for nurses in their practice environment. The maintenance officer at the nursing post also acted as a security officer and often played an important but unobtrusive role in curbing the

harassment of nurses or threats to property. Nevertheless, nurses usually walked alone at night when they left their residence to attend a call out.

Outdoor lights were placed at several vantage points to illuminate pathways around the nurses' accommodation and the nursing post at night. Some sections of the footpaths, however, were overshadowed by a hedge or parts of the buildings. The main door was secured by a bolt inside the door. When a nurse, or anyone else staying in the nurses' quarters, went out at any time the door remained unlocked so that they could re-enter. This, and without a telephone to contact other nurses or be contacted by another nurse for assistance, presented additional difficulties and sometimes potential risks for a nurse. The following observation illustrated this point:

Thursday 10.15 pm. A client presses the buzzer for the nurse on call. The nurse goes out leaving the door unlocked behind her. There is no key to lock the door. At 11 pm the nurse has not returned. Suddenly shouting is heard nearby and a thumping sound of a structure being hit by a heavy object followed by a crashing sound of something breaking. From the open doorway I then see a young man climb over the fence. He approaches a health service vehicle that is parked next to the nurses' quarters and smashes the right side front window with a long thin object. The man then walks out of view to the other side of the building. There is no telephone in the nurses' quarters to check if the nurse at the clinic needs assistance or to warn her about this man who is walking around the grounds.

These problems, as well as several other incidents of trespassing were reported by nurses to a manager of the health service who gave verbal assurances that action would be taken to install a lock and key. In one year, however, a new lock was not fitted.

A further ramification of this situation for obtaining emergency assistance was observed in this example:

Saturday 11 am. A man had been assaulted with an axe during a fight outside the store entrance. The deep laceration that penetrated to the tibia had severed an artery. The store keeper frantically called the clinic telephone number, but there was no response. He had assumed this telephone was connected through to the nurses' quarters. The man's

condition was rapidly deteriorating, so the store-keeper ran up to the nursing post in search of a nurse. A store assistant, who had once trained as an enrolled nurse, acted quickly to arrest the haemorrhage until the nurse arrived.

The store-keeper later reported the problem to the community authorities and informed the health service manager. No further action was taken.

Nurses' quarters were aptly named, the quarters being a place for nurses to live-in temporarily and be available to be summoned for duty. The nurses' accommodation was beside the nursing post; the nurses' place of work which was another important element of the practice milieu.

Place of work

The nursing post was the main place of work for nurses. The physical layout of this large building comprised two sections: the front wing facing the road and a parallel rear wing (Figure 5.3, overleaf). These two sections were joined by a covered walkway. Each wing had a wide verandah on either side. Three ramps and steps enabled access to the verandah. Large evaporative air coolers were suspended from the beams under the wide verandahs that surrounded the nursing post. These coolers provided effective air-conditioning in each room during the hot dry summer months.

The size of the nursing post and allocation of the rooms contributed to nurses unavoidably traversing long distances between the two wings. For example, for a nurse to observe a client in the ward at the rear wing and continue to see clients in the front wing, or to answer telephone calls in the office, meant frequently walking back and forth across the walkway.

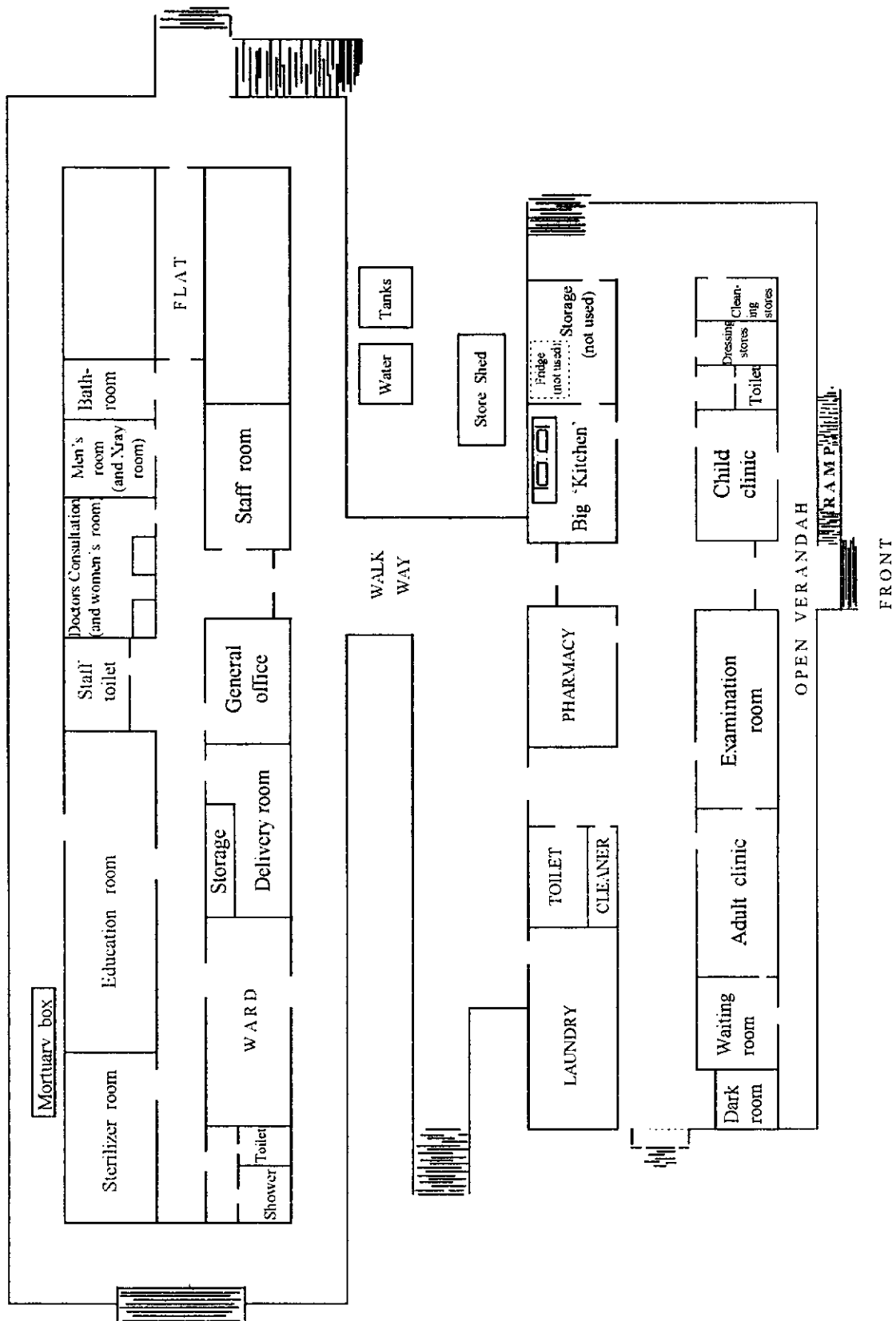


Figure 5.3: Warburton nursing post floor plan (not to scale)
 Outline of Warburton nursing post and surrounding verandah. Rooms are labelled according to use.

The large size of the nursing post, with its aging floor coverings and many surfaces that gathered copious red dust in the desert environment, also resulted in extensive cleaning being required. The daily cleaning was usually undertaken early each week-day by the Facilities Co-ordinator and, when available, women were employed as cleaners by the community office. Several nurses perceived that adequate cleaning was difficult to maintain, as the following comments portray:

- We are not in a clean environment. You have got red dust that comes in everywhere, even if the windows are closed. There are dogs walking around and coming into the clinic.
- The clinic is filthy. There is dust everywhere, old papers lying around and the benches are rarely cleaned properly. I find it hard to work in this environment. I'd like to change it as it sets the standard of care and sets an example that hygiene is basic to health.

Some other nurses, however, did not question a need for a clean and orderly work environment as an aspect of care and did not perceive this as a problem. Furthermore, the frequent turnover of nursing staff meant that changes made for the hygiene of the clinic by one group of nurses were often not continued by a subsequent group.

The physical layout and facilities of the nursing post were factors influencing the daily activities of nurses, such as the four bed ward facility (Figure 5.4, overleaf). In addition, the nurses' conditions of work were also an aspect of the practice milieu that impacted on the manner of care they provided.

Features of work conditions

Working conditions in the remote area were featured in the work-time for nurses, the organisational expectations and the management of nursing at the nursing post. On call and overtime was a standard condition of work in remote area nursing. The organisational expectations were that nurses themselves managed the nursing post

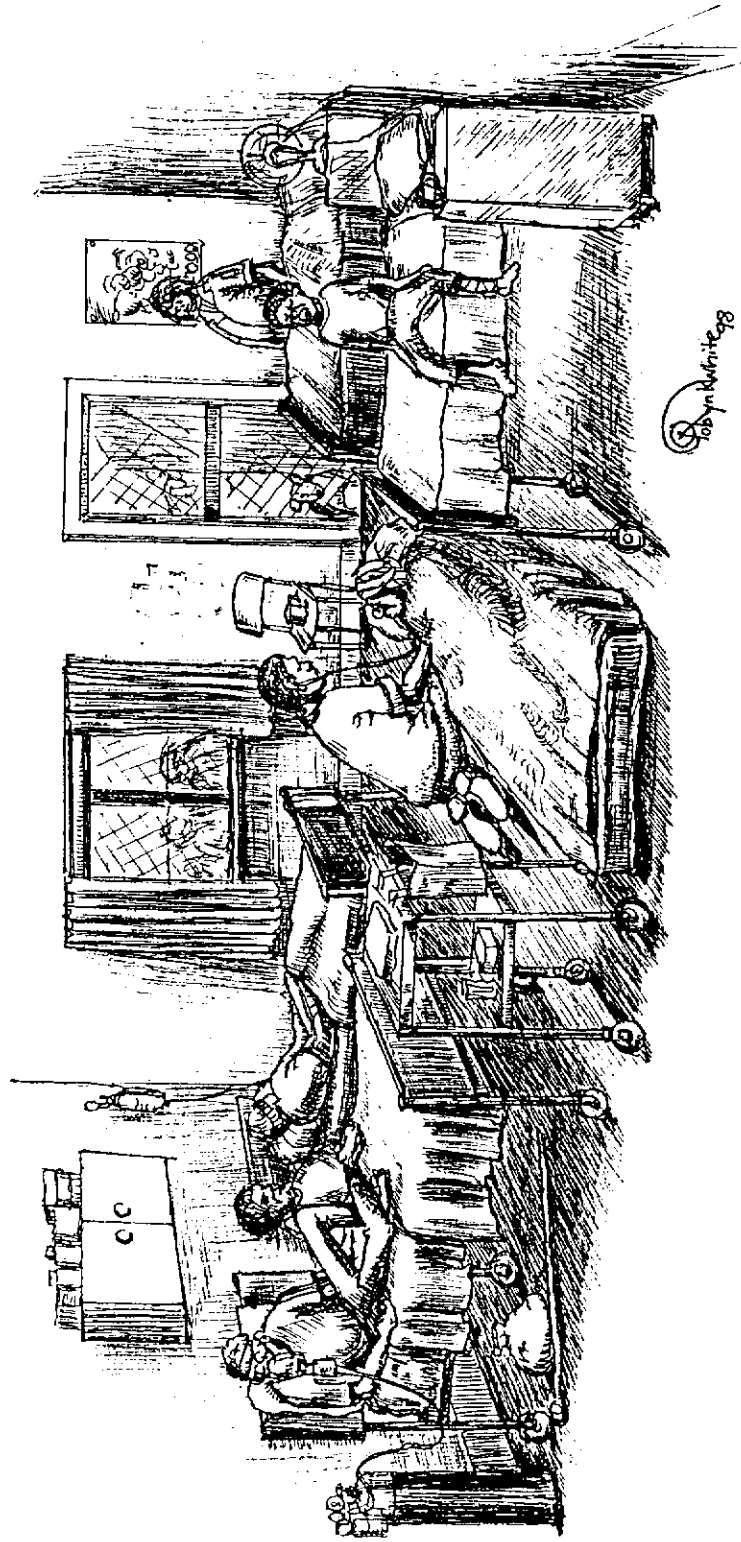


Figure 5.4: Ward scene on a busy day
(Drawing : Robyn K. White)

and client care. The organisational policies available, however, offered limited guidance for nurses in their practice.

On call roster

Nurses' regular hours of work were Monday to Friday from 8.30 am to 5 pm. Outside of these hours, that is overnight, weekends and public holidays, one nurse was always rostered on call. The remote area nurse's job description did not clearly state that a nurse was expected to be on call and to work after hours. The only reference to the availability requirement stated that the nurse was 'to provide emergency care when required and be available for consultation in the community' (Appendix 14).

The nurse in charge usually prepared a roster for the rotation of nurses on call. For a period of five months three experienced Aboriginal health workers were employed and, when available, they had also been rostered for a turn on call. A nurse was then nominated as 'second on call' to provide assistance to the Aboriginal health worker if requested. Under the West Australian Aboriginal Medical Service Employees' Award, No. A 26 of 1987, Aboriginal health workers were paid for the overtime hours worked. They were, therefore, expected to submit after hours time-sheets to the manager's office.

The time on call was usually shared by nurses. The length of time on call for any one nurse, however, fluctuated according to the number of nurses available as well as the turnover of nursing staff. For example, when there were only two nurses and one of these left on sick leave for five weeks the other nurse was required to be on call continuously.

On call and overtime

Being on call meant that the nurse was directly accessible by clients (as described previously in this chapter). They were also available to continue any ongoing client

care as needed. It was usual for a nurse to be called out after normal work hours. On several weekends nurses had worked up to 28 hours of overtime.

Under the West Australian Nurses' (Aboriginal Medical Services) Award No. A23, 1987, Section 26, nurses were not remunerated for the hours of overtime worked. Instead, nurses were paid a 'Nursing Outpost - Availability Allowance' totalling \$56.10 per week plus granted one week special leave every three months. In 1996, Section 26 was changed. The nurses at Warburton, classed as a three nurse post in the Award, then received 12 ½% of their annual basic wage plus the special leave as an 'Availability Allowance'. Nurses who complained to the employer about the hours of overtime they worked were informed to 'take time off in lieu' (of overtime). But, as a nurse commented:

How can we take time off for all the [overtime] hours we work? The work doesn't stop. It just leaves the clinic short staffed and other nurses need time out too.

The attitude that 'overtime is part of the job' communicated how normal it was seen for remote area nurses to work any hours and was, therefore, beyond question. This viewpoint extended to others as well, as shown in the following example:

A visitor to the community, working with a one million dollar mining exploration venture, engages in conversation with a nurse. 'What is it like nursing here?' he asks. The nurse in her reply states, 'There is a lot of on call and there is no additional pay for it'. 'Oh well,' the man remarks as if to console her, 'You are the nurse. It's good experience'. Still mulling over this response, the nurse later verbalises her thoughts, 'It's okay for nurses to work overtime without pay. I bet he wouldn't do it. It's as if you do it out of the goodness of your heart when you are a nurse.'

Either subtly or openly, clients also exerted pressure on nurses to meet their needs during after work hours, as seen in this example:

A man comes to the nurses' residence at 6 pm saying that he has 'chest pain'. The nurse had seen the man a week ago with a similar complaint that was diagnosed as indigestion and effectively treated

with Mylanta. 'The clinic has been open all day', replies the nurse, 'Why didn't you come then? This is not urgent' The client then retorts, 'I could die and it will be your fault'. After a further comment by the nurse, the man raises his voice saying, 'I'm angry. I will burn down the clinic'. The nurse then tactfully diverts the conversation to talk about an event with bush turkeys that he had once shared with the client. The client calms down and after a short while goes away.

Being on call in the practice milieu of a remote area also had additional meanings to attending call outs from clients. Frequently a nurse's care of a client that began during work time continued beyond these hours. For example, a client who was first seen by the nurse in the late afternoon and required several hours of care:

Friday 4.30 pm. A nurse is in the staff room completing client records. A woman comes to the doorway. The nurse looks up and notices the woman's appearance as unusual and that the woman behaves slightly agitated. The woman then says, 'I'm going to have a fit'. The nurse immediately goes to the woman and, taking her arm, escorts her to a bed for the woman to lie down. The nurse observes that there is twitching of the extremities and facial muscles. The husband arrives. He informs the nurse that the woman has not taken her medication (Dilantin 300 mg daily) for three days. The nurse administers intravenous Valium according to the Standard Treatment Manual, then takes the woman's vital signs. Another nurse is requested to stay with the woman while the nurse goes out to the office to telephone the medical practitioner. The doctor orders the nurse to observe the woman for one hour, then give her the usual dose of oral Dilantin. Valium 10 mg. is to be repeated if necessary. The nurse notes that focal twitching continues intermittently. After one hour the woman is able to take the Dilantin capsules and oral Valium 10 mg. The nurse continues observations while the client, who is now drowsy and relaxed, dozes. At 7.15 pm no further twitching has been observed for one hour and the woman is awake. The nurse then discharges the client into the care of her husband to be driven home. The nurse invites them to return at any time if they have any concerns. The nurse then completes the client's record and clears up the clinic. It is now 8 pm.

Another aspect of overtime involved continuity of care arising from treatment regimes initiated by a nurse, a medical practitioner or as part of a hospital discharge plan. The following examples typify such situations:

- A woman on daily intramuscular Ceftriaxone ordered by a medical practitioner.
- A child discharged from hospital with orders to have daily post-operative dressings.
- Two women having Ventolin nebulisers twice daily.

Most nurses stated that being on call and overtime work were the most stressful aspects of remote area nursing. Both beginning and experienced nurses often related this stress to their feelings of tension and uncertainty in not knowing what to expect if and/or when they were called out alone, especially at night. Nurses often experienced feelings of tension when on call from an inability to completely relax. This was evident in a nurse's reaction to the sight or sound of someone approaching the residence who seemed likely to be seeking their attention. For example, as seen in the following observation:

Wednesday, 9.30 pm. The nurse who is on call sits in the living room reading a magazine. The nurse will not go to bed until after 11 pm. That is a time when clients are known to often call. So the nurse avoids the possibility of that sleep disturbance. In the distance the sound of a car engine is heard. The chugging of the engine becomes louder as the vehicle slowly draws nearer to the nurses' quarters. The approaching headlights are visible through the window. The nurse stops reading and listens to the sound, as if expecting the lumbering car to come to a halt at the gate. 'I just hope it goes away', the nurse remarks. As the car gradually passes by the nurses' quarters there is a look of relief on the face of the nurse.

Following a call out at night, nurses often spoke about staying awake for hours. This was because they still felt concerned about the client's condition and their responsibilities for 'doing all they possibly can'.

Aboriginal health workers too, disliked being on call. One health worker explained how she was afraid of coming alone to the clinic at night. She feared the ghosts of those who had died at the nursing post and who the Ngaanyatjarra believed stalked the clinic during the night. The Aboriginal health worker also feared that someone might call her falsely to the clinic when it was deserted and try to harm her.

Sometimes nurses also felt ill at ease at night in the gloomy darkness of the nursing post. For example, a nurse who had been called out at 12.45 am had this to say:

Last night, while I was walking in the semi-darkness of the corridor from the storeroom, I heard footsteps behind me. I thought of the spirits and prayed for protection.

Nurses were sometimes harassed by youths from the community when going out alone at night in answer to a call. For example, late one night a group of teenage boys rang the buzzer. When the nurse went out they called to her, 'Get out here and do your job'. Another example illustrated the vulnerability of a nurse to serious harassment:

A nurse had been called out at 1.30 am. After the clients had departed together in a car, the nurse walked back to the residence. As she entered the yard and approached the door she heard a male voice call out, 'Sister!'. The nurse asked, 'Who is it?' Again the voice called, 'Sister!' The nurse could not see anyone and, feeling apprehensive, repeated, 'Who is it?' She then saw a young man walking from the direction of the women's centre toward the nurses' quarters fence. The nurse walked part way toward the fence. The youth said his name then asked, 'Sister, will you have sex with me?' The nurse replied, 'I don't think so', and quickly retreated into the nurses' quarters. Once inside, the nurse said she felt shaken and the harassment 'has made me feel creepy'.

The practice milieu in the remote area was notable for a lack of demarcation between private life and public workplace and between work, on call and time off duty. Within such an environment, nurses expressed feelings of:

- as if work is your life
- you live on the job
- time is not your own
- its a way of life out here

The job description also, implied a non-separation of work and time off. It was stipulated that nurses:

Demonstrate the ability to live and work in a remote area, this includes personal adaptation to isolated living in a different culture and the ability to work with the management style practiced (sic) in the community (Appendix 14).

Nevertheless, with such an erratic work pattern nurses tended to neglect their personal health, as seen in the following example:

Sunday, 8.30 pm. The nurse has just finished a cold dinner of yoghurt and cereal and the buzzer rings. 'I've been called out so many times today', she exclaims, 'I have not been able to finish a cup of coffee or have a meal uninterrupted or even take time for a shower'.

Reflections on this way of living and working evoked the depths of feeling. With tears in her eyes one nurse stated, 'This nursing makes me feel totally consumed'. In a similar vein, the following quotes were also expressed:

- I'm so tired. I feel as if the blood is being sucked out of me.
- I feel so tired. Last night I couldn't sleep. I felt like curling up in a little shell or crying for hours. I can't take it. There is no back-up. If I wasn't leaving in six weeks I don't know how I could carry on.

Coupled to these conditions of work in the remote area, nurses tried to rely on each other to make life easier. Hence the nature of relationships between staff was paramount.

Staff relationships

In situations where nurses worked co-operatively with their colleagues they communicated frequently, shared in the day to day workload and supported each other by helping out in situations when additional assistance was needed. Conflicts occurred between nurses when, for example, there was a lack of communication or a nurse was seen by a colleague to habitually leave work unfinished. The following example illustrated this problem:

Thursday 11.30 pm. A male client presents to a nurse who is on call. The nurse has no prior knowledge of this client. On checking his record the nurse discovers that he has suspected peritonitis and had

been administered Pethidine by another nurse following a medical order in the afternoon. The nurse then remarks, 'F___ (the other nurse) didn't bother to give me any handover or even tell me about this man'.

Gender relations were also seen to be a factor in staff relationships. A pattern was observed where in often subtle ways a male nurse or nurses tended to undermine their female colleagues and sometimes excluded them from their activities or discussions.

An Aboriginal health worker also felt excluded by these nurses and had this to say:

I don't know about these two nurses (referring to two male nurses). They are together all the time. They don't discuss anything with anyone else [at the nursing post]. They are now going together to discuss L___ and B___ (two clients who had been involved in a fight) with Y___ (a community leader). There was no need for them to get involved.

Staff meetings were held intermittently at the nursing post to discuss issues pertaining to their work. In addition, most nurses were invited to attend meetings that were arranged by the Staff Development Officer for nurses employed on the Ngaanyatjarra Lands. These meetings were held approximately every two months. Despite the problems of staff relationships, nurses somehow managed to maintain an appearance of harmony.

Organisational expectations

An important feature of the nurses' work conditions in the remote area was the organisational expectations of nurses. From an organisational perspective, the nurse was responsible for 'running the clinic'. According to a manager of the organisation:

Nurses' work includes primary health care, first aid and maintaining health programs...I mean programs can differ for the simple reason that not every community is the same. Their needs are not the same and after the main programs that we do - we insist on the nought to five, the STD [Sexually Transmitted Diseases], diabetics, the immunisation program. It's up to the nurse to see what problem is in their community and (to) set programs to fit that community. But where the clinic is concerned we have certain statistics that they have got to keep, certain ways they have got to keep them.

The organisational manager expected nurses to consult the Staff Development Officer or RFDS medical officers for advice about problems in their clinical practice, but in the final analysis, how the clinic was managed depended on the abilities and discretion of the nurses. In the view of a health service manager, the main role of the Staff Development Officer was the education of Aboriginal health workers. The orientation of nurses was seen, ideally, as the responsibility of the nurse who was handing over to an incoming nurse. This was stated as follows:

The role of the Staff Development Officer is health worker training. Yes, that is one of his duties, and also peer support for his nurses. But the health worker training needs to have more put into it [than has previously been done]...He [the Staff Development Officer] needn't take part in the orientation of nurses. The ultimate is that the outgoing nurse orientates the ingoing nurse. And sometimes that can't happen with the shortage of staff at the moment...but we usually send a nurse where there is an experienced nurse for orientation.

Nurses frequently expressed the view that the organisation lacked planned goals for the service and that individual efforts to improve the service were not sustained. This viewpoint was stated by a nurse in these terms:

There are no long term plans for the place, or even what happens today. Nobody is concerned about what happens tomorrow. Some nurses try to make inroads into these issues, but if they are only here a short time their work goes down the drain when somebody else [another nurse] turns up.

Organisational policies that related to the expected practice of nurses were found in the Policy and Protocol Manual prepared by a Staff Development Officer. These written policies covered a limited range of responsibilities pertaining to the nurse's employment, such as maintenance of clinic equipment and vehicles and the storage and ordering of drugs. Adherence to these policies, however, was generally unchecked by the organisation.

Other policies implied that a nurse employed by the health service was expected to take exceptional responsibilities. No educational preparation was offered to acquire the knowledge and skills required to perform these functions. For example, the policy statement regarding emergency equipment was, 'Emergency equipment will be supplied to each clinic and staff must familiarise themselves with the placement and usage of all such equipment'. Another policy stated, 'A blood test for HIV (Human Immunodeficiency Virus) will be offered to all clients in an "at risk" group and clients who request the test and all ante-nates'. Clients were to 'receive adequate pre-test counselling'. An outline of the HIV/AIDS National Counselling guidelines was included. Only one nurse who was at Warburton during the year of fieldwork had any previous training or experience in HIV testing.

Another policy required nurses to 'adhere to the policies, protocols and procedures' as described in the 'standard treatment manuals' listed. These included the Central Australian Rural Practitioners' Association (1994) Standard Treatment Manual (hereafter referred to as CARPA Manual) and the Minyma Kutju Tjukurpa Women's Business Manual (Congress Alukura & Nganampa Health Council 1994). The exception stated was, 'unless advised otherwise by Health Service Management or a Medical Officer'. The purpose of this policy was, 'to promote continuity and consistency in client care and provide guidance and legal protection for staff members'. Reference to 'legal protection' was, in fact, misleading for nurses. Furthermore, there was no written medical authorisation available for the nurses use of Schedule 4 and 8 drugs that were nominated for treatments in the manuals.

In reference to competencies, the Policy and Procedure Manual stated that the nurse was required to, 'Inform the employer of nursing interventions requiring knowledge and skill beyond own level of competence'. Nevertheless, in one year I was not aware of any nurse who had informed the employer accordingly. Neither were these competencies observed to be checked by the employer.

Within the remote area practice milieu, conditions of work such as the work place and staff relationships, on call and organisational expectations were part of the framework in which nurses practised. The primary focus of nursing care, however, was the client population.

Remote area clients

The client population and their health needs are a central feature of the practice milieu of nursing. Furthermore, the characteristics of the client group has an influence on the nature of care required to be provided by nurses. A description of the remote area clients begins with an overview of the population served by nurses and the pattern of morbidity and mortality at Warburton. This is followed by the client's perception of care and carers.

The client population consisted of all who utilised the Warburton nursing post. This included the permanent and temporary residents, transient visitors and travellers *en route* to other destinations. In addition, nurses routinely travelled to the outstation of Karilywarra in the Gibson Desert to conduct a clinic and occasionally visited other nearby outstations (Figure 5.5, overleaf). On occasions clients from these outstations also came into Warburton to be seen by a nurse. The population was composed of all age groups. The majority of clients were Aboriginal people, mainly Ngaanyatjarra, who comprised 86% of the population. The remaining 14% were mainly Caucasians (Table 3.1, p48). A major feature was the morbidity and mortality pattern of the Aboriginal population group.

Pattern of morbidity and mortality

Daily client attendance records revealed that attendance at the clinic averaged between 30 to 40 clients per week day, with additional attendance after hours and at weekends. The most common presenting health problems for adults pertained to muscular skeletal problems, respiratory diseases, skin disorders, renal tract infections,



Figure 5.5: A family group at an outstation

(Drawing : Robyn K. White)

diabetes mellitus and trauma. Young children most frequently presented for failure to thrive, acute respiratory tract infections, gastro-enteritis, pyrexia, skin infections, fitting, trauma and renal infections.

Children were disproportionately represented in evacuations by RFDS. In each year between 1990 and 1995, the 0 - 5 year age group accounted for more than half of the emergency evacuations to a regional hospital. This pattern, however, was not repeated in the year of field observations when 34% of evacuations were in the under 5 age group (Table 5.2, overleaf). Evacuations of these children were mainly for pneumonia and diarrhoea with dehydration. Adults were most frequently evacuated for trauma, acute respiratory infections, renal disease and diabetes related pathology.

All emergency evacuations of clients were with the RFDS aircraft due to the vast distance between Warburton and the regional hospital. In addition, all clients who were referred for specialist medical appointments were flown on the regular air service to Kalgoorlie and, in some cases, continued on by commercial flights to Perth. These referrals were generally made by the visiting RFDS medical practitioner. (Table 5.2, overleaf).

Mortality data were obtained from the Births and Deaths Record at the nursing post. These data showed a decline in the number of deaths annually in recent years. Community leaders attributed the reduction in mortality to the banning of alcohol and lead petrol in the Ngaanyatjarra Lands. In their view, many premature and unexpected deaths resulted from the abuse of these substances. In the year of fieldwork, one woman aged 35 died from trauma following a motor vehicle accident and a four month old child, born at 36 weeks gestation, died from failure to thrive.

In the five year period 1989-1994, there had been 38 deaths recorded for the Warburton population. All, but one of these deaths were Ngaanyatjarra people. The other death was a Caucasian male who was killed in a motor vehicle accident. Of

Table 5.2: Emergency evacuations and medical referrals
(Source: Warburton nursing post records)

WARBURTON NURSING POST
EMERGENCY EVACUATIONS AND MEDICAL REFERRALS
May 1995 - April 1996

<u>MONTH</u> (1995 -6)	<u>EMERGENCY EVACUATIONS</u> (Royal Flying Doctor Service)			<u>MEDICAL REFERRALS</u>		
	AGE GROUP	AGE GROUP	AGE GROUP	AGE GROUP	AGE GROUP	AGE GROUP
	0-5	6-16	ADULT	0-5	6-16	ADULT
MAY	-	-	3	1	-	4
JUNE	2	-	-	-	-	7
JULY	2	-	2	2	1	8
AUGUST	3	-	6	-	-	13
SEPTEMBER	6	-	3	-	-	8
OCTOBER	-	2	4	1	3	12
NOVEMBER	-	-	5	1	-	12
DECEMBER	1	-	3	-	2	8
JANUARY	1	1	3	2	-	8
FEBRUARY	3	-	-	1	-	11
MARCH	2	1	4	(not recorded)		
APRIL	3	1	6	-	-	7
TOTAL	23	5	39	8	6	98

these deaths, 22 were under 50 years of age. The highest cause of death in this time period was stated as 'petrol sniffing related illness'. Nine of these persons were aged between 19 and 32 years. (Table 5.3, overleaf).

Table 5.3: Causes of Death: Warburton Community (1989 - 1994)

(Source: Warburton Nursing Post records)

<u>WARBURTON COMMUNITY</u>			
<u>CAUSES OF DEATH</u>			
1989 - 1994			
AGE GROUP (in years)	CAUSES OF DEATH (as stated)	MALE n	FEMALE n
< 5	cerebral abnormality	1	
	pneumonia	1	
	pyogenic meningitis	1	
5 - 14	asthma	1	
15 - 25	petrol sniffing related illness	6	1
26 - 34	petrol sniffing related illness	2	
	trauma (motor vehicle accident)		1
	meningitis	1	
	ARDS/septicaemia/renal failure	1	
35 - 49	trauma (assault)	1	
	trauma (motor vehicle accident)	2	2
	alcohol related	1	
	leukaemia	1	
	(cause not stated)	1	1
50 - 65	cancer (not specified)		1
	cancer (liver)	1	
	diabetes related		1
> 65	diabetes related		1
	renal failure/pneumonia	1	
	renal failure		1
	'aged'	2	2
	cancer (not specified)	1	
	(cause not stated)	1	1
		24	14

The pattern of morbidity and mortality provided one aspect of the characteristics of the client population in the remote area. Another important aspect pertained to the clients' perception of care and carers within this setting.

Perception of care and carers

The clients perceptions of care and carers in the remote area community were revealed in their reasons for attending the clinic and in their expectations of carers. Additional insights into the clients perception were gained through observations of their interactions with nurses and in their stated satisfaction and/or dissatisfaction with the care received.

Clients generally expected a nurse to be available 24 hours a day, seven days a week, to attend to their needs and demands. As a group, people recognised that the after hours service was only available for serious health problems. Individually, however, adherence to this rule varied. Nurses were called out almost every evening or late at night even for non acute illnesses.

Clients themselves stated that they came to the clinic to 'see sister' and/or 'for medicine'. 'Medicine' included 'tablets', 'eye drops', 'cough medicine', 'rubbing medicine' and 'needles'. Often clients specifically requested these medications from a nurse, or sometimes an Aboriginal health worker. [The seeming popularity of western health care symbols of medicine, such as 'needles' and tablets, amongst non-Western groups has been reported in various research, both in Australia and overseas (Tonkinson 1974, Nathan & Japanangka 1983, Wyatt 1984, Etkin & Tan 1994, Whyte & van der Greef 1994).]

The extent of the belief that it was normal for a person to go to the clinic to obtain medicine was illustrated in Lesson 1 of the Ngaanyatjarra Language Learning Course. The first lesson included the following dialogue:

'Nyaakun?' ('What do you want?')
 'Medicinekurna'. ('I want medicine'.)
 'Pikatjarran?' ('Are you sick?')
 'Yuwa. Katapika'. ('Yes. I have a headache'.)

Not all clients expected only medicine. The general perception of clients was also that nurses were 'here to look after people', to 'fix up' their complaints and to 'treat sickness' (sometimes expressed as '*pika wiyalku*'. A literal meaning in future tense, is 'to finish a sickness'). An Aboriginal health worker attributed these perceptions of the nurses' role to clients previous experiences. In her words:

From early days nurses were helping people, going out giving tablets and getting people and following them up. 'It's their job', people came to think.

Such a perception of nurses' role often applied to Caucasian clients as well as to Aboriginal clients. If expectations were unmet some people became dissatisfied. Thus, nurses who were not seen to fulfil these expectations risked being labelled as a 'bad nurse'. The following statement by a long term resident portrayed this point of view:

People, white included, see you as doctors. When they don't feel that they have been helped they will come away and say, 'It's a bad nurse'. They expect you to know about everything.

In contrast, a 'good nurse' was one who was perceived by community members as tolerant and who was 'kind' and 'helped' people. An Aboriginal health worker, however, described a 'good nurse' as one who 'learns from people' and who 'works well with people'.

The most frequent attendances at the clinic were for treatment of minor disorders, chronic health problems and/or social support from a nurse. The clinic was also a place for community residents to visit in the course of their routine daily activities. The clinic seemed to provide a diversion for these clients. As an Aboriginal health worker commented, 'people often come for something to do'. A Ngaanyatjarra informant, who confirmed this view, added:

I don't come to the clinic unless I am very sick. Some people go to the clinic all the time.

This use of the clinic as 'something to do' was plausible. When other activities that attracted interest took place, such as preparation for a journey, card gambling games on a 'pay' day, an arrest by police or a public argument, fewer people tended to remain at the clinic. Another example was when a nurse organised a weekly session for women at the swimming pool. Women of all ages attended. A nurse who remained at the clinic observed that, at these times, 'the clinic was deserted'.

There also appeared to be a perception amongst clients that to obtain attention they needed to present with a complaint. Such clients came to the clinic almost daily with non-specific health problems, such as generalised muscular pains. Other adult clients who came to the clinic regularly had chronic illnesses, such as diabetes and respiratory diseases. These people usually came to obtain relief for their symptoms from a nurse.

A behavioural change sometimes appeared to be adopted by clients as they entered the clinic as if to invite the sympathetic attention of a nurse. For example, I observed women at other centres engaging in communal activity, such as arts and crafts, in a jovial manner. A short while later some of these women had assumed a plaintive demeanour when they were seen at the clinic interacting with a nurse.

When attending the clinic, clients usually expected to be seen promptly by a nurse and, at times, simultaneously. Their attitude tended to be impatient and demanding. The nurse was seen as a service provider - doing for the clients even basic things they could do for themselves. For example, demands from ambulant clients for a nurse or an Aboriginal health worker to provide transport to and from the clinic, to give towels for a bath or to get a facial tissue that was scarcely out of arms reach for the client. Some nurses and Aboriginal health workers voluntarily offered this assistance and thus reinforced an expectation for this form of service.

Often clients did not verbalise their problem to a nurse. Instead, with monosyllables, or anguished facial expressions and/or hand gestures to the general area of discomfort, for example, these clients seemed to assume that a nurse would or should

be able to discern the problem. This perception of a nurse's capabilities was evident in the following observation:

Saturday 11.30 am. A woman is waiting outside the clinic with her husband to see the nurse who is on call. The nurse arrives and invites the couple into the clinic where they sit down. The nurse stands before them. The woman looks down and away from the nurse. She moans as if in pain, pressing the palms of her outstretched hands against her abdomen. The nurse's persistent questions to the woman about this pain are ignored. 'How can I help you if you just won't speak to me?' exclaims the nurse. The husband then interjects and, in an exasperated tone of voice, turns to the nurse stating, 'S___ (his wife) has been coming here for two days. I'll burn down the clinic. You should know by looking. Doctors can tell just by looking'.

Clients also expected the nurse to be able to solve all kinds of problems when self-help ability was lacking. There appeared to be an assumption that nurses had additional avenues of communication or authority not available to them and could bring about a solution. This occurred even when the decision for an action had been taken by the client themselves as seen in this observation:

An elderly man had been admitted to a nursing home in Kalgoorlie for long term respite care at the request of his wife and family. Within one week his wife returned to the nurse, stating that her husband was homesick and she wanted the nurse to arrange for his return.

Often there appeared to be a total dependence on the nurse. Not only were health care needs met by a nurse, but there was an expectation that all other needs connected to the health event would be dealt with by a nurse as well. Nurses too often anticipated clients needs and acted accordingly. For example, when clients had medical appointments at the regional urban centre, nurses arranged with the community office to have their 'pays' ready to give to clients just prior to their departure. On the day of the RFDS medical clinic, nurses usually organised for clients to be collected in the health vehicle if they did not attend themselves. Generally Aboriginal health workers were assigned this task and presented with a list of names by a nurse. The more experienced health workers disliked this role because they felt that people were well

aware of the fortnightly medical visits and should make their own way to the clinic unless they had a disability. Clients were also often provided transport for what they called 'check up', such as when asked to attend the clinic during a screening program or a medical specialist's clinic.

Clients who perceived their problem to be significant, generally expected to be seen by a nurse rather than an Aboriginal health worker. This was confirmed by Aboriginal health workers. These health workers stated that when they saw clients in the clinic, a request was frequently made for them to get the nurse. Clients in the community also affirmed this perception. A senior man asserted that, 'When I feel sick I want to be seen by a professional nurse'.

There appeared to be a general acceptance by clients of the care provided by nurses. Acceptance of the care administered, however, did not necessarily imply that clients were satisfied. Dissatisfactions emerged when, in the client's perception, a nurse did not fulfil or acted contrary to their expectations.

Client dissatisfactions

Client dissatisfactions usually pertained to their perception of a nurse's inappropriate behaviour toward them or to a perceived lack of care as they expected it to be given. These dissatisfactions were interpreted from the comments made by clients and observations of their behaviour both during and following interactions with nurses.

Clients who believed that they had been given the 'wrong medicine' felt dissatisfied with their care. The medicine was often not taken and discarded after the client left the clinic. It also appeared that when clients viewed a medicine as no longer required, it was usually discarded. Partly used boxes or strips of antibiotics or analgesic tablets, for example, were observed lying on the ground outside various premises. A resident who was concerned about this disposal of unused medications, on one occasion gathered up a small cardboard boxful and incinerated them. One woman for whom the

safe storage of medications in the home was a problem, refused tablets that were offered to her by a nurse. The woman stated:

I don't want tablets. It is hard to keep them away from the children. I keep any tablets locked up in a room so that the children can't get them. Last week I saw children playing with scabies medicine. They had mixed it with water and it looked like milk. I was afraid the children would drink it, so I took it away from them.

Several clients recalled how they had doubts about the medication or advice they had been given by a nurse. While a few of these clients had made their doubts known to a nurse, others had carried the medicine away with them but had not consumed it. The following observation was an example:

A client with a chronic renal disease was given his dosette box filled with one week's supply of medications, He later found that one lot of white tablets were not identical to the white tablets he was familiar with as it had different markings. The client returned to a nurse who confirmed that these tablets were incorrect. The nurse then removed and discarded the tablets into a rubbish bin and replaced them with the tablets as had been prescribed.

The demand for medicine by most clients was viewed with scepticism by a few others who were more wary of medications. For example, in indignation at people's apparent desire for medicines and the nurses seeming readiness to dispense medications, a woman declared in the clinic for all those present to hear:

They are wanting for tablets to drug themselves. They are taking too many tablets, overdosing themselves for nothing. They are crazy for tablets.

Occasionally clients had refused a treatment or a medication when it appeared that they felt their problem had not been addressed satisfactorily by a nurse. In the following example, this dissatisfaction was conveyed in the client's unresponsive behaviour:

A 35 year old woman who is physically emaciated and subdued, presents at the clinic. She has a productive cough and a mild fever. The

woman had travelled from another community and was not known to the nurse. The nurse takes the woman's observations and, without further communication, decides that the woman has a respiratory tract infection and to treat her with intramuscular Penicillin. As the nurse approaches the bed where the woman is sitting, she asks the woman to position herself for an injection. The woman does not move or speak, but turns her face away from the nurse to indicate her refusal to have this treatment. The nurse then offers her Penicillin tablets which she accepts in her hand. Still without speaking, the woman then gets up and leaves the clinic.

Medical screening programs for Aboriginal clients (non Aboriginal clients were not included) that tended to take an aggressive approach, such as openly going house to house to locate clients for screening of sexually transmitted diseases, were sometimes resented. Several individuals who had been approached at their homes for a urine sample for a survey of chlamydia and gonorrhoea, for example, had protested to an Aboriginal health worker and a nurse who had been sent to 'round people up'. These clients objected to being asked in public for a specimen because, 'this does not happen to people in the city'. As well as the stigma of being seen as suspected of having a venereal disease, these clients had felt singled out, insulted and humiliated.

Clients also felt humiliated and rejected when they perceived that nurses seemed not to listen or to trivialise their problem or to undermine them in some way, especially when this occurred in the presence of onlookers. The following observation illustrated such a situation:

An elderly woman, just arrived at the clinic, approaches a nurse who is standing with another woman in the passage way. The nurse then says to her in a teasing manner, 'You again B_____! You are always wanting something. What is it this time?' The woman turns her head towards the wall, leans against it with her hand and looks displeased. The woman then remarks in Pitjantjatjara, '*Nyakunin painu? Nyuntu kulintja wiya*', and added, '*Kuntaringuna*'. (Why are you scolding me? You don't listen, or understand. I'm ashamed)

At times dissatisfaction was apparent when an intervention by a nurse or a medical practitioner had been viewed by a client with suspicion. The following observation depicted this viewpoint:

A six year old girl became unwell at school one afternoon and subsequently fitted repeatedly after she was brought to the clinic by an Aboriginal education worker. In the morning she had been brought by her mother to the medical clinic for a routine review of long term medication for seizures. Later, after visiting his daughter, the father told me, 'This morning she had been well and happy going to school. Then she was taken to see the doctor at the clinic. Now, after that she became sick. Maybe something happened there [at the clinic]'. The father insinuated that the sickness of his daughter had occurred because of something that had happened, or what someone (a nurse or a doctor) had done, at the clinic.

Client dissatisfactions and their expectations of care and the carers in the practice milieu of a remote area were closely linked to the relationships between nurse and client. The strength of these relationships was based upon mutual respect between nurse and client.

Nurse and client relationships

Nurses related to members of the community on both a personal and professional basis. In the remote area setting nurses and clients formed relationships that were not only confined to nurse-client interactions. One of the rewarding aspects of remote area nursing was that the nurse often entered into the lives of people in a closer encounter than merely a clinical relationship. Nurses who had shared mutual concerns with a family for a client's well being in times of an acute illness or trauma, for example, were often taken into their confidence. In these intimate relationships nurses could gain insights into Ngaanyatjarra beliefs and other aspects of their lives that were rarely shared with an outsider.

Individual nurses occasionally accompanied clients out to the bush to gather native fruits or to collect wood for making artefacts or when they participated in communal

activities. During such occasions nurses also became more aware of the Ngaanyatjarra people's character and of their life skills and intricate knowledge of the environment. Clients often sought out a nurse with whom they had established a rapport, especially for a private consultation. These clients were sometimes observed to wait in the background of a busy clinic to try and attract the attention of a particular nurse.

In the nurse/client relationship, clients appeared to trust a nurse by seeking and accepting their care interventions and by confiding in them. This, however, did not mean that a client always understood the reasons for a procedure or treatment, as shown in the anecdote below:

A woman, an Aboriginal education worker and I are seated on the verandah outside the clinic. The woman, who has walked from her house to the clinic, is perspiring. She states, '*Ngayulu pakuringkula. Pawun-pawunpana yirrami yurrarnyangka*'. (I've become tired. I am weak [a third person, a nurse] having collected the blood [samples]). Saying this, the woman stretches out both arms and then points to each of her inner elbows and finger tips to indicate that blood was taken from these sites. When asked why all these samples were taken, she replies with a shrug, '*Ngurrapana*' (usually taken to mean, 'I don't know'. Nevertheless, a more precise translation in this context is, 'I'm ignorant of this thing being talked about').

Furthermore, clients generally asked few, if any, questions of a nurse about the procedures or treatments used. A nurse expressed this vulnerability as follows:

It's very easy. I could take a sample of blood or a sample of urine and test someone's urine. I can do that without permission and without that person asking or knowing at all why I am doing it.

Some nurses considered that the clients' seemingly unquestioning trust in their capabilities was related to the clients' lack of knowledge of both the nurses' professional limitations and of their right to qualified and competent carers. Furthermore, most nurses and several Aboriginal health workers as well, felt that clients submitted to routine tests and screening programs, for example, because it was requested and not necessarily because they saw it as a benefit to themselves.

Nurses witnessed the social relationships of their clients everyday lives that were apart from the clinical practice situation. This familiarity with clients and their social circumstances provided the nurse with an opportunity to better understand the needs of the people they served. Familiarity and/or a desire for approval, however, also contributed to some nurses volunteering assistance to clients and being expected to give assistance in ways that were unrelated to the nursing role.

This aspect of the nurse - client relationship also appeared to contribute to a perception by clients that personal assistance was an available service. For example, some clients sought personal favours from the nurse to obtain access to the resources available at the nursing post, such as the use of the telephone for personal calls or for the nurse to provide transport in a health vehicle for social excursions. Sometimes a distinction between personal favours and nursing care appeared to overlap. For example, a request to stay in a bed at the nursing post 'for a rest' or a request for a nurse to provide a bath for an ambulant elderly client. Some nurses considered this assistance was part of their nursing role. Other nurses, however, were of the opinion that less reliance on the clinic and on the nurse was important to encourage client independence.

At social occasions in the community, nurses were still expected to be willing to discuss client problems. As a result most nurses felt that there was no escape from being always seen as the 'sister' in their relationships and, by implication, not being seen as an individual person. This was seen in the following example:

Attending church on a Sunday morning a nurse is immediately approached with a request to find out about a client's prescription glasses. Following the church service, as the nurse walks out the door, she is again approached to draw her attention to a woman who is seated on the ground beside the church and has obvious dyspnoea. 'I can't walk', she states. The nurse then responds by saying she will get the vehicle and take the woman to the clinic. Later that day the nurse exclaims, 'I can't even go to church on my day off without somebody wanting something from me. You are always the sister!'

The image of the nurse as a 'Sister', not a person, and always available to respond to client needs was confirmed by comments made by other members of staff in the community. These remarks were an illustration:

- People can't see you as anything (sic) other than a Sister.
- You are 24 hour open roadhouse. Whenever people want something, the nurse will be there. I really firmly believe that nurses who work in these areas lose any humanity they have as far as the community is concerned. They are not people. It is incredible that someone can't walk down the street without being the nurse. They can't go to the store without being the nurse, always on call. Even if it is a social gathering there is always somebody who will ask some health related question. They never ever ask the nurse. 'How are you?' ... You [the nurse] are always the Sister.

Most nurses seemed more inclined to go out of their way to help clients who they perceived as appreciative of their care, or as having genuine needs, or as influential in the community. On the other hand, there were clients who reacted in an anti-social manner toward nurses when they felt rejected or believed that not enough had been done for them and their felt needs were not met or their demands had been refused. Onlookers to these altercations were sometimes more objective. For example, when a woman was seen to be unreasonably demanding of a nurse who was busy in the clinic, she was remonstrated by another woman who stated:

They are not doing this proper way. They are not being fair to the Sisters.

The general effect of a show of frustration and/or anger, however, was for a nurse to comply with clients demands for attention. A perception amongst community members of the nurse as a constant care-giver often seemed to initiate tensions and conflict in the relationship between the nurse and clients.

Nurses too, provoked client annoyance unwittingly, such as when they were tactless in asserting their position or their limitations. This was observed in the following example:

A nurse, feeling harassed in the busy and crowded child clinic, spoke in a loud voice to a man walking through from the doorway. Addressing the man, the nurse stated, 'Don't come in this way. The adult clinic is

at the other end'. He replied, 'You can't talk to me this way'. The nurse insisted that he use the other entrance. The man then replied abruptly, 'You had better watch out!'

Intimidatory behaviour by clients included the use of disparagement, for example, 'You are not a good nurse', or 'That's what you are here for' or 'I will report you to ___' (name of an authority figure in the community). Verbal threats made in the hearing of nurses were to 'hit' a nurse or to damage the nursing post property, such as to 'smash' or 'burn the clinic' or 'smash the Toyota'. Infrequently, these threats were acted upon. Such threats, however, often provoked in nurses a feeling of guilt, or of irritation or of being offended and sometimes, of fear. For example, a woman who was frustrated at a nurse's refusal to comply with her request and the nurse's irritation was observed as follows:

Friday 11.30 am. A woman enters the adult clinic and demands that the nurse go [in the health vehicle] and get her adult son who has a 'sore foot'. The mother states he is unable to walk. The nurse refuses and adds, 'He can get here himself'. The woman then says to the nurse, 'That's what you are here for'. 'No I'm not' retorts the nurse. The woman apparently displeased with the nurse's refusal says, 'I will smash the Toyota and report you to the council office'. The nurse also annoyed by the request, replies, 'You do that'. The nurse in charge then enters the room and speaks with the woman. She explains to the woman, 'It is not the nurse's job to go and get people to come to the clinic'. The woman accepts this from the senior nurse and turns to apologise to the other nurse.

Nurse and client relationships were further strained when physical aggression was displayed by clients, such as when these clients felt that a nurse was impatient or their demand for attention was unheeded by a nurse. For example, outside the clinic, picking up a rock or a piece of wood as if intending to hit the nurse or actually throwing a rock at a nurse. The usual way nurses dealt with anti-social behaviour toward them was by denial, such as smoothing the conflict over or subsequently ignoring the behaviour. The following example was not an isolated incident:

Wednesday 11.15 am There is one nurse in the clinic. The adult clinic is crowded. Suddenly angry voices are heard outside the window. A

woman is standing on the ground below the verandah. She is holding a rock the size of a softball in her right hand as if ready to throw it towards the clinic. The woman yells out saying, 'I am sick and the nurse refused to come and get me.' She then hurls the rock at the window. It bounces off the security mesh that shields the window. Then the woman rushes up onto the verandah with a heavy digging pole and holding it up with both hands, tries to thrust it through the mesh against the window. Several woman call out for her to stop, while another woman locks the door between the waiting room and the clinic. The woman then enters the waiting room and batters the door and wall with the pole. Failing to gain entry the woman, still enraged and shouting abuse at the nurse, goes out and then lies down quietly on the verandah as if exhausted. Her sister gently takes the pole from her without resistance. The nurse then announces, 'We are closing the clinic. We cannot work with this aggressive behaviour.' The nurse continues to see the clients who remained inside the clinic. Twenty minutes later the woman gets up from the verandah. The door is opened by the nurse and the woman enters the clinic and sits down. The previous behaviour is not mentioned. The nurse proceeds to attend the woman as if nothing untoward has happened.

On one occasion nurses reported clients aggressive behaviour to a health service manager. This manager's response was to attribute the aggression and apparently unprovoked instances of verbal threat or threat with a weapon as, 'due to the seasonal changes and the beginning of the hot and windy weather'. She also added, it was her belief that when ceremonial activity was underway throughout the region 'people become uptight because no-one knows who will be grabbed' [for men's initiation]. Nurses were expected by management to report any problems in the community, or in their community relationships, to the Community Development Advisor. On several occasions when there had been a series of incidents a nurse in charge had discussed these problems with the Community Development Advisor. The nurse was not informed, however, of any subsequent action being taken. This nurse also made requests to individual community leaders, most of whom were willing for her to attend a community meeting, to discuss issues of nurse-community relations. Nevertheless an invitation was not received. The nurse had assumed an invitation was required. [It was a condition of employment in the community as stated in a memorandum issued from the Ngaanyatjarra Council head office, dated 25 March

1996, that, ‘Staff do not attend Community meetings unless specifically requested by the Community Development Advisor or Chairman’.]

The dimensions of responsibility that clients could attribute to a nurse was implied in the extent to which a nurse could be blamed in the community for an adverse or fatal outcome associated with the care given. An informant who had lived in Warburton for many years described several situations in which a nurse had been blamed for an adverse outcome or a death that had occurred to a community member. None of these situations had been dealt with formally. He added, ‘however, people do not generally continue to hold a grudge against the nurse’.

These different aspects of the client-nurse relationship in the remote area practice milieu impacted either positively or negatively on the nurses emotions as well as on their nursing performance. An additional factor shaping nursing care in this context was the availability of resources for practice in the remote area.

Material resources for practice

The material resources available to the nurse at the nursing post and their maintenance were an essential component for the delivery of client care. At Warburton these resources included equipment, furniture, record keeping and communication facilities and stocks of goods. Two Toyota four wheel drive long wheel base landcruisers, also known as personnel or troop carriers (colloquially known as ‘troopies’), were based at the nursing post. These vehicles were regularly serviced by a mechanic at the community workshop.

Equipment for the performance of clinical assessment and procedures at the nursing post included:

- 3 metal dressing trolleys (one set up as an intravenous trolley)
- 1 low powered mobile Xray machine (dated pre 1970)
- 1 Ultrasound (obtained 1992 and not in use)
- 1 haemacue haemoglobinometer (circa 1975)

- 1 glucometer
- 1 insulcot
- 1 set oxygen and suction attachments for Size D oxygen cylinder
- 1 portable suction apparatus (circa 1965)
- 1 Oxyviva
- 1 Ambu bag
- 2 auriscopes
- 1 Electrocardiograph machine (circa 1968) purchased second-hand in 1992.
- 1 ophthalmoscope
- 4 stethoscopes
- 3 sphygmomanometers (one digital)
- 1 Doppler foetal heart monitor (digital)
- 1 pulse oximeter (purchased 1995)
- 1 low trolley and canvas stretcher (with two poles)
- 1 wheel chair
- 1 car refrigerator (for storage of pathology specimens)
- 1 'emergency box'
- 1 optivisor

The acquisition of new or replacement equipment depended on requests to management from the nursing staff and the subsequent approval of management. A problem with this method was that nurses who had requested equipment had usually left the service before the equipment was obtained. Alternatively, it was not supplied and was either re-ordered at a later date or was not followed through with a changeover of staff. Also nurses had different preferences for the kind of equipment needed in the setting. For example, a pulse oximeter had been ordered at some previous time and then arrived unexpectedly at the nursing post. Initially it had remained in its packaging until a nurse decided to 'try it out' on her colleagues. It came into use on a few occasions, mainly because it was there.

The lack of requests for replacement and/or repairs and additional equipment was not unexpected in view of the short stay of most nurses and the limited experience of these nurses in remote area nursing. According to the health service manager:

Different nurses requested different pieces of equipment which seemed to relate to where they had worked before.

Additional equipment were only purchased if funds were available to supply the ten clinics in the Ngaanyatjarra Health Service. This was explained by the manager as a 'principle' of the health service.

Requests by nurses for a portable stretcher were refused by the management representative. The low trolley stretcher, as used in RFDS aircraft, and the canvas were the only mechanical means of transferring recumbent clients. To transfer a recumbent client to the airstrip for an evacuation, for example, the heavy trolley had to be lifted high up into the back of a Landcruiser vehicle. The trolley had only safety straps and no safety rails. This feat required at least four strong people. Furthermore, there were no fittings in the vehicle to secure the trolley or an oxygen cylinder. One vehicle was too short to fully accommodate the trolley. The back doors of this vehicle were then observed to be left opened when transporting a client on the trolley.

The outcome of these arrangements and the lack of administrative assessment of the equipment needs was that equipment in use was often out-dated, not regularly calibrated and sometimes in disrepair. For example, a nurse found a metal clip was missing from the electrocardiograph machine and that the rubber caps were perished. Each year equipment was to be serviced by a maintenance officer from the Health Department of Western Australia. This had been done in April 1995, but was not observed to occur during the year of fieldwork.

Faulty equipment was a problem for nurses. This problem was observed in the following examples:

- On a medical consultation a nurse was requested to take an electrocardiograph (ECG) tracing on a client with a history of a bleeding disorder and possible cardiac problems. The machine 'does not work properly' and the nurse then repeats the tracing. Another nurse, experienced in coronary care nursing, observes that there are 'blocks' on the tracing. The nurse, however, states that she 'is unsure if this finding is due to the machine being unreliable or to an abnormality of the client's cardiac functioning'.

- Following a routine ante-natal assessment of a client, a nurse complained that, 'the doppler fetal heart monitor doesn't work very well and requires a lot of manoeuvring to get the fetal heart sound'. To overcome this problem the nurse stated, 'I used the Pinnard's [stethoscope]. With that I can hear the quality of the fetal heart beat'.

Nurses at the time had stated their intention to report these faults to a health service manager. This, however, was not observed to be done on either occasion.

The availability of the equipment seemed to influence the choice of procedures undertaken. For example, a nurse who had previously completed a short course in radiography wanting to use the Xray machine. This was implied in an observation as follows:

A young woman complained of pain in her right forearm. About two years before a steel pin had been surgically inserted in this forearm to repair a fracture. The nurse remarked to the client, 'I'd like to take an Xray of your arm'. The client, however, ignored the remark and turned her body away from the nurse.

In the year of field work there were two nurses who had completed a two week course in the operation of basic radiography (but not during this period). These nurses had been approved by the Health Department of Western Australia to Xray chests and extremities following medical direction. The room used as an Xray room had walls made of asbestos sheets. Two lead aprons and one pair of gloves were available for operator protection. Only one radiation monitoring film badge was in use. The two nurses, however, on different occasions and in separate time periods were observed to operate the Xray machine.

The small 'dark room' for developing Xray film was ventilated with an exhaust fan. The only refrigerated air conditioner at the clinic was installed in this room. A set of protective clothing for use by authorised staff when mixing chemicals used in radiography was not available in the dark room. In a telephone conversation on 28 November 1996, the consultant radiographer for the Health Department of Western

Australia informed me that he had 'taken a set of protective clothing out to Warburton about four years ago'.

Several nurses who did not feel competent in the use of certain types of equipment were reluctant to use it. For example a nurse who was unsure where to place the chest leads of the electrocardiograph machine declined to attempt a cardiac tracing on a client. The availability of the 'diagnostic' equipment contributed to a perception that it needed to be used or that this was expected of a nurse. For example, a nurse believed that because a haemoglobinometer and a glucometer were available she should include these tests in routine women's health screening. Another nurse explained what she considered to be the impact of the equipment available on a nurse's duty of care and on nursing care priorities:

I don't think you should get any equipment unless you feel comfortable and you know how to use it. Otherwise if you get something and it is there, I just wonder, legally down the track, can something go wrong? [They will say,] 'You had this piece of equipment. Why didn't you use it? You didn't know how to use it? Wasn't it your responsibility to find out and to learn how to use it?' And you could spend so much time learning how to use equipment and implementing it in your practice, that once again primary health care has just gone by the by, because you are carried away with 3% of emergency trauma cases which might come in that use this piece of equipment.

Office equipment was used for record keeping and communication. All record keeping and correspondence at the nursing post was performed manually. Hand-written records were kept in separate bound notebooks, such as client medicare numbers, evacuations book, pharmacy prescriptions record and a births and deaths book. (Record keeping is described in chapter 8, pp248-51.)

Equipment in the office included one telephone line, a facsimile machine and a bench-top photocopier. The one telephone line was also connected to a portable cordless telephone. The cordless telephone, however, only functioned within a twenty metre radius of the connection point in the office. Consequently nurses had to leave the clinic to converse on this telephone while standing on the verandah or otherwise cross

to the rear wing of the building. On January 24, 1996, two extension lines were installed to each clinic, using the same telephone number. This line, therefore, could not be used for internal communication or concurrent outside telephone calls. A community office staff member explained that the limitation to the number of lines available to be connected to Warburton was the reason for the one telephone line to the nursing post office and clinic.

On repeated occasions the telephone line was 'out' for periods ranging from less than one hour to more than 24 hours. A constant engaged signal indicated this predicament. During a telephone call the line sometimes suddenly cut out to an engaged signal. According to a maintenance officer, this was because the telephone lines were overloaded. How this occurred, however, could not be explained by the informant. If an urgent medical consultation was needed the two-way radio had to be used. I asked a nurse, 'What do you do when the telephone is out and you want to make a consultation or a consultation is cut off?' The nurse replied, 'I'd use the two-way radio, but I don't know how it works!' On an occasion when an emergency consultation was needed and the telephone was not functioning only one nurse knew how to use the two-way radio. An emergency two-way frequency radio call had to be made to Jandakot RFDS base in Perth (approximately 1500 kilometres distance away). Jandakot was the only available base always tuned into the two-way radio. The call was then re-directed to the Kalgoorlie base. Hot and stormy weather also interfered with the two-way radio reception. At these times radio communication was difficult, if not impossible, to achieve.

Other resources for practice, such as pharmacy supplies and pathology services are described in detail in chapter 8. The resources available for practice and how these were used by nurses were an important determinant of actual nursing practice in the remote area.

Summary

A conceptual model of the practice milieu described the relationships between the nurse and the conditions for practice, and the client population and the conditions for care in the remote area. These characteristics were linked to the nurse and client relationships and to the resources for practice. Together these components comprised the practice milieu or context in which remote area nursing occurred.

A feature of nurse recruits to the remote area was their widely varying educational and experiential backgrounds in nursing. The initial attraction to remote area nursing for these nurses was often offset at entry to the practice setting by the frustration of a lack of preparation and by the demanding conditions of work. A high staff turnover reflected the difficulty of nurse retention.

A dominant feature of the practice environment was the proximity between the nurse's residence and the nursing post together with the overlap of private and public life from the on call and overtime hours routinely worked by nurses. The organisational expectations were that nurses were responsible for client care in the community and adhered to policies of the service. These expectations, however, were not observed to be checked.

Clients perceptions of their care and carers were that nurses were available to attend their health needs 24 hours a day. Nurses were expected to provide treatment and medicines to alleviate clients health problems and to provide the initiative and/or assistance in health related events. Client dissatisfactions emerged when their expectations of care were unmet or when the treatment given by a nurse was seen as inappropriate. A rewarding aspect of remote area nursing was the relationships formed with clients. These relationships were based on mutual respect. Tensions were observed when conflicts occurred between client expectations and the nurse's preparedness to comply with them.

The material resources of equipment available for use as aids to practice also influenced the priorities of care given by nurses. The limitations of these resources contributed to the frustration of nursing practice in the remote area. The practice milieu was a fundamental element shaping the day to day delivery of care by nurses. Nurses at entry to the remote area setting were required to become acclimatised to the place and conditions of work as well as the client population and their health needs. Within this milieu, these nurses were also to learn the established patterns of care performance. The following chapter explains how nurses learned remote area practice.

CHAPTER 6

LEARNING REMOTE AREA NURSING

Through my language and socialisation I did learn to see as sensible many arrangements in my society which an 'outsider' (who did not share my socialisation) would find absurd
Dale Spender (1990)

Introduction

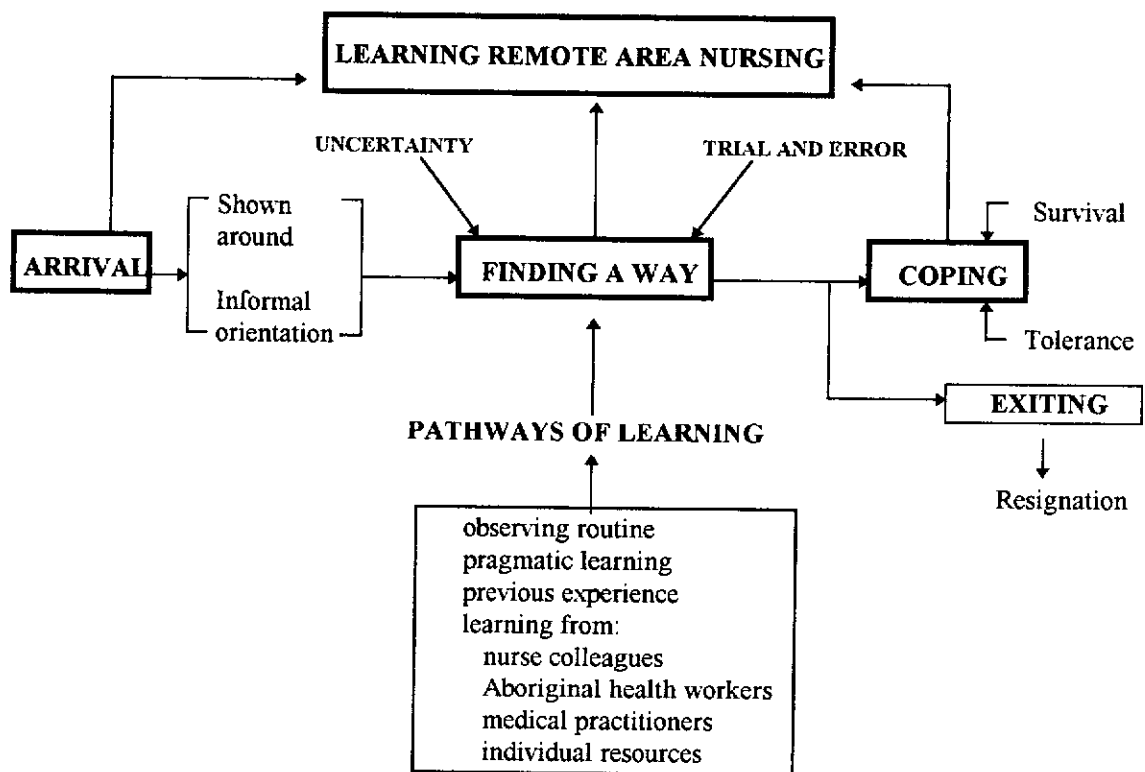
A nurse on arrival in the remote area community must learn how to adapt to the mode of practice within a remote area. This adaptation involves multiple transitions in 'both work and personal life' for a nurse and includes acclimatisation to a strange living environment (Latack 1984, p302). In addition, a nurse has to learn an unfamiliar way of practice and, at the same time, adjust to an alien lifestyle where work and living are intertwined. Thus, in the perception of nurses, the transition to remote area nursing 'is a total way of life' and in 'a totally different world'.

An adequate orientation to a practice setting is basic to a nurse's fulfilment of the role expectations of the organisation and to the effectiveness of nursing care for clients (Schmalenburg & Kramer 1979, Paulk, Hill & Robinson 1985, Melia 1987, Snow et al. 1992). The same principle applies to nurses in all settings. In the remote area, however, nurses were informally orientated to a practice that was unusual for nursing as it is generally understood by the profession.

Furthermore, as Hurley-Wilson (1988), Calkin (1988) and Wanous (1992) contended, the socialisation process of newcomers whereby the rules and norms are introduced and reinforced in a setting shapes subsequent practice behaviour according to the over-riding organisational goals. Thus, how nurses learned the rules and norms of practice in the remote area tended to influence their attitudes and approaches to care performance.

This chapter examines how nurses were prepared for their remote area role. It explains how nurses learned to practise in the setting by being shown around, finding a way through varied pathways of learning in order to cope (Figure 6.1, below). In keeping with an ethnographic study this is described through the articulated and observed experiences of nurses.

Figure 6.1: Learning remote area practice



Learning remote area nursing began with the arrival of a nurse. The shortcomings of an informal orientation and being shown around contributed to the need to find a way to practise through uncertainty, trial and error and by individual pathways of learning. Thus, nurses learned to cope.

Before a nurse arrived in the remote area there was an anticipation by nurses in the community of the new arrival. There was also an apprehension and anticipation by the incoming nurse as to what awaited them in this 'alien' environment. Nevertheless,

most newly recruited nurses expected that there would be an opportunity for them to learn in the setting what they needed to know.

Anticipation of the new nurse

The anticipation of a newly appointed nurse's arrival affected the morale of other nurses at the nursing post. Nurses felt a sense of reassurance, or anxiety, for the continuity of various aspects of the service depending on the advance information received. Prior to the arrival of a nurse recruit, nurses in the community speculated about the qualifications and experience of the nurse based on the information available to them as well as how this would affect roles and working relationships. The uncertainties felt by nurses were illustrated by the following comments:

- The nurse is a midwife so she should be able to take over antenatal care and women's health.
- I'm told that the nurse has only worked in paediatrics. That won't be much help in adult clinic.

The organisation's administration usually provided details of the nurse recruit at short notice and by telephone or memorandum. The information was mainly limited to name, date of arrival and, sometimes, specified qualifications. For instance, this facsimile was sent to the 'Sister-in-charge' from an administrator seven days before a nurse's arrival:

I have recruited another nurse who will arrive on --/--/-- [date] - next Tuesday. She will be available until end of February [two months].
Name: R____ A____. Trained in the UK (United Kingdom).
Experienced in paediatrics and child care and special care baby unit work - neonate. Will forward CV (Curriculum Vitae) when to hand.

The availability of replacements, together with the limited information supplied, was often a source of consternation to a senior nurse. For example, nurses expressed concern when the recruit had no adult nursing experience, or was not a midwife, or when the full complement of the three nurses would be male. In these situations

nurses anticipated that some programs would lapse, such as ante-natal care or women's health program. Nurses also expressed views about how this newcomer would affect the working of the clinic, such as the area of responsibility in adult or child health or other programs that could be allocated to a new nurse.

Clients were also affected by the frequent changeover and mix of nursing staff. On hearing that two nurse replacements were men, for example, a group of women expressed their preference for a female nurse for particular aspects of care. This was what several women had to say:

- It is not good. We need a woman nurse. We want women nurses for the women, children and old people.
- Women don't want a male nurse for things on their bottom. They want to see a lady nurse. Women with babies want to see a lady nurse. If there is a male nurse they will see him there and just go away.
- Old people want a woman Sister [nurse].

Men, on the other hand, generally preferred to consult a male nurse in particular for health problems of a personal or sensitive nature.

Beginning nurses, before coming to the remote area setting, had feelings of excitement mixed with uncertainty. Often they did not know what awaited them at the nursing post. This was illustrated in the following remarks by nurses:

- I was really excited when I was offered the job. But a friend said, 'It may not be all that you think it is'.
- I did not have a clue what it would be like.
- I was told by the agency that it was more like an adventure than work.

These new nurses arrived and were uninformed about what nurses and clients in the setting anticipated from them. The beginning nurse, in turn, anticipated a lead time when they would be orientated to practice in the remote area setting.

Arrival

Nurses generally arrived via the Ngaanyatjarra Air service from Alice Springs if the nurse was from the southern or eastern States, or from Kalgoorlie if they were from Western Australia. Nurses on arrival were usually greeted at the airstrip by the Facilities Co-ordinator of the nursing post and sometimes a nurse. The nurse was then transported to their place of residence. The Health Service Manager, based in Alice Springs, made the decision about accommodation for each nurse and usually communicated this to the senior nurse.

Contrary to the expectations of most new nurses, time for the settling in period was minimal. On most occasions nurses were immediately escorted from the residence to the clinic by a nurse and introduced to other staff. This was termed as being 'shown around the clinic'. When the Staff Development Officer was present in the community, this nurse assumed the role of introducing the new nurse to the clinic. At the time of introduction, faced with strange surroundings and feeling totally unprepared, beginning nurses usually expressed feelings of anxiety about their adequacy for undertaking the role of a remote area nurse. For example, one of these nurses on her first day in Warburton remarked, "I am starting at zero. I am green". Several nurses had assumed prior to their arrival that the probationary period was for orientation. This was seen, for example, in the following quote:

I came straight from a city hospital. I thought the eight weeks probation time was for orientation. Now I find out that it is not.

The anxiety felt by nurses who were beginning work in an unfamiliar setting was not conducive to gaining confidence for practise in remote area nursing. In addition, the cursory introduction to the layout of the nursing post did little to relieve the anxiety and to build the confidence of a beginning nurse.

Being shown around

'Being shown around' entailed an orientation to the clinic by a senior nurse. This meant being introduced to the basic practicalities and the daily routine of the clinic. The functions of each room were explained together with the location of commonly used equipment and supplies. This also included the method of documentation of health records, such as the Daily Patient Record sheets (Appendix 15) and the Dangerous Drugs of Addiction Register.

Introduction to manuals

On the day of arrival a nurse recruit was usually given several documents to inform themselves about the health service and its requirements. A Pre-employment and Orientation Manual, the Ngaanyatjarra Health Service Policy and Procedure Manual (see chapter 5, 122-23) and a booklet, 'Into Another World' (Glass 1992) were offered to the nurse recruit. The booklet provided a 'glimpse of the culture of the Ngaanyatjarra people' (Glass 1992, p1). Only two nurses had received the Pre-employment and Orientation Manual prior to their arrival. The Remote Area Nursing Orientation Manual written by Menere (1991) was sometimes offered as an additional aid. This manual, however, was not specific to the health service but written as a general introduction to the practice environment of remote area nursing.

The Pre-employment and Orientation Manual provided an introduction to the structure of the Ngaanyatjarra Council as well as to the Health Service and included information pertaining to conditions of employment in the community, such as the terms of the eight week probationary period and a job description. It offered minimal guidance, however, on how to conduct nursing practice in the remote setting.

A questionnaire was included in the Pre-employment and Orientation Manual inviting the nurse recruit to note 'areas of skills which need to be upgraded and developed' as well as their 'plans for developing/ upgrading skills'. These forms were not routinely

used. Nurses who had completed the form and recorded the additional skills that they were aware of needing, had not been offered any planned learning opportunity. One nurse described the experience of orientation as:

Actively nothing is done. There is not the question, 'Is there anything you would like to learn?' There is supposed to be the assessment tool, what are your strengths, what are your weaknesses and how you would go about rectifying those things. Its listed there [in the orientation manual]. Its actually getting anything done [for staff development]. There is nothing to make it happen.

New nurses were informed that the Central Australian Rural Practitioners' Association (CARPA) (1994) Standard Treatment Manual, produced in the Northern Territory, was endorsed by the health service (see page 123). According to the remote area nurse job description, nurses were 'obliged to follow the protocols' in this manual for client treatments (Appendix 14).

Several beginning nurses expressed misgivings about using the manual because it focused on drug treatments and assumed that nurses were qualified and competent in the functions of medical diagnosis associated with its use. For example, a nurse on being told it was the accepted protocol for nurses to follow the CARPA Manual's directions for medical treatments, expressed a reluctance to comply with this practice.

The following statement summed up the objection:

But ultimately you are responsible for what you are doing and you owe it to the client. I question that [the accepted protocol] because in anything that I have been taught, it is illegal. It is very hard for me to grasp that this is what is expected of a nurse out here and I don't quite comply with this being the accepted protocol.

Adherence to the CARPA Manual as a norm in remote area practice was reinforced by its availability as well as convenience for nurses use at the nursing post. In interactions with nurse colleagues and with medical practitioners it was often referred to as the treatment guide to be followed by nurses. Thus, after eight weeks in the

remote area, the nurse (quoted above) remarked with a hint of unease, 'You come to believe what they believe'.

In addition, nurses were usually given the Australian Immunisation Procedures Handbook in order to familiarise themselves with the immunisation procedures and schedules (National Health and Medical Research Council 1994). Nurses who were expected to perform immunisations were offered the Immunisation Certification written examination as conducted by the regional Goldfields Public Health Services based in Kalgoorlie. No nurse, however, was offered the opportunity to prepare for or to undertake the clinical examination for Immunisation Certification as is the requirement set out by the Health Department of Western Australia (Goldfields Public Health Unit 1995).

Being shown around the nursing post and provided with these manuals to be read in their spare time was one way by which new nurses were orientated. Nevertheless, in this unfamiliar practice setting these nurses also needed to acquire new skills.

Acquiring skills for remote area practice

There was a lack of opportunity available in the setting for beginning nurses to learn practice skills relevant to the remote area. A lack of structure in their orientation contributed to nurses adopting individual ways of practice and to a variation of practice behaviours between nurses. Several nurses explained these individual variations in their acquisition of skills and, by implication, the influence on nursing practice in this way:

- I don't know whether you are learning. You are not educating yourself in what you are doing. You've given yourself an experience. In my mind there is a subtle difference between education and experience... You are not learning anything. You are actually putting into practise your own ideas and they are not based on nursing practice. They are based on the individual's ideas of what you have done, or what can be done.

- There is no structure, no education as far as drugs go. It is only through the basic guidelines there [referring to the CARPA Manual], but there is no restraint. In that sense if you feel justified in doing anything then no-one is going to stop you. You will be there for your own mistakes. If someone has a reaction to Flucloxacillin or something then you will be the one that cleans up.

The organisation appeared to take-for-granted that nurses were familiar with and could treat common health problems that occurred in the community, such as extensive skin infections, scabies lesions and the non-specific complaints of clients that presented each day. Nurse recruits were given the impression by the manager, and sometimes their colleagues as well, that they should be able to perform in a remote area. This was so even when they had no remote or community health nursing experience or had not previously encountered these health problems. This experience was still vivid in the mind of a nurse after two years working in remote area nursing, as expressed below:

I arrived on the 30th ____ (date) having flown from Adelaide the day before and started working alongside another nurse the next day. She left one week later. I'm thinking what do I do first? Like I've never dealt with scabies before. I think I may have seen it once, but nothing like out here. And the chronic suppurating ears of otitis media. I'd never seen it before.

There was also a tacit assumption by the organisation that nurses already possessed the knowledge and skills necessary for the remote area. For example it appeared to be assumed that nurses already had knowledge and skills, such as to perform medical procedures or manage communicable disease relevant to the setting. Several nurses, however, questioned how they could acquire this knowledge and the skills required to perform them or to deal with diseases not previously seen by them. For example, a nurse expressed this view as follows:

Why is it when you get out here you are expected to have all these skills? It is assumed you have these skills, but in a hospital you are not allowed to do these things, like suturing, intravenous cannulation, and taking a complete history, or feeling for enlarged livers or an enlarged spleen. How is a nurse meant to take a good medical history? How do

you learn? I don't listen to chests with a stethoscope. I've never been shown how. And communicable diseases like STD (Sexually Transmitted Disease) and trachoma. Where do you learn about these?

A lack of orientation contributed to the difficulties nurses experienced in acquiring the skills expected of them in the remote area. The informal direction provided to them by their colleagues tended to foster compliance with the existing mode of practice.

Learning and compliance

The manner of a nurse's introduction to remote area practice seemed to promote an attitude of tolerance and acceptance of the dominant mode of care. This appeared to be due to the stark differences between nursing practice as it was known from their educational and nursing experiences in other settings and as it was practised in the remote area. A lack of an educational basis for this unfamiliar way of practice contributed to a tendency to comply with the norms of the isolated environment. The process of acclimatisation also appeared to be influenced by the degree of a nurse's internalisation of professional nursing values. For example, a few nurses who were familiar with the details of the Nurses Code of Practice established by the Nurses Board of Western Australia (1995) challenged the acceptance of instructions that they perceived as being in violation of their statutory duties in nursing.

Some nurses described the experience of being introduced to the clinic as 'disorientation'. This was at least partly because of apparently conflicting information given to the nurse about practice routines. For example, a nurse, three days after her arrival at the nursing post, stated:

I feel disorientated coming here and trying to settle in. Yesterday I gave an immunisation. The nurse in charge told me I wasn't trained to do that. But then we are not trained to put in intraosseus infusion or other procedures either and I'm told by this nurse we are allowed to do that.

Feeling disorientated undermined the confidence of these nurses. They began to doubt their nursing knowledge and its application to practice with unfamiliar responsibilities in a remote area setting.

The brief orientation period introduced nurses to the daily routine of the clinic. Such an introduction, together with a lack of prior preparation, fostered compliance. It was, however, inadequate for nurses to successfully undertake their new role. Following this introduction, therefore, nurses had to find a way to practise in the remote setting.

The need to find a way

Initially a nurse recruit worked with another nurse in the clinic and was guided on the routines to assess and to treat clients. In situations where there were insufficient nursing staff a new nurse commenced work with the guidance of an Aboriginal health worker or alone. A nurse described her need to find a way to practise in the remote area as follows:

Following your nose. That's how I feel. Finding things out, working out how to deal with clients needs as you go along and I learn from other nurses.

Finding a way was frequently accompanied by feelings of tension. Most beginning nurses found the first few months in remote area nursing stressful. Their stress was associated with feelings of uncertainty and inadequacy about their level of knowledge and abilities for remote area nursing. As nurses learned of the clients' health and social needs they also became aware of their own lack of expertise to meet these needs. For example, after nine weeks experience in the remote area, a nurse stated:

I think counselling is pretty important and I don't feel adequate in that area. The woman who doesn't want to be pregnant, the trauma things, the people who have been assaulted. People who are aggrieved in some way or by the treatment of someone at the clinic. Counselling is involved in all of those. Counselling people about a good diet for their children or for themselves. It's all counselling, and I worry that I am not adequately skilled to counsel these people.

Beginning nurses usually felt apprehensive in anticipation of unpredictable emergencies that they feared could occur at any time and for which they felt unprepared to manage in the remote area. For example, one week following her arrival a nurse was called out at 8.30 pm in response to the words, 'There has been an accident'. No details could be given by the caller. As the nurse drove out in the darkness to the road-side where the accident had occurred she expressed her fear of not knowing what to expect or how she would be able to deal with the situation. Arriving at the road-side the nurse found a man who had fallen from his motorcycle and had sustained minor injuries. Later that night the nurse reflected on the possible implications for her in attending an accident. Her apprehension from feeling unprepared for a paramedical role was stated as follows:

Tonight, what if I had been on my own and the man was out there seriously injured? I am not prepared to take that responsibility. It is a huge responsibility. I am not a paramedic or a doctor. I am a nurse.

Nurses endeavoured to absorb a large amount of new information whilst attempting to find a way to practise in an unfamiliar role. These nurses often felt daunted by their perception of the magnitude of what they needed to know and this further eroded their confidence. Two weeks following her arrival a nurse explained in this quote how she felt overwhelmed by the breadth of her new role:

It's like in the situation I worked before there is this small area of skills and knowledge that I can know a lot about [cups hands together on the table to demonstrate]. But out here there is this huge range of things that I am expected to know something about. [The nurse then spreads her hands out to the full width of her arms.] I feel I am losing confidence here because of all that I don't know.

Another nurse also described how her self-confidence and work performance had been adversely affected by a superficial introduction to the setting. The nurse had previously held a position as a unit nurse manager. Following three weeks in the remote area setting, however, trust in her former nursing capabilities was diminished and, instead, the nurse relied upon her moral senses. This was stated as follows:

I don't know how I have survived, looking back [laughs]. Certainly a good orientation with a bit of preparation would have made it a less

stressful first few weeks. Also it would have been less confidence sapping. My confidence was sliding almost continuously for these first few weeks because I couldn't remember where things were put, or where we document such and such. In which card file did we find out where something or other happened? There was just so much that was forgotten from my first cursory lap around the clinic on the first day. I had so little idea of what I was coming to. I mean the community itself didn't surprise me. I knew what the community would be like and I wasn't wrong about that. But for the work of the clinic, I don't really think I had a clue. I had no previous knowledge to help me with that, only what I feel inside is decent and proper...So it is quite shattering to your confidence when you are used to practising with confidence and competence and then coming out to a different setting where those competencies are almost irrelevant.

The experience of stress for a beginning nurse in the unfamiliar remote area environment together with its alien norms for practice, such as to prescribe medications, was a barrier to learning effectively. *Ad hoc* learning on an unsystematic needs basis appeared to add to this stress. The fragile confidence of a new nurse could be easily diminished by insensitive colleagues, such as a tactless remark from a 'more experienced' remote area nurse or when a nurse recruit felt that the nursing expertise she did possess was dismissed by a senior nurse. This was illustrated in the following interaction:

A new nurse asks a senior nurse to check a client with her. The client had said he had 'a stick' in his eye. The nurse then explains to the new nurse, 'Sometimes people say stick when they mean dust. Their concepts are different'. The foreign object is a piece of grit and is then removed by the senior nurse. As the two nurses walk out of the clinic, this nurse remarks to the new nurse, 'I wonder what would happen if we were three novice nurses here'. The new nurse does not reply. Later in the day the nurse recalls this episode and states, 'Being referred to indirectly as a novice nurse undermines the knowledge and skills I do have'. She then added, 'I may not know all about the broad range of things here, but I previously worked in a specialist unit for five years and I think I could handle just about anything that was thrown at me there.'

The lack of a formal orientation was an important factor in a nurse recruit's feelings of inadequacy. Nurses individually, therefore attempted to meet their need to find a

way in the unfamiliar setting. This situation led to varied pathways to learning about remote area practice.

Pathways of learning

A diversity of pathways were observed in the patterns of learning for nurses. Like in any new learning situation, learning in the beginning appeared to be intense. Nurses frequently remarked on the 'sharp' or 'steep learning curve' they had undergone. A nurse who had worked for several years in various remote area settings added, 'You keep learning all the way. You just keep learning all the time'. Much of this learning occurred by applying previous experiences to the new environment.

In the patterns of learning nurses used a pragmatic approach and/or applied their previous nursing experience to new situations. In addition, they obtained information from other health care workers, such as colleagues, Aboriginal health workers and medical practitioners and from individual initiatives to assist them. These patterns are described below. Initially, however, observation of the environment was one of the main ways used by nurses to familiarise themselves in the practice setting.

Observing routines

In observing the surrounding environment nurses looked around and checked the clinic facilities as well as watched the pattern of clinic procedures used by other nurses. They listened for cues from colleagues or from clients to find an appropriate way to interact and to respond to various practice situations. To learn more about the clients' health problems, several nurses read client histories and other files pertaining to the management of client care. These files included a Forward Planner in which nurses had recorded dates for immunisations, various health checks and long term medications as prescribed by a medical practitioner (Appendix 16). Nurses generally followed the examples of practice that they had observed.

Pragmatic learning

One of the patterns of learning was seen in the tendency of nurses to take a pragmatic approach, rather than to use problem solving. For example, nurses learned to use mainly palliative measures for care by providing symptomatic treatments. Such a way of learning did not allow a nurse to fully utilise their nursing knowledge for solving practice problems. Instead, in pragmatic learning it often seemed to suppress the use of even fundamental nursing knowledge. This pattern of a pragmatic way of learning, and applying that learning in practice, was illustrated in this quote made by a nurse six weeks after his arrival:

I think the longer you are out here you start to recognise that a couple of Panadol's and they will be right in the next couple of days. But the problem with chest infections and the problem with abdominal infections is in the environmental health. We give them medicine to try and combat that [the deficits in the environment]. I think for any of these things to be changed we need to go back to basic nursing practice and start thinking a bit more.

Previous experience

As another way of learning, some nurses applied their previous nursing practice knowledge and skills and common sense to new situations or to the problems at hand. Use of past experience included recalling principles previously learned in nursing and using the skills attained in nursing assessment. Nurses also relied on intuition that they had developed in a particular area of their nursing career. A nurse explained in this quote her way of learning, by using her past experience as well as observation of practitioners in other health care settings:

You remember what you saw someone else do, like the doctor...You remember some basic principles of nursing. And you have a go. If you don't do it, it's not done...I previously worked in the asthma ward in the children's hospital. My experience with asthma, gave me a good grounding in that. As a regular thing I listened to kids chests.

In using their previous knowledge and experience as a pathway for learning, nurses often personally reflected on their actions, questioning the decisions they had made and the actions they had taken in the light of subsequent outcomes. A nurse explained her way of learning by reflection in this statement:

I sit back and reflect on what I have done and whether there may be more that I could have done. The incident on Saturday where a man had a severed artery. I look back on that now and think, I shouldn't have stood him up to go to the toilet. Even though he did not put weight on that foot, I thought he couldn't do any damage because he wasn't weight bearing. And look what happened? He started bleeding all over the place! You have got to learn from what you have done.

A major way of learning for nurses was experience in the setting. Nurses had learned from a previous occasion when they had managed a situation, often with limited information, and then used this knowledge on subsequent occasions to deal with similar problems. Familiarity with a client's health problems and usual response was another factor influencing how nurses learned to treat clients. This point was made by a nurse as follows:

In the hospitals you have got the security of knowing the white cell count or knowing the results of a blood culture. Out here you have only got the physical assessment and the observations. Through your empirical knowledge you have learned that the chances are what you have got is a *Streptococcus pyogenes* infection. I mean its only through experience you gain those observation skills and can say, last time this happened this is what I did. Or if you stay long enough in one situation, [you can say] this lady does this all the time and one night in the clinic does cure her and she is alright the next day.

The added possibility for error in this pattern of learning for remote area practice was, however, a source of concern for some other nurses. A nurse who had experienced the risk inherent in making assumptions about a client's problem, described it in this way:

Like M__ M__ the other day. She has asthma and she told me she had the 'asthma pain'. I could have given her Ventolin (routinely used to treat the client for acute asthma), but I opted not to give her the Ventolin. I just had this gut feeling, this is not M__ the asthma, her

normal asthmatic self. She was clammy and had an irregular pulse and I was suspicious of the central chest pain. I did an ECG (electrocardiograph tracing) and saw that she wasn't in sinus rhythm. If she had had the Ventolin she would have been in a worse state. That could so easily have happened if I had just assumed it was asthma.

On many occasions nurses applied their common sense as a way to resolve practical problems in unfamiliar practice situations. For example, nurses learned to manage a burdensome clinic workload by using their common sense in discriminating between urgent and non-urgent client needs to divide the time available. Common sense did not always prevail, however, especially in the uncertainty of the practice setting. As this nurse found, the magnitude of his initial shock and fear of remote area nursing had adversely affected his ability to use common sense:

For me coming out here was more than a transition. It was a culture shock, not being told what was expected. It is such a shock and it is very frightening. Even though you tried to use as much common sense as you could, that was pushed into the back of your mind and you just hoped what you were doing was right.

The application of previous nursing experience, personal reflection and common sense, however, had limitations as pathways for learning remote area nursing. Nurses, therefore, also learned by being shown what to do by colleagues.

Being shown what to do: learning from colleagues

The guidance of colleagues was an important way for learning in the setting. Nurses often consulted another nurse for advice when they were unsure of a health problem, treatment modalities or therapeutic interventions. Being 'shown what to do' by colleagues was the usual way to learn an unfamiliar procedure. For example, the first emergency evacuation undertaken was usually supervised by a nurse colleague, such as being shown the appropriate forms to be completed and the information needed as well as explaining the routine involved in meeting the RFDS aircraft on arrival.

Not all nurses, however, were 'shown what to do'. The following observation was an example:

A nurse asks a senior nurse, 'How can I learn to suture?'. The senior nurse replies, 'You will learn as you go along'. 'That's no way to learn. You don't learn in an acute situation, especially out here where there is no-one else,' the nurse exclaims.

Nurses generally looked upon more experienced colleagues as a role model, irrespective of their remote area nursing expertise. The colleague had been there for a longer period of time and was assumed to know more. Reliance on colleagues as a way of learning, however, tended to perpetuate the dominant way of practice in the remote area. For example, the use of intravenous therapy appeared to be influenced by the role model of a senior nurse who almost routinely administered intravenous fluids. This practice then became the pattern followed by nurse recruits. A new nurse explained that she had been urged by the senior nurse to put up an intravenous on an adult client who had mild dehydration. She had obeyed this instruction, but not questioned its appropriateness for the client.

Several problems were encountered by beginning nurses in learning from colleagues who they presumed were more experienced. For example, when this colleague was unable to offer any additional advice beyond what a nurse already knew, or when the advice given conflicted with the existing knowledge of a nurse. In an unfamiliar situation where a nurse lacked self-confidence the influence of colleagues and conformity to their advice often seemed to take priority over a nurse's own judgement. The following example illustrated this point:

I was unsure about treating a child and asked for advice from the Sister-in-charge. I was told to give an antibiotic. I may disagree with this advice but still feel obliged to follow it. They [other nurses] always fill people up with antibiotics, but don't use other measures for care of the patient. People here are taking partial courses of antibiotics repeatedly and that's my concern.

In the pattern of learning remote area practice these limitations contributed to nurses' seeking knowledge from other sources as well. This included the various health care providers with whom a nurse interacted. The only other health care workers with whom a nurse interacted with on a daily basis at the nursing post were Aboriginal health workers.

Learning from Aboriginal health workers

Some nurses sought guidance from Aboriginal health workers as a way of learning about practising in the cross-cultural environment. On request, Aboriginal health workers taught nurses by explaining family relationships and customs of the Ngaanyatjarra people pertaining to behaviour and illness. Several Aboriginal health workers felt that they were under-utilised for teaching nurses how to understand the behaviour of Aboriginal clients. Furthermore, nurses often did not consult them for information in dealing with client problems or for advice on communicating effectively with these clients. In the following observation a nurse did consult an Aboriginal health worker about the acceptability of visiting clients' homes to collect specimens for a screening program. The Aboriginal health worker considered the question before making a comment on what was pertinent to her. Her response, an indication of the submissiveness of clients to being tested as well as their embarrassment stemming from their perception of ill-mannered behaviour on the part of a nurse, was perturbing:

Thursday 3.30 pm. Standing beside the vehicle, a nurse asks an Aboriginal health worker, 'What are your feelings about going around with the nurse to people's homes to collect urine specimens?' The Aboriginal health worker looks at the nurse but remains silent. As the three of us get into the vehicle, the Aboriginal health worker then states to me, '*Anyway palyalpai tjapinyangka* (they will do it because they are asked), "Give me blood. Give me urine". I had to tell that lady Y___ (name of another nurse) not to go straight up to people [at their homes], but wait at the gate'.

Sometimes, as in the above example, when an Aboriginal health worker believed it was essential for a nurse to know about a matter or to understand polite behaviour, they took the initiative themselves to instruct a nurse. For example, during a ceremonial time a number of clients attended the clinic with red ochre rubbed all over their skin. They were visitors to the community and had camped out near Warburton 'in the bush'. A relieving nurse, uninformed about the secrecy and sacredness of ceremonial activity, had examined a woman's ear then suggested that the woman wash her ear. The nurse also questioned the woman about where she was staying and when she would return to the clinic. The Aboriginal health worker observed this interaction and later took the nurse aside. He then explained to her in the following manner that in this situation clients whereabouts and activities were not a matter for the health staff:

What are you going on about people in the bush? What they do out there [for ceremonies] is nothing to do with us. We [as outsiders] don't ask them questions. When you talk to people don't talk to them like saying, 'Are you going out bush? Are you going to be back tomorrow?' Who wants to know? Nobody.

Learning from medical practitioners

Nurses also learned informally from medical practitioners as a way of obtaining information relevant to their practice situations. This was mainly the RFDS medical staff or the visiting paediatrician. Overtly, nurses learned from medical practitioners when, for example, nurses obtained their advice or guidance to manage a health problem. At a more subtle level, nurses were also observed to be influenced by medical practitioners who, either tacitly or explicitly, communicated their expectations of the nurses' role and practice in the remote area. For example, nurses initiated intravenous antibiotic therapy or screened clients to be seen at a medical clinic according to medical practitioners' expectations of them. (This aspect of medical and nurse relationships and its impact on nursing practice is described in chapter 7.)

Nurses often obtained advice from medical practitioners during a routine medical visit when they were seeking additional knowledge about the medical conditions seen by them. Less frequently, nurses' sought information in a telephone consultation with a medical practitioner. For example, as portrayed in this quote:

I sometime make medical consultations just for my own knowledge. I know they [clients] are not going to die or anything like that, but I'd really like to know what the go is. Such as eye things. Those little pustules I saw on the eye [of a client], from the sclera to the pupil to the iris. Just bizarre things like that...If I can get a name to it at least next time I can say, 'You've got blah, blah' or something like that.

Most medical practitioners were willing to teach nurses about basic medical assessment and the management of specific diseases or trauma - provided the nurse requested this information. For example, a nurse asked a medical practitioner to show her how to use an ophthalmoscope for an eye examination. The medical practitioner then demonstrated to the nurse how to use the ophthalmoscope and explained to her the characteristics of the eye to observe. Subsequently the nurse demonstrated this new found skill to other nurses.

One motivated nurse requested the RFDS medical officers to present a topic to staff prior to the fortnightly medical clinic. This nurse wanted the topic to be chosen by nurses and in keeping with what the nurses' felt they needed to know. The medical staff willingly agreed to this suggestion. Ideas and interests in the search for medical knowledge varied between nurses from the unusual, such as 'spinal fractures' to the common, but frequently problematic, 'headaches' and 'fits'. Three sessions were held, but then lapsed on the departure of the nurse. Prior to her departure the nurse voiced her view of the importance for nurses to determine what they needed to learn from medical practitioners as follows:

It is important that RFDS when they come here to have half an hour or an hour for a tutorial. It's important for us as nurses to get together and to decide what we want him or her to talk about. I said this to another nurse and the reply was, 'Oh I think I'll let them talk about what they are happy to talk about'. I said, 'No. We are nurses that know our weaknesses and that know our strengths. You have got to

give them a topic. Say this is coming up every day. We are not treating people particularly well because our knowledge is lacking in this area. Can you bring some information? It's no use them coming out and talking about something we will only see 1% of the time in our work.' This is the thing, nurses are saying, 'Let them talk about what they want to talk about'. Nurses should start thinking about our own knowledge and what we need.

On a few occasions nurses learned from medical practitioners when they were corrected for a perceived inappropriate medical treatment. For example, a visiting specialist medical practitioner reviewed a six year old client's history. He noted that over a period of time nurses had repeatedly prescribed antibiotics on presumption of a recurrent infection, even when he had previously given orders to the contrary. The specialist advised the nurses that the antibiotic therapy used was unwarranted. He then explained to the nurses why antibiotic use was inappropriate in this case

Use of individual resources

The lack of preparation and the limitations of knowledge available from colleagues and other health team members for remote area practice often contributed to nurses also seeking alternative sources of information. For example, a nurse described how she had used her own initiative to obtain additional knowledge:

You rely on the people you are working with to be able to give you a bit of assistance. I guess you rely on the RFDS too, not greatly but you rely on them a bit. You rely on different individual departments, particularly for primary health. I've relied on ringing up public health for information or things like that. If public health sent any results I haven't understood, then I ring them. Other than that, working with people and just learning.

The use of telephone communications with different agencies was sometimes used by nurses to obtain advice when they were unsure of the care needed. The use of this option was also influenced by a nurse's prior acquaintance with the agency concerned.

For example, a nurse who had formerly worked at a major paediatric hospital consulted staff at this hospital to obtain current information:

The only good thing that CARPA [Manual] says is, if in doubt ask. If in doubt ...we can get on a telephone. I mean when I saw that kid with the burns I know what to do with burns, but I still 'phoned Princess Margaret [Hospital] because I thought maybe it has changed. It only took me three minutes to get on the 'phone to Princess Margaret and ask, 'Am I doing the right thing?' And they said, 'yes'.

Most nurses routinely used the CARPA Manual as a source of information and as a prompt for learning, such as for an assessment and to decide a provisional medical diagnosis or a drug to prescribe as a treatment. The extent to which nurses depended on this Manual for their learning varied. Some nurses attributed a major part of their learning for remote area clinical practice to the CARPA Manual, as seen in this example:

The CARPA Manual was able to get me through the learning time, where someone presents and it told me what to do. And it gave pretty rigid guidelines on what to do. It definitely helped me through the period of not knowing things I have never had to do before - that is the big thing.

Other nurses, however, found the CARPA Manual of limited benefit for teaching or guiding them in remote area clinical practice. Their ambivalence was expressed in the following quotes:

- You have got the CARPA Manual, but that doesn't really give you any information, and it's just a diagnosing and treating book. It is not teaching you.
- I think the CARPA Manual is good in some places, some aspects. You look at something and you think, 'Oh I would not have thought of that'. So it's good in that respect. I think nurses have always been taught that you do not diagnose...yet that is what the CARPA Manual is directed at... And I think too, if you follow the CARPA Manual they are covering themselves. They - I am referring to the medical practitioners that put the book together. If you are not sure, consult somebody else. That is written quite a number of times throughout the book. So if you follow what they say and you make a mistake, they are covering themselves by saying, 'But you did not consult. Why didn't you consult?'

Medical practitioners with the RFDS, however, were the primary source of medical reference for nurses. These medical practitioners did not formally acknowledge the Manual as a learning tool for nurses and were reserved in their acceptance of its use, especially for beginning nurses. The Senior Medical Officer conveyed this reservation, as well as an expectation of nurses' role performance in the remote area, in this statement:

I am more anxious when there is a new member of staff and I don't quite know what their capabilities are. I would say that if they [nurses] were following the CARPA Manual then I would be quite happy to back someone up if they had a reason for doing something. Even so you have got to make a diagnosis of the infection, the correct diagnosis, before you give them [clients] treatment. I think that initially probably nurses out here should ring up every time they prescribe drugs. In a probationary period that should be the rule, until one gets the feel for what is right.

As an adjunct to medical consultations and the use of the CARPA Manual, nurses referred to the MIMS Annual (1995) for drug information. The MIMS Annual was observed to be used by nurses for instant information, for example, pertaining to the dosages, precautions or contra-indications for the use of a drug. This was illustrated in the following observation:

A client had presented with an acute allergic reaction to a substance he had ingested. On medical consultation, IM. Phenergan 50 mg. and IV. Solu-Cortef 200 mg. is ordered. Prior to administering the Solu-Cortef the nurse takes the MIMs Annual and, locating the section on Solu-Cortef, quickly reads down the page. This was done, the nurse explained, 'To inform myself of the precautions to administering the drug'.

Several nurses also used other reference books, such as the Merck Manual (Berkow 1992) or various other medical and surgical textbooks. This was to obtain additional knowledge about health conditions they had seen or to learn diagnostic and treatment procedures. Nursing textbooks were rarely the primary source of written information used by nurses. For example, a nurse described an instance of his use of the Merck Manual or similar textbooks in the following quote:

It is implied that I have a fundamental knowledge of renal disease, CAPD (Continuous Ambulatory Peritoneal Dialysis), heart failure and all those things that I am asked. But I don't know everything about everything. It's only when I race back here [to the residence], open up a textbook and look up nephrotic conditions in the Merck Manual or something like that that I've got a little bit more knowledge that is contemporary to what they are doing in hospitals.

The informal learning opportunities, such as available for individual nurses in discussions with visiting personnel, usually focused on curative medical interventions. For example, a session was initiated by a renal nurse specialist from the regional hospital. In this session the medical assessments used in hospital for chronic renal failure and the recommended screening tests that nurses could perform in the remote area were described. One nurse, however, questioned the priority of this approach for primary health care. His question was, 'Rather than wait for people to develop chronic renal failure, what can we do to prevent people getting into the situation of needing CAPD?'

The search for medical knowledge and acquisition of medical skills was a predominant feature for most nurses in their desire to learn in the remote area. These patterns of learning reflected the medical orientation of remote area practice and the nurses' own feelings of inadequacy in their knowledge and abilities for this role. Nevertheless, a conflict for several nurses was the moral and legal problems of practising in a medical domain. A nurse, who regarded the unofficial medical role as a 'danger' for nurses and nursing, stated:

Nursing out here is fraught with danger. We are doing a job we are not really trained to do. It's the prescription of drugs that really worries me.

It appeared to be taken-for-granted, however, by the organisation, medical practitioners and by some nurses themselves that nurses already possessed the medical knowledge and skills they needed for a remote area position. This assumption also implied that nursing knowledge for remote area practice was less relevant than

medical skills. There also appeared to be a lack of distinction between the responsibilities of nursing and of medicine in these perceptions. For example, the health service manager, when asked who nurses called upon to deal with nursing problems, replied as follows:

The RFDS is the medical director...and we do have a Staff Development Officer on board who is a nurse and who is well aware of the problems and is experienced in the area. So any medical stuff can be put to him. But it should be the RFDS first.

Thus, the nurse's socialisation into the practice setting conveyed the impression that the nurse's primary role was as a medical substitute as well as a care provider and that this role was sanctioned (at least, unofficially) by the system of health service delivery. Most nurses described their actual role as 'an extension of the doctor' or as 'a pseudo medical practitioner' or 'like a general practitioner'. This adjustment together with the broad demands for their care in the community contributed to nurses' learning an unfamiliar form of practice by coping with each situation that arose. A dominant feature in the varied pathways of learning was the individual ways in which nurses gained knowledge and skills for remote area practice. These individual ways were used by these nurses as a means to help them to cope in the remote area.

Learning to cope

In the remote area most additional learning was acquired by nurses, both in non-acute and acute care situations, as the need for the knowledge and skills occurred. In new situations, therefore, nurses 'coped' at the time by responding to and dealing with the immediate problems and client's needs as they perceived them to the best of their ability and knowledge. Learning to cope appeared to be the main aim for nurses in staying in the remote area.

Coping was frequently expressed by nurses as 'doing the best you can', to 'sink or swim', to 'fly by the seat of your pants' and/or 'skating on thin ice'. For example, nurses' used such expressions as follows:

- You can be put in stressful situations where you are not sure what to do. Like I said yesterday, you fly by the seat of your pants sometimes.
- So you just cope the best way you can. And basically that is what you do. Coping. Trying to do what you can.

Nurses used the expression 'have a go' as a way of coping, such as to test their skills or to attempt a procedure when they lacked prior knowledge and/or experience. This kind of trial and error appeared to be an experimental, rather than experiential, form of learning. The following observation was an example:

Sunday 10 am. A three year old child is brought to the clinic by her mother. She has been scalded when she pulled a pot of boiling water from the top of a stove. The skin around the right axilla is severely burnt. There are also scald marks and blistering on the child's lower jaw and trunk. The child is distressed. The two nurses who attend the child immediately decide to put in an intravenous line. Neither nurse, however, can find a vein. One nurse then says, 'I'll have a go to put in an intraosseus needle to give the haemaccel', Checking the instructions in the CARPA Manual, the nurse then tries to perform the procedure and succeeds on the second attempt. This involves the nurse bending over the child with his arm raised and elbow bent up in order to force the needle through the tissue. The pulse oximeter indicates oxygen saturation as 99%. The other nurse then insists that sterile towels be found because of the unsterile surroundings and the risk of infection going into the bone and to the raw surface areas. No sterile towels are available, so the nurse opens a midwifery pack to obtain them. The child is subsequently evacuated by the Royal Flying Doctor Service to the regional hospital. Late that afternoon the nurse who assisted remarks, 'I don't feel that I am a safe practitioner. Neither L___ [name of nurse] or I have ever done an intraosseus fluid replacement before'.

In coping with diverse situations nurses said that they 'learned to survive' in order to remain in remote area nursing. The inference was that a nurse who was unable to

'learn to cope' could not continue as a remote area nurse. For example, a nurse remarked:

You just have to learn to cope and survive or you run away.

Coping, as meaning a tolerance for the adverse conditions of practice, seemed to be inversely related to an intolerance of individual nurses who appeared unable to cope. For example, a Sister-in-charge commenting on nurses being able to remain in remote area nursing, added:

For nurses who are stressed out and can't cope it is time to leave and not come back.

In the remote area there was a relationship between perceptions of coping and attitudes toward a nurse's endurance. Being seen to cope was also a way for nurses to disguise their feelings of distaste or inadequacy in awkward practice situations, as was portrayed in this example:

A nurse had disagreed with her two male colleagues about the handling of a hostile situation involving two female clients. Despite her objections, the nurse was expected by her colleagues to take part and risked being assaulted. The nurse, however, wanted to conceal her feelings of inadequacy in this situation from her colleagues. She later remarked, 'I feel like leaving Warburton, but don't want to as it would seem to the other nurses I couldn't take it. I couldn't cope.

Coping was interpreted as a measure of the 'success' of a nurse. Equating the appearance of an ability to cope with any complex problem with attainment in remote area nursing was also evidenced by nurses themselves. As an illustration, a nurse who had worked more than one year in the setting, still blamed herself for feelings of an inability to 'cope'. The nurse stated:

I feel badly that I am perpetuating a cycle of dependence and I feel like saying [to clients], 'Don't be so pathetic'. Then you might thrash yourself thinking, 'Oh, I'm being too hard on them... You still think, 'It must be me, I can't cope'.

Coping was seen by some nurses as the only way to learn to practice in the remote area. These nurses distinguished between what they felt could and could not be learned prior to arriving in a remote community. This pertained to a perception of the difficulty in adequately communicating a picture of 'what it is like' to an outsider, such as seen in this comment by a nurse:

It's totally different out here. No-one can really tell you and you can't imagine what it is like until you see it for yourself.

Nurses' ideas for what could be learned in advance were centred on tasks and 'practical' skills for clinical procedures, such as physical assessments, suturing, blood taking and intravenous insertion. Amongst a few nurses, however, there was a tolerance and even satisfaction for an experimental way of learning to 'cope', as in this example:

When I first started treating someone's eye with Chlorsig I thought, 'Is it all right for me getting the Chlorsig and putting it in someone's eye? Or should I be ringing up [the doctor] for such things?' Your learning curve is extreme. I've accepted that. I enjoy that. I don't know how I would cope not being able to do that. I can't see how we can learn any other way to be honest.

Learning remote area nursing was an unending cyclical process both for individual nurses and for nurses as a group; a situation that was further complicated by the high turnover of nursing staff. Each beginning nurse started practice in the remote area from 'zero'. In the view of most nurses, acclimatisation to remote area nursing took many months. The frequency of new beginnings also seemed to hinder the progress of clients' care as well. A nurse explained this view as quoted below:

I reckon it took a minimum of nine months for me before I started getting a bit of knowledge of the people and to integrate everything that I have learned...The precedent keeps coming all the time that every nurse who comes out here has got to learn the same questions and has got to see the people for the same things for the first time.

The manner of learning remote area nursing not only impacted on individual nurses' emotions, on the attitudes they developed and on their ability. It also had a fundamental influence on the shaping of nursing practice in the remote area. A major feature of this practice in the remote area was clinical decision making.

Summary

Learning to practise in a remote area the initial step to a beginning nurse's role performance. There was a whole transition from the familiarity of urban life and nursing practice in urban settings into the unknown isolated setting. In addition, within this strange practice setting nurses were required to undertake an unfamiliar and responsible position. This transition often resulted in feelings of stress for a beginning nurse.

The lack of a formal orientation limited the nurses' opportunity to learn the knowledge and skills appropriate to health care needs in the remote area. These circumstances led to the varied pathways taken by nurses for learning about remote area practice. The pattern of learning in the new environment included observation, applying their previous experience and being shown what to do by colleagues. Additional ways of learning in the remote area were from other health care workers and the use of individual resources, such as reference to textbooks or CARPA Manual.

Most nurses initially found dilemmas in the apparent anomalies between the unorthodox aspects of remote area practice and nursing as it had been taught to them in their formal nursing education and former experiences. With positive reinforcement, however, such as tacit approval by colleagues, medical practitioners and the organisation for performing according to the norms of the setting, nurses had gained confidence. The moral and legal dilemmas posed by the unconventional aspects of

remote area practice were denied or became suppressed by those nurses who unequivocally adopted the new role.

In the absence of clear organisational policies, nurses adapted to the rules and norms of remote area practice according to the expectations that were imposed on them and their individual interpretations of their role. The ultimate goal of acclimatisation for these nurses in the remote area appeared to be to have an ability to cope, that is, just survive. This mode of learning for nurses underpinned clinical decision making for client care in the remote community. Decision making by nurses in the context of the remote area setting is described in the following chapter.

CHAPTER 7

DECISION-MAKING IN REMOTE AREA PRACTICE

Decision making itself is a social process that deals in symbols
Amatai Etzioni (1968)

Introduction

The nature of nursing practice requires decision-making at all levels and in all phases of client care (Thomas, Wearing & Bennett 1991, Reilly & Oermann 1992, Dunn 1993). Clinical decision-making generally refers to a process nurses use for the assessment, diagnosis and management of client care needs in order to resolve or alleviate a health problem. This process involves both intellect and action (Tanner et al. 1987, Brooks & Shepherd 1990, Hurst, Dean & Trickey 1991, Tschikota 1993, Singleton & McLaren 1995, Pease 1997). How clinical decisions are made is influenced by the physical and social context of care, resources available and the knowledge and skills of a nurse (Jenkins 1985, Corcoran 1986, Prescott, Dennis & Jacox 1987, Luker & Kenrick 1992, Orme & Maggs 1993, Baron 1995, Moore 1996).

Within the remote area various contextual factors were found to influence the way in which nurses made clinical decisions. The emerging domains from the data included the organisation of the clinic, client expectations, and isolation from and relationships with other health care providers. Other domains included the availability of staffing and equipment (see chapter 5; the practice milieu). Within this environment the individual nurse's abilities and experiential knowledge were important determinants of how decisions were made and of the subsequent care.

In this chapter the care environment of the clinic within which nurses usually made their day to day clinical decisions is described. The processes used by nurses for decision-making are then explained. The difficulties nurses experienced in this process

pertaining to limitations and communications are also explored. These features are outlined, using a systems model in Figure 7.1 (overleaf).

The care environment

The care environment in which everyday clinical decisions were made by nurses occurred mainly in the clinic. Clients attended the clinic both during clinic hours (between 9 am and 5 pm) and after these hours. Nurses occasionally assessed a client in other locations, such as the scene of an accident, at the police post or in the home (Figure 7.2, p184).

A working day of a remote area nurse in the clinic began about 8.30 am. This was where clients congregated and often packed the consulting room to capacity. Few people waited outside the clinic consulting area to take their turn for consultation. During clinic hours usually two nurses, together with an Aboriginal health worker were involved in client consultations. Each nurse worked separately in the adult clinic and child clinics. When nursing staff was limited to one or two nurses, and when an experienced Aboriginal health worker was available, the health worker also managed clients on their own. The Aboriginal health worker, however, usually sought the advice of a nurse as needed. Aboriginal health workers generally preferred to work along with a nurse in the clinic.

In a routine consultation the nurse often stood up before a client who was seated. This appeared to be associated with a lack of space and the pressure felt by a nurse to work rapidly. A nurse described this manner of attending clients:

People all come in at once and crowd into the clinic. I thought, 'Hang on a minute, there is a waiting room'. No-one wanted to leave and wait in the waiting room. So I saw them one by one while they all sat together. [The nurse then stands up, turns around and bends up and down to demonstrate how he attends to clients in the clinic.]

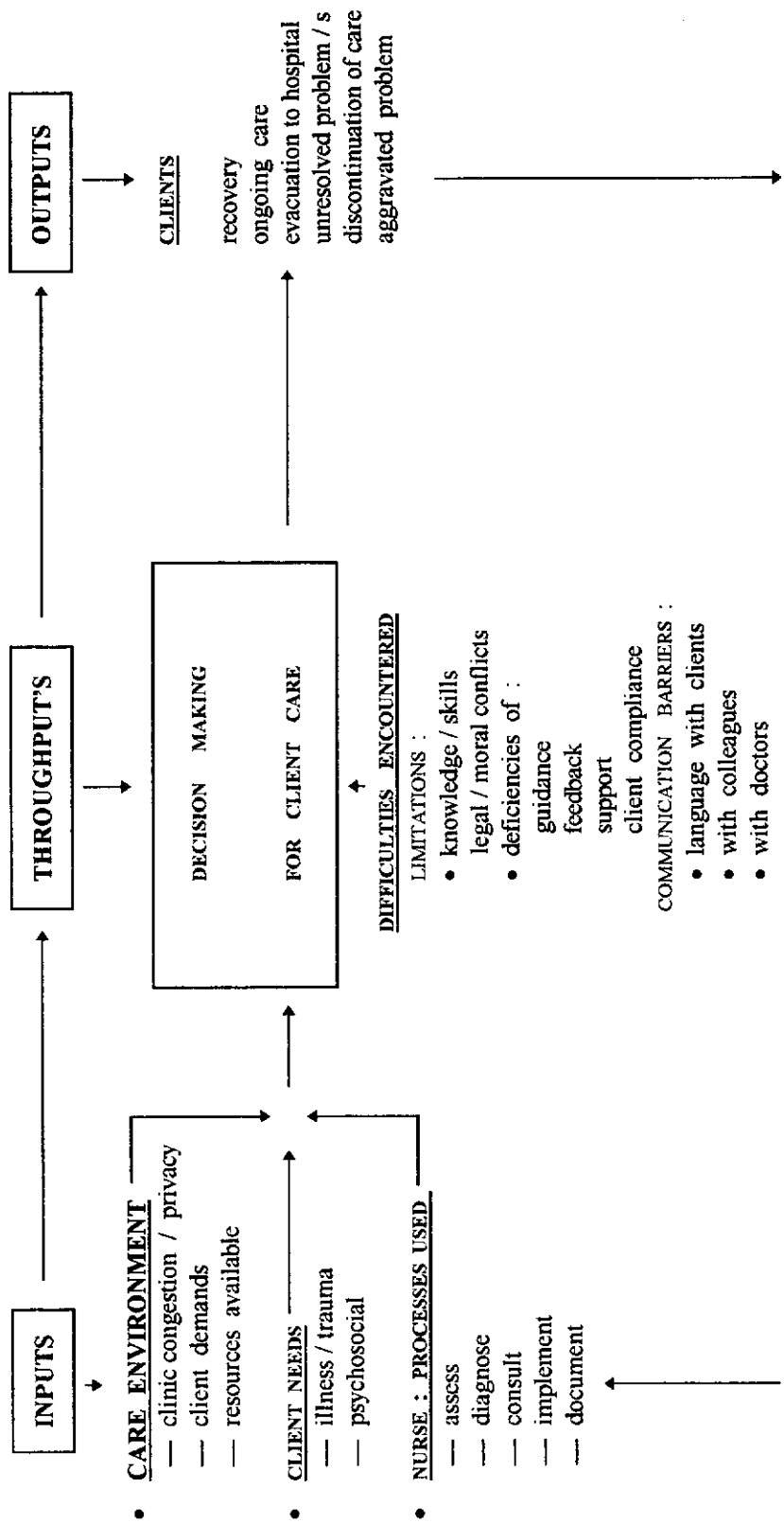
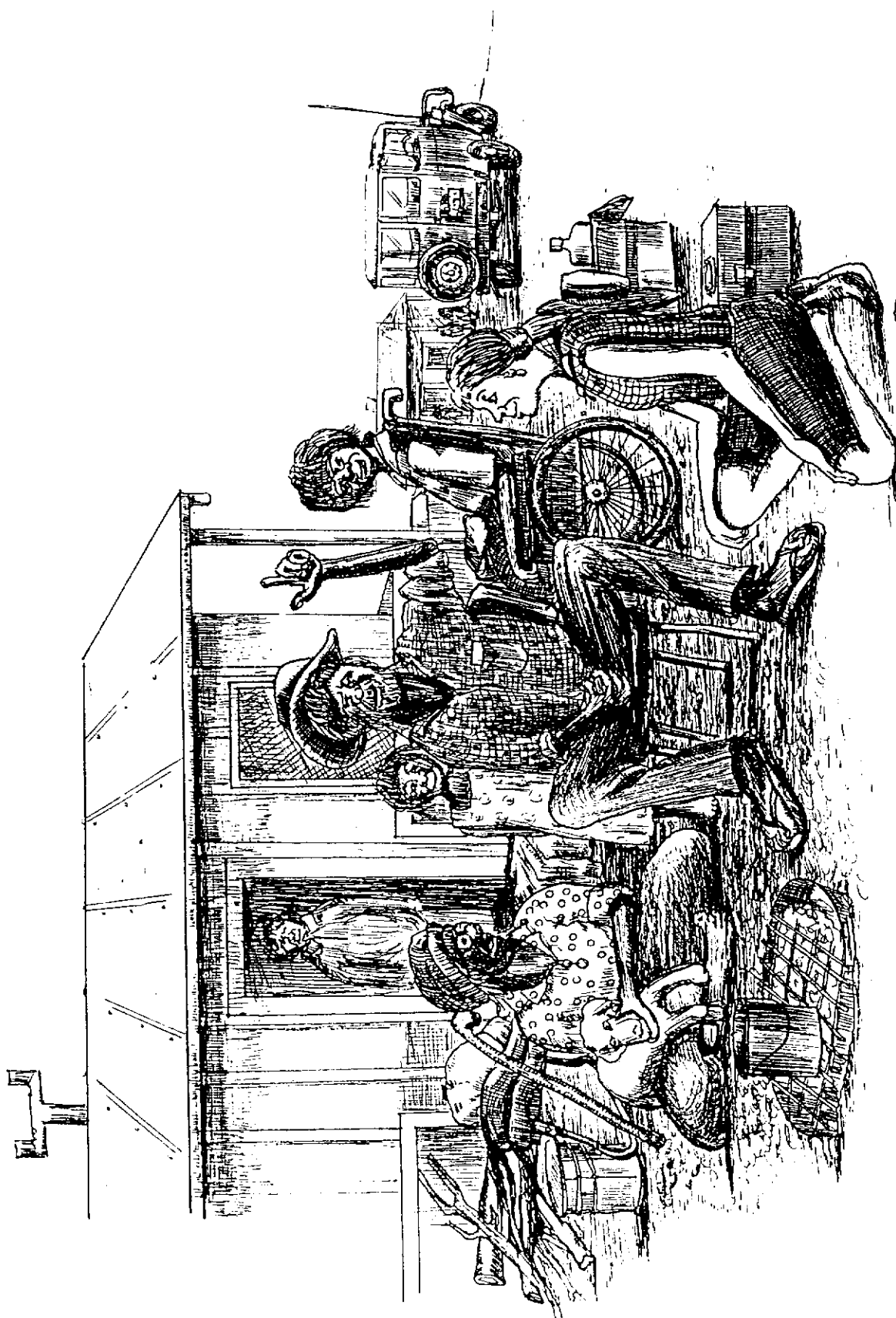


Figure 7.1 : A systems model of decision-making in remote area practice

The inputs of decision-making in remote area practice were the care environment, client needs and the processes used by nurses. The difficulties encountered influenced the throughput of decision-making. Together these elements contributed to the outcomes of client care and ongoing needs.



Robyn K. White '98

Figure 7.2: A home visit
(Drawing : Robyn K. White)

Most nurses perceived that sitting down with a client was important to their relationship and rapport with a client. A lack of space in the clinic, however, often made sitting down impractical for a nurse. Nurses made this point as follows:

- I always try and sit down. It is not always very practical. If someone is sitting down and having to talk up to you, or you are talking down to them it is intimidating. If the client is sitting down and I am sitting down, then we are on the same level. If you stand up over them then you have got this psychological advantage and that is not good for communication.
- I like to sit down when I talk to a patient and not stand over them. It makes for better rapport and a more even relationship.

Several clients did accept a nurse's request to wait outside the clinic in the waiting room or on the verandah. This arrangement, however, was not sustained. No co-operative agreement was reached amongst nurses about its importance or a way to effect this change. For example, as observed in this conversation between two nurses:

Nurse 1: If you are trying to see three children and there is the noise of kids running in the passage you have to take off your stethoscope and go out to tell them to be quiet. It becomes unmanageable and drives you crazy. But how do you stop it?

Nurse 2: Just rouse [rebuke] those kids. I don't mind them about. I don't mind if they run up and down the passage.

In addition, the short stay of most nurses together with the persistence of clients adherence to their routine patterns of behaviour made it difficult to establish changes in the organisation of the clinic. For example, a group of nurses and Aboriginal health workers, in consultation with community leaders, decided to close the clinic on Tuesday and Thursday afternoons to set time aside for other programs such as an ante-natal clinic. At a change of nursing staff, however, this time reverted to the former open clinic attendance.

A few nurses also viewed the congregation of clients as an invasion of clients' privacy and a deterrent to disclosing their personal problems in a consultation. As one nurse stated in defence of her preference for seeing clients privately:

Like this, I can give good nursing care and talk with each one [client] privately and without them being embarrassed.

Individual clients also felt self-conscious when their personal problems were exposed to curious onlookers. This was observed in the following example:

A woman who had been asked by a nurse for a urine specimen, returned from the toilet and noticed several other clients openly staring at her. The client then said to the nurse, 'I don't like all these people looking at me'.

The manner of most consultations with clients within the busy clinic demonstrated the harassing environment in which nurses often made day to day clinical decisions and managed their care. The tendency to distract and interrupt a consultation, for example, was apparent in the following scene that was typical of the congregation of clients in the clinic at mid-morning on a week-day:

Thursday 9.30 am The child clinic is noisy and cluttered. The women and children are crowded around. Three mothers are seated on the bed with their babies. Two older children go to the table and take wooden swabsticks from a jar. Another child, three years old, is seated in the cot. This child has a large abscess on the top of her scalp, the size of a large marble. The nurse has decided to lance the abscess and assembles the equipment. At the same time she tells the two children to replace the swabsticks, adding that these are not toys. The three year old child resists as the nurse's attempts to clean the abscess. She cries loudly and refuses to sit still. The mother then picks up the child to embrace and console her, but still the child resists the nurse and screams. The other women watch and express pity for the child.

A nurse expressed her feelings of harassment and frustration in attempting to deal with multiple demands in a busy adult clinic, as follows:

Tuesday 12:30 pm. I always feel so tired.. This morning I felt like tearing my hair out. I was in the clinic seeing three people at once. One had a thermometer in her mouth, another was going to give a urine specimen and I was being told by a third person what they wanted. I

reckon A___ (name of another client) said 12 times, 'Sister!' to try and get my attention. 'You should get out', I thought to myself.

The congestion in the clinic and the impatience of clients was often observed, like in their demands for immediate attention. This tended to place pressure on nurses to deal hastily with problems as they arose. Under these conditions nurses generally took short cuts to appease demands for instant care. The following observation, for example, was over a time span of fifteen minutes:

Wednesday 10.15 am. Four clients are seated in the adult clinic, while three others are standing by waiting for the nurse. Three clients simultaneously claim the attention of a nurse. One client says briefly, 'Panadol, Sister. I have a headache'. Another client, with an empty medication dosette container in hand, holds it out to the nurse indicating that she wants it refilled. A third client is seated by the oxygen cylinder cupping her hand over her nose and mouth to indicate that she is waiting to be given a Ventolin nebuliser. Acting quickly, the nurse prepares the nebuliser and commences the administration. The nurse briefly speaks to the woman with a headache. She then reaches into the cupboard, takes out two Panadol tablets, hands them to this client and offers her a disposable cup for water to consume these tablets. The nurse then takes the dosette box and walks out of the room to the pharmacy to get the third client's medication. This involves checking the medication orders written by a medical officer, counting out the numbers of tablets needed for seven days supply and placing them into the dosette box accordingly. As she returns with the dosette box, another client standing in the passage-way detains her with a request for 'scabies medicine'. The nurse asks her to wait. Back in the adult clinic hands back the dosette box with a few words of explanation to the client. She then checks the nebuliser. At 10.30 am, following these activities the nurse jots down the names of the clients seen in this time on the Daily Patient Record (Appendix 15).

Most nurses also recognised that, by their immediate response to feelings of pressure for attention from clients, they reinforced this apparently impatient behaviour. This point was illustrated in the quote below:

I also bought into this thing that if I knew someone was a chronic asthmatic, for example, and they just couldn't wait five minutes, I would run out the door and say, 'Just hang on.' Basically because I knew the consequences that later that night I'd be called out to an

asthma attack. So you buy into this thing of responding to their impatience, which is not very good because you are just reinforcing that they can have a tantrum and you are going to respond to that.

In succumbing to the felt pressures of clients demands, nurses were frequently interrupted during a client consultation which again was disruptive to a nurse's concentration. A nurse described her feelings of frustration and the added difficulty in managing an ill client in the presence of other clients' demands. In her view, this distraction also increased the likelihood of a mistake:

I get very frustrated when there are so many people demanding your time all at once. If you've got one or two sick babies, a mother will say, 'Ooh I've got this pika (sore) sister'. I will answer, 'The baby is first and then I will see you'. They want you to stop in the middle of looking at the child, but I won't do that. I nearly made a mistake the other day with a formula because I was distracted. And that worries me. One day I might get so distracted and give the wrong drug to a child.

The congested clinic environment obstructed the movements of a nurse who then had to manoeuvre around clients, the children and the furniture to carry out their work. During a busy clinic, for example, nurses were observed to frequently thread their way through a crowded room to retrieve a client's record, to answer a telephone call or to collect equipment.

Further disruption occurred when a client vented their feelings of annoyance at a nurse. This was observed at times such as when there was a delay in the attention given by a nurse to a client who seemed impatient or when a nurse had demanded that a client wait in another place. Less frequently, nurses had been intimidated by clients who seemed to be aggrieved in some way and had threatened to throw rocks at a nurse or to 'smash the clinic'. On a few of these occasions nurses had informed clients that they would 'close the clinic'. At other times when there had been widespread social upheaval in the community, such as when two guns were stolen from the store, the community chairman had instructed nurses to 'close the clinic'.

Within this environment of daily clinical work and nurse/client relationships nurses had to muster all their resources to manage care competently and humanely. Individual differences were observed in the clinical decision making processes used by nurses. Generally, however, a similar pattern was followed as described below.

The clinical decision-making process

Distinct steps were taken by nurses in making their clinical decision. On seeing a client enter the clinic several nurses stated that they intentionally noted the physical appearance and behaviour of a client. This was before the client was aware of the nurse's attention. On presentation, a nurse usually greeted the person and acknowledged the client by name. When the nurse did not know a client, after a preliminary account from the client of their problem, the nurse asked for the client's name and place of living. The nurse then retrieved the client's record from a filing cabinet kept outside the consulting area. If no record was available an interim record was commenced on a 'Progress Notes' sheet.

Most nurses also attended to the comfort of a client, depending on their apparent needs and the situation. For example, nurses assisted a client to lie down on a couch or a bed if they complained of feeling faint, or took a client to a separate room if they had been assaulted. A clinical decision was preceded by an assessment.

Assessment

The process of assessment usually began with history taking. Questions were asked about the present problem and its duration. The nurse observed a client as vital signs were taken. A physical examination followed to locate the problem and to assess its severity. The physical assessment usually included inspection, auscultation and palpation. A basic urine test was often taken as well to assist in the assessment. The appropriateness and choice of pathology tests at the time was decided on the

individual judgement of a nurse or, where a doctor was consulted, as directed by a medical practitioner.

Several nurses took the time to check through a client's history to obtain information about past illnesses and the treatments administered. Other nurses, however, often relied only on their existing knowledge of the client's health or the information supplied by a client. If possible, when a client came from elsewhere nurses usually contacted the previous clinic which she or he had attended. This was in order to obtain additional pertinent information on a client's past illness and treatment.

An assessment was adapted by nurses to meet the perceived needs of a client at the time and according to the situation. Clients who were clear about what they wanted usually had their requests met expeditiously, such as for reissuing a supply of prescribed medications, administering Panadol for a headache or 'rubbing medicine' for aching muscles.

Nurses were observed to take a three level approach to clinical assessment. The level depended on a nurse's perception of the severity of the illness or injury and of the client's needs. When a problem was judged by a nurse to be minor and self-limiting only a minimal assessment was undertaken. A more detailed assessment was used when a client's health problem was uncertain or serious. An acute problem was the most thoroughly assessed. Nurses were also more likely to consult with a colleague when they felt unsure of their assessment or with a medical practitioner in the case of significant abnormal findings, such as hyperpyrexia or acute abdominal pain. For example, a nurse described this by making the following distinction :

For anything absolutely serious I will get on the telephone to consult RFDS. If I am unsure of something I will get someone else [another nurse] to come in and have a listen to the chest, for instance, and see what it is there.

At the first level, assessment was cursory for apparently minor problems which a nurse regarded as transient, such as headaches, a cough or minor skin abrasions. In this assessment basic observations, such as vital signs were often not taken. Nurses usually treated these clients symptomatically. For example, a client who complained of a headache but reported no other symptoms, was usually administered one or two doses of Paracetamol tablets. A nurse described this approach for making an assessment as follows:

If it is a non-specific problem and there are no other significant symptoms, I will say give a Panadol if there is pain and ask the person to return if there is no improvement.

Another factor influencing the detail of a nurse's assessment was a client's return with a persistent health problem. This was explained by a nurse in the statement below:

You don't do a full assessment on everyone who comes in with a headache. I can't think all headaches are a subdural haematoma. I can't think all chest pains are a MI (Myocardial Infarction). I can't think all guts aches are a twisted bowel. You have got to work on 97% will resolve itself and by their [clients] frequency of coming into the clinic. I will do a full assessment because they keep coming in and this is something they have kept complaining about.

At the second and third levels, when a preliminary assessment of the problem was uncertain or a possibly significant symptom was observed by a nurse, a more comprehensive physical assessment was performed. In these situations an adult client was assessed in the privacy of the examination room. If a nurse decided that a medical opinion was warranted then a medical practitioner was contacted by telephone. Alternatively, the nurse either kept a client in the clinic for further observations or commenced symptomatic treatment and asked the client to return for further assessment if symptoms persisted. When a nurse's assessment was inconclusive, giving a treatment to alleviate the symptoms seemed to be the only option, especially late at night as shown in this example:

Tuesday 11.15 pm The nurse is called out. The client is a young woman who states that she has 'asthma'. In the clinic the nurse takes her observations. Temperature is 37 degrees Celsius, Respirations are

38 and shallow. The nurse then listens to her chest sounds with a stethoscope. After listening to the back of the chest the nurse states, 'I can hear wheezing sounds'. The nurse then asks the woman, "Have you had this problem before?" 'No', replies the woman. 'Do you have any pain?' asks the nurse. The woman points to her upper central chest area with her hand saying, 'Yes'. She is shy and appears slightly anxious. The nurse then checks the history in the woman's file. There is no previous record of asthma, only chest infections as a small child. There are gaps in the history, however, as in the past three years the woman has lived at another community. The nurse decides to treat her symptomatically and to give her a Ventolin nebuliser with oxygen, using 1 ml. of Ventolin to 2 ml of Normal Saline. The woman accepts this treatment while the nurse continues to closely observe her appearance. On completion of the nebuliser the nurse talks quietly to the woman. She then records her observations and the treatment given in the client file. The woman's respiration rate is now 16. The nurse asks her, 'Do you feel any better?'. The woman, still shy and not making eye contact with the nurse, replies 'Yes'. As the woman leaves the clinic with her brother [who waited outside] the nurse advises her, "Come back if you feel unwell again during the night. I also want you to come back in the morning so that I can assess you again".

The decision to consult a medical practitioner in these situations was influenced by a nurse's confidence to assess and treat a problem. It was also influenced by other considerations, such as whether it was felt important enough to inform the medical practitioner and/or to seek medical advice or a prescription for treatment.

Clients with an acute illness or injury were accorded priority by nurses and were assessed as fully as possible. Following an assessment, nurses documented their findings. They also often made a tentative medical diagnosis and decided the care and treatment to be administered.

Documentation

The nurse's documentation in the client history generally included the date, presenting symptoms and signs, observations, findings on examination and the treatment administered, such as a medication or a wound dressing. Nurses rarely included the nursing actions they had undertaken, for example, when a tepid sponge was given to a child with fever, or a particular wound dressing a nurse had devised to withstand local conditions. One day I remarked on my impression of a lack of nursing documentation. 'Yes,' agreed one nurse, 'nurses do not document the nursing actions, yet these are an important part of the clients' care.' The extent and method of recording, however, varied between individual nurses.

Diagnosis and care decisions

In the majority of cases seen each day, nurses made decisions about a client's illness or injury and its treatment and/or care management in response to the signs and symptoms they had observed. A diagnosis as speculated by a nurse usually pertained to a medical problem.

On frequent occasions nurses formed an opinion or made a judgement of the medical diagnosis based on their assessment of a client, such as 'It is a Urinary Tract Infection', 'It could be pancreatitis', or 'I think it is cellulitis'. Most nurses usually sought a confirmation for this provisional diagnosis from a medical practitioner. They were, however, often reluctant to specify a diagnosis. For example, as seen in this statement by a nurse:

When I rang the doctor the other day, I said he has got this, this and this. There is also a letter from a specialist and I read it out to the doctor. She said to me. 'Are you thinking along the lines of a PC (pericarditis)?' And I said 'Yes, that has crossed my mind. That is what I've been thinking'. She said, well it would be unlikely, but because of that C reactive protein that is missing in his genes or whatever it is, he has the potential for it. It has got there in the letter if he goes on flights in a 'plane, or drives long distances or has surgery he has got to be aggressively treated prior to any of those things happening, with a

prophylactic dose of Warfarin or something like that. He is a smoker and smokes up to 30 cigarettes a day and is young and fairly wild. I know that is stereotyping him, but you have to think of those things as well in an assessment. I didn't say to the doctor, 'I think he has got a PC'. I said that was in the back of my mind. She made that diagnosis coming back on the 'phone after seeing the ECG (electrocardiograph tracing), that he might have pericarditis. So I mean I don't make a diagnosis.

Clinical decisions pertaining to the nursing care needed was at the prerogative of an individual nurse. Often it appeared to be secondary to decisions made for the medical treatment of a client, or even not made at all. The following observation illustrated these points:

Tuesday 10 am. A man, 50 years old, is brought in from an outlying community. He has muscular weakness and has difficulty standing. The nurse records his blood pressure as 70/40. The man has a previous history of non-insulin dependent diabetes mellitus and renal impairment. The nurse who takes his observations also takes the intravenous trolley to the four bed ward where the man is accommodated. The nurse then goes to the telephone to consult the medical practitioner. Another nurse, seeing that the man has not been given water, takes him a waterjug and glass and offers him a cup of tea. The man is very thirsty and drinks two glasses of water then two large cups of tea. At 4.15 pm, however, the nurse attending the client tells me, 'I put up an IV (intravenous) with Hartmann's. He has also had two Haemaccels for his low blood pressure.' This was ordered by the RFDS medical practitioner. The client is to be evacuated later tonight. On visiting the client at 7 pm. I observe that he is unwashed and still dressed in the soiled shorts he wore on arrival. The air conditioner is on and the room is cold. The client is lying on the bed uncovered and curled up to warm himself. No regular observations have been taken. His urinary output is unrecorded.

Nurses referred to a medical practitioner when they decided that a medical need was beyond their capabilities. Medical advice was usually sought when a nurse was uncertain about the client's health problem and/or the treatment needed and its authorisation. For example, following a client assessment when a nurse felt unsure of the significance of their findings, or when a course of treatment administered by a

nurse had been ineffective. In these situations nurses wanted guidance and medical orders for an appropriate action. On most occasions there was a feeling of support from consulting a medical practitioner when a nurse sought reassurance and direction. In addition, the medical consultation provided an opportunity to discuss the problem. For example, as stated by this nurse:

If I am unsure I will ring up the RFDS, even if it means just getting some support and agreement for what I am doing. Too bad if it's 2 o'clock in the morning. Trying not to do things I don't know how to do. Sometimes that's difficult. Sometimes I have to discuss it with a doctor and say, 'This is what I've got. What do I do?' or 'What can I do?'

Authorisation for treatment of a client was a major reason for a medical consultation. Nurses had often decided that a particular drug treatment was needed, for example an intramuscular antibiotic for the treatment of a suspected lower respiratory tract infection. They then consulted a medical practitioner to prescribe a drug. This practice was observed to vary between nurses. A few nurses usually consulted a medical practitioner before administering prescription drugs. Others, however, only consulted for authorisation if a more infrequently used drug was needed. Nurses made individual judgements about the problems they could identify and treat themselves, the drug treatments they could prescribe and when a medical consultation was needed. This was expressed in the following example:

I am quite happy to treat chest infections and UTI's (Urinary Tract Infections) and things like that. No worries. If they need more than Amoxil, they need some sort of antibiotic like Ceftriaxone or some sort of proper management and it is something more complicated beyond my skills, I will involve the RFDS.

Nurses routinely used the guidelines, as available in the CARPA Manual, to assist them in making a provisional medical diagnosis and in prescribing a treatment. Within such a context, often a diagnosis could not be decided upon even though a nurse retained the client in the clinic for further observation, as shown in this example:

Monday 2.30 pm. A six year old child is brought to the clinic by her parents. The child has abdominal pain and a frontal headache. The parents inform the nurse that the child has vomited twice before coming to the clinic and has not passed urine since the early morning. In addition the child has not eaten since breakfast when she ate 'two weet-bix'. Her temperature is 38.5 degrees Celsius. The nurse does not find any evidence of neck stiffness. The nurse is unsure of what the problem is and checks the index of the CARPA Manual. A condition relevant to this problem is not found and the nurse decides to consult the RFDS medical practitioner. The medical practitioner tells the nurse that he 'thinks it is one of three things, a viral infection, meningitis or a urinary tract infection'. He orders a urine test when the child voids. The nurse gives the child Panadol suspension for pain relief. The child will only accept sips of water. The mother sits beside the child on the bed and mops her daughter's brow with a moist cloth given to her by the nurse. At about 4 pm the grandparents arrive and sit near the child. The grandfather sits at the foot of the bed and strokes the child's limbs. The child's temperature is now 37.5 degrees Celsius and her pulse rate is 104. She dozes on and off, then complains of abdominal pain again. It is now 5.15 pm. The child still has not voided. The nurse suggests the parents go home with the child and that she will visit them after supper to see how the child is. The father picks the child up in his arms and walks into the passage-way. The child begins to retch and vomits brown fluid containing flecks of curd. Together with the nurse, the family return to the ward and the child falls asleep on the bed. The grandfather sits beside the child and says he will take her to the *ngangkari* (traditional healer). At 6.30 pm. the nurse repeats the observations then again suggests that they return home and that she will visit them in a couple of hours. Following the departure of the family, the nurse declares, 'I feel so dissatisfied. I feel that I have not been able to do anything for this young girl'.

Faced with such a dilemma, nurses had the choice to consult a medical practitioner for the evacuation of a client to the regional hospital or to monitor their progress at the nursing post. When clients were retained, their stay could be up to 14 hours, or longer depending on their progress, before discharge or an evacuation by the RFDS. In an emergency the time lag was less, but still took between two to four hours. In making this decision, therefore, nurses also had to calculate their personal and material resources to manage the problem. For example, as stated by this nurse:

You are a long way from back-up. And also you have got to think about three hours down the track. You have got to think about the

next day, if you are working hard and its midnight or something like that... Do I have enough energy to do all this and work next day? Do I have enough oxygen? The truck is coming up in three weeks [from Perth], that's the earliest I can get another supply of oxygen..

Medical practitioners often instructed nurses to 'sit on' a client or to 'keep an eye on' a client to defer making further decisions for their care. These terms were used on similar occasions where a nurse was expected to continue surveillance of a client's progress and response to treatment. In general use, to 'sit on a client' meant to 'wait and see' and to 'watch' the client as well as to implement the measures of care ordered. This was a medical practitioner's explanation of the use of such terms:

If someone rings up first thing in the morning and it is a child who is dehydrated probably because it hasn't been given anything. To sit on it in the clinic is to wait and see if they are going to improve. What I also feel fairly strongly is not to sit on anything after 5 o'clock. When you realise what the circumstances are, that the Sister [nurse] has to be up all night watching this patient, then they should be evacuated. I also feel that with a lot of things that will present that nothing has been tried. Simple measures can be tried during the day and you can instruct a mother, for example how to carry on and things will improve. Obviously this is difficult if someone is very sick.

The different uses of the terms pertaining to monitoring clients and decision-making, were apparent between situations of non-urgent and acute illness. The following observation illustrated the way in which to 'sit on' a client was used in the sense of 'wait and see', but not 'watch':

Wednesday 9.30 am. A one year old child is brought to the nurse at the clinic. The mother reports that the child has had diarrhoea since last Friday and that yesterday she had vomited. The child has lost 400 grams in weight since being weighed five days ago. The nurse consults an RFDS medical practitioner by telephone. He then instructs the nurse, 'Give the child GOES (glucose oral electrolyte solution) and sit on her for 24 hours'.

The expectation of nurses as individuals to diagnose, treat and monitor a client also presented other dilemmas for a nurse, such as in assuming responsibility for client

consent and for the outcome of medical decisions. A lack of preparation together with the continuous isolation of the nurse and the client from other health and allied care providers, however, contributed to the recurrent difficulties encountered by nurses in clinical decision-making.

Difficulties and limitations

Decision-making by nurses was adapted according to the exigencies of a situation and various factors in their relationships. The difficulties they encountered included the limitations to nurses abilities together with a lack of a system for guidance and review of care decisions. A particular problem for nurses was in dealing with the psycho-social aspects of care. Other difficulties pertained to communication barriers with clients, with colleagues and with medical practitioners.

Most nurses experienced feelings of insecurity when making clinical decisions in acute care situations and in performing clinical procedures for which they lacked adequate knowledge, skills and resources. In dealing with everyday health problems as well, such as skin infections, nurses still felt uncertain as to whether they had made the best decision. Other factors that contributed to this difficulty included the assessment of unfamiliar clinical problems and the adoption of medical functions.

A fundamental problem was that nurses were nurses and thus unprepared to make a medical diagnosis. Several nurses stated that they utilised their nursing assessment skills to make a medical diagnosis and prescribe medical treatments. The dilemma posed by guesswork in decision making in the remote area was described by a nurse as follows:

You make assumptions that you are diagnosing correctly. You just hope that what you thought their pain was and why they felt sick, was right. You go through the motions, sure, because you have seen other people do it, more so than having the knowledge yourself. You really don't know what you are looking for. That is the way I feel about it. A lot of it is assumed because you are not trained in the [medical] techniques of examination, what you should be hearing, what you

should be feeling and where the organs are in respect of where you are palpating. You really don't know.

In a similar vein another nurse had this to say:

I'm no expert on mental health. But social problems like abuses, whether it be physical or sexual or substance abuses, they are never properly assessed. Nurses here generally aren't equipped to deal with them.

Furthermore, the problem for nurses making a medical diagnosis was exacerbated because there were insufficient means to rectify this problem due to an absence of evaluation or feedback. One nurse expressed how this problem affected her:

Out here there is nobody checking on how you are doing, like your clinical decisions. Nobody has come back to me and said, 'Oh, Eleanor (pseudonym), Why did you do it this way?' when they have seen a client who I had previously seen. It has never been my role to diagnose, but out here we need to assess the signs and symptoms and come up with a [medical] diagnosis. I am sure I am making mistakes, but nobody has questioned anything I have done which seems really odd to me.

Other nurses also experienced these feelings of uncertainty in their ability to make an appropriate clinical decision due to a lack of formal feedback and the unavailability of expert guidance. The following quote was an example:

You have got to be with people who have done it and so you can get feedback on how you handled something. Out here you never really know if you have made a good decision.

Most nurses stated that the outcome of an evacuation was one of the few times they had received feedback on their decisions. This feedback, however, depended on a nurse making contact with the hospital and was usually informal in nature. For example, in this statement by a nurse:

A satisfaction for me was when I had a couple of people evacuated and both of them needed to go. Like when the 'plane takes off with the patient you worry until the next day when you 'phone up the hospital [for feedback] and you hear, 'Oh yes, the patient with query

appendicitis did have an unhealthy appendix when it was removed', 'The patient with asthma did have a filthy chest and needed to go' and 'The child with an injured shoulder did have a fractured clavicle that needed to be checked out'. So there was some of them that I was instrumental in having shifted out and I was right.

Another limitation for nurses' decision-making was a lack of back-up. Nurses' concerns were often associated with their feelings of insecurity about medical and/or organisational back-up. 'Not knowing' was frequently expressed by nurses as a problem for them in taking full responsibility for the consequences of their decisions and actions. A nurse described the difficulty of 'not knowing' and the feeling of a lack of back-up in this way:

It is not knowing. Sometimes you don't really know what you are dealing with. I honestly believe if something went wrong I don't think management would back you up. You are there on your own. The only accountability you've got is your own. Now, if you feel you are not accountable for what you have done or you are not responsible for what you have done, nobody else is going to say anything. The doctor isn't. They are a thousand kilometres away. Management isn't [going to say anything]. But you know as a nurse if you shouldn't have done it. So you are it.

'Not knowing' was also used in relation to a nurse's assessment and choice of treatment. These nurses felt that in 'not knowing' what a health problem was, or how to manage it effectively, they had used 'blind treatment'. Furthermore, this kind of decision-making seemed haphazard. A nurse used this term as follows:

With this blind treatment, the worst thing is you don't know what it is. You never know what it is. You treat it with some broad [spectrum] antibiotic. It goes away. All you know is this is what happened and I did this, but it could have resolved itself or something.

Nurses who perceived that they were ill-prepared for the medical oriented decisions and procedures expected of them stated that they 'felt out of their depth' in assessing complex health and social problems of clients in the remote area. The lack of assistance or expertise available on-site also prevented a nurse from being able to

hand over these responsibilities to, or to collaborate with, a more qualified person. In addition, apart from the minority of clients seen by a medical practitioner, there appeared to be no-one to affirm what they had done. This lack of confidence in clinical decision-making was revealed in unguarded remarks such as, 'You are not sure if you've done the right thing', or 'I'm not sure that I've done everything that could be done'. The following nurse's statement was an example:

Like the head injury situation I had earlier [in the day]. You are wondering if you can do the assessment alright and get it right and wanting things to go smoothly. And when they don't you are a bit more nervous, like when you have to put a drip in and it doesn't go into the vein. That's when it is nerve racking, because you feel that everyone is relying on you. So all that can be a bit nerve racking.

Most nurses often feared 'missing something' in a client assessment that could be important to a client's well-being. These nurses also felt that they may 'make a mistake' in their conclusion. The complexity of decision-making where 'missing something' or misdiagnosing may have adverse consequences was often accompanied by lingering anxieties for a nurse. The lack of organisational guidelines for managing client care in special circumstances, such as a client in police custody, further added to the difficulties for decision-making faced by a nurse. The experience of this nurse illustrated such a problem:

Yesterday I was called down to the police post to see a man who had a sore wrist and a sore toe. And I couldn't find anything to tell me how to manage somebody who was at the police post. You hear so much about deaths in custody and he had a sore wrist from the handcuffs and he had a sore toe because somebody in boots had trod on his toe and cracked off his big toenail. But he also said he was an epileptic and a diabetic. I was really worried about leaving this man up there in police custody. In his notes I found out about the epilepsy and if he was on medication and what it was caused by. I couldn't find anything about the diabetes. I spent the night worrying about whether he was going to be alive in the morning. Worrying whether I had missed something. But there was nothing to guide me as to what I should be doing in that situation. That's a worry. There is no guidance. It's really important that the man is safe in there [the cell] and that he had whatever medication he needed. I felt very responsible having been called down [by a police officer] to see him even though I was told it was only the wrist and the toe. The man disclosed to me he had these other

problems. It only came to me later in the night that I could or should have consulted the RFDS for advice.

The CARPA Manual nurses routinely used as a guideline for treatment decisions on a range of health problems did not account for the individual differences of clients or for alternative measures of nursing care. These instructions, which the organisation directed nurses to follow, were not always perceived as acceptable or justifiable to a nurse. The difficulty this posed for nurses decision-making was illustrated in the following observation:

A 14 year old youth attends the clinic with his mother. He has scabies lesions with a pustular discharge on the wrists, elbows and lower legs. The mother asks the nurse to, 'give him a needle'. Two nurses together check the CARPA Manual to find an appropriate treatment. The direction found in the manual for infected scabies are to treat with AP Bicillin or L-A Bicillin, unless the client is allergic to Penicillin (Appendix 17). Neither nurse feels satisfied that this treatment is required.

In the discussion that followed between the nurses these points were made about the difficulties they experienced in adhering to the Manual's instructions and in repeatedly using antibiotics for skin infections in this setting:

- The problem is hygiene. It is not appropriate just to give antibiotics.
- The repeated administration of antibiotics has long term implications for the child's health.
- It reinforces an expectation that injections are the answer.
- What is the authority of the Manual? Would they give antibiotics in Leonora or Kalgoorlie? Do they follow CARPA?
- There (in Leonora or Kalgoorlie) would be a doctor. Here there is no doctor and the CARPA Manual is a guide in their absence

Nevertheless, nurses who disputed the authority of the CARPA Manual for their use to diagnose and prescribe still felt unable to consult a medical practitioner every time

a medical authorisation was needed. A nurse summed up this dilemma in the following statement:

One of the new nurses got told that CARPA Manual is an unwritten doctor's order. That is garbage. We are all supposed to follow that because we work in a remote area. But legally 90% of that stuff we should not be doing and we know that. But what do you do? If we are going to ring up RFDS all the time when we need something, they are going to get that way and say, 'Oh there is that stupid Sister again'. And they won't take any notice when we really need help. So what do you do?

Within this unstructured and isolated practice environment there appeared to be a greater possibility for making an inadequate observation or care decision. Nurses, who doubted their abilities and/or who questioned their decisions as well as the outcomes of care were often observed to mull over their actions. The quote below illustrated this point:

You have got to reflect on what you have done and whether there may be more you could have done. You have got to question whether you are doing the right thing or the wrong thing. If you start feeling that you are *blase* and you know everything, that is when the problems start. When V__ came in today with chest pain. I picked her up and walked her to the car. Well really if she had heart problems I shouldn't have walked her. And there was the thing, should I give her Ventolin or not? I opted not to give her Ventolin. At the time I don't know why I did not give her Ventolin, but I was not happy giving it. Something told me, 'Don't give it'. I didn't even think, 'I shouldn't give her the Ventolin because of some reason'. I just thought 'This is not V__ her usual asthmatic self'. She was clammy and had an irregular pulse. Even though she had said it was asthma pain and she could not give me a true picture of her chest pain. If I had given the Ventolin when she was in atrial fibrillation it would have tipped her over into another irregular rhythm. This came out when I was talking with the doctor. He said, 'Do not give the Ventolin' It wasn't until I did the ECG (electrocardiograph) that I saw she wasn't in sinus rhythm, but was in atrial fibrillation. I have worked in a cardiac unit, but someone with no experience could have given her Ventolin quite easily, assuming it was asthma, and sent her back home. [The client was evacuated to the regional hospital.]

In the absence of systems of review for the nurses' practice it was left to nurses themselves to reflect upon their priorities in decision-making and its consequences. In the wake of managing life-threatening illness or trauma the emotional strain weighed heavily on the mind of a conscientious nurse. There was also no respite for these nurses and usually no-one to share their concerns. These points were illustrated in the following example:

Sunday 9.15 am. Well I was thinking when that guy was brought in yesterday and he had lost all that blood [from an assault with an axe]. He needed fluid replacement. He needed Haemaccel. I was looking at that packing tape around his leg and I thought, 'Gee, how long do I leave that on there? That is a constrictive bandage. He is going to have nerve damage there, permanent damage if I don't get it off. It was more or less a tourniquet that he had on. So that is why when F__ [the off duty nurse] came. I said, 'Get the IV. (intravenous) trolley and put the drip in and I will get the packing tape off. I was not really sure of what the top priority was. Is he going to have permanent nerve damage or is fluid replacement the priority. That is how you are prioritising. I think if I had been on my own I would have definitely left the packing tape on and got fluids into him first. That is another thing I have been thinking of. 'Did I do the right thing? Was I thinking in the right order?' I know that he needed that fluid replacement urgently. Basically all at once. If the woman [a witness to the assault] had not put the packing tape on he might have bled to death. It was a priority to get that off. How long had it been on for? Do they say a maximum of twenty minutes for a tourniquet to be on? I think it is about what they say. If I'd been on my own I would have put the drip in first. I did not take the packing tape off until I had a constrictive compression bandage on from the knee down. The thing is I was not thinking. It just came automatically. In hindsight afterwards, it must have been half past one or two this morning, I had a lump in my guts. I had a headache and then I had people trying to break into my place on top of that. Then I had a guy with DTs (Delirium Tremens) who needed treatment. By that time I was a nervous wreck myself. So I think I shouldn't be here.

The inexperience of some nurses in general nursing was another limitation observed in their reasoning for decision-making. Often it was only in hindsight, with additional knowledge and experience acquired by chance, that a nurse comprehended the real import of their decisions. In these situations nurses felt a sense of uneasiness for the harm that could have (or may have) eventuated. They also recognised how differently

they would have acted had they possessed this knowledge at the time it was needed. For example, a nurse recalled situations in which her lack of a midwifery qualification and inexperience had contributed to her unknowingly risking the welfare of clients:

When I first started work out here I was told by a senior nurse who did not have midwifery, 'You don't need midwifery. You are more cautious when you don't know too much'. But this was my greatest fear - antenatal care and delivery. There was a woman in labour and when I consulted the doctor by telephone I was told to do a vaginal examination. I told him [the doctor] I hadn't done this before and that I didn't know how. The doctor then told me over the telephone how to do the vaginal examination and I then did it. Later talking to a midwife I realised a vaginal examination should not have been done because the woman had a history of an antepartum haemorrhage in this pregnancy. Another time a woman came to me in premature labour and I put up a Salbutamol drip [intravenous] following the CARPA Manual. The woman had ruptured membranes. I know now I probably shouldn't have done this because of the danger to the baby. The CARPA Manual section on 'Stopping Labour' does not mention ruptured membranes (Appendix 18).

Performing in an unprepared role in uncharted waters and with no follow-up for corrective action there appeared to be a *laissez-faire* attitude to client care. This was illustrated in the following extract from an observation:

Thursday 9 am. A 12 year old girl enters the adult clinic alone. The girl is walking stooped as if in pain and clutches her long full skirt gathered up in her hands. The nurse notices the girl and promptly invites her into the examination room. The girl is assisted onto the couch by the nurse. Almost in a whisper she tells the nurse that she has a 'boil' and indicates the left groin region with her hand. The nurse gets the child's record. In the file she notes that the child was seen the day before by another nurse. The entry records a 'lymph node swelling in the left groin'. There is no description of a lesion or the care given. On examining the child the nurse finds a large peaked swelling above her left groin. The surrounding tissue, extending across the lower abdominal and pubic area and to the right side of the pelvis is inflamed, tense and hot to touch and extremely tender. The nurse then inspects other areas of the child's skin, including the buttocks. Here the nurse observes three small boils. One boil is draining pus. The nurse remarks, 'I've learned to always examine the buttocks as well when there are lesions on the anterior pelvic region'. The observations are also taken by the nurse and all these findings documented.

Moral as well as legal dilemmas in making medical decisions were frequently expressed by nurses. For example, most nurses acknowledged that they did not possess the authority or the skills and knowledge required to make a medical assessment or to prescribe a drug treatment for a client. Nevertheless, they still attempted to perform these procedures. In spite of their limitations, most nurses felt that they 'did their best'. In their view, if they didn't provide the care needed to the best of their ability there was no-one else available. A nurse described this pragmatic outlook as his 'basic principle':

You just have to accept I'm one person. I can only do what I can do and no more. That is my basic principle. I am one person. If I can't do it, bad luck, I can't do it. I'm sorry I can't do it. For example, there was a guy with a broken finger. I tried to get it right. I ultimately did. But if I couldn't, I'm sorry mate, I can't fix that. If I misdiagnose somebody, I'm only one person and I can't do any more than one person can do. For instance, one guy I missed a diagnosis of, he had an enormous liver. I just looked at it as being just a really fat guy. Well I got him examined a couple of weeks later by the RFDS doctor. He said, 'Can't you feel this big liver?' Yes well I felt it but I just thought it was fat. I've never had anything to do with such things before and I am only me. And that is my underlying philosophy. I can only do what I can do and if I wasn't here it wouldn't get done, would it?

In most situations the nurses only identified their limitations for decision-making in relation to physical care. Most clients presented with a physical complaint and these were attended to accordingly. In these decisions, however, the psycho-social aspects of care were at times also a consideration.

Psycho-social aspect of decisions

Several nurses recognised the importance of psycho-social needs, however this was often not dealt with in routine decision-making. The difficulties experienced by nurses were the limitations from their lack of knowledge, skills and resources for managing complex social problems, the constant pressure of clinic demands, their unfamiliarity with clients' beliefs and a tendency for clients to avoid disclosing abusive social situations.

A nurse told of an experience that had reaffirmed for him that social circumstances as well as physical signs and symptoms mattered in making an assessment:

A woman repeatedly came to the clinic with aches and pains that did not seem to respond to any treatment. She was also looking after her husband who was disabled and dependent on her. After he died, she changed completely and had no more complaints of these pains. It is the psycho-social aspects of it as well. But you can't deny someone the possibility that it might be some sort of organic aetiology. You have to go through that process of investigations as well.

The social effects of a decision made necessary by a client's physical condition, were also a factor. For example, several nurses perceived that the decision to evacuate a client to a hospital had social as well as health implications. The social outcomes could, at times, cause more anguish for a family while the client's health needs remained unmet or were even exacerbated. Despite their limitations in dealing with the unintended social consequences there were nurses who still felt responsible, as illustrated in this quote:

I think that evacuating somebody has to be taken very seriously. If they leave or abscond from the [urban] hospital and go out on the grog, it's not only the damage alcohol does to people, but the violent situations they get involved in. This can cause lots of trouble and you've caused the family more grief than benefit by evacuating them out [from Warburton]. I did have somebody moved, taken to Kalgoorlie, who said she didn't want her pregnancy to continue. She wasn't evacuated by the flying doctor [RFDS] but she was evacuated out on the regular 'plane with her husband who had gone down with her. They got down to town and she wasn't in the hospital for more than a few hours and her husband went out on the grog and she felt the need to go out [from the hospital] and look for him. So she didn't have her needs attended to. Yes, there are many considerations in getting somebody out.

Sometimes clients associated their physical complaints or mental anxieties with sorcery. In these situations it was assumed that a nurse could provide symptomatic relief without needing to know, or the client being able to communicate to the nurse, the beliefs that related to the cause of the disease. Cure from the supernatural forces or foreign objects causing these illnesses, such as '*purli*' (a stone) or '*purnu*' (a stick

or wood) within the body, however, were only believed possible by traditional healers (see chapter 3, p54).

Nurses experienced difficulty in detecting occasions of physical or sexual abuse that were unreported. This problem was not generally spoken about. Nevertheless, as an indication of concern amongst women, when a policewoman visited Warburton to speak about sexual assault and the law, approximately 80 women had attended the meeting.

Nurses had sometimes learned of a woman who had been abused, for example, from an account given by other women or from an Aboriginal health worker or a client who had confided in a nurse. Nurses who were aware of the problem of abuse did consider it in their assessment but often felt limited by their inexperience. Furthermore, they had no preparation or guidance for assessing and managing the care of clients who had been abused. For example, as this nurse explained in assessing a child:

Another thing with assessing kids, and I tend to do it automatically in my head, is that you have always got to look for child abuse. Like that kid with a burn on his hand and a bump on his head. It's always got to be in the back of your mind when seeing these little accidents. Sexual abuse I would recognise obvious things, physical signs, but I would find it hard to pick up emotional signs. I'm afraid I haven't had enough exposure to it and no matter how much you read, its all seeing lots of it.

A few nurses were alert to the possibility of an abuse when a female clients in particular presented with multiple trauma or with apparently severe physical symptoms that were non-specific and not possible to establish. This was the nurse's concern in the following observation. The medical practitioner consulted, however, was not attentive to the nurses suspicion of an abuse:

Wednesday 9.30 pm. The nurse is called out. A woman, brought to the nurse in a car by her husband. stands outside holding her small baby and is bent over as if distressed and in pain. The nurse takes the woman into the clinic. The woman's observations are satisfactory. She describes her pain as 'all over' the abdominal region and in the central chest area. The woman is obese. On physical examination the nurse is unable to palpate any specific area of a problem A urinalysis reveal

glucose in her urine. The nurse finds nothing in the client's history of previous abdominal problems. There is, however, a previous account of an assault by her husband. The nurse then thinks about the woman's relationship with her husband. He has waited outside in the vehicle and toots the horn impatiently for his wife to return. In her uncertainty and the woman's obvious distress, the nurse decides to telephone and consult the RFDS medical practitioner for advice. The nurse also informs the medical practitioner of the previous assault. The medical practitioner, however, expresses his opinion as, 'She is just getting attention. Give her two Panadeine Forte, but tell her not to return'. The nurse gave the analgesic, but did not say to her not to return. During the night a storm blew up with heavy rain and strong winds. The nurse remained awake, lying in bed, and worrying that the woman might still be in pain and not be able to get back to call her.

The limitations that pertained to nurses' knowledge and abilities for total health care together with a lack of systems for guidance, feedback and back-up in the setting were important factors in the difficulties they experienced in decision-making.

Another major factor contributing to the difficulties of decision-making was observed in the area of communications.

Communication barriers

The ability to communicate is a fundamental aspect of decision-making in nursing practice. Nurses in the remote area frequently encountered difficulties in their communication with clients. In addition, they also experienced problems that impacted on clinical decision-making in their communication with colleagues and with medical practitioners

Communications with clients

The ability to communicate with Aboriginal clients in the remote area was often limited by language barriers. In addition there were differences in customary behaviour and in cultural beliefs about the causes and cure of illness. Such difficulties

were observed in history taking and in the interpretation of information provided by, or to, a client.

Nurses were unable to speak Ngaanyatjarra, so when a client was not fluent in English, history taking became well nigh impossible. Furthermore, these clients were often uncommunicative. A male client remarked to me that, 'some nurses ask too many questions', as if the range or choice of questions were too invasive. The following quotes were representative of some nurses' views on history taking:

- Histories! We are told in our nursing education the importance of getting a history. But out here it is nearly impossible to get a history partly because of the language barrier.
- Getting a history from these people is really hard. All you get is monosyllabic answers. They say, 'I am sick'. You ask, 'When did you get sick?' No answer. 'Today?' 'Yesterday?'
- I don't think people necessarily understand what you mean by 'yesterday', or what you mean by 'this morning'. Not everybody's English is good enough to understand my meaning and certainly I don't have any Ngaanyatjarra language, so I don't know what they are telling me in their own language. It is particularly difficult when you are trying to get symptoms from people and trying to assess somebody's pain. Pain is very difficult where they don't understand when I am trying to ask if it is continuous pain, or does it come and go, is it in the same place all the time? Or even as simple as 'When did the pain start?'

Questions from the nurse about the location of pain was an example of communication difficulties when questioned. Clients often responded by gesturing with their hands to the general area of discomfort. In making an assessment, therefore, nurses resorted to prompting clients by asking "Is it here?" "Is it there?" as they used their hands to indicate specific places on the client's body. In assessing pain, nurses also offered cues to the client, such as 'Is the pain like stabbing', 'Is it a dull pain?', 'Does the pain come and go?' At times the client would answer 'Yuwa' (yes) to all these questions, thus further confusing the nurse. Nurses tended to compensate for poor verbal interaction with observations, as shown in the following quote:

The language barrier is a difficulty for making an assessment. With older people there is almost a total lack of understanding English, although they have had to understand some. So that is where your different skills get honed up. You can't rely on a verbal description of what is wrong. People don't have a great string of adjectives to describe things, like what sort of pain is it? Like a knife stabbing or a stinging pain? If you gave people five different choices, they would probably nod their head to all of them.... Here you are mainly looking and observing, which is a nursing skill.

Even though there are specific words in the Ngaanyatjarra language that can be used for pain, like '*wakawakara*' (from the word 'spearing') for a sharp piercing pain, '*patjapatjara*' (from the word 'biting') for a gnawing pain, such words were not understood or utilised by nurses.

Another problem that was observed in Ngaanyatjarra clients communication with nurses was in their use of English terms, which had different meanings for them. For example, a client may say to a nurse that they have 'asthma', or that someone is 'having a fit'. The term 'asthma', however, could be used to mean breathlessness or chest pain. 'Having a fit' could also be used to mean being feverish or trembling. On some occasions clients also appeared to use these terms when calling a nurse as a way to obtain a prompt response. Nurses, in their assessment, tended to take the use of these terms literally.

In situations where minimal language communication was possible, nurses often requested an Aboriginal health worker or another client who spoke English as well as Ngaanyatjarra, to interpret. This option depended on their availability as well as ability to assist a nurse and client. Several nurses maintained, however, that they could perform an assessment in spite of their lack of language skills. This was conveyed in the following quotes:

- You've got to assess them [clients] purely on observation of wherever you look. If they are in pain in an area they are going to give some reaction. If they've got a problem with their chest, pains in the chest, you can hear it. You know that that wheeze is not quite right. It shouldn't be there. Abdominally, if they jump in the air and

it's specific then you don't need the language. You can do it by getting them to point to it, even though they tend to generalise. But from a generalised area you take it from there. And by observing their faces and their eyes, that will give it away if you've hit the right spot. If you are in trouble you can get a health worker. That's their big advantage because they can verbalise with people.

- Getting a history is more so a problem with children than with adults. Even if there is a language barrier, you can always find someone to interpret for you. That is easier than dealing with a child.

Another difficulty encountered was in assessing clients who came from another area and the nurse was unable to obtain a history from them. The following observation portrayed this problem:

Wednesday 7.45 pm. The nurse is called out. She is told that a woman has 'collapsed' at someone's house. This woman had been seen in the morning by a medical practitioner at the medical clinic and commenced treatment for a suspected urinary tract infection. The nurse goes in the vehicle to see the woman, who is now sitting up, and brings her to the clinic. The woman has recently arrived from an outstation community near the South Australian border. Other than a recent presentation at this clinic and an early history obtained from a community clinic in South Australia where the woman once lived, there is little information available. A nurse at the clinic in South Australia had reported that the woman had an impaired liver from alcoholism. The nurse now examines the woman, who complains of tenderness in the lower abdomen. Her blood pressure is 190/125. At the medical visit it was recorded as 150/100. The woman does not respond to the nurse's questions. Feeling at a loss, the nurse remarks, 'It's so hard. She has had an operation in the past. There is a well healed scar above the pubis and a scar near the navel, possibly from a drainage tube, but she can't tell me what it was. I have no history'.

Similarly, poor nurse/client communications compounded by poor follow-up procedures often led to subsequent treatment problems. For example, in situations where clients had received multiple or incomplete treatment regimes. The following observation illustrated this problem:

Saturday 6.30 pm. The nurse answers a knock at the door. A woman carrying a child about 3 years old, tells the nurse that her child is 'hot'. The nurse does not know the client. She escorts them to the clinic to

assess the child. The child's temperature is 39 degrees Celsius. The mother tells the nurse that the child was seen three weeks ago at Laverton, but 'I couldn't afford the medicine'. From there the family had travelled to Alice Springs where the child was again seen by a doctor and given medicine. This had become lost after two days. The woman did not know the name of the medicine. On the way back to Western Australia the child was taken to a doctor at Ayer's Rock. Again she was given 'medicine'. The mother no longer had the medicine and did not know what it was. The nurse is unable to elicit from the mother what the child's illnesses were at these times. At this hour none of the doctors who had seen the child on these occasions are able to be contacted by the nurse.

Nurses sometimes remarked that clients would respond to questions by saying what they thought the nurse wanted to hear. In such situations it was difficult to obtain reliable information. A nurse described her first experience of this communication problem as follows:

My first day in the clinic I saw three small children who had thrived in the first six months of life then gradually their growth on the percentile chart had levelled off or even dropped off. And when I talked to the mothers about what they were feeding these babies I had three in succession telling me they were giving them potato, pumpkin and weetbix. Then I woke up. The ladies knew what to say, but the children were probably not actually getting it. They knew what I wanted to hear so that is what they told me

As well as the limitations of verbal communications between nurse and client, there also seemed to be an expectation that a nurse could know instinctively what the problem was and could offer a treatment for its alleviation. This manner of non-verbal communication with a nurse was common, as this nurse explained:

People point to what they want done. They point to a knee or they point to an eye, for example, without speaking. And you are supposed to work out what the problem is and be able to treat it.

Clients sometimes used an indirect way to communicate with a nurse, particularly if the problem was related to a taboo, or a sacred ceremonial activity, or a personal or

embarrassing problem and/or was associated with shame. At these times, nurses were often unable to obtain sufficient information for an assessment. In this example, the client used indirect speech as a cue for a private consultation:

Saturday 2.15 pm. A woman enters the clinic. She is from another community. The nurse greets her and asks, 'How can I help you?'. 'I have a burn', she states. 'Where is the burn?' the nurse asks. 'On my leg' the woman replies. 'Show me' the nurse then asks. 'It is high up' remarks the woman. The nurse then takes the client into the privacy of a separate room. Here the client lowers her pants to show the nurse her vulva. On examining the woman, the nurse finds two lesions in the inside of the labia.

A nurse's sensitivity to clients' non-verbal cues was another factor, such as to a client's desire for a private consultation. Here clients were often more willing to communicate with a nurse, as shown in this quote:

Some of the younger women won't speak to you. They just won't talk. I might take them into a room on their own. I offer, 'Do you want to go to the women's room?' I ask them single questions. I don't really construct anything in my head, but I find they are much more likely to talk with me when I take them aside. Especially anything to do with women's stuff.

Indirect speech was also used by clients to communicate a problem but to avoid shaming or humiliating another person. A nurse's prior acquaintance and rapport with clients appeared to be the key to this interaction. The following observation was an example:

While out on a home visit, a woman calls the nurse and beckons her to come over to her house. The woman is standing under the verandah. Her husband, Y___, is standing nearby in the doorway. The woman simply says to the nurse, 'Y___ has come from Laverton the other day'. The nurse looks at Y___. From previous contact with this man and her fleeting observation, the nurse is able to interpret this cryptic message as meaning that the husband has been drinking alcohol in Laverton and is now experiencing withdrawal symptoms. Indirectly, the woman is asking the nurse to supply the medications Y___ is usually given to alleviate the withdrawal symptoms.

Veiled threats were occasionally used by some clients when they felt dissatisfied with the treatment offered by a nurse or showed their dislike for a nurse who 'didn't do enough'. The following example illustrated the difficulty of decision-making when a nurse felt intimidated. It was unclear, however, what further attention the client wanted from the nurse:

Saturday 9 pm. A woman with her daughter, aged about 20 years, arrives at the nurses' quarters to see the nurse on call. The young woman with her mother has been seen on two occasions earlier in the day, at 10 am and again at 7.15 pm. This time they are accompanied by a male relative. At the first consultation, the daughter was assessed and diagnosed by the nurse as having a chest infection. She was then commenced on an oral antibiotic and an analgesic medication. At 7.15 pm, the daughter had again been brought to the nurse. At this time her condition had improved. The mother agreed with this assessment by the nurse. Now, at 9 pm. the mother states that her daughter is still sick. The nurse explains to her, 'The medicine will not help her immediately. She is better now than when I first saw her this morning'. The mother appears unconvinced. She accuses the nurse, 'You are not doing enough'. The nurse replies, 'What else can I do? Here look at the notes. They show that I have seen her and treated her'. The mother begins descending the steps outside the clinic. She then declares, 'I will see you in a community meeting. You will be sacked'. 'What have I done?' asks the nurse. The man then intervenes saying, 'I have been like this having the shakes when I used to drink'. He goes on to inform the nurse that the young woman has been 'drinking in Kalgoorlie' and returned to Warburton yesterday. The nurse then realising the young woman may also have alcohol withdrawal symptoms still makes a judgement that the young woman 'will be all right' without further assessment or treatment. 'She will get better, but it takes time' the nurse repeats to the small group. The mother, now contrite, strokes the nurse's arm and says, 'Sorry Sister. Sorry Sister'. After their departure, the nurse remains standing on the verandah. She puzzles over the mother and daughter's behaviour saying, 'Why did she return? What did they want from me?' The nurse then says, 'I feel offended that the mother threatened me when I had done what I could'.

In addition to the difficulties in communication with clients when making assessment and care decisions, a further problem for nurses was in communicating treatment regimes and in the frequency of client's non-compliance. Some nurses acknowledged the added limitations of not being understood when explaining a regime to a client. To

overcome this problem nurses sometimes monitored the clients daily, as expressed below:

These people [referring to Aboriginal clients] don't take their medicine according to instructions. Unless you get them to come back every day the medications are probably not taken, or people take three or four tablets at once...As far as explaining medication to patients and when you take them. All you've got is your little stickers which say, in the morning, midday and at night time. Then you usually have got to say, one or two tablets three times a day and hope that the person complies with it. Because you don't really know and you have no other means to explain it, especially when you don't know their language. That's the biggest drawback. You hope that they can understand you better that you can understand them.

The expectation of clients often appeared to be that, even without their understanding or compliance with a treatment regime, a nurse could provide relief for a problem.

This difficulty was expressed in frustration by a nurse as stated below:

People are shocking in their compliance with treatment regimes. They are just not willing to comply for whatever reason. It wastes a lot of time, unfortunately. There is still the expectation that the clinic will fix it, we will give them an injection to fix it, what is wrong. We are still here to pick up the pieces.

Such a problem was not unusual with skin infections. More severe treatment was then perceived to be required. Nurses often felt frustration and dissatisfaction with the *ad hoc* care that was given in such situations. Some also regarded these problems as reflecting negatively on their ability, as seen in this example:

Thursday 10.15 am. A child, approximately 3 years old, is brought into the clinic by her mother. The nurse recognises them. She had seen the child ten days ago with an abscess and, after consulting a medical practitioner for advice, had commenced her on an oral antibiotic. The mother had been asked by the nurse to return to the clinic the following day, however, the child was not seen again until today. Now the mother tells the nurse they had gone to Laverton. At Laverton the child was taken to the hospital for treatment of the abscess. The doctor there had commenced the child on Flopen oral suspension. The mother has not brought the medication with her, so the nurse asks her to get it for her to see. When the mother returns with the bottle of Flopen, the nurse observes that only one day's quantity has been taken. The nurse

then explains to the mother the importance of continuing to give regular doses of the antibiotic. 'Now the abscess has become worse', says the nurse. The mother shrugs her shoulders, looks away from the nurse and does not reply. The nurse is undecided about continuing the antibiotic and telephones the medical practitioner for further advice. The doctor now orders for the child to have intramuscular Ceftriaxone daily for three days with the dosage measured according to the child's weight. Following this episode, the nurse expresses her feelings by stating, 'I feel frustrated and dissatisfied at the *ad hoc* kind of care this little girl was given and my own inability to provide proper care. I also feel that the mother has made little effort to see that her child was adequately treated. As a result of these problems the child has suffered more pain and fear and, at the same time, the belief that 'needles' are the answer for cure has been reinforced to the mother'.

It was usual for clients to return to the nurse for care when the illness, for example, had become worse. This had sometimes occurred even when a client had the prescribed treatment with them. The difficulties for nurses were in communicating the importance of taking medications regularly and in deciding a further course of action. It also often contributed to additional work hours, especially when the client did not attend during clinic hours but presented late at night. This observation was an example:

Thursday 10.20 pm. A nurse is called out to attend a woman who is having an 'asthma attack'. The nurse has already attended four after hours calls and says she feels exhausted. The nurse now drives the vehicle to the woman's home and transports her back to the clinic. The woman is dyspnoeic and has difficulty walking. After she has been given treatment as ordered by a medical practitioner consulted by the nurse, the nurse asks the woman and her daughter why she did not come to the clinic during the day. The woman replied, 'We were asleep in the day'. The nurse, checking the medications in a dosette box that the client has with her, finds that none of these tablets have been taken. The woman also has a Maymed pump at her home and measured doses of Salbutamol and Normal Saline. Although she had been instructed how and when to use the pump by the nurse, she had not been using it.

Faced with multiple communication problems, nurses at times tended to make errors of judgement. For example, an Aboriginal health worker felt humiliated when a nurse

had painstakingly explained to a client how to take his medications. The nurse had assumed the man did not speak English. The Aboriginal health worker recounted the episode as follows:

Some Sisters [nurses] get sidetracked. A bloke who has lived in Kalgoorlie most of his life came in [to the clinic]. He knows what is going on. And here was the Sister giving him antibiotics. 'See these yellow and black ones they are your antibiotic tablets'. She points to the stickers on the packet and says, 'Morning. Take this one lunchtime'. The young fellow stood back and looks. After that we could laugh [the Aboriginal health worker and the client].

Barriers to communication that contributed to the difficulties of decision-making by nurses included a lack of language skills, non-communicative behaviours and a lack of understanding and/or compliance with treatment regimes. Other difficulties were experienced by nurses in communications with colleagues

Communication between colleagues

Difficulties encountered in communication between colleagues for decision-making were often due to their different attitude and abilities. The frequent turnover of nursing staff was also a factor in the problems of communication. Adding to the difficulties experienced by individual nurses was their sense of responsibility for the decisions or actions taken by another nurse or an Aboriginal health worker. In some situations nurses felt a need to communicate these concerns to their colleagues. For example, the following observations of nurses who had felt it necessary to tactfully verbalise their concerns to colleagues regarding treatments:

- An adult male client has an intravenous drip put in by a nurse. He is also taking oral fluids. Another nurse observing the client states in a tone of concern to the nurse, 'I hope he is not haemodiluted'. The nurse replied, 'Could be. He is still unsteady on his feet but he needed rehydration'.
- A staff meeting is in progress. A nurse, who has recently arrived and is now working in the child clinic, states, 'I want to speak to everyone. I've observed in the children's records that excessive doses of Panadol and Ventolin have been given to the children. In

one instance a child was given 10 millilitres of Panadol when the correct dose should have been 4.5 millilitres. It is current practice that all children must be bare weighed before giving Panadol or any other drug so that accurate doses can be given according to weight. Anyone who is unsure how to calculate the dose for a child can come to me and I will show them how to work it out. It is dangerous to give excessive doses of drugs to children. As health carers we have a serious responsibility to give attention to the drugs and dosages we administer to clients’.

Differences in point of view between nurses about an assessment or an appropriate treatment or management for a client’s problem were not uncommon. Factors that were observed to contribute to these problems of communication included the frequent turnover and varied experience of nursing staff and when different nurses attended the same client on their subsequent visits to the clinic. For example, a difference in clinical rationale between two nurses was observed in this case:

A nurse decides to lance a boil on the scalp of a four year old girl and that had peaked to a head. The nurse also prescribes an oral antibiotic to be administered to the child. The child has no other adverse symptoms. The reasoning stated by the nurse is, ‘lancing the boil and giving an antibiotic will assist the resolution and elimination of the infection’. She further defends her decision by stating that incision and drainage of boils is advocated in the CARPA Manual. Another nurse, however, is opposed to this practice. She believes that bathing, use of hot packs and magnoplasm dressings would aid the resolution of the boil without occasioning further trauma to the child and that antibiotics are not indicated. This nurse also states, ‘I prefer to involve the mother in the child’s care and to teach her those techniques to deal with a boil that she could use in her own home’.

Nurses were described by their colleagues as ‘gung ho’ when they appeared to adopt a cavalier attitude when independently assessing and/or treating clients. A nurse explained the use of the term in this way:

Gung ho means to me attempting things that you are not really capable of doing - being the hero.

Several nurses acknowledged that they were 'gung ho' at times, but appeared unconcerned. In contrast, other nurses perceived that this decision-making behaviour was inappropriate and an added risk to client care. A daring attitude to decision-making was conveyed in these remarks by nurses:

- Some nurses take their position as a freedom to treat people at their own discretion and use drugs casually. Why do they come out here and become gung ho?
- The liberty is there to take [to attempt procedures and give drugs]. If you don't notify management, who is to know?
- Nurses out here have access to drugs and for treating people without any supervision or accountability. Its a source of power.
- There is no restraint and if you feel justified in doing something then no-one is going to stop you.

Problems of communication for decision-making also arose when nurses did not record all their findings or the actions they had taken. This had the potential to mislead other nurses who subsequently saw a client for a similar or the same problem.

This was illustrated as follows:

A nurse inspecting a large swelling on a child's forehead, suspected a haematoma because of the collection of blood under the skin surface. Another nurse who had seen the child the previous day, however, had written 'abscess' in the notes. The nurse then went to ask for more information and was told by the other nurse, 'Oh, I pricked it'

Communication between colleagues was a recurrent problem where nurses did not share a similar perspective of their decision-making responsibilities. Another feature of the difficulties encountered in decision-making was in the area of communications with medical practitioners.

Communication with medical practitioners

Medical practitioners communicated their expectations to nurses in the questions asked and the directions given by them. These questions and directions implied that a nurse was expected to have a knowledge of medical pathology, pharmacology, medical procedures and the capability to administer treatments as ordered as well as to monitor a client's progress. They also appeared to expect nurses to possess the knowledge and skills required to perform a basic medical assessment that was appropriate to what the medical practitioner needed to know. Problems of communication for decision-making in clinical practice were observed in the domains of consultations, nurses abilities, evacuation and monitoring of clients.

Consultations with medical practitioners at the RFDS base at Kalgoorlie was the major source of back-up for nurses in clinical decision-making. Their verbal support, reassurance and advice was often sought by nurses, following a client assessment, for dealing with significant health problems. In the view of most nurses, these medical practitioners generally seemed to acknowledge their isolated circumstances. Constraints for nurses arising from the limited number of staff and personal resources, for example, appeared to be less understood. Nurses were heard to repeatedly state their limitations to medical practitioners. Nevertheless, a nurse described the importance of this medical back-up as follows:

Really the RFDS is the main back-up we have. Nine times out of ten they are receptive. They will listen to us and they will agree with us. I think it depends. Like all of us we all get into our frame of minds...There is essentially if we ring up and say someone needs to go out, they (RFDS) will come and collect them. Or, 'Look I just need some advice'. They are very good. They do understand the isolation within which we work. They occasionally say, 'Oh just keep them [clients] there for a bit longer. Keep them overnight', which we are not geared for.

The opinion of medical practitioners pertaining to the ability of a nurse also communicated their expectations. In their view, if nurses were not competent in this

role and able to perform the functions as required then they were unsuitable for working in a remote area. For example, these medical practitioners stated their expectations in the following way:

- There are huge differences between nurses. Some are organised. They have the clinic in order and have assessed the patients to be seen. In consultations some nurses are hesitant and unsure when presenting a patient. This is because of their lack of experience. For instance, a nurse who says over the 'phone, 'I think the patient has a stiff neck'. I then ask, 'Does he or doesn't he?' The nurse will then say, 'Yes'. I expect the nurse to know. Some nurses are just not suitable for working out here. I've seen inadequate nurses in ICU (intensive care unit) as well. Its not just in remote areas.
- If a nurse can't take responsibility for administering drugs, she shouldn't be out here [in a remote area].

These expectations, however, appeared to be ambiguous. As medical practitioners expected nurses to perform tasks as requested, they also expected nurses to set their own limits as to the procedures they were willing to undertake. Nurses were expected to verbally communicate their limitations if necessary. It appeared that these practice boundaries related to the nurses assessment of their own capabilities rather than to the scope of nursing. A medical practitioner stated this view as follows:

A nurse should give a good description and be happy to attempt most procedures once instructed how to do it. Or say, 'I'm not happy'. Know your own borders and your own cut off point if you are not happy rather than go ahead and try. You've got to be fairly adventurous, I think. I mean in our job, if you haven't got a specialist standing over your shoulder, you are going to have a go.

In most situations medical practitioners accepted a nurse's refusal, such as an instruction to perform a procedure or to give a drug, when he or she gave their reasons. For example, in the following observation the nurse's unwillingness to perform a procedure as requested was related to both her own limitations and to her assessment of the client's need for treatment resources not available at the nursing post:

Tuesday 6.30 pm. A six year old boy is brought to the nurse. He had fallen from the branch of a tree. A thin stick, about three inches long, had penetrated into his thigh and became embedded under the skin. On consulting with a medical practitioner the nurse is asked, 'Can you attempt to remove the stick?' The nurse refuses. Her reasons stated to the medical practitioner are that she had no experience in how to perform the removal of a foreign object. She is also aware that other debris could be retained in the wound, even if the stick is removed. In her opinion this is a surgical procedure. The medical practitioner accepts her refusal, but then asks, 'Is there a more experienced nurse there?' 'I am the most experienced,' the nurse informs him. The medical practitioner then agrees for the child to be evacuated to hospital. No regular transport is available within 24 hours and the child, escorted by his mother, is then evacuated by RFDS the following morning.

In telephone consultations, medical practitioners sometimes did not specify the dosage, the route or the duration of administration of a drug ordered. They either directed the nurse to give the dosage 'according to the CARPA Manual' or 'per CARPA' or they appeared to assume that the nurse could or would be able to make the decision. For example, a nurse was ordered to give intramuscular Ceftriaxone to a client. No duration for administration of the drug was stated. The nurse remarked following the medical consultation, 'I think I will give it for five days'.

A barrier to communications was apparent from the hesitation of most nurses to consult a medical practitioner. These nurses perceived that they needed to justify why they were consulting. A 'reticence' of some nurses was observed by a medical practitioner. He appeared to attribute the behaviour to being female:

Male nurses out here are more confident than female nurses. Maybe its a female thing to be reticent.

Nurses usually felt that they should be able to 'cope', confident or not. It was as if the need to consult with a medical practitioner for non-urgent problems, as well as their communication skills during a consultation, reflected on a nurses' ability. Nurses also felt inhibited when in their previous experiences they had felt inadequate, or that a

consultation was seen as trivial and thus wasting the time of a medical practitioner. Indirect messages sometimes given to nurses during a consultation tended to reinforce this perception. These feelings were illustrated in the following observation:

Wednesday 4.45 pm. A client has presented with a headache and a history of a nose bleed. On assessment she is found to have a high blood pressure. The nurse decides to consult the medical practitioner to seek advice for the management of this client. The nurse has also taken another client's record to ask for advice about repeating an oral Valium medication. When the nurse completes the first consultation, she then says, 'I have another client I want to ask your advice about'. The medical practitioner replies, 'Well hurry up'. Following this consultation the nurse states, 'I feel rebuked for wasting his time and as if this inquiry for advice was trivial'.

Nurses had also felt discouraged from making a consultation because of a medical practitioner's abrasive manner. A nurse recalled this difficulty in communication. Already feeling fatigued from an extended period of on call and overtime, the nurse had attended to the care of a child throughout the day. At 5 pm, undecided about what further care was needed, the nurse consulted for a medical opinion. Her account was as follows:

Today I had a situation with a kid who wasn't obviously sick enough to be evacuated. I felt I had to cover myself by telling the doctor what was going on and I found that a very discouraging conversation because I felt like - it was almost this feeling that I had to be pretty definite that the kid was sick, otherwise 'why bother ringing me up' sort of thing. Its not as blatant as that, but it's just talking around in circles. I mean. I wasn't ringing up to evacuate the kid. I just wanted to communicate what was happening and to get some advice. And it's a terrible feeling when you get off the 'phone and you feel that you sounded stupid. I mean I ended up crying a couple of hours. It was just like you can't win in this job.

Most nurses repeatedly encountered dilemmas in having responsibility for the care and treatment of clients and, at the same time, feeling that medical consultations for advice in non-urgent situations were unwelcomed and/or interpreted as a nurse being inadequate. This predicament was portrayed in the following example:

You are so responsible. Yet you are aware if you are operating in a mindful way that you should ring up in certain situations that are not necessarily like, let's evacuate and get dramatic. Sometimes the response you get from the doctor is that they sound like they are wondering why you called. They are not actually saying it, but they are asking or talking to you like they are wondering why you rang up. They probably think, 'well you sound like you've got it under control'. It's almost like that tone coming out. And even the other night, the doctor said, 'So you want me to say such and such treatment order so that if something goes wrong, you will be covered?' It's not even that necessarily. And that sort of reaction, sort of response, from a doctor just felt like pressure to me. I mean you don't want to ring up all the time and try to ring up only when necessary. You've got your integrity as a nurse. You don't want to be thought of as someone who will ring up at the drop of a hat. So you are trying to negotiate all that. It gets a bit stressful.

Several nurses felt that communication was often 'easier' for an obviously serious problem. On the other hand, nurses often felt discouraged by a medical practitioner's inappropriate response to a non-urgent inquiry. A nurse described these feelings in this comment:

Like the other night when I wanted to tell the doctor what was going on. He said, 'So you want me to say such and such a treatment order...' That sort of response makes it prohibitive to ring them. It's a lot easier when someone is outright sick, when someone has to be evacuated and that is all there is about it.

Furthermore, these nurses felt that the potential consequences of consulting, or not consulting, was an added stress. As an example, a nurse described situations that were stressful for her and added:

Another mental stress is consulting with the doctor. You worry with the RFDS doctor. I get the feeling that the doctor is very distant. He or she expects you to have already commenced the patient on something. But if you gave something without consulting for medical orders and there is an adverse reaction, the doctor would then ask, 'Why did you do that? You didn't consult'. They wouldn't back you. There is another mental stress.

Nurses often experienced difficulties in obtaining adequate medical advice or a medical assessment for all clients with a medical problem. This was observed particularly in the conduct of the fortnightly medical clinic. In preparation for this clinic nurses made decisions about the clients who needed, or had requested, to be seen by a medical practitioner. Medical practitioners expected nurses to assess all clients prior to a consultation and were reluctant to see clients who they regarded as not warranting their attention. This was partly because of the three hour time limitation allocated for the clinic. As nurses often explained, however, a medical practitioner saw only a minority of clients and there were many others who may have needed an examination by a medical practitioner or who wanted a personal medical consultation. Furthermore, nurses wanted a medical practitioner's opinion on clients who repeatedly presented with complaints of ill health that nurses themselves felt unable to deal with effectively. This view was stated by a nurse as follows:

They expect us to triage, as one doctor said. It's what the doctor doesn't seem to think we are capable of doing. There are many more out there that we could get him to see - many more. But the time is the factor. He is only here for three hours, 8.30 to 12 (o'clock), and he is always watching the clock. So the doctor only sees the ones that are important and acute at the time or very often it is for drug referrals and updating of medication prescriptions. But he wants it triaged. Is he saying we are wasting his time with the people that we present to him? These are people we have dealt with, if not over a fortnight or maybe from the day before he comes [for a medical clinic].

Visiting medical practitioners usually relied on a nurse to inform them of a client's current problem and recent history to assist them in a clinical assessment. A few acknowledged their problem in communication with a client for obtaining an adequate medical history. This quote by a medical practitioner portrayed such a view:

Medicine out here is so different. You scratch your head not knowing what to do. You don't just give a script to the patient. The health problems are different too. The patient says nothing. I can't get any information from the patient. It is very difficult to get a history. I couldn't have managed without the nurse. It would be hopeless without the nurse to organise the clinic and give the patient's history, for example.

In an emergency situation the decision to evacuate a client was apparent to both a nurse and a medical practitioner. In other situations, however, the responsibility but not the authority for this decision was often delegated to a nurse. This was in response to a medical practitioner's question such as, 'Do you want the person evacuated?' or by a nurse insisting that a client's care could not be managed at the nursing post. In the view of a medical practitioner, it was often difficult for them to accurately assess a client's need for an evacuation via the telephone. For example, as expressed in this quote:

You [nurses] need to be able to assess as step one whether they [clients] are sick or they are not. You [medical practitioner] can have two similar descriptions over the telephone and one will be sick and one isn't. And I often say, 'Is the patient really sick?' They [clients] look sick and they can tell you the signs and symptoms, but you [medical practitioner] don't know if they are really sick or not. In the end, the final decision rests with the nurse, whether they are happy to keep the person there or whether they need evacuating.

Nurses often hesitated to request an evacuation during a medical consultation. This was because they were unsure whether the problem was as serious as they had assessed it to be and because they did not want to appear inadequate. By the time of an aircraft's arrival or arrival at a hospital the client's condition sometimes had improved. Therefore, it seemed that an evacuation may have been unnecessary. That clients were evacuated and on arrival at the hospital were not, or were no longer, acutely ill was substantiated by a medical practitioner in this quote:

It happens sometimes that you get them [to the hospital] and there is nothing wrong. They are bright and smiling. You feel the casualty staff look at you and think, 'What have you brought this one down for?' The nurses [in the remote area] feel embarrassed, and I say, 'That's fine. Just don't take it as an insult. We did the right thing. Sometimes we are going to fly out children to Kalgoorlie and they are going to be fine. It does not mean you have done the wrong thing. On the story we had at the time that is what needed to happen. It can go either way'

A medical practitioner's decision to postpone or to avoid an evacuation of a client was related to an expectation that a nurse would take added responsibility for care at

the nursing post. Thus, when a medical practitioner expressed a reluctance to evacuate a client, nurses had to articulate their reasons for wanting an evacuation, such as on the basis of their resources or their assessment of the needs of a client for hospital care. As an example, in a consultation with the RFDS medical practitioner, a nurse decided that a child with a large lower abdominal abscess needed to be evacuated (see observation p205). Following this consultation the nurse explained:

The doctor left it to me to decide if the child should be evacuated. I made my decision on the basis that this is a child. There is no expertise or facilities available here to drain this extensive acute infection. Being near the reproductive organs there could be long term consequences for her fertility. The environment here is unhygienic. It is also the week-end.

Medical practitioners often directed nurses to monitor a client's progress for a length of time prior to deciding whether or not to evacuate the client. The expectation appeared to be that with treatment a client was likely to improve. This was sometimes in spite of a nurse clearly communicating to a medical practitioner that a client needed hospitalisation. These circumstances often generated additional problems for a nurse, such as if there were complications or when other clients' needs for acute care arose at the same time. The following observation illustrated these points:

Sunday 10 am. A man presents to the nurse who is on call. The man has travelled from a community about 800 kilometres away and is *en route* to another community. He is now doubled over in pain. In her assessment the nurse finds that the man is 29 years old and has acute abdominal pain with tenderness in the right upper quadrant. The pain radiates to the back. The abdomen is tense and there are no bowel sounds. The temperature, pulse and respirations are elevated. In giving his history the man states that he has vomited twice before coming to the clinic. He has had the pain overnight and it is now worse. The nurse consults the medical practitioner by telephone. He orders Pethidine 75 milligrams and instructs the nurse to 'sit on him' for one hour. The nurse then tells the medical practitioner that in her opinion the man needs to be evacuated for a medical assessment in hospital. The medical practitioner replies that he wants to 'wait and see'. The medical practitioner also tells the nurse to contact the other community, where the man lives, for a history. He states, 'There are two nurses there and one should be on duty'. When the nurse

telephones to this community she discovers that there is only one nurse there and the nurse is not on duty. This nurse, however, on receiving the message telephones back to inform the nurse that the client has a history of pancreatitis, diabetes and is a 'binge' drinker. A serum cholesterol taken one month ago was 23.9 mmol/L. The nurse then assesses his blood sugar with a glucometer. It registers as 13.6 mmol/L. A urine test reveals glycosuria and haematuria. At 11.30 am the nurse again reports to the medical practitioner and informs him of this history as told to her. The nurse again states, "He needs to be evacuated". The medical practitioner, however, is reluctant to comply with the nurse's opinion and again states to 'sit on him' for another hour. At 1 pm the man is again in severe pain. At the medical consultation the nurse is ordered to give a repeat dose of Pethidine 75 milligrams. The medical practitioner now agrees to evacuate the client and gives additional orders for the nurse to 'put up an IV (intravenous) with Normal Saline, to run 1000 millilitres over 8 hours'. The Pethidine dose does not control the man's pain and the nurse consults again for a further order. During this time another male client has presented and complains of a headache. His blood pressure is 180/130. He is also travelling from elsewhere and has not brought his medications with him. Another medical consultation is then needed. Drug treatment is ordered and the nurse monitors his observations as well, while the man rests. A child with acute asthma, who has been brought to the nurse by her mother, is also treated and is observed by the nurse. The first male client is evacuated at 4 pm. It is 8.40 pm when the nurse finally leaves the clinic.

The barriers experienced by nurses in communications with medical practitioners impacted negatively on their decision-making for client care. For example, it often appeared to deter them from routinely making consultations for medical advice or from asking sufficient questions, such as to obtain all the information needed to administer a drug order. In the day to day care of clients, however, most decisions were made independently by nurses. On many occasions, and at all odd hours, nurses were observed to undertake responsibility for major decisions pertaining to a client's care and its implementation.

Summary

Decision-making by nurses in diverse and often complex clinical situations and for a broad range of health problems was an essential feature of practice in the remote area. Factors that influenced day to day decisions included the pressures of the care environment such as a crowded clinic and in the nurse-client relationship. Within this context, the experiential knowledge and abilities of individual nurses as well as their collaboration with colleagues and with medical practitioners were important determinants of how clinical decisions were made.

The general process of clinical decision-making involved assessment, diagnosis and care management. Nurses were observed to use three levels of client assessment according to whether a health problem was severe, uncertain or minor in nature. In this process the tendency was for nurses to seek a medical diagnosis and to provide medical intervention. The style and completeness of documentation of client care varied between nurses.

Difficulties experienced by nurses in the process of decision-making pertained to the limitations of their expertise as well as an unfamiliarity with clients' health problems. Other difficulties arose from a lack of systems for guidance, back-up, feedback and evaluation. This was a particular problem for nurses in making medical assessments and prescribing treatments. Psycho-social aspects of clients' health were recognised by some nurses, but they usually lacked the ability and resources needed to deal with these aspects of care in the remote area.

Language barriers were a recurrent difficulty in communications between nurse and client, such as for obtaining a history or communicating a treatment regime. Furthermore, a lack of communication between colleagues, as well as differences in attitudes as well as nursing experience, contributed to inconsistencies in clinical decision-making.

The majority of everyday clinical decisions were made independently by nurses. A medical practitioner was consulted by telephone or at the fortnightly medical clinic, when nurses perceived that medical advice and/or treatment orders were needed. Nurses in these communications, however, had felt undermined by a tendency of medical practitioners to trivialise their requests for non-urgent assistance. A medical consultation was necessary for the evacuation of a client to hospital with the RFDS. Paradoxically, medical practitioners expected nurses to make the final decision whilst they retained the authority to over-rule a nurse's assessment.

The process of clinical decision-making together with the recurrent difficulties, limitations and barriers to communication that nurses encountered were dominant factors shaping practice in the remote area. Another major domain was the implementation of care. The following chapter, 'Instrumenting care: keeping track', describes this feature of remote area practice.

CHAPTER 8

INSTRUMENTING CARE: KEEPING TRACK

*The fatal availability of nurses helps to make
all this feasible (and) can be taken for granted*
Luther Christman (1991)

Introduction

The practice of nursing in a remote area does not end with decision-making for client care. It goes beyond this domain. Interwoven into practice is the continuation of care that has to be instrumented. The term instrumenting refers to a broad domain of activities enacted by nurses in the remote area. This entails organising, co-ordinating and implementing care as well as managing the nursing post. In other words, instrumenting meant ‘making it happen’ and ‘keeping track’; arranging for and dealing with the details involved in the maintenance of service delivery. The aim is to bring into effect the requirements for current and ongoing care.

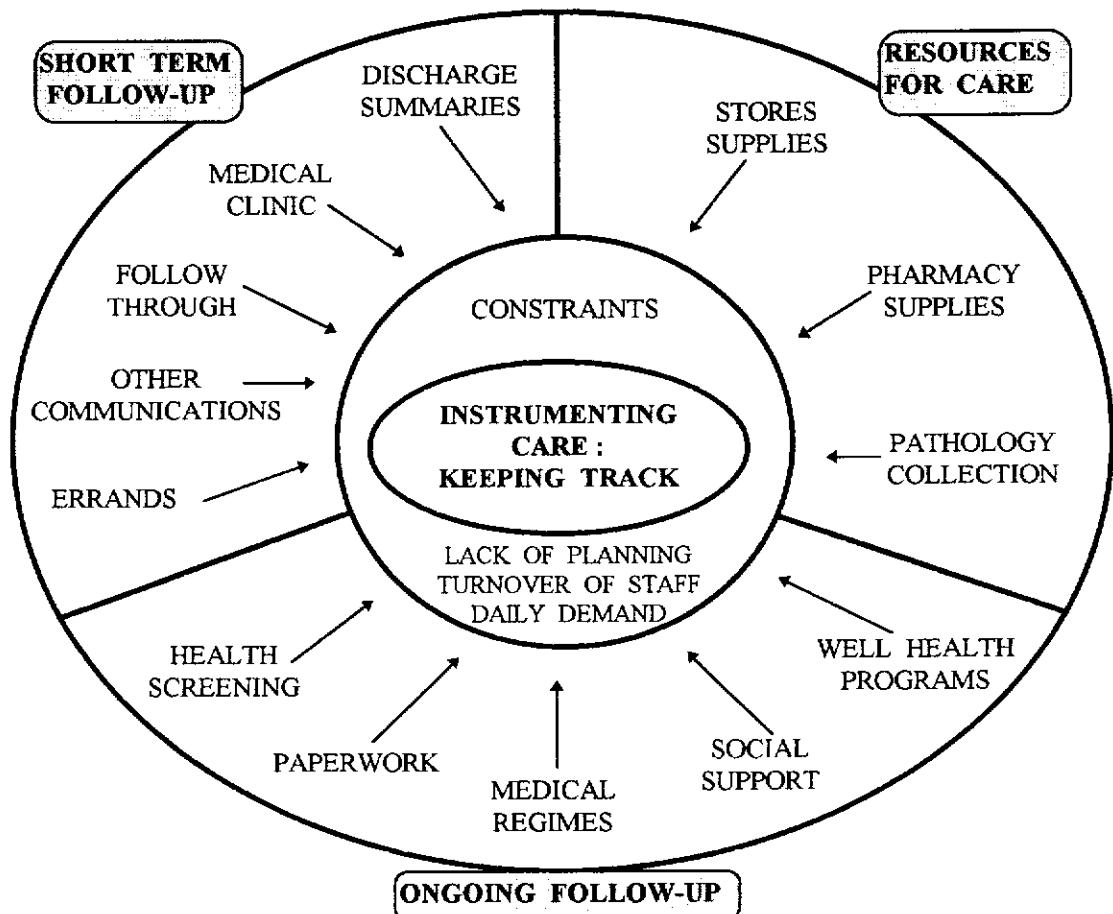
The nature of nursing, especially in a hospital setting, is to provide care on a continuous basis. This usually occurs until the responsibility for care is handed over to another care-giver or when a client is discharged from the care setting. Within the remote area, however, there did not appear to be a termination point for a nurse’s responsibilities. ‘Care’ extended from dealing with any health or related needs to whatever was perceived as needing to be done by a nurse on behalf of absent care providers. One of the reasons contributing to this part of remote area practice is the nurses’ ready availability to manage whatever is required in order to orchestrate as well as to implement client care.

In remote area nursing, instrumenting care was often subsumed within the more overt duties of a nurse; less visible, but one of the most arduous aspects of practice. The

recurrent problems encountered in instrumenting care were generally accepted, as nurses viewed such practice as the norm in this setting.

This chapter portrays the features of instrumenting care which were peculiar to practice in a remote area. Two particular domains emerged from the data; they were short term follow-up and the ongoing follow-up of clients. Each of these domains included sub-domains that pertained to the organisation and implementation of follow-up care. A third related domain was the upkeep of resources for care, especially pharmacy and other supplies and the requirements of pathology collection (Figure 8.1). These domains are described below, beginning with the general characteristics of follow-up care. In conclusion, the general constraints for nurses in instrumenting care are explained.

Figure 8.1: Instrumenting care: keeping track



Instrumenting care: keeping track encompassed short term and ongoing follow-up and management of resources for care. Constraints to these activities related to planning, staffing and daily demand.

Follow-up: general characteristics

Follow-up was a comprehensive term routinely used by nurses in instrumenting care. It explained a range of actions they perceived as necessary for ensuring the care of clients was implemented and maintained. The general character of this broad domain involved the nurse dealing with past and current requirements for care implementation as well as preparing for future activities.

Follow-up was perpetual and time consuming in character. It was associated with the availability of a nurse to perform work that was delegated or transferred to them as requested by others, such as health service administrators, medical practitioners and other health or social services. The nature of follow-up was also influenced by the clients' reliance on a nurse to co-ordinate procedures to meet their health needs, such as the administration of treatments, keeping medical appointments, liaising with outside agencies, and obtaining repeat drug prescriptions.

The following observation over a two hour period illustrated the above points of work delegated or transferred to nurses and their mediating role in instrumenting care. It also revealed some of the constraints to accomplishing this work and how this was dealt with by a nurse:

Friday 2.30 pm. The nurse collects several record books and a pile of papers from the in-tray in the office and carries them into the staff room. There are several prescriptions that have expired. These clients need to be reviewed and their scripts re-written at the next routine medical clinic. The nurse records their names and the word 'script' in the 'Royal Flying Doctor Service Book' to 'make sure' the client is seen at the medical clinic. Next in the pile is a facsimile received from the regional hospital regarding a client. It requests the nurse to provide a medical report for the anaesthetist before the client has eye surgery next month. The nurse decides to add this request to the medical visit list. All these clients now listed will need to be visited by the nurse and informed that they are to see the medical practitioner at the medical clinic. There are 26 pathology result slips. Each one is checked by the nurse and the medical practitioner's orders or other comments by the pathologist are noted for treatments or further tests to be followed up. The remaining slips are then placed aside to be filed in the clients' records. Three clients from other communities and who are now

staying at Warburton need to be checked. Two of them are booked to travel on Monday from their home community. One is for admission to the regional hospital. The other two are a child with an escort. The child is to be admitted to Princess Margaret Hospital. There is a form, addressed to the parent, that is to be filled out prior to the admission. This form is accompanied by a request that the hospital is notified in advance whether the child will attend or not. The nurse cannot be sure that this will happen until she speaks with the escort and knows that the child and escort are here to travel on the air service on Monday morning. A client who is awaiting an elective admission to the regional hospital for a renal biopsy has had blood specimens taken earlier in the week. If the blood results are too abnormal the client will be flown by the Royal Flying Doctor Service to the regional hospital. The results have not arrived and the nurse then telephones the pathology service for this information. A facsimile of the pathology request is sent back stating that the blood specimens were 'too old' for the tests required. It is not possible to repeat the tests today as there is no transport out until Monday. When the nurse visits the house where the client usually stays to inform him, she is told he has 'gone to Karilywarra'. The nurse suspects that the client is unwilling to go to hospital. She then telephones the community advisor at Karilywarra, but there is no answer. At this impasse the nurse decides to try again on Monday. A list of women who will attend a mammography screening at Laverton has previously been compiled by a nurse and an Aboriginal health worker. The women will leave by bus on Monday and camp out overnight at a nearby community. A facsimile has arrived addressed to the nurse from a health service administrator stating that the women must take blankets, food and money. The nurse then promptly notifies the community office staff so that 'pays for the women will be ready on Monday for them to go'. During this period of observation the nurse also attends six clients. They have come to the clinic to be seen, to collect reissues of medications, for a Ventolin nebuliser and to obtain other treatments, such as a dressing, from the nurse.

Follow-up was generally characterised in colloquial terms as 'running after people', 'chasing people up', or 'chasing up information'. These terms conveyed the extended efforts nurses perceived as necessary for follow-up, such as to implement a treatment regime, to remind a client of a test that was due or to telephone the laboratory for pathology test results. These quotes are an example:

- There is a lot of following up and running around just from Public Health [services] ringing up and saying, "So and so has been named as a contact [for a Sexually Transmitted Disease]. Can you go out

and find that person?' So you go out one time and the person is not there. So you've got to go out again. You can't leave a message because it is a private affair, like something you want to talk to the woman directly. And if the person can't be found then you have to notify Public Health [nurse].

- I am still chasing up people from the RFDS visit last week, doing blood tests and things like that. If you don't catch someone they have gone off on holidays or things like that.

Nurses often felt frustrated by the seemingly endless time and effort involved for follow-up care, as expressed below:

- We are chasing people up for STD contact tracing. For one hour of client involvement there area ten hours work generated for the nurse.
- Nurses could always be chasing up sick people and screening people for disease, without actually working on education and the prevention of illness.

Expressions, such as 'running after' or 'chasing up' clients for follow-up were also used by nurses to explain the way a relationship of dependency was reinforced. The following statement illustrated such a view:

[Aboriginal] people seem to be so used to white people running around after them and providing resources and doing things for them, giving them things...We [nurses] are part of that group of white people who run after people, chasing them up to make sure they have had their medications, chasing them up for screening programs. So we've taken that responsibility for people's health away from the people.

The character of follow-up care was differentiated by whether it was short term or ongoing. For example, treatments for a single episode of illness or trauma was considered a short term follow-up. In contrast, ongoing follow-up related to continuing care, such as monitoring those clients with chronic health problems and/or on long term medical regimes or maintaining well-health programs.

Short-term follow-up

The large domain of short term follow-up was the implementation of the current and immediate care requirements. It consisted of smaller domains relating to the work involved with fortnightly medical clinics conducted by visiting medical practitioners, with clients returning to the community after a stay in hospital as well as communication from other care providers external to the setting.

One of the main parts of short term follow-up involved the nurses attempts to ensure that courses of treatment were administered or a management plan was implemented and/or that clients followed instructions. Nurses were expected to assume responsibility for carrying out the follow up orders as delegated to them. By implication, the nurse was also delegated responsibility for explaining a diagnosis as well as obtaining the clients informed consent for treatment. Every order or instruction for a specific treatment, plan of care or investigation set in motion a chain of events pertaining to a client that had to be initiated and managed by a nurse. A particular example of the work entailed in instrumenting follow-up care, and the problems of this follow-up, was seen in relation to the routine medical clinic.

The medical clinic and follow-up

At a routine RFDS medical clinic the nurse was responsible for implementing all orders given by the medical practitioner. These included instructions such as, to supply medications, take pathology tests, perform regular dressings, and/or organise referral for a client. The following was an observation of a routine medical clinic:

The first consultation is between a female client and the medical practitioner. The client's symptoms are reported to the medical practitioner by the nurse as recurring lumps in the groin, dysmenorrhoea and menorrhagia. The medical practitioner detects no other problems on his physical examination. At the conclusion of the consultation the medical practitioner decides to refer the woman to a gynaecologist. He then instructs the nurse to carry out several investigative procedures so that the results will be available to the specialist at the time of the appointment. No pathology request forms

are completed by the medical practitioner. The medical practitioner directs the nurse in the following manner:

If possible, a full women's check is to be done prior to [the client] going to Kalgoorlie [to see a gynaecologist]. If a full check can't be done then take urine for PCR (Polymerase Chain Reaction) and serology. That covers most things. Also do a HVS (high vaginal swab) and have some pathology results for Y___ (name of gynaecologist).

The next client is an adult male who has a leg ulcer. He is a diabetic and treated with oral medications. These medications are not taken regularly. The man is also under a specialist physician in Perth. The nurse is directed by the medical practitioner to, 'check his bloods and see how the diabetes is going and have the pathology results ready for the specialist'. He adds, 'Do the dressings every day'. Turning to the client the medical practitioner states, 'You must come every day to the clinic for dressings. This includes Saturday and Sunday'. The inference is that the nurse is available to work every day of the week to continue this care.

The following client seen by the medical practitioner is a woman who is on medications for diabetes. At the completion of the consultation, the medical practitioner instructs the nurse to commence treatment with Glibenclamide and Metformin. The nurse then explains to the client that he will 'follow-up the doctor's orders' and send the script to the pharmacy [in Alice Springs] and give them to her when they arrive next week.

In a medical clinic follow-up, nurses often acted as an extension of a medical practitioner by performing functions usually required of a doctor. This included completing pathology request slips or informing clients about their diagnosis and the pathology specimens to be taken. Nurses acquiesced with medical practitioners in this role relationship. For example, on completion of a physical examination of a client, the following interaction occurred between a medical practitioner and a nurse:

The client sits in a chair beside the desk. The medical practitioner turns toward the nurse and comments, 'There isn't anything to find. I will do baseline blood tests, FBE (Full Blood Examination), ESR (Erythrocyte Sedimentation Rate), LFT (Liver Function Test) and random blood sugar'. The nurse replies, 'We can't do ESR here'. [The actual collection of these specimens is then performed by the nurse.]

Nurses and Aboriginal health workers generally met together in the afternoon after the medical practitioner had departed from the clinic. This, however, depended on the groups of nurses at the time. Whereas one group had held these meetings routinely, other groups only met at the instigation of a nurse. At this meeting a nurse reported the medical notes for each client seen and the follow up orders, such as drug treatments, prescriptions, pathology tests and client referrals for specialist appointments. Completed Patient Assisted Travel Scheme (PATS) forms for specialist referrals were forwarded to the health service office for the relevant appointments to be made. Subsequently a list of these clients and the dates booked for their travel on Nagaanyatjarra Air was sent back to the nursing post. A nurse then informed the clients and ensured they met the aircraft accordingly.

The expectation of some clients that a nurse should follow up with their treatment was illustrated in a consultation between a visiting medical practitioner and a client. The client had hypertension, for which drugs had previously been prescribed, and complained of recurrent headaches. The medical practitioner asked the client, 'Why aren't you taking your tablets?' The client replied, 'The nurse did not bring them to me'.

The orders given at the medical clinic for daily and recurrent monitoring or treatments of clients were often not achieved, such as taking second daily blood sugar levels or the administration of a Ventolin nebuliser four times daily. Nevertheless, nurses and medical practitioners seldom discussed this as a problem. There appeared to be minimal collaboration with a client to find a more realistic regime or alternative therapeutic measures that could be accomplished under the conditions of the client's lifestyle and at the busy nursing post. In addition, some of the tests requested by medical practitioners were beyond the ability of a nurse. For example, an audiometry test for a disability pension claim, a tissue 'scraping' of a perineal lesion to test for suspected donovanosis, or a high vaginal swab for a woman with a possible pelvic infection. Nevertheless, nurses who did state that they were inexperienced in these skills, rarely declined from performing such diagnostic procedures.

Follow-up schedules for medical review of a client were addressed to the nurse. For example, when a medical practitioner wanted to review a client in a certain period of time such as in one month or six months, the nurse was given charge of this responsibility for the return of the client. Also nurses had responsibility for routine follow-up investigations, such as a review of Thyroxin levels (Thyroid Function Test) for the clients who had been prescribed Thyroxine medication. The inference was that nurses would remember or had a system of recall and could ensure that the review occurred as and when it was needed. The medical practitioner, therefore did not need to remember and the client, by implication, was not relied upon to remember the time or the need for their review. Nurses, it was assumed, would take care of these reminders as part of their follow-up duties. Another aspect of follow-up that was generated from medical orders was the performance of care as directed in hospital discharge summaries.

Discharge summaries

When a client was discharged from a regional or metropolitan hospital and returned to Warburton, nurses were expected to follow-up any care needs as required. This follow-up for continuity of care was mainly communicated to nurses in discharge summaries that were dispatched from the hospital. There were separate nursing and medical discharge summaries. The nursing discharge summary usually arrived by facsimile at the time when a client was discharged. This summary included a section, 'nursing follow up required'. Medications and treatment administered to the client as an inpatient were also included in these summaries, but did not constitute a medical order. Medical discharge summaries, however, were often not forwarded promptly. In these situations where specific medical instructions were needed to continue treatment, the nurse had to telephone for a medical summary. The following observation was an example:

Friday 2 pm. A female client has had a cataract removal at a city hospital. Today the woman returned to Warburton on Ngaanyatjarra Air. She has with her two types of eye drops and a 5 day supply of Metformin and Daonil tablets. No medical discharge summary or prescription is sent and the nurse is not informed of the dosage and

duration of the treatments. Furthermore, the eye medications are not available in the nursing post pharmacy stock. The nurse then telephones to the hospital requesting further information and to obtain a prescription for the medications.

On several occasions when clients were discharged from a major metropolitan hospital, the medical discharge summary had not been supplied. The reason given was that a medical discharge summary could only be forwarded to a doctor. This situation was illustrated in the following example:

A client had had surgery and was discharged two weeks previously from a major hospital in Perth. When the nurse telephones to medical records to request the medical discharge summary she is informed that the hospital cannot release the discharge summary except to a medical practitioner. The nurse then explains that there is no doctor working at Warburton. Instead, she gives the name of an RFDS medical practitioner. Within a short time a facsimile of the client's medical discharge summary arrives. It is addressed to, 'Dr W_____ [name given by nurse], Warburton'.

Regional or metropolitan hospital staff in their discharge plans generally did not appear to be aware of, or take into account, the conditions in a remote area and/or the circumstances of a client or of the nurses at the nursing post. Daily management or monitoring of a client following discharge, however, was sometimes required. The instructions recorded in these discharge summaries tended to be unrealistic in that they were often unfulfilled in the remote area setting. Nurses in the remote area were rarely involved in hospital discharge plans for the ongoing care of a client. This example followed the discharge of a client who was a diabetic and in early pregnancy. The woman had been admitted to a hospital for 'review of blood sugar levels'. The nursing discharge summary 'follow-up required' was to monitor administration of insulin and blood sugar levels and to 'reinforce diabetic diet'. The insulin was self-administered with a Nova Pen four times daily and blood sugar levels were to be monitored four times on every second day. The nurse was also instructed to report the client's progress by telephone at 9 am each Friday to the physician. The difficulties of

fulfilling these follow-up medical orders and for obtaining the supply of medication in a remote area were observed as follows:

Friday 5 pm. T__ returned today from the regional hospital. She had been diagnosed as having gestational diabetes. The nurse visits the woman at home to see her and to find out if she has brought a discharge letter. No discharge summary has been sent. The woman, however, has a booklet with her that contains a description of the insulin regime and two Nova Pens, one for Humulin R and the other for Humulin NPH. The woman shows the nurse how she has stored the Insulin in a compartment of her refrigerator. She also demonstrates to the nurse that she is able to administer the correct dosage for herself. No additional cartridges of Insulin, however, were supplied. The dosages required are high and the supply provided will not last for the coming weekend. Prescriptions had been sent from Kalgoorlie to a pharmacy in Alice Springs and two lots of Insulin had arrived for this client on the previous day. The Insulin supplied, however, is in vials not cartridges. The nurse writes down the regime as stated in the booklet. He then returns to the clinic to telephone to the hospital staff in Kalgoorlie and request the medical discharge summary. The nurse also contacts the pharmacy in Alice Springs and explains the problem of having vials instead of cartridges which the client had been taught to use. None can be supplied until next Monday when the routine air service arrives from Alice Springs. Only the nursing discharge summary arrives by facsimile. The nursing follow up order is for second daily, four times a day, blood sugar levels. The nurse remarks, 'That would normally be done in a hospital situation, but how do you do it out here? Do you come to the woman's house at all these times?' The nurse, who is also on call, arranges with the client to attend the clinic to assess her blood sugar levels.

Monday 9 am. The client with gestational diabetes did not present to the nurse at the week-end, nor did this nurse visit the client. The nurse now visits her home and is told by a neighbour that the woman has 'gone away' to another community. The woman did not return for a supply of Insulin nor has there been any review of her blood sugar levels.

In another example, a four year old child with 10% burns had been admitted to the Burns Unit at a metropolitan hospital. The extent of daily care needed was evident in the following management orders as written in the nursing discharge summary:

- *Daily bath using normal soap.
- *Massage all healed areas with Oily Glycerol twice a day.

*To wear hydrophobic vest, then Tubi-grip vest at all times. Only to be taken off for bathing (garments to be washed in luke warm water using lux soap, no washing powder).

*Encourage active arm exercises to maintain axilla range of movement.

*Ensure sunscreen used when in the sun.

*Encourage milky drinks post meals.

One day after the child's return the family left the community and, without informing the nurse, went to stay at an outstation. In these situations most nurses found it difficult to determine the limitations to their responsibilities. On the one hand, the client appeared to make a choice to discontinue treatment. On the other hand, the nurse knew that treatment could be important for a client's recovery as well as for the prevention of complications. Such intensive regimes, although ideal, were often totally unrealistic within the constraints of a client's or a nurse's reality. These orders rarely moved beyond the page on which they were written.

The early discharge of clients also contributed to problems for nursing care in a remote area. As seen in the following example, this could present problems for a client as well as for the nurse:

A woman was discharged from a hospital to Warburton six days following major abdominal surgery and with tension sutures still in place. Her home, however, was at another community where there was no nurse available to provide the care needed. Despite daily attendance by the client and regular dressings performed by a nurse, the wound became infected and broke down. Subsequently the client suffered pain and delayed wound healing, and was submitted to additional antibiotic treatment. She also experienced inconvenience in remaining in Warburton. The woman's care was discontinued after three weeks when she returned to her home, still with an unhealed surgical wound.

Another problem occurred when the appropriate care needed for a client on early discharge was unavailable in the remote community. This observation was a pertinent example:

A woman is discharged from hospital to Warburton five days following a termination of pregnancy. The termination was for a fetal death in utero at 20 weeks gestation, and was complicated by a major post-partum haemorrhage and a cardiac arrest. The parents had been highly delighted at this pregnancy since the woman had lost two previous

pregnancies in the first trimester. The nursing discharge summary notes 'follow-up' only as, 'observe PV (per vaginal) loss'. No female nurses are employed in Warburton at this time. The midwife is a male nurse and not on call. At 8 pm on the night following discharge the woman comes to the nurse who is 'on call', saying that she has a pain in her left side. The male nurse offers to get the male midwife. The woman, however, declines to be examined by any male nurse.

Even discharge summary instructions for follow-up care that in other circumstances would appear to be reasonable, or otherwise the responsibility of clients themselves, often proved to be difficult to enact in the remote area setting. For example, the daily supervision of milk preparation for an infant who was discharged from a hospital on bottle feeding. This problem was partly because of other everyday activities and demands that claimed priority attention of a nurse, as well as the co-operation and availability of a client to attend the nursing post for the continuing care that was required. Apart from hospital discharge summaries another area of short term follow-up resulted from the various communications with a wide range of care providers external to the setting.

Follow-up and other communications

Communications between the nursing post and other neighbouring community clinics, distant health and related centres or the administrative office were important for the follow-up of clients. As an example, these communications were to inform a nurse at another community, where a client had moved or usually resided, of a particular treatment to be administered. Nurses from other communities also telephoned or facsimiled to communicate information, such as informing a nurse of a client or clients who were in Warburton and required specific care or who were expected to attend for an out-patient appointment at the regional hospital. The following examples illustrated these communications by facsimile, as well as the way instructions were often implicit:

- Y__ apparently got off [an aeroplane] at Warburton on Friday after her first ante-natal visit in Kalgoorlie. She is only 14 years old. B_____ [a doctor] rang today. She has Trichomonas on HVS (high

vaginal swab) and requires Canestan Pessaries 1 Gram nocte for 6 nights.

- E__ is at Warburton. She is going to Perth tomorrow for an appointment. Was booked with escort out of M__ [name of community]. Thanks. (The implication is that a nurse at Warburton will locate E__ and ensure that she and her escort board the Ngaanyatjarra Air flight to Kalgoorlie the following day in time to meet a connecting flight to Perth to keep the appointment.)

It was common for nurses to receive facsimile messages with requests for information about a client's medical history. For example, a facsimile was received from a metropolitan hospital. A child who had been admitted there was now to have renal surgery. The request was for a nurse to provide a 'medical history' for the anaesthetist. A nurse then prepared the 'medical history' from information obtained in the child's record.

Telephone calls for information or for follow-up of clients were an every-day feature of the nurses' work. Often the demands of these callers interrupted a nurse's work plans and contributed to additional work for a nurse. For example, in an expression of exasperation a nurse described the telephone calls she had received in one morning:

If I chased up everyone who came into Warburton as I was asked it would take all day. A nurse from Public Health rang today and gave me three names to follow-up for chlamydia contact. I had a call from the nurse at B__ [another community] asking me if a client who came from here was allergic to anything. Another nurse at Laverton 'phoned for the medications and history of H__ M__ [a client] who is now living there.

Nurses' time often appeared to be taken up in telephone communications with sorting out problems in the co-ordination of care. In this illustration the problem was related to client transport:

A flight nurse with the RFDS telephones to the senior nurse at Warburton. The problem is that two children were admitted, without escorts, to the regional hospital from another community [where there is no nurse stationed]. They are now due for discharge. The nurse is asked if the children can be accommodated at Warburton since there

are no direct flights to their home community. There are no close relatives known in Warburton, however, who can be nominated by the nurse to care for the children. The nurse then telephones a health service administrator to consult her for advice. The administrator then informs the nurse that they had not been notified that the children were admitted to the hospital. 'It's a real mess', comments the nurse following the telephone calls.

Other agencies frequently contacted the nurse to follow-up on various matters pertaining to the care of clients. For example, a nurse from the Public and Primary Health regional office or a nurse from a regional or State prison would telephone to Warburton for a nurse to seek out persons who had been named by their clients as STD (Sexually Transmitted Disease) contacts or were partners of these clients.

Messages, such as for follow-up of STD contacts, were common and often entailed the nurse driving out into the community to locate these clients. Most nurses were also aware of the confidentiality and privacy necessary in speaking with these clients and the stigma for them of being suspected of having a sexually transmitted disease. The nurse then had to inform a client that they had been named by another person and to obtain their consent for a pathology test as required. At times clients who were named denied that they had any sexual contact as claimed. This situation posed a dilemma for a nurse, as shown in the following example:

On Friday I was telephoned by Public Health [nurse in Kalgoorlie] and given a name as an STD contact to follow up. I said [to the client], 'Look you have been named as a contact. Have you been with a man?' She replied, 'No'. What do I do? Is she denying it or has somebody used her name for convenience? Do they [the infected person or the agency] just put anybody's name down?

Nurses were expected, by implication, to have an extensive knowledge and counselling skills in their follow-up strategies to deal with these sensitive interpersonal health and social problems. The observation below highlighted this point:

Thursday 2 pm. The nurse receives a telephone call from a community health nurse in Kalgoorlie. The community health nurse informs her that a man from Warburton was arrested and taken to gaol 10 days ago. He is now tests positive for syphilis. He has also named his wife as his only contact. The nurse is asked to check back through his history for previous serology tests and records of treatment. On checking back through the man's record it is noted that a VDRL (Venereal Disease Research Laboratory) test had been taken one month ago and was negative. Further back in the history, however, the nurse notes that within the past three years the man has had recurrent chancres and had frequent courses of Amoxil 3 grams with Probenecid 1 gram, oral Flucloxacillin, intramuscular LPG Bicillin, oral Erythromycin and a course of Doxycycline. Two years ago, it was recorded, he also had cauliflower type lesions on his genitals and had been admitted to hospital for a biopsy for suspected cancer. This had not been done as the man had refused the investigation. An Aboriginal health worker now informs the nurse that the man was known to have a sexual relationship with another woman, who is then named. This woman lives in another community. The man's wife knew of this affair, however the Aboriginal health worker advises the nurse not to tell the wife until after the funeral [of a relative] tomorrow. He adds, 'But she will have to know'. The nurse then telephones the nurse in the other community to inform her about this woman as a contact for 'follow-up'.

Not all these attempts to carry out the follow-up instructions, as communicated by other agencies, succeeded in locating a person named. Nevertheless, this work was frequently time-consuming for a nurse. This was illustrated as follows:

Wednesday 3.30 pm. A telephone call is received from a regional hospital to inform the nurse about two women who are to be followed up as named STD contacts. The names are unfamiliar to the nurse. The nurse, however, drives around the community and asks several people if they know either woman and where these women are. The nurse is told, one woman is not known in the community. The other woman, the nurse is informed, has 'gone to Karilywarra this morning'. The nurse then telephones back to the hospital to inform the nurse there that these women are not in Warburton.

Letters were also received from various agencies containing information that required a nurse to follow-up a client, such as a treatment that had been commenced

elsewhere. Often few details were provided to assist a nurse in providing appropriate management. Furthermore, often no attempt had been made by the institution to ascertain if the ongoing care needed by a client was available in the remote area. For example, no nurses in Warburton had experience in mental health nursing. Nevertheless, with minimal information provided to them, it was assumed that these nurses in a remote area could manage clients with psychiatric problems. This point was illustrated as follows:

A letter was received from a medical practitioner at a state prison health service to inform the nurse that a man recently released from the prison was now coming to Warburton. The letter reported that his diagnosis was 'schizophrenia' and that he was 'hearing voices'. A list of three long term medications that had been prescribed were recorded. One of these was Clopixol Depot 200 mg, a long acting intramuscular antipsychotic drug available only on limited prescription. Three ampoules had been supplied. It was due to be administered the day after the letter arrived. No other information was provided. There was no health record of this client at the nursing post. It was another six days before the client was seen by a nurse.

It appeared to be often left to nurses in the remote area to 'chase up' additional information as needed. A distinctive feature of this follow-up from communications with nurses in the remote area was in the expectation of them to perform errands

Performing errands

Requests for nurses to carry out miscellaneous errands on behalf of others was another aspect of short term follow-up activity peculiar to remote area practice. Performing errands was inconspicuous, but required a nurse's time and effort. For example, relaying information to a client or obtaining information on behalf of someone else and reporting back the response. This was illustrated as follows:

The manager of a nursing home telephones the nurse stating that he has money for a woman who had been recently discharged to Warburton. He asks the nurse to find out where he could send the money and whether the woman is returning to the nursing home. If she is not returning her 'bed space' will be given to someone else. The woman is not found. Her relatives inform the nurse that she has gone to Karilywarra. On return to the clinic the nurse contacts the community

advisor at Karilywarra by satellite telephone for him to seek out this information from the woman and to notify the nursing home manager.

In another example, a nurse from a distant community telephoned to the nurse and stated that a client's line tubing (for peritoneal dialysis) had been left behind in Warburton. The nurse was then asked to find it and send it on to the other community where the client was now staying. This involved the nurse searching the clinic and, failing to find the item, visiting the relatives where the client had stayed to locate the tubing. The tubing was then packaged and delivered by the nurse to the airstrip to be freighted accordingly.

Telephone calls to the nursing post from a client who was admitted to a hospital with a request to speak with a family member in the community were also common. Nurses or the Facilities Coordinator usually volunteered to locate the relative so that he or she could return the telephone call from the nursing post. Most of the staff felt that these telephone communications were important, however, as a way to reassure these clients and their families.

The diverse activities pertaining to client care in short term follow-up together with its recurrent problems that impeded the completion of care regimes were perceived by most nurses as a normal part of everyday practice in the remote area. Short term care that was accomplished according to the care required by a client was sometimes referred to by nurses as 'follow through'.

Follow through

Nurses perceived that they 'followed-through' with client care, either initiated by themselves or by other care providers, such as a medical practitioner. Following through also meant reassessing the effects of care provided, such as a mother's comprehension of an infant's feeding regime and the infant's progress. Nevertheless, the outcomes of care were not routinely checked, unless a client returned with an unresolved problem. This was, at least partly, due to the constant flow of client

demands, acute care needs and the associated work that often overtook the opportunity to ascertain the outcomes of care given.

Follow through indicated that a treatment or an investigation was completed and reported as needed or requested. The following example illustrated this point:

A child who had been seen on a Wednesday at a paediatric clinic was found by the specialist to have renal problems and a viral infection. A nurse was asked by the paediatrician to undertake second daily weighs, blood pressure and urinalysis. The nurse was then to follow through and report the child's progress to the paediatrician on the following Monday. If there was no improvement in the child's condition, he was to be admitted to hospital for further investigations.

As another example, a nurse described how she followed through a woman's health check:

I ask the woman [at a consultation] to come back after 10 days or two weeks, so that I can tell them the results and I sit down and go through it with them. Other times if there is something that has been detected [from a pathology investigation], maybe Chlamydia, you tend to find out a lot quicker. So I go out to visit the woman and talk to her about that. I will then treat her if she is willing and also find out about any partners. I pass this information on to Public Health. The other thing is once I've treated a woman, let's say for Chlamydia, then three months down the track I will follow it through and see the woman again and retest to find out if she has still got that.

There were clients who moved to another community and who required follow through to communicate their ongoing care management. Nurses at the nursing post then usually communicated the information needed for their care to a nurse at that community. These various features of short term follow-up for the organisation and implementation of immediate and current care of clients was one aspect of instrumenting care in remote area practice. Another domain of follow-up was the ongoing long term care for clients.

Ongoing follow-up

The domain of ongoing follow-up mainly involved the maintenance of ongoing medical regimes and continuing programs, such as children's immunisations. Individual Forward Planner sheets for each client were used by nurses as a reminder of this ongoing follow-up (Appendix 16). Other areas of ongoing follow-up included the management of health screening programs and social support, such as for families with children under Family and Community Services surveillance. Maintenance of medical regimes was undertaken for clients with chronic health problems and/or on long term medications. It involved 'keeping track' of these clients' treatment regimes and the supply of prescribed medications as well as monitoring their progress and maintaining a regular medical review. For example, clients with diabetes, hypertension, epilepsy, hypothyroidism, asthma and chronic muscular-skeletal problems were often prescribed long term medication regimes that were then supervised by nurses in the remote area.

Medical regimes

The ongoing follow-up of long term medical regimes was a major aspect of practice. Nurses maintained a supply of prescribed medications at the nursing post for clients on long term drug treatments, such as for diabetes, hypertension or epilepsy. A file was kept for these client's medication orders, as written by a medical practitioner at the routine medical clinic. Another file was kept for these clients' medication scripts. A nurse routinely checked each client's supply. This supply of prescribed medications was stored on separate shelves in the nursing post pharmacy. Nurses also reminded a medical practitioner on medical visits when a prescription renewal was required or a new order needed to be written. They then forwarded the prescriptions to the head office in Alice Springs for a pharmacist to supply these particular medications back to the nursing post.

The follow-up of clients on long term medications, however, often fell behind. Recurrent problems associated with the use of long term medications included the difficulty of regularly monitoring the large number of clients who were prescribed long term medications, the sporadic way in which these medications were consumed and the inconsistent manner of recording the date and quantity of drugs when these were issued to clients. These medically prescribed drugs were usually issued to clients in smaller quantities than as dispensed by the pharmacist, such as a week's supply in a dosette container or in a separate bottle that were labelled accordingly by a nurse.

Regular medical review of clients and their long term drug treatments occurred infrequently. A nurse described some of these problems as follows:

Many people who are on long term prescribed medications have not taken these medications for periods of up to more than a year. Some medication orders have not been reviewed for several years. There is a low level of compliance with long term medications.

Whilst there were many clients requiring ongoing follow-up for the continuity of care and management of chronic health problems, all clients in a relevant group, such as ante-natal women and children under 5 years age, were generally taken into account for the follow-up of well health programs.

Well health programs

Well health programs were preventative programs aimed at the maintenance of health in the remote community. These ongoing follow-up programs were initiated and managed by nurses at the nursing post. A few health programs were of limited duration, such as a school health survey or a BBC (Breathe, Blow and Cough) program with school children during the school term. The implementation of these programs of limited duration also depended on the initiatives taken by individual nurses.

The ongoing programs included women's health, antenatal care, immunisation and STD (Sexually Transmitted Diseases) serology screening. Lists and systems of recall were compiled by nurses for each of these activities. For example, each month a nurse reviewed the childhood immunisations due and prepared a list as a reminder to ensure that the immunisations were given accordingly. This program also involved the nurse completing a Monthly Immunisations Statistics form naming the child immunised, date of birth, the immunisation and date administered and the batch number. Copies of the report was then forwarded by facsimile or posted to the administration head office and to the regional division of Public Health and Primary Care. There were usually five to six ante-natal clients at one time. A midwife was usually available to provide educational advice and to monitor the progress of these clients.

Apart from immunisation and ante-natal care, however, most of these programs were not regularly sustained. This lack of continuity in ongoing health programs appeared to be influenced by factors such as the immediate demands of day to day client care as well as the priorities and expertise of individual nurses in these areas of nursing practice. Another factor was a lack of support from other health professionals. This view was explained as follows:

Doctors aren't interested in preventative health to a large degree and that affects our work. At present our role is being caught in the clinic to a greater extent. There is not enough time for being able to run preventative health care programs. As it is you have got to try and mix it in with what you are trying to do in the clinic, which is a lot of work. We are trying to run a clinic and we are also trying to run programs. Physically it can't work, not to do it effectively.

It appeared that the programs of main interest to medical practitioners and other health professionals, who were external to the setting but apart from the RFDS, were in health/disease screening. In addition to the well health programs instigated and managed by nurses, medical and other health practitioners occasionally visited the community to conduct single screening programs.

Health screening by visiting practitioners

The performance of surveys for health screening in the remote area entailed additional work for nurses as it included the preparation as well as the ongoing care that was required. Medical specialists or other visiting personnel such as a dentist, always seemed to assume that nurses would organise as well as follow-up their screening programs. This resulted in nurses and Aboriginal health workers also being expected to inform and organise individual clients for screening. This activity was referred to by nurses and Aboriginal health workers as 'rounding people up', as stated by an Aboriginal health worker:

I dread tomorrow. I'd like to stay home. There were notes [written by a nurse] to give to people about the dentist's visit, but they weren't handed out. The nurse was doing other things. I suppose I will be expected to round people up. I don't like doing that.

In addition, nurses were expected to undertake responsibility for the follow-up of clients who had been screened in medical surveys. This expectation was bluntly stated to a nurse by a visiting medical practitioner during a screening survey. The nurse had asked, facetiously, 'Who is going to do the follow-up?' 'You are!' the medical practitioner retorted. It appeared to be taken-for-granted that nurses would or could assume this responsibility together with any other activities created by the conduct of medical screening, such as to complete the health records, to notify individual clients of their results or to identify clients requiring further investigation and its organisation. There appeared to be few, if any, plans made by the visiting practitioners for these essential facets of a screening program.

In another survey the visiting 'eye team' had screened members of the community for trachoma. The results indicated a high prevalence of trachoma. In its wake, and without specific instructions from the visiting ophthalmologist for further management or treatment, a nurse decided to blanket treat the school children with Septrim oral suspension according to the usual treatment administered on previous occasions. The logistics of treating whole families was considered by this nurse to be impossible. In

anticipation of the additional workload and resentful of an indifferent attitude as implied in the 'eye team' taking the nurse's role for granted, a nurse stated:

I dread the eye team coming. This screening leaves so much work. They [medical personnel] take it for granted that you will do it [organise, follow-up and treat people].

'Doing it' for this nurse involved consulting with the school principal for approval and taking cartons of Septrim suspension, medication measures, scales and the list of children's names to the school. Individual parents were not informed. Each child was weighed to calculate the appropriate dose of Septrim. Administration of Septrim was continued by the nurse each week day, twice a day, for three weeks. Less than half of the school children had a course of treatment because of their absences from school. This information was not reported to the ophthalmologist, nor did he inquire about the follow-up performed. The nurse then recorded each treatment given on the list and in the child's health record.

The ongoing management and implementation of care required for following up medically related programs was an important domain of practice. A less prominent domain of instrumenting care for ongoing follow-up by nurses in the remote area, was that of social support.

Maintaining social support

Providing social support for clients was integral to the day to day management of nursing care. Individual nurses were observed to provide ongoing care for social needs in various situations, such as clients who were lonely and/or who suffered persistent abusive relationships. For example, a nurse made regular social visits to an elderly woman who often sat alone outside her house.

Nurses also provided social support in their nursing care of clients on long term treatments. For example, clients on Continuous Ambulatory Peritoneal Dialysis

(CAPD) or clients under review by social welfare services. The nurses support for clients on CAPD, included making home visits and/or assisting them with sending monthly inventory returns of their stocks to the supplier. There were two clients on CAPD. Frequent care and support by nurses was needed for one of these clients and his family. These clients were regularly seen by a renal specialist at the regional or metropolitan hospital. Nurses made the arrangements for these appointments and the organisation needed for the appointments to be kept by a client.

The regimes nurses were to follow for a client's management of the dialysis in the home, together with the management of complications, were described in the Remote Area Continuous Ambulatory Peritoneal Dialysis Manual (1995). Most nurses were inexperienced in renal nursing, however, and for a beginning nurse in the remote area this Manual seemed unhelpful, as seen in this example:

A nurse, recently arrived at Warburton, is on call for the first time. She asks another nurse about the care of a client on CAPD who is expected to arrive in the community in the evening. She states, 'I know zilch about renal dialysis'. The other nurse offers her the Remote Area CAPD Manual and says, 'Do a crash course in CAPD!' The nurse reads through it and comments, 'That doesn't help me much'.

Officers from the Department of Family and Community Services based in Laverton and Kalgoorlie referred to nurses for the support of clients in situations of reported child neglect. An officer from these services described their relationship with nurses in the remote area in this statement:

The importance of nurses in remote communities is that they are the main providers to this service for consultation and for developing a framework for dealing with cases, such as failure to thrive and neglect. Nurses are able to inform me about where a child is at. They are a major source of advice.

The long term support role of a nurse in instrumenting care for these clients was also observed in a meeting between the Family and Community Services officer and a nurse. The interaction was observed as follows:

Two cases are being discussed. The nurse has brought the client record for each child. She knows the first child and his mother well and has frequent interaction with them. The nurse reports that the mother brings her baby to the clinic almost daily and that there are supports available from the family. The nurse adds that the child's progress in Warburton is most affected by the husband's continued violent abuse of the mother. In reply the officer states that the child was reported to them as at risk in Kalgoorlie. There, both the husband and wife had been drinking alcohol heavily. The husband had beaten his wife causing serious injury and the child had been subjected to neglect and physical abuse by the mother. It was to be decided if the child should be placed in foster care. The assurances of the nurse that there was support and family protection for the mother and child in Warburton, however, influenced the decision to retain the child with his mother. The other child is not well known to the nurse and, according to his record, he has not been seen in the clinic. The family have been away with the child for several months. The officer, however, states that this child is now in the community and requests that the nurse keep a record of his progress.

A sub-domain inherent to the organisation and implementation of ongoing care, and to instrumenting care in general, was documentation. Nurses referred to the upkeep of these records and files as 'paperwork'.

Paperwork

Record keeping was an essential component of the organisation and management of follow-up as well as for maintaining an account of clients and of the services provided. Paperwork included the keeping of lists, completing forms, updating records and filing reports, and attending to correspondence. It comprised a proportion of the day to day tasks of remote area nursing.

Compiling lists was usual in preparation for visiting health personnel and for screening programs or other mass activity conducted by, or involving, nurses. It was also normally expected by visiting practitioners that a nurse would prepare a list of clients and have clients ready in order to facilitate their clinics. For example, a dentist

planning a visit to the community, telephoned to request a nurse to make a list of those clients he needed to see. Following his arrival he expected that, 'a nurse or an Aboriginal health worker would collect these people'. Between every fortnightly medical visit the nurse prepared a list of clients who were to be seen by the medical practitioner.

Maintaining records and files also entailed checking all the reports and other correspondence that arrived by mail (either from Kalgoorlie or Alice Springs) at the nursing post. Pathology results arrived in bulk. One copy of these pathology results were sent from the administration office. Another copy was brought out by the medical practitioner and handed to a nurse at the fortnightly medical visit. Thus, a duplication of pathology reports occurred. In a usual fortnight approximately 40 pathology reports were received. The nurse then undertook the task of cross-checking and sorting all these results. Duplicate reports were discarded. Those reports for clients who required follow-up treatment, as instructed in a note written on the report and initialled or signed by a medical practitioner, were set aside (see, *Dealing with pathology reports*, p273). Nurses tended to assume that all pathology results had been reviewed by a medical practitioner at the RFDS. (Due to the duplication of pathology results not all were signed or initialled by a medical practitioner). The remaining results were then filed in the client's health record.

Other records pertaining to the domain of instrumenting care that were all maintained by hand at the nursing post included a Births and Deaths book, Evacuations book, Medicare book and Pharmacy Accounts record. The Evacuations book was used to record clients evacuated to hospital by the RFDS as well as clients who travelled to attend outpatients appointments at regional or metropolitan health care centres.

The records kept by nurses at the nursing post were usually not reviewed by the health services administration. Their main purpose appeared to be for documentation of care and services within the nursing post. The decision to maintain these records, however, was taken by nurses. The arbitrary nature of record keeping was evident

with nursing staff changeover. For example a newly appointed 'Sister-in Charge' took the decision to discontinue and to incinerate the Births and Deaths book and the 'File in /Files Out' record (a record of client files either forwarded to or received from another community). The reason given by the nurse was that these records were also being maintained on computer by administrators at the health service head office. In this nurse's view, when the information was required a nurse could obtain access by communicating with the office during office hours.

The Facilities Co-ordinator assisted nurses in dealing with routine paperwork. At the end of each month the Facilities Co-ordinator prepared a monthly 'Performance Indicators' report and forwarded it to the health service manager (Appendix 19). This summary numerical report was compiled from the Daily Patient Record (Appendix 15), the Evacuations record book and medical clinic lists that had been completed by nurses and the Facilities Co-ordinator. Numbers counted in the management's interpretation of a clinic workload. For example, an administrator basing her information on statistics as recorded in the 'Performance Indicators', told nurses at Warburton:

This is not a busy clinic. The nurses at A___ (another community) see more people than you do at Warburton.

The influence of numbers recorded on paper as a measure of work performed was also illustrated when some nurses described their day's work in terms such as, 'We saw 52 people today'. Or as a nurse stated following a screening drive, 'I collected 24 specimens'. This emphasis on numbers tended to disguise a need to ascertain the quality of care provided and time involved as well as the outcomes of care. The Facilities Co-ordinator described her perception of the problem as she had observed it in this way:

The major problem with this system [Daily Patient Record] is that it purely states how many people walk through the door on a particular day. It doesn't say how much time is taken...even things like the spaces that are provided are basically inadequate. I was doing some statistics yesterday and the forms are incomplete. For instance, a woman who comes in for a Pap. smear or a breast check. There is nowhere to write

them down. Unless they come in for obstetrics they don't count. So its supposedly giving an idea of who is coming through the door and what health care is provided to people. It's not complete in that way. Like I said, it doesn't record the time that's given to providing care. The work is not recognised in the statistics. Then you get people [in administration] saying basically nurses don't do much out here. They [nurses] are flat out [constantly busy].

A further aspect of paperwork in instrumenting care were the tasks involved in keeping clients' Medicare cards and Health Care Cards. The Facilities Co-ordinator dealt with Medicare applications on behalf of clients. Medicare cards were then filed at the nursing post. Health Care Cards were mailed individually from Social Security to the community office and then passed on to the nursing post. The Facilities Co-ordinator recorded the names and numbers given on these cards in a separate notebook. The backsheet of the Medicare cards, with the client name/s and number, as well as Health Care cards, were then forwarded the health service head office. Nurses and the Facilities Co-ordinator likened their functions in keeping clients' personal Medicare cards and medication prescriptions, for example, to a 'caretaker role'.

Other papers received by post that had been addressed to individual clients, care of the nursing post, included Pap smear reminders and a questionnaire from a researcher at a metropolitan women's hospital undertaking a survey of client satisfaction. The tacit assumption seemed to be that nurses in the remote area would deal with this correspondence by taking responsibility to deliver it to the client concerned as well as to ensure that a client responded accordingly.

Nurses were also expected by the administration to 'bill' clients at a charge of \$2.70 for non-prescribed medicinal items that were supplied from the pharmacy store, such as topical creams and antibiotic tablets or injections. This 'Pharmacy Account' was to be signed by the client and by the nurse who supplied the medication (Appendix 20). At the end of each month these accounts were sent to the community office for

reimbursement to the health service (p44). Most nurses, however, did not regularly complete the Pharmacy Account, some did not obtain the client's signature, while others declined to use it at all.

The broad domain of instrumenting care covered the diverse activities performed by nurses for the continuity of client care and related needs. Inter-connected with these elements in instrumenting care, were the domains pertaining to the upkeep of resources used for care.

Instrumenting care and care resources

Part of the organisation and management of care in remote area practice was to ensure the availability of care resources. In particular, the dominant domains that emerged in relation to instrumenting care were the supply of pharmaceuticals, maintenance of stores and dealing with the requirements of pathology specimen collection and the subsequent results. The most complex of these responsibilities for care was that of pharmacy supplies.

Pharmacy supplies

Nurses in their everyday practice assumed responsibility for the storage, dispensing, prescribing and administering of drugs scheduled under the Poisons Act 1964 (Western Australia). Nurses maintained stock supplies in the nursing post pharmacy and routinely ordered drugs from the regional hospital pharmacist. A Poisons Permit (Industrial) issued under the Poisons Act 1964 to the Ngaanyatjarra Health Service from the Health Department of Western Australia authorised the purchase of Schedule 2,3 and 4 drugs and a restricted list of Schedule 8 (narcotic) drugs. This Permit also set out conditions for the security and use of these drugs in the remote area (Appendix 21).

The usual procedure to acquire drugs for the nursing post pharmacy supply began with the nurse in charge checking the drugs shelved in stock, the quantity available and the drugs over or within two months of the expiry date, approximately every four weeks. The frequency of this process was influenced by the rate of use of drugs as well as the individual preference of a senior nurse. Drugs due to expire were packaged and sealed in a cardboard carton and freighted back to the regional pharmacist by the regular air service.

The choice of drugs and quantity required was decided by the nurse. There was no standard inventory of drug stock levels held at the nursing post. As a result, nurses estimated the drugs needed on the basis of replacement of used or expired supplies and the frequency of use.

A 13 page imprest form, issued to the nursing post by the pharmacist at the regional hospital, listed all the drugs available for order, including Schedule 8 drugs (narcotics) (Appendix 22). This form, together with an invoice of the drugs received, represented the only record of the drugs supplied and stored at the nursing post. The date and quantity of drugs required was recorded in the columns provided for this purpose on the imprest form. The order was usually sent by facsimile to the regional hospital pharmacist. Drugs, or other items, such as dosette containers, required but not listed on the imprest were handwritten at the bottom of the form. In situations where additional supplies were needed at short notice, drugs were ordered individually by a nurse in charge.

Supplies of drugs ordered usually arrived back within four to five days. They were packaged in cardboard cartons and transported by the regular air service to Warburton. The Facilities Co-ordinator or a maintenance worker delivered these cartons to the nursing post. From there nurses unpacked the drugs and stored them according to their categories, either on a shelf, in a locked cupboard or in a refrigerator. An invoice of the drugs dispatched to the nursing post and their cost was enclosed in the carton. Each drug received was checked off from the invoice. These

invoices were then forwarded to the administrator at the health service office in Alice Springs. As previously stated (p262) the drugs listed on the invoice plus the imprest list on which drugs were ordered represented the only documentation of the range of drugs stored at the nursing post.

Range of drugs stored

The range of drugs ordered was observed to vary with individual nurses and their perception of the requirements for stock and according to the demand, such as from medical orders. This variability of drug orders associated with different nursing staff as well as a lack of a system of control for pharmacy supplies and stores was confirmed by a pharmacist at the regional hospital who received the orders. In making this point, he stated:

It's a free for all. The changeover of nurses influences the range and quantity of drugs ordered. The orders vary widely between different nurses. The actual drugs stocked at the nursing post is left to the discretion of the nurse. I have a rough idea of the drugs in stock at Warburton, but the only inventory is the imprest list from which orders are made by the nurse.

Nurses individual preferences, however, were not the only factor influencing the ordering of pharmacy supplies. Other factors also contributed to the variability of drug orders. These factors are discussed below.

The medications ordered by medical practitioners was an important factor. For example, an increasing quantity of Ceftriaxone, an antibiotic, was required as medical practitioners more frequently ordered the drug for administration. At the time fieldwork commenced six vials of Ceftriaxone were stocked and the drug was seldom ordered. Within six months Ceftriaxone became the broad spectrum antibiotic of choice by medical practitioners, therefore additional supplies were then ordered by nurses. As another example, Azithromycin, a new oral antibiotic drug not previously prescribed at the nursing post, became the preferred treatment for chlamydia

infections by medical practitioners. Thus, quantities of these drugs were added to the pharmacy at the nursing post.

The range of drugs nominated in the CARPA Manual influenced the selection of drugs used for client treatments by nurses and, less often, by medical practitioners as well. As described in chapter 7, the CARPA Manual was used as a guide by nurses for the prescription of drug treatments for clients. For example, this Manual named the drug Nitrofurantoin to treat adults with urinary tract infections. A supply of this drug was, therefore, kept in the general pharmacy stock.

An Emergency Resuscitation Kit, called a 'Parry Pak', was supplied by the Health Department of Western Australia to the nursing post (Appendix 23). It contained a range of 25 emergency and other drugs, including drugs nurses themselves appeared to have added at some previous time to the standard kit. These drugs were mainly in ampoules for parenteral use. The Emergency Kit was rarely used. To maintain the currency of these drugs, however, replacements were ordered as the drugs reached the expiry date.

Occasionally drugs arrived that had not been ordered by nurses. For example, two drugs were sent to the nursing post by internal mail from another community. The drugs were one ampoule of Anexate 0.5 mg. and four ampoules of Lasix 250 mg. They were accompanied by a note from a nurse from another community stating that they were to be added to the Emergency Resuscitation Kit. A facsimile also arrived from an administrator of the health service instructing nurses about changes to the 'Emergency Drug Box' list. These alterations were changes in the dosages of three drugs, the removal of another three drugs, and the addition of Anexate 0.5 mg. and Lasix 250 mg. ampoules.

An outcome of these various influences on the drugs ordered was that a large array of drugs were kept in stock. Many of the drugs were not used in the year of fieldwork, such as the parenteral drugs Dilantin 200 mg., Serenace 5 mg., Hypnoval 5 mg and

Apresoline 20 mg. There appeared to be no regular system for scrutinising or rationalising the range and quantity of drugs held by nurses. Furthermore, there seemed to be no routine system for documenting the drugs stocked and dispensed at the nursing post. These unstructured arrangements for the use of pharmaceuticals contributed to one of the main problems for nurses in remote area practice.

Nursing problems and pharmacy

Responsibility for the storage and supply of drugs posed major difficulties for nurses and for nursing practice. These difficulties pertained to the lack of statutory authority for registered nurses to supply, prescribe and dispense drugs, as well as to their lack of knowledge specific to these responsibilities and the lack of a method to monitor and control drug usage. The nature of health service provision and practice in the remote area, however, obliged nurses to perform these functions on a routine basis. Another difficulty arose from the lack of qualified and experienced personnel available to provide professional guidance and the lack of qualified practitioners and emergency facilities usually regarded as necessary to safely use quick acting drugs.

Several nurses also grappled with moral questions pertaining to their lack of authority and expertise as well as to the quantity and type of drugs available for use in the remote area setting. For example, these nurses often expressed concerns about the possible long term adverse consequences for clients' health from frequent treatments with antibiotics. They also felt that the availability of such an array of drugs and a lack of supervision could increase the likelihood of these drugs being used indiscriminately.

A nurse with this viewpoint stated:

Out here it is so informal. It's 'Oh give them a bit of Pethidine or Panadeine Forte and we'll put her on Ceftriaxone for ten days'. You can't do that in the city. Every drug has to be prescribed specifically and by a doctor. Here we can just take them off the shelf. It is only the specific things that are medically prescribed, and even 90% of them are on the shelf any way.

Some nurses perceived that they had an unreasonable burden of responsibility in holding large quantities of restricted drugs. This was related to their anxiety about administering potentially toxic drugs to clients in the remote area, even when they had been ordered by a medical practitioner. The medical practitioner, after all, was still located almost a thousand kilometres away. For example, while checking the contents of the Emergency Resuscitation Kit, a nurse commented:

I wouldn't be prepared to use most of them [the drugs in the kit], especially under these conditions where I have no medical back-up. The fact that these drugs are here means that they are more likely to be used. What will they expect us to do next?

A few nurses were also concerned about their own accountability and the informal manner in which drugs were distributed in the remote area, describing the situation as 'dangerous' and 'casual'. Nevertheless there was minimal, if any, consultation with nurses to inform them and to obtain their agreement to accept this exceptional responsibility. For example, at the unexpected arrival of the three ampoules of Anexate 0.5 mg. (p264) the three nurses remarked that they, 'haven't ever heard of it before'. One nurse added, 'It is the responsibility for these kinds of drugs that makes working here impossible'. Together the nurses read through the pamphlet enclosed with the drug. Under 'Indications' it emphasised that the drug was only to be used 'in hospitalised patients' and, 'under continuous professional observation'. The nurses decided to raise this problem with a medical practitioner at the next RFDS medical visit. In the ensuing discussion it appeared that the medical practitioner had a limited understanding of the nursing problem. The observation was as follows:

At the completion of the medical clinic the nurse asks the medical practitioner, 'Are you aware of the addition of Anexate and Lasix 250 mg. ampoules to the 'Emergency Box?' The nurse then shows the facsimile containing this direction the medical practitioner. She adds, 'I'm unhappy about having this responsibility especially in view of the specific restrictions described in the pamphlet'. In reply the medical practitioner states, 'I know nothing about this. It hasn't come from RFDS and I was not consulted. Anexate would rarely be used. I've only seen it used once in hospital'. He does not respond to the nurse's remarks pertaining to the information on the pamphlet but states, 'Anexate is for reversing the action of Benzodiazepines'. The nurse then points out, 'Nurses are expected to take responsibility for possession of such potent drugs'. The medical practitioner disputes the

nurse's claim and states, 'It is rarely used and would only be given on a doctor's orders. I've only seen it used once'. Unconvinced the nurse replies, 'But the doctor is a long way away. In court it would be asked of the nurse why she gave the drug when the enclosed information clearly stated that it is not to be given outside a hospital'. The conversation was terminated. Later that evening the medical practitioner, who is staying overnight, raises the subject again. He then concedes to the nurse that, in his opinion, it is 'overkill' to hold these rarely used drugs in a remote area nursing post.

It was usual for medical practitioners to sidestep the issues basic to nursing concerns about drug use in the remote area, such as the nurses' authorisation and their independent accountability for the drugs they administered. Furthermore, there appeared to be assumptions made and misinformation circulated between care providers about the authority of nurses in remote areas to initiate drug treatments. For example at a meeting called by the nurse in charge with a visiting medical practitioner, the nurse asked him for information about the assessment and treatment regimes for venereal diseases. (The medical practitioner was an author of CARPA Manual, but was not employed by the RFDS where the nurses formally referred clients.) The conversation was observed as follows:

Nurse: What are the protocols for the treatment of STDs?

Doctor: In here [points to a copy of the CARPA Manual lying on the table]. The Health Department [Western Australia] and the Ngaanyatjarra Health Service says it is alright to use CARPA Manual for the treatment of STDs...If you follow the protocols and it goes bad, you [nurses] are covered.

Nurse: Basically I've been given a book that says, if the patient has this and that, then you do this and that. To me its a book of preferred treatment. There is nothing making it clear that you have it ratified that this is the standard treatment. I wonder if the Nurses' Board will cover me for giving out antibiotics when it is in conflict with the Nurses Act? Being told to use the CARPA Manual is like a rumour, but its not concrete.

Staff Development Officer: Under the Nurses Act you can give antibiotics for three days [The regulation presumably being referred to has not been implemented]. I'm not sure what it actually says.

Another related problem impacting on nursing practice in the remote area was that the availability of pharmacy stocks and the nurses' use of these drugs also appeared to influence clients perception of it being a nurse's role to prescribe and dispense medications.

Being a 'chemist'

Nurses were often approached in a manner similar to that expected of a local chemist (pharmacist). For example, requests were frequently made to nurses to supply Panadol or other analgesic tablets, or to recommend and supply a topical ointment for a skin problem. In similar fashion, a tourist came to a nurse after work hours and requested 'a medicine to stop nausea'.

The lack of a pharmacist or other source for purchasing 'over the counter' drugs together with the availability of a pharmacy store at the nursing post, often pressurised the nurses to supply drugs on request. The local store did stock basic items, such as Paracetamol, eucalyptus oil, Vicks vaporub and band-aids. The cheaper option, however, was to obtain these at the nursing post at minimal, if any, charge. For example, nurses were requested on several occasions to provide a box of 'basic medicines' and dressing materials for a client to take out camping with a group of people.

The presence of a pharmacy supply, as well as the manner of issuing drugs by nurses, also contributed to an assumption by clients that these nurses had the authority to give out drugs. Clients often requested nurses to give them specific drugs that they knew were stored at the nursing post, such as a 'needle' (expression used for parenterally administered drugs), 'pain tablets', 'rubbing medicine' (such as Metsal cream), cough mixtures, eye drops, 'scabies medicine' (Ascabiol) and bandages. As well as keeping pharmacy supplies, nurses also 'kept track' of other stock required at the nursing post.

Other stores

Surgical stores, such as dressing materials and disposable equipment, such as oxygen tubing, intravenous giving sets and syringes, were maintained by nurses. These supplies were ordered at regular intervals from the Kalgoorlie regional hospital pharmacy. An order form listed the items available together with the catalogue number, quantity and, where appropriate, the sizes available. Orders were delivered from Kalgoorlie by the Ngaanyatjarra Air service usually within five days. Nurses then packed the goods in the store-room ready for use.

Oxygen cylinders were ordered through the Ngaanyatjarra Transport Service and transported by road to Warburton from Perth. The Facilities Co-ordinator was responsible for ordering other general purpose goods, such as cleaning materials from the 'buying service' provided by the Ngaanyatjarra Transport Services based in Perth (whereby goods could be purchased in Perth and supplied to Warburton). Stationery was ordered by the Facilities Co-ordinator from the Health Service administration office and sent by the air service to the nursing post in the internal mailbag.

Equipment was also ordered as part of stores. Specimen containers for the collection of pathology specimens, were ordered from the Western Diagnostic Pathology service based in Kalgoorlie. A prominent domain in the management of resources for care in the remote area was dealing with the collection of pathology for investigation and with the results.

Pathology collection and reports

Collection of pathology specimens and dealing with subsequent results, together with the associated activities of recording this information and treating clients, directly impacted on instrumenting care in remote area practice. The decision to collect pathology samples for investigation was sometimes made as part of a client's assessment by nurses or was often ordered during medical consultations. Pathology specimens were also collected by nurses in screening programs, such as serology for

syphilis, Papanicolaou smears in women's health screening and at the routine screening of ante-natal clients. The procedures involved in pathology specimen collection and the results, therefore, comprised a major proportion of the follow-up required for client care.

The procedure used by nurses for the collection of pathology specimens followed a routine pattern. A decision was made to collect pathology either from a request by a medical practitioner or a nurse. A pathology request form was then completed and signed by a nurse either prior to taking the specimen or before it was transported to the pathology service. Most nurses respected the privacy and confidentiality of a client by seeing them in a room separate from other clients. When a client was not already present at the clinic, a nurse went out to inform them or to remind them as needed.

Prior to taking a specimen a nurse usually briefly explained why the specimen was being taken and obtained the consent of the client. It was uncertain, however, how much the client understood of these explanations due to the language barrier between nurses and clients. Consent, therefore, was often implied by the co-operation of a client in the procedure. For example, at a request to the client for a urine specimen to be sent to pathology and explanation of the procedure, a client accepted the urine container and provided a urine specimen accordingly.

Nurses selected the container or blood tube for each specimen. Nurses who felt unsure of the correct container referred to the Laboratory Handbook provided by the pathology service (Western Diagnostic Pathology 1992). The staff at the pathology service were also available during work hours to give advice by telephone to nurses as requested.

Pathology specimens, once collected, were usually labelled with client details and the type of specimen and tests required. The specimen taken was recorded in the client's file. Specimens were stored in plastic biohazard bags with a side pocket to attach the pathology request form. Specimens requiring refrigeration were stored in a portable

car refrigerator (referred to as 'cold' specimens) or otherwise kept at room temperature (referred to as 'hot' specimens) until transported to the regional pathology service . Storage of specimens was usually between less than 24 hours to three days.

On the morning when the Ngaanyatjarra Air service was due to arrive all the pathology specimens that had been collected were taken from the refrigerator or place of storage and packed ready for transport. Packing specimens was usually performed by the Facilities Co-ordinator. This involved checking that individual specimens and pathology request slips were together. Cotton wool was added to each bag containing specimens in order to soak up any spillage during transport. The bags were then sealed. The specimens were divided and placed in separate plastic bags labelled according to whether they were 'hot' and 'cold'. The name of the clients and the type of pathology being sent was recorded in a 'Specimens book'. This notebook was a reference for nurses to verify who had what specimens taken and when these were sent (until it was discontinued by a nurse in charge, who stated that it was 'unnecessary'). The specimens were then placed in a foam esky ready to take to the airstrip when the aeroplane arrived. On its arrival, the Facilities Co-ordinator transported the esky to the airstrip. At the aircraft specimens were removed from the esky and placed in other eskies carried by the air service. A red esky was used for 'hot' specimens and a blue esky containing an ice pack for 'cold' specimens.

The standards required for carriage of pathology specimens by aircraft are set by the IATA (International Air Transport Association) Dangerous Goods Regulations. Adherence to these standards had been at the request of Ngaanyatjarra Air service pilots. Using this transport, a wide range of pathology specimens for investigation were collected by nurses.

Pathology investigations

As previously stated, most pathology investigations for clients in the remote area were undertaken on request by a medical practitioner from the RFDS or were decided independently by a nurse. Occasionally, medical specialists also requested nurses to take pathology specimens as part of follow-up for a client's care. For example, a medical specialist at a metropolitan hospital requested a nurse to take 1 ml of blood in a plain tube for MCAT biochemistry from an infant diagnosed with hypoglycaemia. In addition, the nurse was asked to take similar specimens from the infant's two siblings. In another example, a renal specialist required blood tests to be obtained prior to seeing a client on his visit from Perth to Kalgoorlie. The tests requested were FBC (Full Blood Count), LFT (Liver Function Test), U and E (Urea and Electrolytes), Creatinine, and Calcium Glucose and Phosphate.

The pathology investigations initiated independently by nurses were usually wound swabs, urine specimens for micro culture and sensitivity or a range of tests that were assessed by a nurse to be appropriate for a routine health screening program. Some nurses also initiated pathology tests, such as collection of a range of blood specimens following an intravenous cannulation, on an assumption that a medical practitioner would need the results to assist the diagnosis on the client's admission to hospital. Nurses were also influenced in their selection and initiation of pathology investigation by the tests nominated for collection in the CARPA Manual or Minyma Kutju Tjukurpa Women's Business Manual (1994), such as for a 'Well Women's Checkup'.

Most medical practitioners, however, stated that they did not expect nurses to initiate pathology investigations. Nevertheless they did expect nurses to be able to take pathology specimens as requested. For example, in response to a question about his expectations of a remote area nurse in the routine collection of blood for pathology specimens, a medical practitioner stated:

Well I wouldn't expect the nurse to take any blood tests at all. Maybe the routine RPR (Treponemal test), the routine screening, but any other blood tests other than that, unless it is written in the notes that a

guy needs his U and E's (Urea and Electrolytes) done every year. Even then I would have thought if he needs his U and E's done he should be seen in a [medical] clinic once a year and the blood test should be done as part of that. I don't think nurses should be doing blood tests without a consult [medical consultation] to check the fact. If you want to take bloods you want to make sure you take all the right ones.

The variety of specimens that were collected by nurses for pathological investigations was illustrated in the following typical example. In one fortnight 43 pathology results were received. There were 16 different tests performed on six different types of specimens. The tests included Serum Tegretol levels; urine micro, culture and sensitivity; faeces micro, culture and sensitivity; Papanicolaou smear; blood urea and electrolytes; liver function tests; creatinine; full blood picture; herpes simplex serology and Human Immunodeficiency Virus (HIV) serology. The results of these pathology investigations and any orders arising from them were all dealt with in the remote area by nurses.

Dealing with pathology reports

Following laboratory tests at the pathology service in a regional centre, the results were forwarded to medical practitioners at RFDS in Kalgoorlie for their review. Nurses could also telephone to the pathology service to request results. Medical orders for treatment were usually noted on a pathology report slip. When immediate treatment was needed a photocopy of the result with the drug order written on it and signed by the medical practitioner was sent by facsimile to the nursing post. At a convenient time, the nurse checked the pathology results that were delivered by a medical practitioner on the routine medical visit (as previously described in paperwork, p258).

The instructions for drug treatments that were written by various medical practitioners on the pathology slips frequently lacked specific details, such as dosage or duration of treatment. The assumption appeared to be that a nurse would be able to

make a decision pertaining to the details omitted from the drug order. For example, a wound swab report noted a 'heavy growth of *Streptococcus pyogenes*'. The client was four months of age. The medical order was written on the result slip as, 'LA Bicillin, paediatric dose per CARPA manual'. On a serology result reporting 'active Treponemal infection', the medical instructions were, 'Needs LA Bicillin'.

Other medical notes written on pathology reports implied that a nurse could select the appropriate drug treatment from a range of options. For example, a urine micro culture and sensitivity result reported a urinary tract infection with *Enterococcus faecalis*. The medical orders for treatment stated, 'Needs treatment - either Trimethoprim 300 mg BD for 1/52 or Nitrofurantoin 100 TDS 1/52 or Amox. 3 g stat + 250 tds 1/52'. Several of these medical orders were even less specific. For example, for a client with a urinary tract infection with *Escherichia coli*, five antibiotics were printed in a list by the pathologist as sensitive to this pathogen. Alongside the list the medical practitioner had drawn a bracket and written 'Treat if not already on appropriate therapy'. On another pathology result for a client with urinary tract infection the medical practitioner had merely written, 'UTI needs treatment'.

Another problem was that reports of abnormal pathology had sometimes not been acted upon. For example, a medical practitioner when reviewing some client histories noted several abnormal results on pathology reports. He found that there was no documentation to confirm that these had been properly investigated or treated. Other problems pertaining to specimens collected for pathology investigations were noted by the pathologist.

Problems from a pathologist's perspective

From the pathologist's perspective there were several problems associated with collection and transport of pathology specimens from remote areas. The range of specimens were limited to those that could survive for at least 24 hours before laboratory testing. Some specimens, such as ESR (Erythrocyte Sedimentation Rate)

could not be transported adequately because of anti-coagulation damage to the specimen.

Other problems included contaminated specimens and leakage of specimens such as, when lids had not been tightly secured. Blood specimens that were clotted were unsuitable for testing. Specimens were also received without a request or were inadequately labelled in respect to a date or time of collection. Thus, the age of the specimen was not known. Incorrect specimens received included urine samples for micro culture and sensitivity which were not a mid-stream specimen. When these problems occurred the pathologist notified nurses at the nursing post by facsimile. Specimens then needed to be repeated as required

These problems related to the knowledge and attitudes of staff and to the resources available for adequate pathology collection as well as the difficulties of following up the subsequent results. In the remote area organising resources for care together with instrumenting care for clients were major domains of practice. Nurses, however, experienced recurrent constraints in their overall ability to organise, co-ordinate and maintain all the follow-up and the ongoing care required as well as to manage the resources for care at the nursing post.

Constraints in instrumenting care

In addition to the specific problems for nurses in instrumenting care and the upkeep of resources for care, more general constraints emerged that were peculiar to remote area practice. These general constraints to instrumenting care in the remote area included the frequency of nursing staff turnover and the volume of day to day demands in the clinic together with the availability of clients. Furthermore, a lack of organisational planning appeared to be basic to these constraints.

Lack of planning

Within the organisation there appeared to be minimal planning for health service delivery in the community, such as direction for the conduct of designated health programs and controls for the supply and use of pharmacy stores. A lack of planning together with a lack of awareness of the day to day work involved in instrumenting care as well as in the upkeep of resources for care contributed to the assumptions made regarding a nurse's scope of care. It also appeared to contribute to the unrealistic expectations of nurses in remote area practice. For example, the organisational monthly Performance Indicators report listed 12 health programs for different client groups (Appendix 19). The expectations of the organisation, however, were not adequately communicated to nurses. Consequently nurses were placed in a dilemma, as seen in this quote:

I keep saying that I want to have programs running in 12 months, but I don't know what that means. I've got a whole list of RPRs [clients for serology tests] that haven't been done for two or three years. We [nurses] are trying to separate them into people in a risk group, people with medium risk and a non-risk group. The Aboriginal health worker is helping us with that. But it's still a bit of a dilemma on how we should tackle these problems.

Another consequence related to a lack of planning was that the implementation and outcomes of care and use of care resources were seldom reviewed. This was illustrated by a nurse in the following remark:

Programs are not working. The thing is once you have treated, let's say chlamydia, then three months down the track you've got to go and get the woman again and retest to find out if she has still got that. Now none of that is going on, I don't think. Probably its because the organisation has no formal program for doing it. So that is all being missed out to make sure the treatment has been effective. That's a bit of a problem.

The problem of a lack of planning and evaluation of care implementation was exacerbated by a lack of staff continuity. The frequency of staff turnover, both nurses

and Aboriginal health workers, appeared to contribute to a disjointed follow-up service.

Changes in nurse staffing

A major constraint to nurses' ability to 'keep track' of the needs in instrumenting care was the high staff turnover. Thus, for example, at each turnover of staff the follow-up stalled and the unattended paperwork accumulated. In a period when two nurses were stationed at the nursing post, the work involved in instrumenting care was even more difficult.

As an example of these problems, checking the incoming documents was often left to the nurse in charge or a permanent nurse. A nurse in charge returned from ten days leave to find that none of the papers placed with the incoming mail had been dealt with by other nurses in her absence. Another nurse commented on this as a problem with relieving staff:

W___ (relief nurse) wanted to do audiometry tests on the school children, but the ENT (Ear, Nose and Throat) specialist and an audiometrist are coming out at the end of the month. Its in a memo [memorandum] from the manager. When I pointed this out to W___ she said that she didn't see it or know about it. The problem is that relieving nurses never deal with the in-tray or check the information that is put there as it comes into the clinic. They don't even think to do the filing or to check what needs to be done for follow-up. That is all left to the permanent nurse.

Several relief nurses on short term contracts perceived their role as, 'mainly helping out in the clinic'. Various factors appeared to influence the limited involvement of short term staff in the ongoing care of clients and in the management of care resources. These included a lack of orientation, an unfamiliarity with clients and their follow-up requirements as well as a nurse's attitude. For example, a relieving nurse remarked:

There has been no handover of clients with chronic problems. I don't even know half of them, who they are. I am a short term nurse faced

with this daunting task. I think, 'Oh well, I'm only here for three months, so it's not my problem'.

A major outcome of the high staff turnover together with frequent short term staff appointments was that ongoing follow-up care was accorded a lower priority. In the view of most nurses, this was because the everyday demands in the clinic and after clinic hours as well as the management of the nursing post were a full workload.

Everyday demands

Instrumenting care was in addition to the fluctuations in the clinic workload associated with client demands that occurred day and night. The ability to keep pace with follow-up, for example, was frequently curtailed by an irregular pattern of time available for follow-up amidst these demands. Nurses often felt daunted by the extent of follow-up work that was explicitly and tacitly expected of them, such as from medical regimes, screening programs, discharge summaries and pathology results. This was illustrated in nurses comments, such as 'There is so much follow-up I don't know how I can do it', 'Follow-up is endless' and 'The follow-up all falls back in your lap'. Furthermore, the nature of follow-up and programs for clients seemed mainly curative orientated, such as for drug treatments and pathology investigations, and had the effect of constantly adding to their everyday workload. A nurse explained this problem as follows:

When I asked about primary prevention of renal disease, I was answered with a 'take more bloods' and do more screening. This is what most questions you ask in a primary prevention sense are answered with; advice to do more screening. And the job gets bigger because we are the ones taking blood and doing the screening. Then if we find out the answer we are the ones who are following it up. Someone [a medical practitioner] will write in their [clients'] progress notes, 'Give education, low protein diet', or 'low fat diet' or whatever. And so we also have to go around and do that. That's fine. It's good to do education, but it is too late. Its always just treating disease that is already there.

The pattern of work in the clinic fluctuated according to the number of clients and the events involving serious illness or injury. Often it was only when the clinic was quiet that nurses had the opportunity to organise themselves for instrumenting care and the upkeep of resources, such as to check the stocks at the nursing post or to follow-up clients on long term medication regimes. At these times, however, clients were also often away from the community. A nurse, who perceived an irony in this constraint, remarked:

We are already out of date about three months behind with the Forward Planners. We don't have time to follow these people up. Today there is time, but few people are around for us to carry out the follow-up needed. We have time because few people are about!

The constraints experienced by nurses from the recurrent problems encountered in instrumenting care together with daily demands of clinic work and overtime hours often contributed to feelings of demoralisation and of being exploited. For example, as stated by this nurse:

It all gets you down. There is so much follow-up...They are getting a really cheap service through the nurse, but a really good service because nurses are very skilled people.

Nurses also perceived that the clients who presented almost daily in the clinic and involved much of the nurses' time represented a minor proportion of the community population. It seemed to these nurses that the health needs of other clients were then neglected. For example, a nurse expressed this perception as follows:

In the clinic we see the same people nearly every day. These are only a minor proportion of the population. We do not see the health problems of the remaining population.

In spite of the constraints on nurses for the implementation of care and for maintaining the continuity of existing programs, some nurses attempted to introduce additional programs, such as an intensive STD screening program or a program for home care of 'the oldies' (a term used on the Daily Patient Record and by some

nurses to describe elderly clients). Often these plans did not eventuate as other more pressing demands assumed priority, or the nurse who had intended to initiate the program had resigned or had completed their short term contract.

Summary

Instrumenting care referred to a broad domain of activities that entailed the organisation, co-ordination and implementation of care. The particular domains of instrumenting care that emerged were short term follow-up and ongoing care. Inter-related domains pertained to the management and upkeep of care resources at the nursing post. General characteristics of the follow-up domains were the wide ranging and perpetual nature of dealing with the current orders as well as continuing needs of clients. Colloquially, follow-up was termed 'chasing people up' or 'chasing up information'.

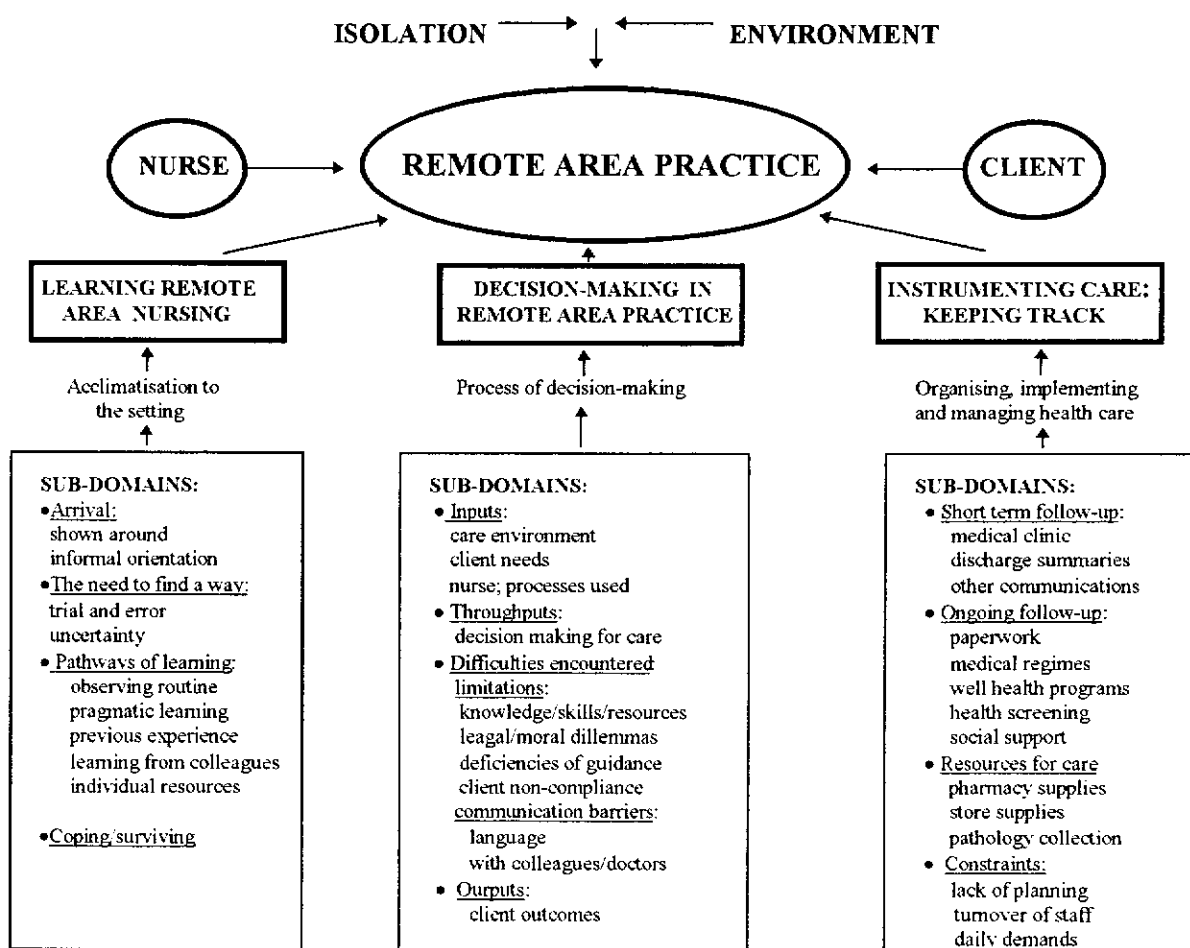
Short term follow-up involved the implementation of immediate care or care that was ordered or directed to nurses from a medical practitioner at a medical clinic, from a hospital discharge or communications with other care providers external to the remote area. Ongoing follow-up comprised of the management of long term medical regimes as well as other programs that aimed to maintain clients' health. Another less prominent domain related to ongoing care was social support for clients. Record keeping, or 'paperwork', was integral to the organising aspects of instrumenting care. Major difficulties encountered by nurses in follow-up pertained to the lack of continuity of care. Consequently, outcomes of this care for clients were seldom evaluated.

A peculiar feature of instrumenting care was the organisation and management of resources for care. In particular, these were the domains of pharmacy supplies, stores and the requirements of pathology specimen collection and dealing with pathology reports. The maintenance and use of pharmacy supplies in the remote area posed complex problems for nursing practice.

The main underlying constraints experienced by nurses in instrumenting care appeared to be a lack of organisational planning, frequent changes of staff and the volume and variability of day to day demands in the clinic. Instrumenting care, together with its specific problems and general constraints, and how these were dealt with by individual nurses had an important impact on the practice of nursing.

The pattern of practice in the remote area has been described in the chapters of learning remote area nursing, decision-making in remote area practice and in instrumenting care: keeping track (Figure 8.2, below). The cultural themes that were revealed from data collected and analysed in the practice setting are explained in the following chapter.

Figure 8.2: Pattern of remote area practice



Remote area practice is based on the nurse-client relationship within the setting. It is represented by the large domains of learning remote area nursing, decision-making in remote area practice and instrumenting care: keeping track, and their sub-domains.

CHAPTER 9

REMOTE AREA NURSING PRACTICE REVEALED

Normalising the unthinkable...can only be acceptable once distance has been established... The whole unthinkable process remain(s) virtually invisible and acceptable.

John Pilger (1994)

Introduction

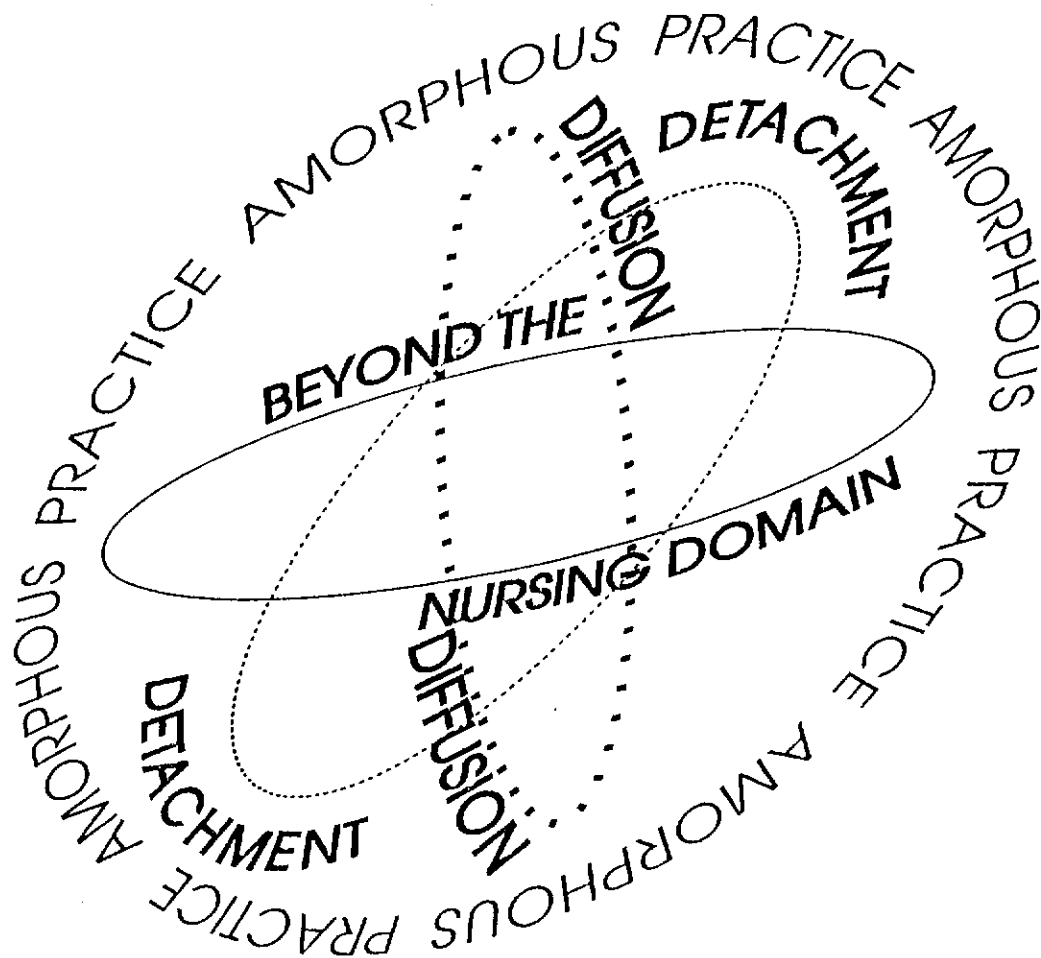
In previous chapters of this ethnography I described the recurrent patterns of nursing as it was practised in the remote area. These patterns pertained to learning remote area nursing, decision-making in remote area practice and instrumenting care: keeping track (Figure 8.2, p281). Concurrently the inquiry led to the discovery of cultural themes that represented what nurses learnt and routinely used in their practice and what influenced their practice behaviour (See chapters 6,7 and 8).

The overall theme emerging from all the data collected and analysed, using the Developmental Research Sequence Method of domain, taxonomic and componential analysis, was that remote area nursing practice was seen as *amorphous*. The major themes, seen as contributing to *amorphous practice*, were termed *detachment*, *diffusion* and *beyond the nursing domain* (Figure 9.1, overleaf). These themes were identified by their linkages with most of the domains of practice as well as to the overall theme. For example, the theme of *diffusion* formed a general relationship between a large number of domains that included decision-making, medical consultation, organising activity and the client's expectation of a nurse. It also formed a major sub-category of *amorphous practice*.

In this chapter the cultural themes that emerged in the study are revisited in order to portray the dominant patterns of the culture of nursing in a remote area. The term, 'cultural theme' in this research is first explained. An overview of the themes is

then presented. This is followed by an exposition of the study's substantive theory of *amorphous practice*. Each major theme contributing to *amorphous practice* is described separately within the substantive theory as a way to explain the phenomenon. These themes, however, are inter-related and hence they overlap.

Figure 9.1: Themes of amorphous practice



Amorphous practice was the overall theme to emerge from this study. The major themes contributing to *amorphous practice* were termed *detachment*, *diffusion* and *beyond the nursing domain*. These themes are inter-related, overlap and appear over and over again.

(Graphic design: Jim Mitchell)

Cultural theme

The term 'cultural theme' in an ethnography refers to any cognitive principle that is found to be recurrent in several domains of practice and which serves to form a general relationship between the categories of cultural meaning (Spradley 1980). Cultural themes in this study were either tacit or explicit elements in the patterns of behaviour together with the relationship between these elements in the meaning of remote area nursing. The themes were formulated from the general expressions repeatedly used by nurses in everyday practice as tacit 'rules' of the nursing culture in a remote area. An overview describes the dominant cultural themes as revealed in the shared understandings used by nurses when practising in the remote area.

Overview of cultural themes

Amorphous practice was identified in this research as the dominant cultural theme of nursing in a remote area. It describes the nurses practice as it varied according to the perceived roles of nurses, as well as their ability and motivations to deliver a health service. The practice also varied according to situational factors and the resources available. This recurring theme was expressed by nurses in terms of 'doing my best', 'I can only do what I can do' which meant that each nurse's 'best' tended to be different. The major themes seen as contributing to *amorphous practice* were labelled as *detachment*, *diffusion* and *beyond the nursing domain*. The inter-relationships among these themes is described in the phenomenon of *amorphous practice*.

Each major theme has distinctive attributes and is explained as a facet of *amorphous practice*. This approach is taken in order to portray and clarify the nature of remote area nursing practice. In reality, the themes are not separate but overlap, inter-relate and are interwoven into the whole cultural entity of *amorphous practice*.

The theme of *detachment* describes the nurses perceptions of separation from institutional systems of control for nursing practice. This cognitive principle was

reflected in recurrent assertions such as, 'You are by yourself', 'Out here nobody sees', 'No-one questions what is done'. *Diffusion* refers to the broad perimeters and all-encompassing nature of practice. Nurses repeatedly verbalised this cultural theme in phrases such as, 'You are it', 'It all falls on me' and 'You have to draw the line'. The third theme, *beyond the nursing domain*, refers to a practice that was considered outside the margins of the nursing domain. This was frequently expressed in terms of, 'crossing boundaries' and/or, 'overstepping the bounds'. The cultural themes are linked as attributes to form the substantive theory of *amorphous practice*.

Amorphous practice portrayed

Amorphous practice describes the changeable character of the delivery of nursing care. The changeability relates to the inconsistency that occurred within a broad routine of day to day practice. Within this changeability a constancy was observed, such as in the everyday demands of clients, but often amid a feeling of chaos as expressed by a nurse:

It is bedlam over here [in the clinic]. The worst part is not only the perpetual on call and the constant demands in the clinic. It is people being in your face continually. Always the nurse. You can't go anywhere without some demand on you as a nurse. You are treating the same sores day after day, the same aches and pains, seeing the same people over and over again. Giving out tablets endlessly.

The practice of nursing, however, cannot be precisely stated. It was not uniform or predictable and shifted from situation to situation, nurse to nurse and over time with different groups of nurses. An early observation recorded in a memo reflected the changeable character that epitomised *amorphous practice*:

Remote area nursing is different for different nurses insofar as each nurse learns as they go along. Each nurse uses the language and treatments according to their experience. They relate to people in their individual style and as the nurse interprets what seems to be appropriate for the situation. The real thing that is constant is the nature of client demands and their expectations of the nurse and the kinds of presentation. These elements together make up what the practice of nursing itself becomes.

Amorphous practice was observed in the way in which the knowledge, abilities and intent of individual nurses influenced their nursing care. These variations were identified in particular situations at particular times and in the care given by particular nurses. An area in which this was evident was in the use of medications.

Use of medications

A feature of *amorphous practice* was the use of scheduled drugs, such as antibiotics and oral analgesics, that varied from nurse to nurse. For example, individual nurses in a group at one period of time were observed to often dispense Panadeine Forte for acute pain relief on their own initiative. In contrast to this practice, another group at a different time only administered this analgesic on medical orders. As seen in nurses decision making in clinical situations (chapter 7, p219), nurses adopted individual ways of practice according to their own interpretations of what could or should be an acceptable practice for the use of medications.

Another example was a group of nurses who routinely initiated the administration of intravenous antibiotics, such as Flucloxacillin or Ceftriaxone. These nurses believed, either explicitly or implicitly, that they could deal with a rapid adverse reaction with the resources available to them. This attitude was observed in the following situation:

A six year old boy is brought to the clinic by his grandmother. He has a fever and complains of pain at the level of the diaphragm. The boy was discharged two weeks previously from the regional hospital with renal problems. On discharge the child was given oral Keflex. The grandmother informs the nurse that this medication has not been taken. The nurse consults with a medical practitioner by telephone. The child will be evacuated back to hospital. Intramuscular Pethidine and Ceftriaxone 'IV or IM' is ordered. The nurse decides to give the Ceftriaxone intravenously. When asked why by another nurse, he states, 'It's less painful given intravenously'. This nurse later remarks, 'I feel confident in giving antibiotics intravenously and I think I could handle an adverse reaction'.

In contrast, other individual nurses usually declined to initiate intravenous antibiotics, believing that they did not have the back-up needed or the resources required for its

safe administration. This view was stated by a nurse as follows:

I won't give drugs intravenously unless there is no alternative. I feel that it is an unsafe practice to give intravenous drugs out here when it is not necessary. We don't know the diagnosis and we don't have the back-up or the staff to care for people as in-patients.

Another example of *amorphous practice* that was observed in relation to medications was the decision to dispense Panadol to a care-giver for administration to a child at night. One nurse stated her reason for giving Panadol in this situation as:

To bring down a child's temperature I will give Panadol [liquid]. I will then draw up the appropriate portion of Panadol [in a disposable syringe], depending on the age of the child. I ask the mother that it be given when the child goes to bed.

In contrast, another nurse used a different reasoning and did not give Panadol for children to be given at home. The nurse explained:

I really do not believe in giving kids Panadol willy nilly and giving the mother some to take home and give it to the kid before going to bed. It's a dangerous practice and shouldn't be done for the simple reason that you might give the kid a dose at four o'clock or half past four and then say [to a mother], 'Give that to the baby before he goes to bed'. They might go to bed at six o'clock. You have no control over what time the mother is going to give the Panadol. It's a pain in the neck having to get up to a kid in the middle of the night, but it's a lot safer

Several nurses perceived that a lack of policies and information to provide safe and appropriate care contributed to inconsistency in the use of medications for client treatments. The following quotes portrayed the nurses' dilemma:

- We don't have information for a rationale of care, like policies for everyday treatments, so there is inconsistency between nurses. We don't know whether to use or not use Betadine on skin sores or for ear treatments.
- You don't want to give people antibiotics all the time. I wonder why they have stopped using Gentian Violet. It was good for clearing up infected skin sores. It can't be any more harmful than using Betadine which destroys the normal flora of the skin and has iodine in it. Yet its [Betadine] used all the time.

The CARPA Manual was used by most nurses as an aid for prescribing a drug treatment. Individually, however, the extent of its use for this purpose varied according to a situation, such as when a medical practitioner was consulted or when a nurse felt confident in their own ability to prescribe a treatment. The following observation illustrated a nurse's use of the CARPA Manual as a substitute for seeking medical advice and a drug order:

A nurse assesses a two year old child with symptoms of an acute respiratory tract infection. She observes that the child 'looks very unwell' and her respirations are 'noisy' and 'rapid'. The child's temperature is 39.1 degrees Celsius. The nurse then, resting the child on her knees, listens to the child's chest with a stethoscope and notes 'rubbing sounds' are heard. The nurse says that she is 'reluctant to commence antibiotics as the child has previously had several courses and this may be a viral infection'. She then consults the CARPA Manual for a 'standard treatment' of this presentation (Appendix 24). From her assessment and a reading of the instructions in the Manual, the nurse decides to treat the child for 'mild pneumonia' and commences treatment of Procaine Penicillin for five days. A doctor is not consulted.

In *amorphous practice* wide variations were observed in individual nurse's adherence to the 'standard' drug treatments as set out in the CARPA Manual. In part, this tended to be influenced by a nurse's assessment of the applicability of the general directions in the Manual to a specific situation and to a client's individual needs. The following example illustrated this point:

A male client, accompanied by his wife, presents to a nurse on a Sunday at 7 pm. The man is unsteady on his feet and he has a smell of alcohol. His wife informs the nurse that they have just arrived from Kalgoorlie and that the man had 'had a fit'. The nurse invites him to sit down in a chair, then takes his observations. She recognises the man who she has seen previously when he was treated for a similar problem by another nurse. As she checks the client's history, the nurse remarks, 'I've seen this man before and remember the nurse gave him Valium 20 mg IV (intravenously) and he passed out'. This information, however, cannot be found in the record. The nurse then checks the section on Delirium Tremens in the CARPA Manual (Appendix 25). The treatment for the condition that is the nearest approximation of the man's health problem is for Valium 20 mg orally that can be repeated in 2 hourly doses to a total of 160 mg. The client is neither 'agitated'

or 'psychotic' as is described in the Manual and no fitting is observed. The nurse decides to modify this treatment and administers oral Valium 10 mg and intramuscular Thiamine 100 mg (as directed in the Manual, 'If there are fits'). The nurse then gives the man's wife another two Valium 10 mg tablets, saying to 'give one tablet if he has another fit'. An additional three Thiamine 100 mg. tablets are also given to the wife with advice to 'give L_____ one each day for the next three days'.

The changeable character in nurses use of medications, such as a decision to use an antibiotic and the route of administration, was also influenced by their perception of the client's compliance with a treatment regime (for example, chapter 7, p216). This observation was another example:

A 5 year old child is brought to the clinic by her mother. The child has a respiratory infection. Following a physical examination and observation of the child the nurse decides to give an antibiotic treatment. As she draws up a Bicillin injection, the nurse remarks, 'I am giving an intramuscular antibiotic because of this mother's low compliance with oral antibiotics'.

Such a view of drug use changed the management of care and implied that the frequent use of injections would overcome a problem of, or a need for, compliance with oral medications. This perception was also held by some Aboriginal health workers, as shown in this statement:

We are supposed to give Doxycycline for 15 to 30 days [to treat donovanosis], but no-one is going to take them. People won't take tablets over a period of time so it's better to give them a shot and fix it up right away.

In addition, there seemed to be a relationship between staff turnover and an inconsistency in nurses attitudes to their legal responsibilities for the prescription and administration of medications. For example, an Aboriginal health worker remarked:

Every new sister comes with different rules. It's a constant hassle. Before I was allowed [by a nurse who no longer worked at Warburton] to give L-A Bicillin [to treat syphilis]. Now I'm told [by a present nurse] I'm not allowed to give it.

The inconsistency between nurses in the use of medications for client care was a prominent feature of *amorphous practice*. The changing nature of practice was also seen in the varying attitudes and behaviours of nurses when assuming a medical role.

Assuming a medical role

Amorphous practice was seen in the different roles played by nurses in the absence of a medical practitioner. Observations of nurses new to remote area practice revealed that those who had mainly nursed in an acute care hospital setting, as opposed to nurses with a broad nursing experience, tended to emulate medical practice instead of initially trying nursing procedures.

The following observations illustrated the practice of nurses who had mainly worked in a hospital setting:

- A 35 year old male client with a large and painful boil on the rear lower left leg attends the clinic. The nurse inspects the boil then decides to lance it. The nurse explains that this procedure is used, 'to drain it. I've seen it done [by a doctor] in the hospital'.
- A young man who has been injured in a vehicle roll-over is being assessed by a nurse. The man complains of a headache and back pain. He has no visible trauma apart from superficial abrasions to the skin. The nurse leaves the room to telephone and consult an RFDS medical practitioner. The medical practitioner orders Pethidine 75 mg stat. and head injury observations to be continued. In the meantime, another nurse attempts to insert an intravenous cannula in the client's hand, stating to him, 'This way we will be able to give your analgesic'. The first nurse overhearing this remark, interjects saying, 'I won't let you do that'. The other nurse replies, 'We do it in ICU' (Intensive Care Unit).

Whilst some nurses felt comfortable in a medical mode of practice there were others who expressed doubts. The following quote expressed the feelings of disquiet and the reluctance of some nurses to move across to the domain of medical practice:

Even though you can say you've got the support of the doctor at the end of a 'phone, [when you consult] he is going to turn around and

say, 'Oh give them so and so antibiotic three times a day and a Pethidine injection'. That's great a thousand kilometres away. He is not taking care, you are. And he is only going on what you are telling him over the 'phone. If you've made a gross mistake in what you have assumed is the correct [medical] diagnosis, or the correct observation, that is still what he's going on. If you are incorrect you are going to do harm and people may suffer. Then they will blame you and I'm not quite happy about that at all.

Moreover, nurses perception of the inconsistencies for them in practising medicine was due to their lack of medical knowledge together with a lack of resources to perform such a role. This was explained by a nurse as follows:

Nurses out here have responsibility for medical assessment, but we do not have the back-up available to medical practitioners. For example, we do not have Xrays and extensive library let alone the medical knowledge base doctors use for an assessment. We are trying to play a doctor's role but don't have the back-up available in hospitals such as results of electrolytes or the personnel to refer clients to. Like R___ [client] who had inguinal lumps and pain. We are trying various treatments but we were not sure what the problem was. A doctor [in a hospital] would have more knowledge expertise and the back-up facilities to make a diagnosis. And N___ [another client] who had the litre of intravenous fluid. We didn't know what his electrolytes were. A doctor [in a hospital] would obtain this information.

Frequently, in situations of both mild and acute illness or trauma, the medical assessment and medical treatment appeared to take priority over nursing management. In the perception of many nurses their primary role was 'more like a general practitioner' or 'the extension of the doctor' (see chapter 6, p175). There were other nurses, however, who perceived that nursing was their uppermost responsibility and acted accordingly. The variability in the care given by each nurse from these different perspectives was revealed in decision-making in remote area practice and included the variable manner in which care was documented. (for example, chapter 7, p205 & p220).

Another characteristic of *amorphous practice* was observed in the different priorities assigned by individual nurses to the use of medical and nursing interventions. The

differing priorities from nurse to nurse in their use of medical treatments shaped their management of nursing care. As medical treatment was used more often, nursing care tended to be overlooked. This situation was reflected in a memo that followed repeated observations of the use of intravenous therapy, as shown below:

A nursing implication in nurses' introducing an intravenous in situations of non-emergency care for clients is that the client becomes an inpatient and a passive dependent in the management of care. The emphasis of self care is lost as the use of medical interventions takes priority over the need for a client's participation in his or her own recovery, such as promoting the actions the client can take to care for themselves with the means available to them. In these situations there is also a tendency for nursing measures of care to take second place to a medical intervention. Rest, comfort, oral fluids and a wait and see approach for how a client responds to this care and the routine use of nursing observations of a client, for example, appear to become of lesser importance to a nurse than medical intervention.

Assuming a medical role was an aspect of remote area practice for all nurses. *Amorphous practice*, however, was observed in the changeable way each nurse assumed this role. The medical substitute role appeared to influence their use of nursing care interventions as well as their approaches to the care of clients.

Care approaches

A typical feature of *amorphous practice* was the varying approaches to the management of care between nurses. This variability in approaches to care was illustrated in chapter 7, p219, in a case of a child with a boil. Whereas one nurse prescribed antibiotics and lanced the boil, another nurse preferred conservative treatment and involvement of the carer in the child's care. Different nurses attending the same client on subsequent days, or even at the same time, were observed to have different opinions on the management of care. The following quote provided a rationale for this difference:

I think what you do is dependent on your own individual outlook. Some [nurses] are gung ho and treat things themselves. Other nurses use more common sense. Like for dehydration. One nurse might put up

an intravenous. Another nurse believes that a couple hours in the cool of the clinic with lots of cool drinks is needed.

The changeability of practice from nurse to nurse was repeatedly observed in the assessment and management of common health problems. This was portrayed in the following observation:

In the evening a 7 year old child is brought to see a nurse. The child has a severe headache and photophobia. His temperature is 38 degrees Celsius and his pulse and respirations are elevated. No neck stiffness is observed on examination by the nurse. The nurse states that she is unsure of the chest sounds and that she suspects meningitis. She then asks a 'Sister-in-charge' to check the child. The 'Sister-in-charge' after examining the child and listening to his chest sounds with a stethoscope concludes that there is 'reduced air entry in the lower lobes of the lung'. This nurse then decides that the illness is 'probably pneumonia'. Without discussing the care with the first nurse, the 'Sister-in-charge' proceeds to administer intramuscular Bicillin to the child. The nurse who first saw the child remarks, 'The child was well until this evening. The antibiotic could mask another problem. It also reinforces the belief [of the client] that an injection is the solution. I would have preferred to consult [a medical practitioner] before giving the antibiotic. This seems so erratic'.

Another example of *amorphous practice* as seen in the inconsistency of care approaches was the management of scabies in children. One nurse, after examining the lesions may or may not take observations, then immediately decides to administer Bicillin. Another nurse at a different time assesses a child and emphasises to the caregiver the importance of regular skin hygiene to reduce the infection and does not give Bicillin. The dilemma was explained by a nurse as follows:

There is a dilemma in how to treat scabies infections. IM (intramuscular) Penicillin, as directed in the CARPA Manual, does bring a quick resolution, but it is short term. Without prevention the scabies recurs. Ascabiol for non-infected scabies has to be reapplied after one week, but clients rarely return for follow-up treatment. The RFDS visits are completely taken up with seeing clients and there is no time set aside to discuss these sort of problems.

A characteristic of *amorphous practice* was a repeated lack of consistency in decision-making for similar situations. From nurse to nurse, practice decisions varied over time and from time to time in relation to the management of recurrent health problems. Arbitrary decisions also appeared to be made, such as whether to lance an abscess or not, or to take an Xray or not, as recorded, for example, in the chapters describing the practice milieu and decision making for remote area practice (chapter 5, p145 & chapter 7, p219). Another example of *amorphous practice* was the varying decisions to take pathology specimens and the kinds of diagnostic tests that were ordered. This characteristic of arbitrary decision making was described, for example, in instrumenting care (chapter 8, p272).

Nurses individually decided when they would consult a medical authority or use their own judgement. One nurse in their approach to care would say, 'I'm quite happy to treat a client with oral antibiotics', whilst another, 'only consults when it is serious'. In contrast another nurse said, 'I always consult before giving an antibiotic' (see similar quotes, for example, chapter 7 pp190 & 195). The following incident showed the inconsistency of care approaches:

At 5 pm a male client arrives at the clinic and takes a seat in the adult clinic. He has sustained a laceration between the left thumb and forefinger while opening a tin can of ricecream. The nurse sits down beside him and, after stopping the bleeding with a pressure pad, inspects the laceration. The nurse also asks the 'Sister-in-charge' for an opinion. The 'Sister-in charge' looks at the wound and then tells the nurse, 'Suture the laceration and give Mr G___ Flucloxacillin. If he's non-compliant give him an AP Bicillin'. The nurse does not reply. She reassesses the wound as superficial and decides to use steri-strips to close the skin edges. After the dressing procedure is completed the client thanks the nurse and leaves the clinic. No medications are given. The nurse then states, 'It wasn't necessary to suture the cut. He is a fit man and the wound will heal itself. To give antibiotics would be an inappropriate overkill'.

Inconsistent decision making for client care as seen in *amorphous practice* also tended to occur because of a mandatory practice policy of the health service, that is, nurses were 'obliged' by the employer to adhere to the CARPA Manual (Appendix 14). The use of the CARPA Manual was a dominant influence in approaches to care as well as

in the use of medications, despite the nurses wavering confidence in its authority. As previously described in chapters pertaining to learning remote area practice (chapter 6) and decision-making (chapter 7), nurses used this Manual according to their various perceptions of its relevance to individual clinical situations and its legal status for nursing practice. The following remarks by different nurses and at different times also revealed these varying views as well as the concerns it aroused for nurses in their approaches to care:

- I like CARPA Manual as it is clear for me to use and gives some legal protection. It's the policy of the Ngaanyatjarra Health Service to follow CARPA Manual.
- I feel uncertain with using the CARPA Manual. When I questioned the Staff Development Officer on its use and lack of legal authority, she told me, 'Take it as an unwritten doctor's order'. How do you know the diagnosis or differentiate between signs and symptoms [from the Manual]?
- I'm uncomfortable that we prescribe. I worry about it and I don't like CARPA Manual for this reason.
- At first, when I was first here I followed CARPA [Manual]. But I don't like it. Legally where does CARPA Manual stand in Western Australia? It is produced in the Northern Territory.

In addition, the changeable character of practice in approaches to care was observed in the irregularity of orders given to nurses by medical practitioners for a choice of a treatment or an investigation, such as blood tests. A particular example was the route of administration for antibiotics, the dosage of a drug or the choice of a drug. At times a medical practitioner specified the route of administration or a drug dosage and at other times the decision was made by a nurse, such as whether the drug was given intravenously or intramuscularly or the dosage administered. This was repeatedly observed in both medical orders given on telephone consultation, such as for an antibiotic, 'Give IV or IM', and in medical practitioner's non-specific instructions communicated in writing on client pathology reports such as, 'Treat as per CARPA' (for example, chapter 8, p274). A nurse then, with or without informing the medical

practitioner, decided the route of administration of a drug and/or the dosage. This was illustrated in the following observation:

At 11.30 pm. an adult male client who has been seen by a nurse during the afternoon for abdominal pains and vomiting, returns to the nurse on call. The nurse examines the client then walks to the nurses' quarters to consult with a medical practitioner [the medical practitioner is staying overnight for the medical clinic the following morning]. She describes the client's symptoms to the medical practitioner who then asks, 'Does he have bowel sounds?' The nurse replies, 'I don't know. I didn't check'. The medical practitioner states, 'If he settled before with Pethidine and Stemetil, give that to him again and Zantac. He must come in the morning if he is serious.' Returning to the clinic, the nurse checks in the MIMS Annual for the usual dose of Zantac. She decides to give oral Zantac 300 mg as a stat. dose. She also checks the dosage of Pethidine and Stemetil as given previously and repeats the administration accordingly. At 3 am. the nurse is again called out to attend a female client with acute asthma. Her temperature is 39.1 degrees Celsius. The nurse tries the telephone to consult the RFDS medical practitioner on call. The telephone is out of order. The nurse is reluctant to disturb the medical practitioner at the nurses quarters. She decides to give a Ventolin nebuliser according to the usual regime given to this client. Checking through the client's record the nurse notes that the woman has previously had a course of Ceftriaxone. The nurse decides to give intramuscular Ceftriaxone 1 gram as well on this basis. At 6.30 am. the woman returns. The nurse repeats the Ventolin nebuliser and accommodates the woman in the 4 bed ward. At 7.30 am. the nurse goes back to the nurses quarters to consult the medical practitioner about this client. She then asks, 'Can Prednisilone be given?' The medical practitioner agrees, but does not state a dosage. I ask her how she will decide the dosage. 'She previously had 50 mg. in December. I will go by that', replies the nurse. At 8.45 am. the medical practitioner goes to the clinic and, after assessing both clients seen overnight by the nurse, states that both require intravenous therapy and need to be evacuated to the regional hospital.

In approaches to care the inconsistency from nurse to nurse and from situation to situation was typical of the nature of *amorphous practice* in the remote area. An additional feature of the unstable character of practice was a susceptibility to change due to peer pressure in interactions between nurses and by pressure from clients.

Interactions and peer pressure

An attribute of *amorphous practice* was the changes in practice that occurred in relation to interactions between nurses and between nurse and client. In interactions between nurses, for example, the view of a dominant nurse, such as a 'Sister-in-charge' (nurse in charge), usually over-ruled another nurse's decision. An illustration of this feature was in learning remote area practice where a beginning remote area nurse felt obliged to follow the advice of a 'Sister-in-charge' irrespective of her own assessment of the client care needed (chapter 6, p167). This situation was also observed in the following example. Consequently client care varied according to the hierarchical structure:

A nurse has been seeing a mother with a 3 year old child over the past two days. This morning the mother returns to the clinic with the child. The child has symptoms of an upper respiratory tract infection, Her temperature is 38.1 degrees Celsius, pulse rate is 96 and respiratory rate is 30. No other significant problems are detected. The nurse advises the mother to give the child lots of fluid and to keep the child rested and warm. She also decides that antibiotics are unwarranted. In the afternoon the nurse in charge also attends the child who has again been brought to the clinic by her mother. Her symptoms are unchanged. Without consulting the other nurse, the nurse in charge decides to give the child intramuscular Procaine Penicillin.

Another example of peer influence was when a nurse in charge consistently communicated to colleagues her concerns for standards of care and for nurses' accountability. The impact of this communication on attitude and behaviour was illustrated in the following remarks by nurses who worked at Warburton at the same time:

- Like W___ [Sister-in-charge] said, IV (intravenous) and suturing are not the really important things. It is most important to observe and assess the client thoroughly. These are the actions nurses have to do all the time.
- Although I've been out here for over a year I didn't think about the legal side of it much before. Just the other day there was a situation with a kid who wasn't obviously sick enough to be evacuated. But just being around other nurses who talk about these things and are mindful

of legalities which we still have to operate within, I felt I needed to inform the doctor.

The presence of different nurses in a situation also appeared to be a factor influencing whether or not a procedure would be undertaken. For example, a nurse was observed to usually commence an intravenous infusion prior to the transfer of a client to a hospital. This practice was altered with the presence of a new nurse who had previously voiced her dissatisfaction with the nurse's arbitrary use of intravenous therapy. The following observation demonstrated this influence:

A male client presented with a history of 'vomiting for three days'. He has previously been diagnosed with pancreatitis. A medical practitioner is consulted and orders Pethidine and Stemetil. The possibility of an evacuation is discussed. The nurse brings the intravenous trolley to the client's bedside and says, 'I think I'll put up an IV (intravenous)'. At that time another nurse enters the room. The nurse then remarks to the other nurse, 'I don't know whether to put up an IV or not'. The other nurse shrugs her shoulders and replies, 'Well I wouldn't have thought it was necessary. Wait for the Stemetil to work, then see if he can drink'. The first nurse then agrees saying, 'I suppose you are right.'

The influence of peer pressure on practice was also observed at each staff turnover. At these times there was a disruption and the existing pattern of care tended to be changed according to the attitudes and priorities of dominant nurses. This revealed another aspect of *amorphous practice* in which practice from one group to another appeared to be discontinuous. For example, at one time a group established restrictions to after hours calls and the overnight stay of clients in the clinic. These restrictions had been communicated to other nurses as reflected in this nurse's comment:

I'm told this is not a hospital, only a clinic. We do not keep patients overnight.

With another group of nurses at a different time clients were accommodated overnight in the nursing post. The likelihood of nurses keeping clients overnight was influenced by their willingness to agree to this expectation from a medical practitioner as well as

the expectations of other nurses. This was illustrated in the following observation:

On a Saturday evening a nurse, recently arrived in the community, sees a client who has a suspected cholecystitis. The nurse consults a medical practitioner and is told to 'put up an IV'. An antibiotic is also ordered. The medical practitioner then adds, 'keep the patient overnight'. The client is to be reviewed in the morning for a possible evacuation. The nurse agrees. He later tells another nurse about the client and the orders given. The other nurse then states, 'You should insist on an evacuation. We cannot keep people for observation overnight. It sets up a precedent where the nurse will be expected to retain patients overnight and there isn't the staff or the facilities to do this'.

Individually nurses also responded in varying ways to pressure from clients to meet their demands or to provide a treatment as requested (for example, chapter 5, pp129-130). A tendency by some nurses to respond to these pressures was shown in the observation below:

A child is brought by his mother to the child clinic. The nurse observes that the child has several partly healed infected scabies lesions on the extremities, impetigo on the mouth and a small boil on a buttock. The mother then states to the nurse, 'Give him a needle, so I don't have to keep running up and down to the clinic'. The nurse then agrees with the mother and proceeds to draw up and administer the Bicillin to the child. No other advice is given to the mother.

Interactions with colleagues, peer pressure and client-nurse relationships were observed to have an important influence on the changeable nature of how client care was managed. This general characteristic, together with the varying use of medications, differences between nurses in assuming a medical role and in the changeability of approaches to care from nurse to nurse and over time, portrayed *amorphous practice*.

The phenomenon of *amorphous practice* is further described and explained in the three major tributary themes of *detachment*, *diffusion* and *beyond the nursing domain*. These distinct but interlinked themes form sub-categories to *amorphous practice*. The first theme of *detachment* explains the adaptation of practice in the

remote area. This is now explored.

Detachment

The theme of *detachment* was an underlying feature implicit in the transition and adaptation to practice in the remote area. This concept denoted a separation and a divergence between conventional nursing and remote area practice as it was revealed through observations and interviews. *Detachment* also referred to an organisational aloofness in that the management had distanced itself from the performance of nursing. These two aspects of *detachment* were inter-related. On the one hand, there was a perception of disaffiliation with conventional nursing practice and its values. On the other hand, there was a disengagement by the employer from the internal management and control of how nursing was to be enacted. Thus the theme of *detachment* is composed of a combination of these elements.

Nurses repeatedly and in diverse practice situations used phrases such as ‘no-one is checking how you do things’. This reflected their sense of *detachment*. Other oft-used phrases were, ‘there is no-one to say, “No. That’s a doctor’s role.”’ and, ‘nobody sees what you have done’. A lack of organisational oversight of day to day practice in the remote area meant that the decisions and actions of nurses were usually unchecked. The theme of *detachment* was aptly portrayed in this statement by a nurse:

I think you are left by default out here because there is no-one checking how you are doing things. I’d have thought in ten weeks [since commencement] somebody would have seen something that I did that wasn’t the way that they think it should be done. But nobody has questioned anything I have done which seems really odd to me starting work in such a different setting to anything I have ever done before.

The theme of *detachment* had distinctive features that added together make nursing practice in the remote area so different. These pertained to transition and adaptation, lack of direction: being allowed, deviation as normal and organisational assumptions.

Transition and adaptation

One of the characteristics of *detachment* was the process of transition, breaking with the nursing rules usual in an urban setting to accommodate the rules of a remote area. *Detachment* was also a time of adaptation that arose from the differences perceived by nurses between the enactment of practice in isolation compared to their previous familiar parameters. These differences included the structural constraints that usually delimited a nurse's role. For example, a nurse's sense of *detachment* was apparent in her perception of a break with organisational or professional systems of control in the transition to an unstructured practice in the remote area, as described below:

The protocols laid down by this health service don't limit what you can do and what you can't do. Whereas if you are working in a city hospital there are parameters set down which allow you to do so much and a lot of that is dependent on your expertise. There, people are generally put into situations that are suitable to your limitations and level of expertise. Out here, because nobody really checks your expertise before you come out here, nobody is really going to say no. I mean who is going to say no?

Detachment was marked by a sudden change to a different mode of practice. This experience was encapsulated by nurses as follows:

- Suddenly you can do that which as a nurse you were not previously allowed to do.
- Before its never been the nurse's role to diagnose. Somebody will tell you very quickly if you are overstepping the bounds, like if you actually rang the doctor with the [medical] diagnosis instead of ringing him with a set of signs and symptoms that you have observed. They didn't like you to make a conclusion or diagnosis. And suddenly out here we need to assess the signs and symptoms, come up with a diagnosis and, if you can, find something in the [CARPA] Manual that guides you to a treatment.

The suddenness of *detachment* was also evident in nurses perception of being 'dumped in', 'dropped' or 'thrown into' the remote area and 'jumping in at the deep

end'. Nurses, new to the remote area, had made a personal choice to accept a position. Following their arrival, however, they had unexpectedly discovered their lack of preparation (see chapter 6, pp153, 158 & 159-60). Such a point of view was also expressed in this quote:

I was literally dumped in a situation of being a single nurse at a two nurse post, not knowing what to do specifically, not having a clue of the paperwork or the running of the clinic. I didn't know how to examine people. I'd never been put in a situation where I had to diagnose ill.

The relatively stable and predictable environment of the previous work world of a nurse appeared to be removed. In its place there was an abrupt transition to a startling new experience where nursing in the remote area was introduced to a beginning nurse as 'different' from other forms and practice settings. The oft-repeated remark that 'it is different out here' implied that the usual rules, scope and accountability for nursing practice were assumed to be less obligatory in a remote area. There were nurses, however, who believed that their own responsibility for adhering to standards of practice remained constant. For example, a nurse describing her first day in the clinic, remarked:

I was horrified to see Flucloxacillin being handed out without any doctor's order. When I commented on it I was told [by another nurse], 'We are not so accountable out here'. I disputed this and was then told, 'It's different out here'.

The unexpected and unfamiliar character of remote area nursing was felt as a nursing culture shock. In the transition into a different world, nurses were expected to comply with an alien set of rules for practice. Nursing culture shock was the realisation by a nurse of being uninformed and ill-prepared for nursing as it was practised in a remote area. This was how one nurse explained the inadequate feeling:

For me it was more than a transition, it was a culture shock. Not being told what is expected is an assumption by management that all nurses are skilled in the type of things they are expected to do out here. And we are not. It is a shock and it is very frightening.

A basic characteristic of *detachment* was the extremes in transition and adaptation to remote area practice. In *detachment*, nurses experienced a lack of direction that was often interpreted as a tacit permission to perform in ways that varied from conventional nursing practice.

Lack of direction: being allowed

There was a general perception amongst nurses that their practice was devoid of direction and control. This was explained as 'there are no guidelines' or 'there are no standards' for nursing practice in a remote setting. The following quote was an example:

There is a lack of systematic control of the nursing practice because there are no guidelines here as to what we are required to do. There is no defined level of nursing practice. I think we are left by default because no-one is checking on how we are doing things. And because there is no direction from above, no flow, no continuity, its all very haphazard

Several nurses assumed that a mode of practice, alien to professional nursing regulations, guidelines or standards, was 'allowed' in the remote area due to a lack of restriction or objection by any authority. For example, a nurse recruit being told by a colleague that in the remote area nurses were 'allowed' to 'put in intraosseus infusion' (chapter 6, p159). This notion was expressed in the following statement by a nurse:

I can see how nurses could be lulled into thinking that, because it is allowed to happen, it is okay to prescribe antibiotics or not to check drugs.

Similarly, the perception of being allowed to perform a procedure, irrespective of prior qualifications and/or experience, was also associated with nurses feelings of sole responsibility for care. For some nurses having sole responsibility was seen as a challenge from which a sense of satisfaction could be drawn. This viewpoint was reflected in the following quote:

It's sort of being allowed because you are the only one here and being

allowed to utilise any skills you have either learned about, observed or actually done. Like I put in an IV (intravenous) in that child [injured in an accident] and that's the first time I have put an IV in a child. She was quite chubby so it wasn't as if her veins were standing up either. I put it in first time. So I felt good about that.

A feature of *detachment* was seen in the nurses varied attitudes in response to a perceived lack of direction. This variability was according to their individual interpretation of a tacit approval to attempt procedures as deemed necessary and irrespective of their skills because no-one else was available. A perception of being 'allowed' because of their isolated situation, and where 'no-one sees' or 'questions' performance, served to rationalise practice as it occurred in the remote area. It also appeared to be a factor in accepting deviation as normal, which emerged as another facet of *detachment*.

Deviation as normal

Most nurses tolerated, to a varying extent, a role and value system that deviated from the formal domain of nursing practice; a domain that was defined in nursing education and statutory as well as common law. In the nature of *detachment*, deviations from the nursing domain were generally accepted as 'normal' expected behaviour for nurses in remote areas. Such practices appeared to be unquestioned by the employer, medical practitioners and often nurses themselves. The normality of routinely performing medical functions, such as deciding an appropriate antibiotic therapy, was a typical example. It was portrayed in the quotes below:

- I always want to use an oral antibiotic regime before I use IMI (intramuscular) or IV (intravenous) wherever possible.
- One child with infected scabies doesn't seem to be getting any better. I first saw him on Saturday and that's when I gave him Bicillin. I don't want to give him another Bicillin where that one should have been sufficient to clear it up within a couple of days.
- Why should I take responsibility for giving intramuscular antibiotics [without a doctor's order]? That's why I always go for oral

antibiotics, because it is safer ground.

- Its okay giving an adult oral antibiotics off your own bat if you check that they are not allergic to it.

Deviation as normal, in the theme of *detachment*, was also revealed in the tacitly accepted performance of a medical substitute role by nurses. This was reinforced daily, such as in the informal delegation of medical decision-making by medical practitioners and by employer policies. In addition, the medical resources available for nurses use reaffirmed a medical role. Available resources included intravenous and suturing equipment, a supply of drugs and an X-ray machine. Nurses unrestricted access to drugs in the pharmacy, for example as seen in instrumenting care (chapter 8, pp263-64), was seen as normal in the remote area. As such, it was also conducive to practice deviations in how medical orders were given, how nurses commonly used drug treatments and how clients perceived that part of a nurse's role was to prescribe and dispense drugs (chapter 8, p268). This sense of deviation from the domain of nursing practice as being normal in the remote area was a characteristic of *detachment*. In addition, there was an assumption by the organisation that nurses could perform any duties as needed.

Organisational assumptions

In a setting of isolation, the nature of *detachment* was further revealed in the separation from organisational aims and controls for practice performance. More importantly the organisational assumptions were that nurses accept a position of being 'all things' to the clients they served. This position that nurses were responsible for deciding the care given was alluded to by a health service manager in the following quote:

Nurses are responsible for the clinics. They are given autonomy [by the health service organisation] to act as seen fit within the community setting.

Furthermore, a health service manager implied an awareness and tolerance of nurses varying priorities in practice. This was deduced from the different kinds of equipment requested by nurses or in the selection of health programs to be conducted. It was considered usual for the individual interests of nurses to influence the nature of work undertaken. The following quote, by a health service manager, portrayed this point of view:

Different nurses require different things [equipment] which seems to relate to where they have worked before...Different nurses have different interests in what work they believe is important. For example, some are interested in heart disease more than diabetes. I feel that the important programs are nought to five year old [child] health, STD (Sexually Transmitted Diseases) and diabetes.

Another aspect of *detachment* was an organisational assumption that nurses possessed the relevant knowledge and skills as well as the authority required to effectively perform the remote area role as expected (for example, chapter 6, pp158-59). A factor was the gap between employer assumptions of nurses' capabilities and their ability to perform independently. Nurses interpreted a lack of orientation, for example, as an assumption that they had an adequate knowledge of the clients' health problems and how to deal with those problems. This view was stated by a nurse as follows:

There is no orientation. You are expected to already have all these skills. It is assumed [by the employer] that you have these skills. But even the common things, like large boils, infected scabies and chest infections, I've never dealt with them before.

In a similar vein, the rude awakening of a nurse to the gap between the assumptions of the employer and her knowledge and abilities was revealed in this quote:

I suppose I expected to be coming to a bandaid post, but I didn't expect to be coming to ethical dilemmas and screening programs and the public health aspect of the job. I have no previous knowledge to help me with that.

In the character of *detachment*, the nurses' dilemma was further compounded by a lack of a support system to ascertain an appropriate work performance. This dilemma was expressed by a nurse as:

You haven't got people with you who have done it, so that you can get feedback on how you handled something. You never really know if you have made a good decision. I think that happens in a lot of places, but in this situation here there is a lot of stuff I haven't done before and haven't seen before.

In such a context, each nurse dealt with a feeling of *detachment* in practice situations according to their individual abilities. This was seen to involve a search for stability.

Detachment and the search for stability

Various strategies were utilised by nurses in their search for stability and predictability in *detachment*. Nurses endeavoured to bring about a feeling of order in a disordered practice environment. For example, in their acclimatisation to the setting some nurses set about reorganising or spring-cleaning the nursing post. These nurses viewed the desire for order as an attempt to function more effectively, as portrayed in the following remark:

I've attempted to clean up the clinic. It is nowhere near what I would like it to be but it is 200 per cent better than when I arrived four weeks ago.

In *detachment*, other aspects of the nurses search for stability in remote area practice that were observed included complying with norms and consulting with other practitioners as well as compensating for deficits in the care setting.

Complying and consulting

A strategy of compliance with the extraordinary rules and norms of the remote area was seen as a way to gain a feeling of stability in the different, difficult and often uncertain practice setting. For example, nurses observance of the 'rule' to 'follow the Central Australian Rural Practitioners Standard Treatment Manual' as they had been informed in learning remote area nursing (chapter 6, p156). Individually, nurses adapted the guidelines given in the Manual according to their assessment of the needs

of a client, but in general it was a way of dealing with *detachment*. The following quote reflected this notion:

I suppose I have tended to stick to the CARPA Manual for things I am not very certain about because that is the guideline we have been given.

In contrast, several other nurses in their search for stability chose to consult a medical practitioner in preference to relying on the CARPA Manual. A nurse in describing such situations stated:

This is what I have done a couple of times to make a decision. I have looked up CARPA [Manual] and thought I will give a drug. Then I have thought, no I won't. And then I actually consult a doctor [by telephone] and what they have ordered does not even correspond with what CARPA says. So they [the doctors] are not going to back you if you make a blue without even consulting them.

Consultation with other practitioners was another way to deal with a feeling of instability in *detachment*. For example, medical consultations were used to obtain reassurance or advice for the management of a client's care (see chapter 7, pp195 & 212). Consultation with colleagues for guidance on nursing problems was often used within the setting. Nevertheless, this information was not always perceived as reliable. A colleague may not have the expertise needed or gave advice that was contrary to what a nurse believed was required. In these situations a nurse's intuition seemed to be her or his only guide to an appropriate practice, as portrayed in the following quote:

Conferring with another nurse can make you more uncertain when you feel that what they have told you is rubbish...I have nothing here to guide me, only what I feel inside is decent and proper.

Detachment, as seen in a lack of personnel resources, such as a medical practitioner or pharmacist services in the isolated setting, had a major influence on the practice of nurses. In such a setting, nurses felt obliged to meet these needs by complying with tacitly approved practice behaviour despite the conflicts with standard nursing practice and legislation. It also involved compensating behaviour that was used in

order to gain a feeling of stability in the practice environment.

Compensating

Nurses used compensating strategies for organisational *detachment*, such as to deal with feelings of instability from a lack of staff continuity and a lack of material resources to maintain a service. For example, nurses planned for immediate staffing requirements in the setting and made provision for continuity of care when there was a lack of replacement staff. This manner of compensating was reflected in the following comment by an acting nurse in charge prior to her departure:

I have only got two weeks to go and I want to make up some sort of roster. Every Monday we do this. Every Tuesday we do that. Because in three months time N__ (a nurse) is going to be gone. B__ (another nurse) is going to be gone and nobody is going to know what they are doing. It is only going to be relief staff. I can't see anybody coming in permanently for some time, not over Christmas.

Compensatory strategies for adapting to the problem of staff turnover and shortages were used because nurses perceived that aspects of health care delivery would otherwise 'just collapse', 'fall down' or 'break down'. The terms were used in this way by senior nurses at separate periods of time:

- When I got here there were some programmes running. It has taken me six weeks to get on top of things and now another new nurse is starting. It is going to just fall down again.
- One of the nurses got a swimming session going once a week and that was enthusiastically received. And that's a problem in working out here that an enthusiastic nurse comes along with good ideas and gets programs going and when she leaves the programs just collapse.
- A 'sister-in-charge' attempts to deal with staffing problems by enlisting the aid of a Staff Development Officer to make a representation to management. The nurse explains that her two colleagues had resigned and only one relief nurse had been recruited. In conclusion the nurse states, 'I have resigned and will finish in seven weeks. This short term staffing is only bandaid. Without permanent nurses, work already started breaks down.'

In *detachment*, to obtain basic material resources for the nursing post nurses felt that they had to 'fight' with the organisation. The inference was that administrators did not voluntarily assess and supply the materials needed. A nurse expressed the difficulty in obtaining equipment and building improvements in the following statement:

We have got to fight head office for essential equipment, like a decent ECG (Electrocardiograph) or a decent auriscope or a decent stretcher. There is more. The clinic could be cleaned up. It could be retiled. There is so much that could make it so much better for working in and you shouldn't have to fight for everything.

'Making do' was a strategy used by nurses for adapting to, and/or compensating for, a lack of material resources (for example, chapter 5, pp144-45). 'Making do' also involved a compromise for nurses in practice in that the equipment available and in use was often sub-standard. For example, to 'make do' with damaged instruments which were all that was available for procedures, as this nurse explained:

You make do with the kind of instruments you have got. N__ (Facilities Co-ordinator) does a good job of washing the instruments and sterilising them, but it is still not up to the standard of what you would normally use. Even just trying to clean your instruments. Look at the calcium build up on the vaginal speculums!

Nurses also 'made do' with other resources, such as paper scissors as supplied by an organisational administrator for cutting surgical dressing materials. Nurses 'made do' with a heavy low trolley and a canvas with two poles to transfer recumbent clients into and out of the high back of a Landcruiser. The ability of nurses to provide safe care was also compromised by a lack of basic equipment, for example, when vehicles lacked safety fittings for carriage of oxygen cylinders or to secure the trolley to the floor for client transport. By the same token there was expensive equipment that was purchased but not used, such as an ultrasound, and expensive drugs that were shelved until the date of expiry then returned to regional pharmacy to be destroyed.

In *detachment* nurses attempted to develop a feeling of stability by complying with norms, consulting others for guidance and compensating for a lack of resources in the

practice setting. The outcomes in *detachment* were revealed in nurses responses to their perception of separation from organised structures to support nursing practice.

Outcomes in detachment

A range of outcomes occurred for nurses in their ability to deal with *detachment*. These outcomes pertained to a lack of role confidence and to an inconsistency of practice standards as well as feelings of complacency and powerlessness. Basic to these outcomes of *detachment* was role uncertainty whereby nurses felt unable to resolve the contradictions for nursing practice they experienced daily in the remote area.

Lack of role confidence

An inadequate system of controls, such as a lack of consistent standards of practice, contributed to nurses feelings of uncertainty and a lack of role confidence.

Uncertainty in practice performance was a major difficulty in *detachment*. Nurses then questioned their own skills and the decisions they had made for clients' care, such as the decision to give a drug, or to withhold a drug (for example, chapter 7, p202). This was apparent in nurses descriptions of their practice where they added comments such as, 'I always question myself', or 'You are wondering if you can do it alright and get it right' (referring to an unfamiliar procedure, such as an intravenous cannulation on a child).

There was also an inconsistency between nurses in their role perception. How nurses themselves interpreted what was an acceptable practice in the remote area and how this varied between nurses was illustrated in the following excerpt:

In the clinic a nurse reports to her colleague, 'I gave an IM (intramuscular) Bicillin to D___ [a 6 year old child] with infected scabies the other day'. The other nurse replies, 'Well I don't. If I had to give an injection to any children I always consult the doctor.'

An outcome of *detachment* was observed in the way nurses linked a lack of oversight for practice to a lack of confidence in performance. This point was revealed by the following remark:

Nobody has questioned anything I have done. I don't really know if I've assessed someone correctly.

Nevertheless, some nurses were 'wary' of the prospect of being questioned about their practice performance. This view implied an awareness of standards usual to nursing as well as a lack of confidence or an uncertainty in their ability to defend their practice in the remote area. Two nurses described their views in the following way:

- I think something like that [being questioned] could only be good for nurses and the health service. But I think a lot of nurses would be wary of that as a tool to get black marks against your name and be used by the employer as reason for, not sacking that is extreme, but as a leverage if something did go wrong.
- They [nurses] are aware that somebody could come in and question their actions. They don't like other people coming in and looking over their shoulder because they've had it their way and don't want to change...If another nursing person comes in who questions their practice they become very wary of that person. All right, RFDS wouldn't question their practice because they only come in once a fortnight, see the patients you want them to see and then they go. The doctor on the end of the 'phone is not going to question your practice, but another nurse would if they believed that it is not right and if you are being a bit gung ho here. They would say, 'Why aren't you doing what you were taught? You obviously know!'

The nurses perception that their practice was unseen and unchecked by other authority figures contributed to an attitude of complacency and a tendency to adopt inappropriate practices amongst some nurses.

Complacency and inappropriate practice

An attitude of complacency toward practice performance was observed in the casual manner adopted by several nurses. For example, a nurse's independent decision to administer an antibiotic intravenously or a nurse's incomplete documentation of client

care. Typical examples observed were an unrecorded observation or a drug administration. Some nurses viewed a tolerance of practice variations in the remote area as conducive to 'apathy'. This was stated by a nurse as follows:

Because the way you were taught nursing is not done here you start to fall into the trap of apathy and think, 'Oh well, its the way it is done here. It's the way I will leave it'.

A casual attitude shown by individual nurses in the documentation and use of drug treatments, for example, was a major concern to some of their colleagues. This concern was illustrated as follows:

A nurse, seeing a child about nine months old, checks the child's history. She observes that on the child's visit the previous day the nurse's notes had recorded no specific problem other than a temperature of 38.6 degrees Celsius and a pulse rate of 164. The nurse had then recorded IM Bicillin as given. Checking back further in the child's record the nurse notes that the child was administered Bicillin the week before for 'infected scabies'. 'I'm concerned that every second week Bicillin is being given to this child. It's as if because no-one is looking it doesn't matter how casually treatments [drugs] are given out'.

Complacency in practice was not only related to a casual attitude. As an outcome of *detachment*, it also appeared to be associated with nurses resignation to systematic problems that they perceived as beyond their control but, from their point of view, seemed to be a matter of indifference to authorities. Nurses generally cared, but they often felt a lack of power to effectually influence the practice expected of them.

Powerlessness

The contradictory nature of the outcomes of *detachment* was evident in nurses perceptions of problems related to power and powerlessness. *Detachment* afforded an illusion of power, such as making practice decisions without the constraint of controls. At the same time, nurses felt powerless to assert their right to practice as nurses and to influence the manner of health care delivery in a remote area.

A sense of powerlessness was also evident in their repeated expressions of frustration in remote area practice. For example, nurses often seemed unable to effectively deal with the pattern of unrelenting client demands placed on them. As an illustration, a nurse who was on call had attended to clients with non-urgent problems intermittently throughout a Saturday. Late that evening three clients arrived at the nurses' quarters to see the nurse. Returning to the clinic to attend these clients, the nurse remarked in a despairing tone,

It is easier to give them what they want than to point out that it is not an emergency and cause an argument. It's been said so many times before that after hours is for emergencies only, and [enforcing] that takes energy and leaves you feeling even more exhausted.

Nurses also perceived a lack of power in their inability to influence the way in which health care was delivered. Most felt that they had 'no say' and were not consulted in the planning for health programs that were initiated external to the setting.

Nevertheless, nurses were expected to implement and take responsibility for 'all the follow-up' of these programs (as described in chapter 8, p254-55). This was how one nurse expressed the situation:

There has been no consultation with us, only a memo [about a screening program]. We have no say in it. Yet we are expected to run around and get all the specimens and do all the follow-up on top of the work we already do.

In another example, a nurse expressed to a medical practitioner his moral dilemmas pertaining to client confidentiality and consent, as well as the assumptions made of a nurse's capacity to inform individual clients about a medical screening survey. The medical practitioner's blunt reply was, 'Bad luck. That's what you are paid for', and thus trivialised the nurse's concerns.

Nurses feelings of powerlessness to deal with the persistent problems found in *detachment* often contributed to a decision to resign. Resignation seemed to be the only alternative for nurses who were unwilling to work without organised structures

of control for practice or to adapt to the norms of a remote area practice setting. This was the view stated by a nurse who announced her resignation three days after commencement at Warburton:

I am not staying. I just want to get out. I don't belong here. This is not nursing and I love nursing and am not willing to risk losing my registration. There is no back-up only a doctor 1000 kilometres away and then there is CARPA Manual.

The outcomes of *detachment* included a lack of role confidence, complacency and inappropriate practice and powerlessness. They added further insight into the nature of *detachment* and its relationship to *amorphous practice*.

Detachment and amorphous practice

The theme of *detachment*, expressed in nurses terms of 'no-one sees' or 'questions', explained nurses' feelings of separation from conventional controls and checks for the enactment of nursing practice. In such a context there was an individuality of practice according to each nurse's ability and their interpretation of an appropriate manner of care. *Detachment* was seen as a major theme contributing to *amorphous practice*. In *detachment* the tacit rules for practice that operated in the remote area setting were accepted. Normalising practices generally censured in other health care settings meant that in isolation they came to be seen as normal and, therefore, acceptable, taken-for-granted and unquestioned by most of the nurses who stayed, and by the system of health care in the remote area.

Detachment inter-related with the theme of *diffusion* in that a separation from controls for practice performance impacted on the extent of the nurse's role in the remote area in that it's scope remained unchecked. *Diffusion* described a recurring theme of the wide dispersion of practice in remote area nursing.

Diffusion

The theme of *diffusion* is defined in this study as the broad outspread of the boundaries of nurses' practice. There was a tendency for the work expected and performed by nurses to be all-encompassing. Their roles appeared to extend thinly over a wide area. Nursing, as it was practised in the setting, was at times stretched to encompass 'all things to all people'. *Diffusion* was typified in nurses' use of the term 'it' to explain their feelings of an all-encompassing role. For example, 'I am it', 'You are it. If I didn't do it there is no-one else' and 'It all falls on me'. 'It' was a term of universality, used to cover everything that was perceived to require health care. Being 'it' was also expressed in nurses' references to themselves as a single object. It implied a feeling of being taken-for-granted as the one to single-handedly deal with and to resolve diverse situational problems. The following quote was an example:

A nurse-in-charge comments, 'I have not been told anything about the new nurses who will be arriving'. She decides to telephone a health service manager to obtain this information. The nurse also tells the manager, 'There are no health workers here and there will be only one nurse'. The manager then asks the nurse to decide about the reinstatement of two Aboriginal health workers [previously dismissed]. The nurse declines to make this decision. On completion of the telephone conversation, the nurse remarks, 'Again it all falls back on me'.

As described in previous chapters (5-8), remote area nursing was more than nursing practice as it is generally understood by the profession. The theme of *diffusion*, therefore, referred to a spreading out of the domain usually attributed to nursing, to encompass the breadth of demands in remote area practice. Practice was diffused in that it was dispersed in an irregular pattern over a wide area, such as in the use of time and space, and in the scope of responsibilities assumed by nurses. These features of *diffusion* are described in all-encompassing care, diversity of expectations, client-nurse interaction, spatial and temporal boundaries, 'filling in' and in the indefinite outer limits or lack of a 'cut off point' that characterised remote area practice.

All-encompassing care

In *diffusion*, nurses' perception of being 'it' was associated with a feeling of being singly and constantly available to provide all-encompassing care. This role also included the associated maintenance needs of the health service within the remote community. Nurses, who were available to work any duration as required day and night, often assumed a personal responsibility to make up for inadequacies in the service. The following remarks illustrated this situation:

- Here in a remote area we work overtime at nights and at weekends and are on call in addition to a normal working week just to provide a service. Even when you are off duty you are still available, if necessary, in the community. Yet, for this we are only paid an availability allowance of \$57 a week. We do it for nothing really.
- The onus is on the nurse in a remote area. As a single person we look to ourselves for the answers to the health problems.

Nurses' feelings that they were 'it' and there 'is no-one else' contributed to their perception that they alone were responsible for the delivery of a service and for all client care, for example as described in chapter 7, pp200 & 206-07. They felt trapped in the situation, unable to extricate themselves from a feeling of holding the final responsibility. In their reality, this was because 'there is no-one else' with the capability and/or authority who was available and/or willing to assume that responsibility. This perception of the extent of their responsibility persisted even when the resources for service requirements were unavailable to them, or when a client's health problem and its outcomes were beyond the scope of an individual nurse.

In the following quote, a nurse used the term 'there is no-one else' as having nobody available to take over responsibility. As a consequence, the nurse still felt ultimately responsible irrespective of her limitations or a client's behaviour:

J__ was supposed to bring her daughter S__ back for a doctor's visit. She was for investigation for fits. But she did not present. As a nurse I still have to think about it. You can't get away from it. You are here all

the time and there is no-one else to hand over too. Like in Casualty [previous employment] I could hand over to someone else and go home. I could not find E___ for the doctor's visit [an antenatal client with an unwanted pregnancy]. She might be avoiding the doctor, but it still comes back on the nurse, although the decision is made by her not to see the doctor for an assessment. It is very frustrating. But I am here 24 hours a day. I feel trapped because I come to the rescue when the person returns and the problem has become worse. You could work yourself into the ground here.

A feature of all-encompassing care in *diffusion* was that individual nurses often felt that they 'have to deal with everything'. This was observed in the multiple levels of activities recurrently dealt with by a nurse, such as from performing errands to administering emergency care for clients, communicating with outside agencies, obtaining material resources or facing verbal threats of physical harm, for examples, see chapter 5, p143, chapter 6, pp173 & 176, chapter 7, pp188, 201 & 204 and chapter 8, pp244-49. The expectation of themselves was to 'deal with everything', regardless of their abilities and their own self-care needs. This was recognised by most nurses as unrealistic. A nurse explained this problem as follows:

You are trying to deal with everything. It's an unrealistic expectation, but it is implied that these are our capabilities. It is a catch 22. When people are all asking you to do these things you think, well maybe its normal. Maybe I should be able to do all these things. Why can't I? That is when the 12 hour days, seven days a week start. When you still have all these oldies for check-up that you know you haven't done. You have still got all these medications to be checked. And you start thinking what aren't I doing? I am putting in so many hours but I am still falling behind. What am I doing wrong?

Another aspect of all-encompassing care that was a characteristic of *diffusion* was the diversity of expectations, both explicit and implied, of a nurse's role in a remote area.

Diversity of expectations

The theme of *diffusion* and its relationship to *amorphous practice* was further

revealed in the multiple and inconsistent nature of everyday practice expectations of nurses. Two basic factors were seen to influence this diversity of expectations. On the one hand, the constant availability of a nurse as the care provider and, on the other hand, the demands for care, normally the responsibility of other service providers, but who were unavailable in the remote area.

The various groups who interacted with nurses each had divergent requirements of them, such as medical practitioners, hospital services, clients and representatives of the employer. Nurses attempts to meet these different, and sometimes contradictory, expectations were a factor in *diffusion*. This was seen, for example, in the expectation of clients that nurses could be called upon as needed at any time and the conflicting organisational expectation that only emergency cases were to be seen outside normal working hours (chapter 5, pp115 & 129). As another example, the employer's expectation conveyed to a nurse on her role with Aboriginal health workers differed to that expected by the Aboriginal health workers. This was what one nurse had to say:

When I first came here I got told by the management that we were to hover in the background. I was to let the health workers do all the basic care and they would come and see me and consult with me if they feel they need to. Alright I was doing that. Then at the last meeting the health workers said, 'Oh we want the Sister right next to us all the time'. But I have found that when I am in that clinic, nine times out of ten the health workers disappear. You can't find them.

In reality, nurses appeared to be taken-for-granted in the extent and nature of others' expectations, for example, a medical practitioner's verbal orders for a nurse to initiate intravenous drug therapy. Such an order took little account of the limited resources available to a nurse, such as for back-up care, work time or for gaining competency in the procedure. If a nurse was willing to attempt a procedure as requested then, in the medical practitioner's absence, there was no objection (see chapter 7, p222). If nurses were willing to work long hours of overtime, then no-one objected. To the contrary, nurses were expected to accept additional responsibility despite a lack of resources or

back-up support from other care providers, as observed in this example:

A nurse informed a visiting medical practitioner that she would be unwilling to take the responsibility for administering potent intravenous drugs that she was unfamiliar with and that were stored at the nursing post. The medical practitioner disputed that the nurse had this responsibility and added, 'These drugs would only be given on a doctor's order'. The nurse then pointed out that professional help and the nearest hospital were a thousand kilometres away if such drugs needed to be administered. His reply then was, 'If the nurse can't take responsibility for administering the drug, then she shouldn't be out here'!

Another factor, influencing the diversity of expectations characteristic of *diffusion*, was the non-participation of the health service management in the everyday running of the clinic. Nurses were expected to make decisions for the scope of care provided as well as to manage every contingency of health care as needed in the community. Most nurses perceived that a lack of organisational involvement also contributed to the indeterminate character of their role. This was explained by a nurse as follows:

There is no real involvement or direction from the health service. [The impression is] as long as a nurse is out here doing something and there are no complaints, nobody seems to care what happens. They [managers] don't seem to care if the clinic is open 24 hours a day, or what sort of care is actually provided to clients. They don't seem to care if someone is practising as a doctor even though they are a nurse. That's the sort of impression filtering down from upstairs, so how are the people [nurses and Aboriginal health workers] who are doing the work on the ground to get some direction?

A feature of *diffusion* was the diversity of the explicit as well as implied expectations of the organisation and other care providers from outside the setting. The nature of client demands and nurse-client interactions within the community were also a factor in *diffusion*.

Client-nurse interaction

Diffusion in client-nurse interaction was portrayed in the clients' broad expectations and assumptions regarding a nurse's role and its functions. As described previously (such as, chapter 7, pp187-88), clients were often seen to exhibit dependency behaviour in order to have their demands met by a nurse. In turn, there was a tendency for nurses to serve clients as passive recipients of health care or to deny their capacity for self-reliance. A nurse described these behaviours of the nurse and the client in this way:

The community, I think, has learned to become very dependent on the clinic. So they come up to the clinic for boils, skin infections, the first sign of a cough or cold to see what you can come up with. They usually like a fairly instant sort of treatment or cure. So the nurses tend to, where they can, find a quick fix solution, like a single dose of treatment.

Additionally, clients or their relatives often requested nurses to provide assistance in situations where they lacked the resources or the motivation to provide the care for themselves. The following example illustrated this use of a nurse's assistance:

A nurse is visiting an elderly female client who has emphysema and difficulty with ambulation. The woman asks to return with the nurse to the clinic for a bath. Her adult daughter is standing by and the nurse asks her to come as well and assist her mother. The daughter replies, 'You wash her. I'm too busy. I have to do shopping. You can wash her'. In the meantime, the woman has collected her change of clothes together and walks over to the vehicle. The nurse, without further comment, assists the woman into the vehicle then drives back to the clinic to give her a bath.

Several nurses perceived that the nature of the interaction between clients and themselves as care providers was influenced by a general relationship of dependency between Aboriginal clients and the 'white' staff in the community. This relationship and a perception of the distress of some Aboriginal clients was often seen by nurses to promote a tendency to 'doing things for them'. This notion further stretched the spread of remote area practice. For example, as stated by this nurse:

They [clients] seem to be used to white people running around after them and providing resources and doing things for them. But the other thing is that people seem very dispirited and despairing and powerless. And its very hard for them to rise above that despair. As nurses we are part of that group of white people who run after people all the time, chasing them up to make sure they have had their medicines or chasing them up for screening programs. So they've taken the responsibilities for people's health away from the people. In some ways nurses contribute to that.

A question pertinent to nursing care in this client-nurse relationship was the moral responsibility to do no harm. It was, however, less obvious than avoiding harm in the more technical aspects of care.

Another aspect of dependency in the nurse-client relationship that pertained to *diffusion* was seen in the tendency of clients to, 'hand everything over to the nurse'. Thus, nurses were expected to deal with medical as well as nursing care and other needs as they arose. This tendency was illustrated in the following account by a nurse:

The father walked through the door [of the clinic] with this girl in his arms. Both had blood coming out of their head. Straightaway I thought, 'Oh no, there are two of them', then I quickly realised he was doing a sort of sadness thing by hitting himself on the head. He wasn't badly hurt, so I concentrated on the girl. She had a big cut from her hairline down across her right eye and it was an open head injury and just bleeding. It's one of those things that looks really bad and if you are not medically trained in any way you just respond with panic. So that's where people hand something over. They hand everything over to the nurse.

At times it seemed that some clients expected a nurse's care to extend to meeting their social and material needs as well as their health problems (illustrated in chapter 5, pp131-32). An example was a situation where a nurse felt intimidated and held to blame by a client for his health as well as social problems that were outside her control. This was the observation:

Tuesday 11 pm. A male adult arrives with his mother at the nurses' quarters. He states that he has a bad stomach pain and has been vomiting. The nurse on call had seen the man earlier in the day for this problem and had administered Pethidine and Stemetil according to

medical orders. The nurse again consults a medical practitioner for advice. This time Pethidine, Stemetil and Zantac are ordered. The nurse sits with the man and his mother for awhile. The man then says, 'I want to stay in the clinic. I am cold.' The nurse replies, 'There is no one to stay with you here and I have to work tomorrow'. At the door of the clinic the man shouts, 'Are you going to let me die out here?' 'I won't let you die' she responds. The man reluctantly leaves to return home. The nurse then returns to the nurses' quarters and comments, 'I feel apprehensive. He was aggressive and it's as if I am to blame for his illness and for his social circumstances. I am to fix it and if he dies it is my fault'.

In the remote area it was often assumed that the nurses available could and should deal with a diversity of expectations as well as client health and social needs.

Diffusion in the spatial and temporal domains of remote area practice further added to the all-encompassing character of a nurse's role in the remote area.

Spatial boundaries

The notion of spatial boundaries refers to the domain of space within an environment. The use of space is determined by its boundaries. Spatial boundaries were a dominant feature of *diffusion* as seen in the overlapping physical arrangements of space for the delivery of nursing care in the remote area. (This feature of remote area nursing was described in chapter 5, pp107-09). The lack of a physical space between nurses and clients enabled more ready access for both to each other. For example, a nurse was usually immediately available for direct physical contact and care as needed by clients. Clients who were in the community were also accessible to a nurse, such as whenever a nurse needed to communicate information to a client or to seek out a client who had not returned for a daily treatment

The proximity between the nurses' place of living and place of work contributed to nurses feeling that the living space occupied by them was for work or to enhance their access to be called for work. The small area of the community meant that walking distance to the clinic or nurses' residence was no more than fifteen minutes from any

direction. In this context, where work, recreation and social life all took place in one setting, nurses often felt that they were always 'on duty'. This feeling was described as follows:

Like going out for a walk in the community or a walk to the store and being stopped all the time, 'Sister, I've got sore eyes', or 'Sister I've got a headache' wherever you go. So that all the time you are in the community you feel like you are actually on duty because there is always somebody asking you for something.

A few nurses, however, stated that they accepted this situation of overlapping spatial boundaries as a 'way of life' in a remote area. The following anecdote showed this viewpoint:

We had one man with a very nasty cut finger. He needed dressings done every day. I wanted him to be seen by the RFDS. I said, 'The RFDS are coming in two days. When you hear the 'plane, come in' [to the clinic]. He was out on business [men's ceremonies] and as it was he missed the appointment. He came every day, invariably after hours [to my house]. I accept that. I am on call all the time. I am living as a nurse. I don't have a worry with call outs. As I said at the start [of the interview] I really enjoy what I do. It's a way of life.

Emergency work also tended to merge the professional/private life of a remote area nurse. In an emergency, nurses who were not on call were still available and used their personal time to assist and/or advise another nurse. The privacy of a nurse was further invaded when visitors came as they were accommodated at the nurses' residence. The effect on feelings of personal space was stated by a nurse as follows:

In the nurses' quarters I feel like I have my space taken away from me because I have to share it with visitors.

Within the spatial boundaries of the clinic there was minimal separation between sections for client consultation and public areas (for example, chapter 7, p182). The *diffusion* from the overlap of private and public space in the clinic and its impact on client-nurse consultations was recorded in a field note as follows:

There is no separation between people waiting to be seen and the nurse attending the client. While the nurse tries to concentrate on the client,

other people around claim her attention and are demanding to be seen at once. ALL at once. There is pressure on the nurse to attend multiple needs and persons simultaneously.

In these situations the work of a nurse was dispersed in an effort to accommodate the concurrent demands of the moment. The feature of spatial boundaries in *diffusion* was closely associated with the use of limited time.

Temporal boundaries

Temporal boundaries refers to the time limits of a nurse's employment, such as rostered hours and days of the week. It distinguishes by time when a working day begins and ends. Furthermore, 'hours of work' is a factor in judicial decisions to establish the employee-employer relationship (MacFarlane 1993, p28). The temporal attribute of *diffusion* in the remote area meant that nurses' availability to clients was spread over a prolonged and unpredictable period of time. Work hours were extended as required according to the needs of clients and the work that nurses perceived needed to be completed after hours (see chapter 5, pp115-19). Medical practitioners also expected nurses to continue monitoring a client for extended time periods prior to making a decision to evacuate a client (for example, chapter 8, pp228-29). One nurse had this to say:

You could run this place like a hospital, which we are asked to do sometimes as understaffed as we are. We are asked to work 14 hours a day or more before they [medical practitioners] will decide to fly somebody out.

The non-specific temporal conditions of nurses' employment was an important facet of *diffusion*. This allowed a lack of limitation to the nature and extent of work, work time and 'on call' for an individual nurse. The job description made minor reference to 'on call' responsibilities, listing it as a duty, 'to provide 24 hour cover for clients'. A footnote to the job description added, 'Any or all of the above duties and responsibilities may be altered as the needs of the communities grow and/or change'

(Appendix 14). The time of 'on call' and hours worked by nurses were not routinely recorded and reported to the employer. Under the Western Australian Nurses' (Aboriginal Medical Services) Award, 1995, the fiscal compensation defined as an 'availability allowance' did not remunerate nurses according to the frequency of on call or the actual hours of overtime worked (see chapter 5, p116). Such Award conditions offered no incentive for the employer to monitor the hours and after hours work or the nature of work performed by nurses.

A characteristic of *diffusion* in remote area practice was observed in the spatial and temporal arrangements for nurses to provide a 24 hour primary care service. Individual workloads were increased when nurses 'filled in' for the shortfall of staff who were absent or unavailable.

'Filling in'

The characteristic of 'filling in' was another aspect of *diffusion* in remote area nursing whereby the services of individual nurses were spread thinly to make up for the absences or shortages of other staff at the nursing post. Nurses perceived 'filling in' as necessary in order to manage the work environment and to meet the unabated health needs of clients. For example, in a three month period when there were only two nurses at the nursing post, one nurse went away on sick leave for five weeks. The nurse was not replaced, even though the full complement of staff was three nurses. During that period the one remaining nurse assumed all the 'on call' activities as well as several other duties normally performed by her colleague. In addition, nurses carried out the work usually performed by Aboriginal health workers or domestic cleaners when they were unavailable through absences or resignations.

In addition, 'filling in' involved individual nurses assuming other roles when an appropriately qualified and/or experienced practitioner was unavailable. For example, in the absence of a midwife, nurses who were unqualified in this area of nursing practice undertook functions of midwifery, such as an assessment of an ante-natal

client or the management of a client in labour (for example, chapter 7, p205). The following observation at a time when a midwife was unavailable also illustrated this point:

At 11.30 pm a man arrives at the nurses' quarters. He tells the nurse that his wife 'needs attention'. His wife is pregnant. The nurse goes together with the man to visit the wife at home then brings her back to the clinic to assess the woman. When the nurse returns to the nurses' quarters he remarks, 'The woman had thought her waters had broken, but I think it is stress incontinence. She was watching TV (television) and coughed and felt this loss onto her underwear. I checked CARPA Manual and the Women's Manual (Congress Alukura & Nganampa Health Council 1994) but there was nothing under ruptured membranes. I know nothing about midwifery'.

The attribute of 'filling in' in *diffusion* broadened the role undertaken by nurses in order to meet the gaps from other deficits in the systems of care. Nurses were observed to 'fill the gaps' from deficits in the systems of family support as well as in the system of health care delivery. For example, nurses frequently provided transport for clients or provided day care in the clinic when the clients' own means for obtaining this support, from relatives or personally, were assessed by a nurse to be unavailable. In relation to the system of health care delivery, for example, nurses compensated for a lack of discharge planning for hospitalised clients or a lack of planning for client follow-up from medical screening programs (such as described in chapter 8, pp241-43 & 254-55). The extent to which all these deficits in the systems of care could or should be met in the remote area was decided by individual nurses. Nurses' perception of a lack of a 'cut off point' to all these role requirements also illustrated the theme of *diffusion*.

Lack of a 'cut off point'

In the theme of *diffusion* there were few end points, or 'a cut off point', that distinguished the outer limit to the scope of the nurses' roles and responsibilities for care. The following quotes illustrated the nurses' feelings of an indeterminate

parameter in the all-encompassing care of remote area practice:

- The protocols laid down by this service don't limit what you can do...Out here, you are in the middle of nowhere without any parameters. I mean you are it. Your only support is a doctor who is a thousand kilometres away. And if it's a situation in which you deem it unsuitable to wait two hours for the RFDS you are going to try something, right or wrong. The more experienced nurse, whether it's experience or not I don't know, might say well we will stabilise the patient and wait for the evacuation. Those that think they have the capabilities will go ahead and do it. They will try out some sort of treatment. There is no limitation, no parameters. Your only parameter limiting what you can do, it seems, is the boundary of the Lands.
- In hospital nursing there is an outcome. The patient recovers and returns home or is transferred to the care of someone else. Out here there is no cut off point. There is a continuum of care and responsibility for the nurse that has no end point.

Despite a perception of 'no end point' in the all-encompassing nature of care in remote area practice, nurses did attempt to contain their role. They, therefore, utilised a range of strategies to deal with an often unwieldy role in *diffusion*.

Dealing with diffusion: 'drawing the line'

Nurses frequently used the term, 'You have to draw the line somewhere', to explain the limits to their role and to the compromises they made in practice. It implied the extent to which they were willing and able to extend their scope of practice in the setting. The term was used in a sense of role containment. The nurses meaning of 'to draw the line' was conveyed in these examples:

- This morning I told a man who was waiting and said he wanted a Panadol for a headache, 'This is not an emergency. We have a child to evacuate. Go to the store and buy a Panadol if that's what you want'. I felt a bit mean when all he wanted was a Panadol and this could easily have been given. But people just come up all the time for these things and wear you out. You have to draw the line.

- It's up to the nurse to draw the line, otherwise you could find yourself on a string trying to do whatever anyone else wants you to do.

Often, there was an expectation for nurses to extend their mode of care. For example, when a medical practitioner instructed a nurse to care for a client overnight.

Therefore, nurses were obliged to restate their limits to care, that is, 'draw the line'.

This was illustrated in the following quote:

Doctors often say, 'Oh just keep them up there a bit longer, keep them overnight', which we are not geared for. It also puts expectations from other people that you will keep me overnight. So you have to draw the line.

Nurses used the term 'drawing the line' in a similar way to the term, 'setting limits'.

These limits included the spatial, temporal and functional elements of practice.

Setting limits to practice

'Setting limits' required a nurse to articulate their preparedness to undertake the work as requested or implied to them. Situations where nurses set limits were, for example, the response to after hours calls, the performance of particular procedures or a duration for keeping an ill client under observation at the nursing post prior to a decision to evacuate a client. (These points were portrayed by observations and quotes, such as in chapter 7, pp222-23). In these situations it was generally not the formal domains pertaining to medical and nursing practice that was at issue. It was an individual nurse's willingness and judgement of her or his own capabilities to independently manage clients and their treatment.

There were variations between nurses and in different situations as to a perception of their personal and professional limits to the scope of their role in a remote area.

Whereas one nurse agreed to perform a medical procedure, in spite of a lack of qualifications and/or experience, such as initiate intravenous antibiotic therapy,

another regarded the procedure as inappropriate for his or her level of competence. Several nurses perceived that their limitations related to ethical as well as clinical considerations, as seen in this example:

A medical specialist proposed that one of three sisters of a male client with renal failure may be a suitable organ donor. The 'Sister-in-charge' agreed with the specialist to take the preliminary blood samples as named. She instructed a nurse to 'take bloods' from these women 'as a first step in determining whether their kidneys are compatible'. The nurse declined to collect the blood specimens and stated. 'I think it is inappropriate to begin these investigations here in Warburton. The sisters probably do not have a full understanding of the implications of donating a kidney. Their own health has not been fully assessed. I doubt if they've been counselled at all about the prospect of donating a kidney or are having a free choice'.

Medical expectations were that nurses would articulate their inability to perform procedures or if they felt unable to meet a client's care needs as requested. Otherwise, the medical practitioner presumed a nurse was able and confident. For example, an RFDS medical practitioner (as previously quoted p222), under an assumption that nurses had an opportunity to be 'instructed', implied that nurses themselves needed to determine and state their own limits in practice:

You have to find your own ground and what you are happy doing on your own...A nurse should give a good description and be happy to attempt most procedures once instructed how to do it, or say 'I am not happy'. Know your own borders and your own cut off [point] if you are not happy rather than just go ahead and try...

Nurses attempts to meet a wide range of responsibilities for care were often described by them as 'coping' or 'working it out'.

Coping and working it out

Nurses frequently used the term of 'coping' as a strategy for dealing with extraordinary demands that featured in the theme of *diffusion*. 'Coping', as described in learning remote area nursing, was to survive the difficulties of practice (chapter 6,

pp175-79). The term also implied an attitude of acting to the best of a nurse's individual abilities. For example, the term 'to cope' within an extended role was used by a nurse in this way:

I think I am able to cope with most things, to no great degree, but enough to get someone down to Kalgoorlie if need be.

The term to 'work it out for yourself', had similar connotations to 'coping'. In the absence of adequate preparation and resources, it was a way to personally manage the scale of work required of an individual nurse in complex practice situations. For example, as described by a nurse in the following event:

I was attending a child with a suspected head injury and extensive facial lacerations from a vehicle accident. The father, who was driving the vehicle, had inflicted an injury to himself in remorse. Relatives had also gathered around the child and were sobbing as they do when they are grieving. I put on a compression bandage to arrest the bleeding from the child's head and assessed her injury. Then I had to leave the child to go to the telephone and consult the RFDS. I realised that it was important to try and give the family a role to play, so they could be part of it and not shoo-ed out the door. I worked it out by asking the second wife [of the father] to keep the child awake so I could tell how bad, or how well she was. Another woman was involved in that too. The other relatives, who are Christians, were involved in praying for the child.

Nurses usually relied on their individual professional and personal resources to deal with the problems they encountered in *diffusion*. Various consequences, however, emerged from *diffusion* and the difficulties of 'drawing the line'.

Consequences of diffusion

The consequences of *diffusion* in remote area practice were seen in its impact on nurses and nursing care, as well as on their relationships. These factors were described as the burden of care, incomplete care, group dissension and work overload. Inherent to these consequences of *diffusion* was a lack of role clarity for nursing practice in the

remote area

Individual burden of care

A feeling of being 'it', and thus accommodating the whole responsibility for health care on a continual basis was a major difficulty in that this presented an unrealistic scope of care. In *diffusion*, individual nurses undertook a burden of responsibility for care that exceeded the normal limits. This scenario frequently contributed to practice dilemmas and their feelings of inadequacy and frustration. For example, as shown in the quote below:

There is a problem with repeatedly giving antibiotics. Like a woman came to me with an infected throat three times in a month. She'd had Penicillin but it wasn't working. I telephoned the RFDS doctor and he said, 'Give Penicillin'. I explained to him that it wasn't working. The problem was still there. But he just laughed. I felt dissatisfied. There was no further investigation of the problem. But you know more than the doctor because you are seeing the person all the time and know them personally. You want help [from the doctor] with a diagnosis and proper treatment. Then when the person sees the doctor [on a medical visit] they are not sick at the time. The doctor will just write that they are okay and that they saw the client. But you [the nurse] are still left with the problem.

At times, the position of 'taking care of everything' in the context of a remote area contributed to a difficulty for nurses in distinguishing between clients' private affairs and their nursing care needs. For example, when a nurse's efforts to take care of a client's health problem overlapped with other social problems. The following observation illustrated the personal dilemma and interpersonal difficulties involved for a nurse in meeting a client's health need in the presence of a social conflict:

K__ comes to the clinic. She has been hit on the head with a heavy object by another woman for an alleged affair with the woman's husband. Her left eye is extremely swollen and she is fearful and crying. On the advice of the medical practitioner who is consulted by telephone, K__ is to be transported out to Kalgoorlie on the regular air service that is due in one hour. A nurse then makes these arrangements. The woman who has hit K___, however, is waiting at the airstrip and armed with a wheel-brace. She says to a nurse that she

will not allow K__ to go on the 'plane. 'She is not sick and is putting it on because she has to go to a court today. You white people you don't understand. You don't see what happens inside my house. She can stay here. We have a hospital here'. The woman then turns and walks away. The nurse expresses her distress at being 'caught up' in this situation. K__ is in the health vehicle with the door locked. A crowd has gathered at a distance to watch the event. Finally, to avoid the woman assaulting K__ again, the Sister-in-charge instructs the nurse to drive K__ down to the far end of the airstrip where the 'plane would stop for K__ to board. Later the nurse who drove K__ to the airstrip, says, 'I felt afraid at the airstrip and I feel shaken up by this tense angry situation, being caught up in it as a nurse unwillingly'.

The nurses' notion of 'You are "it" ', devoid of the professional and organisational structural support needed to provide a proper service, was often associated with feelings of unrelieved stress. Nurses who felt that they were unable to continue practising in a position of sole responsibility, had no alternative but to resign. The following statement (also quoted on p103) typified this situation:

One of the main reasons I have resigned is the on-call. You don't know what is going on out there. And especially at night when you are on your own. I mean it could be anybody going right off and you've got nobody there to help you. You are it. That is what worries me....

In the final analysis, the burden of all-encompassing care as implied in the broad spread of expectations of individual nurses in the remote area, was illusory. As a consequence, care was frequently incomplete.

Incomplete care

The character of *diffusion* was that it imposed on nurses such a wide scope of care that it could not be adequately provided. This contributed to a perception amongst nurses that their work tended to be *piecemeal*, *ad hoc* and *haphazard*. For example, regular follow-up of clients from hospital discharges was often not achieved (for example, chapter 8, pp242-43).

Other factors that contributed to incomplete care were the unrealistic expectations by nurses and other care providers of what could or should be achieved within the time and resources available in the remote area context. This was portrayed, for example, in chapter 8, pp241-44. As a result, most nurses felt defeated by work that was unfinished or that was 'missed' out. Nurses expressed their feelings of defeat, low morale and ineffectiveness in these comments:

- You might be consulting RFDS. You are trying to chase up results. The clinic is open morning and night. When do you get the chance to follow people up? You can't. You are supposed to be doing adult clinic, doing the women's health checks, plus making sure the pharmacy is up to date. Something has got to be missed somewhere along the line. The programs that have been suggested and started, none of them have been finished. Not one of them since I have been here in nine months.
- I don't really know how we can do all the health programs expected of us. Like STD's (Sexually Transmitted Diseases), education of diabetics and mass treatment of trachoma in addition to the daily clinic. If we did all this we would be working 24 hours a day.

Within the general character of *diffusion*, there were varying attitudes amongst nurses toward their role and its responsibilities as well as their limitations in providing client care. Dissension amongst a group of colleagues as to the scope and boundaries of their role, therefore, was not uncommon.

Group dissension

Nurses encountered disagreements amongst their colleagues about the problem of knowing where to 'draw the line' in meeting the demands for all-encompassing care. This group dissension was seen as another consequence of *diffusion*. A lack of organisational guidance for clarifying as well as limiting a nurse's role together with a lack of teamwork for a consistent approach to care between nurses were perceived as a barrier to resolving these dilemmas. This was how one nurse explained the problem:

You don't have the back-up to support the nurse's role. And that is why you put up with a lot more out here. You probably shouldn't. You've got to work together as a team and agree that you will put up

with this to a point and after that if anyone steps over that line no nurse is going to put up with it...You will feel like you can tell a person, 'Sorry, no I am not seeing you. This is not an emergency. It's a condition you have had for a week. You can come in the day time and calling me at 11.30 at night is not good enough'. If everyone agreed you could be fairly confident in saying that. But often nurses themselves have different ideas about what is an emergency and what isn't. What you should see and what you shouldn't. And therefore leaving it wide open to the fact that there is not much support amongst yourselves and you've got to see anyone.

The problem of group dissension as well as the burden of all-encompassing care pertained to a lack of clarification of a nurse's role or agreement of a consistent approach. A major practical consequence of *diffusion* in remote area practice, however, was work overload.

Work overload

The all-encompassing nature of practice, as revealed in the theme of *diffusion*, was a dominant factor contributing to work overload and subsequent feelings of fatigue and stress experienced by nurses. Most nurses who had stayed, therefore, eventually felt less able to manage the day and night demands for their care, for example, when nurses felt anxiety from their inability to attend all the expectations required of them.

The following observation illustrated this point:

A nurse, also acting as nurse in charge, had been on call for a seven day period during which time there were six emergency evacuations.[The nurse had worked eight months in the remote area. Two months were with only one other nurse]. On the next night the nurse had been called out about 1 am and was again called out at 6 am by a knock at her door. The nurse, feeling exhausted, went to the door and told the client to go to the clinic later when it opened. She then returned to bed. Unable to sleep she started thinking, 'There was a baby. I should have seen the baby and not sent her away'. The nurse remarked later in the morning, 'I felt so tired, I was not thinking clearly. I think I'm becoming irrational'.

The accumulation of demands on nurses in space, time and care responsibilities, together with their feelings of exhaustion, also contributed to a feeling of not being respected as a human being. At this point of a remote area nurse's career the meaning of the object 'it' more fully emerged. Nurses seemed to be treated as if indefatigable and, in turn, they experienced feelings of dehumanisation. After two years working in the area, a nurse expressed her feelings about the emotional and physical drain from unabated demands and, by implication, unresolved service problems. In her view it was a cyclical pattern repeated with each beginning nurse. This is what she had to say:

It's such an extremely demanding job and it's quite stressful. People [clients] can get irate if they don't get what they want. It's something I don't handle very well. I feel like instead of getting angry, I feel like just breaking down in tears and pleading, saying 'treat me like a human being, like respect me. Respect that I can't just work 12 days in a row dealing with things that aren't necessary'. I had a thumping headache by the beginning of Saturday morning [when on call], let alone at the end of it. By 7 o'clock [at night] I was exhausted. You open the door to one person [client] and I was crying before that person walked through the door, let alone one hour later when one said, 'I need to have a needle for scabies'. Now the sort of scabies he wanted a needle for he would have had for far longer than one day, so there is no excuse. But you can only bash your head against a brick wall for so long. You either give in and give them [clients] what they want, or you leave. You leave, someone else [another nurse] will come along and they'll go through the same stuff.

The theme of *diffusion* was explained by the attributes of all-encompassing care and the diversity of expectations, together with the problems of 'drawing the line' and its consequences. *Diffusion* is a major contributor to the phenomenon of *amorphous practice*.

Diffusion and amorphous practice

A fundamental feature of *diffusion* was that it appeared to enable the total health care of a community to be undertaken by the only professional group routinely and usually available, nurses. As a contributor of *amorphous practice*, the theme of *diffusion*

revealed the indeterminate and widely spread nature of the nurses' responsibilities for care. It also revealed the impact of this broad scope of practice on the individual nurse's ability to care as a major factor influencing the changeable character of remote area practice. Nurses' role parameters were outstretched to the extent that nurses were compelled to overstep their practice boundaries. Thus, a third theme that emerged from the observational data was an aspect that was considered to be outside the borders of nursing practice. This aspect is described in the cultural theme *beyond the nursing domain*.

Beyond the nursing domain

The theme *beyond the nursing domain* is a contributor to the phenomenon of *amorphous practice*. *Beyond the nursing domain* is defined in this study as a range of practice attributes that are interpreted to be outside the broad domain of nursing. The theme denotes a realm of care that exceeds the parameters of nursing, that is, a practice which is seen as being beyond the repertoire of knowledge and skills of nurses. *Beyond the nursing domain* encapsulates the dimensions of remote area practice that are deemed to be beyond what nursing practice is by tradition and current law in Australia.

The concept of nursing practice is based on a knowledge of professional skilled care that is relevant to the manifold health needs of different client groups. As such it is usual for nursing to be practised in diverse settings and for there to be adaptations in practice accordingly. The practice of nursing is, therefore, dynamic. Nevertheless, nursing practice retains recognisable boundaries of independence and dependence as well as interdependence with other health care providers as expressed in the Nurses Code of Practice 1995, under Section 9 of the Nurses Act 1992 (Appendix 26).

In *beyond the nursing domain*, the practice was not nursing as it is formally conceived. It was considered nursing because it was routinely undertaken by nurses

and/or was delegated to them. Within the remote area context, nurses assumed a dimension of practice that went beyond their professional nursing role. They engaged in a practice that was ungrounded in nursing knowledge and skills. Unofficial sanction for this practice was tacitly communicated via the employer, medical practitioners, clients and between nurses themselves by the day to day expectations as well as in the accepted permissive character of practice performance.

The sense of *beyond the nursing domain* was conveyed by nurses in expressions such as, 'overstepping the bounds', 'crossing boundaries' and 'outside the scope of nursing'. For example, as a nurse stated:

We are overstepping the bounds, making [medical] diagnosis and prescribing drug treatments that are outside the scope of nursing practice.

The theme *beyond the nursing domain* is explored in the features of crossing boundaries - medical substitute, and unregulated practice.

Crossing boundaries - medical substitute

A major attribute of *beyond the nursing domain* in remote area practice was the overlap between nursing and medical practice. Nurses routinely 'crossed boundaries' of nursing practice to perform a medical substitute role. Within a certain range there was an expectation as well as an opportunity for nurses to 'diagnose', 'prescribe' and 'dispense' drugs and 'treat' clients as a doctor would. For example, decision making by nurses routinely pertained to a 'medical diagnosis' and 'prescription' of drug treatments (chapter 7, pp189-92, & pp198-99). Medical practitioners with the RFDS acknowledged this unusual expectation and sometimes the difficulties involved, but did not question its legitimacy or safety, as seen in this quote:

I think that initially probably nurses out here should ring up every time they prescribe drugs. Really in a probationary period that should be the rule so that you [nurse] can get a feel for what to give out and people can get to know your capabilities. Because it is such a change. One day [in a hospital] you follow instructions and check every drug with someone else. Next time [out here] you are on your own. It must be

difficult.

Medical practitioners often expected nurses to make medical decisions on their behalf, such as observed in incomplete medical orders for drug treatments. An example was the imprecise orders written on pathology results (as described in chapter 8, p274). Such orders implied that a nurse should have the relevant medical knowledge to select a drug and to prescribe an appropriate dose for a client.

In *beyond the nursing domain* the assumption of medical responsibilities by nurses crossed the legal boundaries of both nursing and medical practice. A paradox observed was that the medical substitute role crossed the borders of nursing and of medicine but was neither nursing nor medicine. Nurses undertook a medical substitute role despite the concerns expressed by them. These concerns included their lack of relevant medical knowledge, the legal barriers to practising medicine and their independent responsibility for the outcomes of client treatments. In the misty outlines of *beyond the nursing domain*, betwixt and between nursing and medical care, nurses felt their way through a process of trial and error. The following frank quote by a nurse portrayed this point of view:

I told the doctor this person came in and I treated them with this and this. But he said, 'Oh you could do it that way, but a better way would be ___, and he told me what I should have done. I thought, 'Right, this is where I have overstepped the mark. Next time I will make sure. This is not something I am going to do when you have got no-one else here. You have got to ask yourself before you decide to give a drug, 'How can I justify the use of this drug?'

Most nurses tended to accept a medical substitute role, styled on a perception of general practice, as normal in remote area practice. By the same token, there were nurses who also tended to accept without question the 'cost' of nursing care foregone. For example, this tendency was conveyed indirectly in the quote below:

Most of the time in the clinic we are doing GP (General Practitioner) work, not nursing work. We are out here as substitute GPs. By the time you've done that there isn't time for health education and health

worker education. We are too busy putting on bandaids.

The following observation also illustrated this tendency to assume a medical substitute role, according to a nurse's individual judgement of what the role entailed:

A nurse consults a medical practitioner for treatment of an elderly male client who has presented for the first time with an extensive burns injury sustained more than two weeks previously and that is now infected. Flucloxacillin is ordered, '1 Gram stat. and 500 mg. 6 hourly'. No route or duration is specified. The nurse, without further consultation, decides to give the stat. dose intravenously, 'because it is more effective'. He then adds, 'I'm going to take U and E's, Creatinine, FBC, WCC and differentials, LFT's, Albumin and Protein'. When asked by another nurse, 'Why so much?' the nurse replies, 'Well, he is also a drinker and may have kidney damage. It's an oldies check as well'. On the pathology request form in the history section the nurse lists, 'Burns, Cachexia, Alcoholic'. 'I didn't know he was an alcoholic', comments the other nurse. The nurse then says, 'I don't know, he drinks a bit'.

The medical substitute role was circumscribed by the varying degree of authority medical practitioners were willing to concede to remote area nurses. For example, a nurse asked a medical practitioner for his view of nurses initiating intravenous drug therapy without a prior medical order. He expressed his disapproval in this reply:

Intravenous antibiotics are only for acute illness. The nurse should discuss it with me first. Nurses who give intravenous drugs without the doctor being consulted take the responsibility on their own shoulders.

Similar disapproval was portrayed in the following comment by a medical practitioner on what he perceived as an inappropriate use of pathology by a nurse. This was what he had to say:

I had a run in with B___ [a nurse]. She took more blood tests than anyone else. I don't know where these people [nurses] get these ideas of what they should do, but we should know what is going on.

Arbitrary factors, such as time and the situation, also determined a nurse's medical substitute role in remote area practice. For example, when a medical practitioner

visited a clinic, and based on the limited time he or she was available, nurses acted as an 'assistant' to the medical practitioner in order to speed up the throughput of clients to be examined. The mutual acceptance of this changeable role relationship was described in chapter 8 (p237-39). The crossing over and returning to traditional role boundaries, seen as normal in the remote area, was described by a nurse as follows:

Out here the boundaries between doctors and nurses role can be altered. What is done to make it work in the cities [the delineation of roles] may not be appropriate out here. Like in Warburton the RFDS only allow three hours for the clinic. The doctor needs the assistance of the nurse to get the job done, for example, taking pathology specimens and filling out the pathology request forms. The factor is the time span.

The crossing of role boundaries back and forth in situations such as a medical clinic was also considered by nurses to be convenient for themselves as well as for medical practitioners. For example, as this nurse explained:

We slip into the role of the handmaiden nurse when the doctor comes in. Its a convenience. You are doing it to make your life easier. The problem - the nurse gets the patient seen by the doctor because the nurse knows that a diagnosis or further investigations are needed. It is the nurse who continues to be faced with the health problem of the client.

In *beyond the nursing domain* the nurses' role in pharmacy supply was a particular aspect that was seen to be linked to the medical substitute role, and to exceed the bounds of nursing practice. Nurses routinely undertook an independent responsibility for the storage and usage of restricted therapeutic drugs as scheduled under the Western Australia Poisons Act, 1964. These responsibilities for drug use included possession, control, supply, dispensing and prescription as well as administration. For example, as described in instrumenting care: keeping track, a large array of drugs were stored at the nursing post in the total care of nurses (chapter 8, pp261-68).

Overstepping the boundaries into a medical substitute role, including aspects of pharmaceutical practice, was the dominant feature of *beyond the nursing domain*. The

unofficial role substitution also appeared to relate to a further characteristic to emerge in the theme of *beyond the nursing domain*. The tacit approval of nurses practising beyond the domain of nursing, and therefore an assumption that this was outside its rules, contributed to a notion that practice in the remote area was 'unregulated'.

An 'unregulated' practice

The isolation of nurses from professional and organisational structures which sustain nursing practice left it wide open for nurses to practise beyond their professional boundaries. Within this context, an attribute of *beyond the nursing domain* emerged where practice in a remote area was seen by nurses as 'unregulated' and 'outside' of nursing regulations. Nurses expressed this perception as follows:

- The practice is unregulated. What we do is not subject to or guided by the regulations of nursing practice... You might feel like you are a law unto yourself and that you are out of reach of the authorities, but I think that is false. We are still governed by the Nurses' Board, but also practising outside of the regulations.
- It is self directed without regulation by anybody else.

Several nurses seemed to interpret a lack of explicit constraints for practice in the setting as 'autonomy' and independent of professional and regulatory restrictions. The following quotes were an expression of this idea:

- The satisfaction for me is all the autonomy and self-reliance. For me autonomy means self-regulation, really knuckling down on myself so I don't get megalomaniacal about my own skills and knowing where my limits are and regulating myself. Its that sort of autonomy where I can make decisions myself, be it legal or not, then act on those decisions that I have made to a conclusion.
- I enjoy the independence you have got out here and the decreased interference of someone saying what you can and can't do.

Nevertheless, other nurses viewed this assumption of autonomy as being outside the

domain of nursing practice. These nurses perceived that such an assumption was deceptive. In reality, it pertained to situational necessity and individual attitudes rather than professional authority. Nurses expressed this view as follows:

- I don't think autonomy here relates to nursing practice. I don't really think the autonomy has anything to do with nursing practice. It's how you look at yourself. It's that you have to be self-sufficient.
- Autonomy here is by default. Autonomy in this setting is being self-directed without regulation.

Individual nurses' differing ideas on unofficial authority to practise autonomously, and a commonly held belief that there was lack of regulation for practice in a remote area, were important factors contributing to the variability of their care. It resulted in nurses adopting a range of strategies to deal with their situation and in an endeavour to feel a sense of control in a practice *beyond the nursing domain*.

Striving for control beyond the nursing domain

The strategies used to deal with practising *beyond the nursing domain* were seen as nurses striving to attain a sense of control for practice. Its enactment varied according to the perception of what needed to be under control by a nurse or group of nurses practising at the time and according to their perception of pressures imposed on them to conform to role precedents. A lack of a formal framework and leadership for practising outside the boundaries of nursing contributed to the use of individual interpretations of control within the setting. In the theme *beyond the nursing domain* there were various ways that nurses strived for a feeling of control in practice. These strategies, as described below, included the use of caution, identification with a medical role, and referral.

Use of caution

Most nurses felt vulnerable in crossing boundaries to assume an independent

responsibility for a client's medical care and treatment. Nurses who perceived that they needed to safeguard clients from adverse outcomes, as well as to safeguard themselves from legal liability, tended to be cautious in assuming a medical substitute role. For example, a nurse described how she deliberately avoided stating a client's diagnosis, but focused on presenting detailed signs and symptoms in a medical consultation. The nurse explained this use of caution as follows:

If you stick to only your clinical findings and observations and the presentation of the person [in a medical consultation] you are talking about what you know.

Nursing maturity was also observed to be a factor in nurses' use of caution in assuming medical functions for client care. A nurse, who was formerly a clinical nurse consultant in a major metropolitan hospital, remarked:

Some people [nurses] seem to be confident, but to my mind they don't consider carefully the consequences of their actions [in using medical interventions]. People like me with a different experience prefer to tread more warily.

Acting judiciously was another caution used by some nurses in striving for a sense of control in practising across boundaries. For example, several nurses when undertaking responsibilities for which they lacked preparation or felt were outside their practice domain reported that they used their personal judgement as a guide to reasonable action. The following statement by a nurse who had responsibility for women's health, but lacked previous education and experience relevant to this position, illustrated this point:

I have had no formal training on women's' health. So I am only trying to do what I think and how I would like someone to do it to me.

Individual nurses devised a strategy of caution to guide them in making medical decisions or in assessing the responsibilities they were willing to undertake *beyond the nursing domain*, for example in performing a medical assessment or for deciding a client's medical treatment. The following quote explained this view:

I have a system with kids [for a medical assessment]. I always do the basics. I try never to forget, when I think I have finished I say, 'Did I do this, this and this?' Then I might think, 'Oh no, I forgot that!' You have got to look at everything because if you don't you might miss something. I don't administer drugs to kids without a very good reason or without permission.

Caution was a strategy used in striving for a sense of control amidst the recurring conflicts experienced in practising betwixt and between nursing and medical care. It was an attempt by individual nurses to conform to behaviour learned in previous nursing education and experience whilst practising across the boundaries between nursing and medicine. There were nurses, however, who tended to adopt procedures for client care according to their observation of medical practice and were observed to identify with a medical role.

Identification with medical practice

One strategy taken by nurses as they strived for a sense of control in *practice beyond the nursing domain* was an identification with medical practice. In the performance of a medical substitute role these nurses adopted the manner of medical diagnostic and treatment behaviours characteristic of medical practitioners. Since most nurses had previously worked in an acute hospital setting, this also appeared to influence their perception of how medicine was practised in a general medical practice as well. For example, several nurses believed that 'because that is what is done in hospital' the use of medical treatments, such as the routine use of intravenous therapy, was appropriate in a remote area. Other nurses, however, believed that such courses of action were inappropriate 'because we are not in a hospital here'. This point was illustrated in a conversation where a nurse was recounting a day's events to another nurse. The events included treating a client who was involved in a vehicle accident. Part of their discussion was as follows:

The nurse states, 'We tried to get an IV (intravenous) up. B___ [nurse] tried and it went into the tissues. So I knew if he couldn't succeed I wouldn't be able to do it. If K___ [client] had been brought to Casualty

he would have had an IV (intravenous) and Xrays. He would have had that in hospital'. The other nurse then remarks, 'Yes, but we are trying to provide a service without the backup and staffing and expertise available in an acute hospital situation'.

Several nurses appeared confident in crossing the boundaries of medical practice. They identified with a medical role in that they imitated medical practice behaviour and, regarding themselves as acting 'like a doctor', behaved accordingly. For instance, these nurses used terms like, 'doing a renal work-up' or 'doing a diabetic work-up' that identified with a medical perspective of care management rather than a nursing perspective. Identification was also observed, for example, in the manner of client consultation in which a nurse sought a medical diagnosis and medical treatment for a client's health problem. The following quote (previously stated at p195) illustrated the manner of nurses' identification with a medical role, as well as their concept of what the limitations were for a nurse in the remote area:

I'm quite happy to diagnose and treat chest infections, UTI's (Urinary Tract Infection) and things like that. No worries. If they need more than Amoxil, they need some sort of antibiotic like Ceftriaxone or some proper management and it is something more complicated beyond my skills, I will involve the RFDS... Or if I think someone could be getting sicker down the track I give RFDS a brief early on.

Nurses used their individual discretion as to when they could perform medical functions, or when reference to a medical practitioner was needed, or when to redirect inquiries that they perceived as being outside their scope of practice. A group of strategies, jointly described as referral, were also used as a way to strive for control in the management of practice problems perceived as *beyond the nursing domain*.

Use of referral

Referral was a way of striving to deal with problems that nurses perceived were beyond their nursing knowledge and abilities or authority. A few nurses recognised

that, quite apart from their capabilities, clients were entitled to a medical opinion for their health care. Most nurses, however, only referred to a medical practitioner for advice to deal with problems pertaining to a client's medical care that they had assessed was beyond their ability, for example the use of a routine medical clinic to refer clients to a medical practitioner for their opinion and /or advice. Nevertheless, the assessment of the need for such a referral sometimes pertained to a nurse's perception of his or her competence in a medical domain rather than in a nursing domain. The following statement reflected such a view:

When you come to the conclusion that a [medical] diagnosis or a [medical] treatment is beyond your limits, who do you call for? The only one in the day to day life of things is the RFDS. They are the ones who will be able to direct you in the situation because it is beyond your skills at the present time.

In addition, several nurses referred to text and other reference books to acquire information they perceived as relevant to the performance of a medical substitute role. They also referred to medical practitioners for medical knowledge as needed in their practice. These aspects of referral to sources of medical information were described in learning remote area nursing (chapter 6, pp172-74).

In striving for control over practice *beyond the nursing domain* nurses also sought to 'protect' themselves from liability, for example the routine referral to the CARPA Manual, as approved by the organisation, to assist them in making decisions pertaining to medical diagnosis and medical interventions. Some nurses perceived that adherence to this Manual was a way to 'protect' themselves from culpability when providing care that was beyond their individual level of competence and/or outside the domain of nursing. This notion of being able 'to protect yourself' regardless of adherence to a standard duty of care, however, appeared to be based on misleading hearsay rather than an informed legal opinion. Nonetheless, reference as well as documentation was seen by most nurses in the remote area as the main way to deal with the reality of practising across boundaries. This was seen in the nurse's statement that follows:

We really are the vanguard of medical care...To protect yourself [from legal liability] you need to follow the CARPA Manual to a T, document everything back to front and upside down and use the RFDS as much as you can. If you are unsure about something, ring up the RFDS

Similarly, most nurses perceived that 'covering yourself' afforded legal protection. 'Covering yourself' was enacted by nurses in various ways of referral, such as to document and report a treatment and/or to defer to a medical practitioner by notifying them of a client's condition. For example, a nurse had previously initiated and administered an antibiotic medication to a child who had symptoms of a chest infection. Her reason for consulting a medical practitioner was stated as follows:

The child is not obviously sick enough to be evacuated, but being mindful of legalities I feel I have to cover myself by telling the doctor about this child and what is going on.

Nurses also referred by telephone to other relevant service providers for advice, as and when available, for dealing with situations they perceived as outside their scope of practice. Additionally, most nurses when asked by an external agency for medical information that pertained to a client, directed the enquirer to speak with a medical practitioner. Usually these requests were for a client's medical history or for a nurse's opinion of a client's medical status. For example, as illustrated in this request to a nurse for information:

A police officer telephones from the police post and speaks with a nurse. The police officer asks the nurse the nature and extent of injuries to a male client who had been recently assaulted with an axe. [The man who committed the assault is detained in police custody at the police post and faces a possible charge of attempted murder]. The police officer also asks if the injury could have been fatal. The nurse replies that she does not know the extent of the injury. She adds, 'There was a blood clot but I did not dislodge it. Any injury with haemorrhage is potentially fatal'. Without further comment, the nurse then advises the police officer, 'Contact Kalgoorlie Regional Hospital for a medical report on the man's injury'.

The success of these strategies, where nurses strived for control in a practice *beyond the nursing domain*, was limited. The persistent nursing problems of practising beyond their professional scope, as was tacitly expected of them, seemed insurmountable for these nurses alone. Nurses encountered recurrent difficulties in performing in an ungrounded and informal area of practice that exceeded the boundaries of nursing.

Difficulties beyond the nursing domain

The difficulties in *beyond the nursing domain* pertained to practising without the dependent and interdependent relationships with other health carers that are usual to nursing settings. The problems for nursing practice that emerged included role contradictions, a confusion of priorities, anomalous practice and the nurses' accountability.

Role contradictions

A major difficulty of *beyond the nursing domain* was the role contradictions between practising within the boundaries of nursing and crossing these boundaries to perform a medical substitute role. This appeared to be so because there were no clear goals or formal guidance available to nurses as to their practice domain and its boundaries in the remote area.

An important aspect of role contradictions was seen in a displacement of nursing care for medical cure, for example the problem of nursing care being supplanted by medical interventions as described in decision-making for remote area practice (chapter 8, p194). Nurses often related the displacement of nursing to time limitations and to service expectations. It seemed to these nurses that a nursing role and their medical substitute role could not exist simultaneously. This point was illustrated in the views expressed by these nurses:

- The observations are nursing care...Then doing the actual treatment

is nursing care...But often you are just doing the diagnosing and the treating and hoping they will get well soon so you can see the next people who are waiting to be seen. So nursing care in that area can be sacrificed because of a lack of time.

- We are here as a pseudo group. We are here to be the extension of the doctor, and we only do nursing care after medical work. In reality we are not given time to nurse.
- RFDS doctors ask you what do you think it is and they are not always listening to your nursing assessment. It's easy to fall into a medical diagnosis instead of a nursing diagnosis
- There is a strong medical orientation in the way the clinic is set up...We are really the vanguard of medical care. It's very hard to combine nursing care with the medical care. The expectations of the mob [people] here are such that they are wanting a certain treatment and have expectations that are very medically orientated.

In consequence, the reality for these nurses was that their primary practice role was seen as medically orientated. This tended to overshadow consideration of nursing care needs. Nursing care was, therefore, displaced when medical treatments were used as a first-line of care. Paradoxically, nurses use of medical interventions tended to increase a client's need for nursing care. Furthermore, medical treatment was at times less appropriate than nursing care for a client's well being in the remote area context.

These seeming contradictions in remote area practice, peculiar to the theme of *beyond the nursing domain*, were illustrated in the following observation:

An adult male is brought to the clinic. He has a history of cardiac and renal health problems and is assessed by a nurse as being 'dehydrated'. This information is conveyed to a medical practitioner by telephone consultation and intravenous therapy is ordered. The client, however, is able to tolerate oral fluids. A nurse who has participated in the care of this client later reflects on the appropriateness of the care given. She comments, 'I spoke to the doctor about the patient and he asked that I put a drip in and run a litre of fluids over four hours. The patient was actually tolerating oral fluids and in the time I got a litre in, about six hours, the patient had also drunk about 850 mls. And yet - we didn't - we should have rung the doctor back and said, "The fellow is drinking okay, we can push oral fluids"', which is a nursing intervention as opposed to a medical intervention. The nursing intervention is a much safer way to go. He would be rehydrated in a much gentler fashion

than in a sudden rehydration with a litre over four hours going straight into his veins. When we have no idea what his electrolyte balance is or anything and I don't know the cause of his dehydration or if he is really going to respond well to IV (intravenous) fluids. His urine output had started to pick up before he had had 100 mls. of intravenous fluid. I don't think he really needed the drip and in this instance, I don't think it was well managed. So really and truly the medical intervention in this instance was inappropriate. Well, for the half an hour we spent running around with a drip trolley and running [intravenous] fluids through, and having a couple of goes to get the drip in the vein, we probably could have got 200 mls. of fluid into him straightaway, if we were just nursing him as opposed to the medical emphasis. Then after I got back from lunch, I noticed that the urine output was not measured or tested. Nothing was recorded on the fluid balance chart. How could we overlook the most basic things?

Role contradictions, evident in the policy of the health service, pertaining to the overlapping boundaries between nursing and medical practice together with a lack of medical support for a nurse's legitimate role, left most nurses in a quandary. For example, these nurses (previously quoted at p203 & p225) described this dilemma as follows:

- One of the new nurses got told that CARPA Manual is an unwritten doctor's order. That's garbage. We are all supposed to follow that because we work in a remote area. But legally 90% of that stuff we should not be doing and we know that. But what do you do? If you are going ring up RFDS all the time when we need [to give] something, they are going to say, 'Oh there is that stupid Sister again'. And they won't take any notice when you really do need help. So what do you do?
- As a nurse you are supposed to stay within your legal boundaries and ring up the doctor when necessary. Then you've got CARPA (Manual) which is the policy of the health service. It's not really legal if you get down to it. But you don't want to be thought of as someone who will ring up [the doctor] at the drop of a hat. So you are trying to negotiate all that as well. That also gets a bit stressful.

Most nurses felt that they had few, if any, choices about assuming responsibility for

undertaking medical functions because they were a solitary care provider in the remote area. In consequence, the moral dilemmas posed by the contradictions of a practice *beyond the nursing domain* appeared to be put aside. A nurse explained this avoidance as related to the 'limits' in choice available for nurses in a remote area:

I think you do it [give out drugs] because of the limits of where you are. We don't have another choice. You can't have a moral think about it, saying I'm not going to do that because it is wrong. If you are it [the only health professional available], within a 200 kilometre radius what are you going to do? You get into the situation because of where you are and how remote you are. And whether it goes against your ethics and morals or not, you do it.

These role contradictions, as a consequence of *beyond the nursing domain*, also related to a confusion of priorities for care performance in the remote area.

Confusion of priorities

A further difficulty for practice *beyond the nursing domain* was the confusion of priorities between providing nursing care and undertaking tasks of medical intervention. The variations in nurses' perceptions of their objectives for care and of their scope of practice in a remote area also contributed to this difficulty. An example of this problem was seen in the priority of one nurse to prescribe an antibiotic treatment and for another nurse to use nursing measures for the care of a child with a skin infection (chapter 8, p219). Another example was the treatment priorities for skin infections as directed in the CARPA Manual as opposed to the views of a group of nurses about their nursing priorities for care management (chapter 8, p202). These recurrent difficulties pertaining to a confusion of priorities were also illustrated in the following observation:

A client, recently on long term chemotherapy, had fallen and injured her shoulder. A nurse consulted the RFDS medical practitioner who stated that 'an Xray needed to be done'. [Whether the client's recent history of chemotherapy treatment was reported is not known.] Another nurse then questioned the use of an Xray in view of the recent chemotherapy treatment. The nurse who had consulted, however, ignored the nurse's concerns and said, 'It's easy. I know how to do Xrays'. Two days later a visiting medical practitioner reviewed the

client and saw the Xray film. He commented, 'It's over-exposed, but she should not have another Xray'.

In a hazy area of practice *beyond the nursing domain* the confusion of priorities between a nursing and a medical substitute role was an recurrent problem. A further factor that pertained to this difficulty was the anomaly of practising *beyond the nursing domain*.

Anomalous practice

Within the context of *beyond the nursing domain* a major anomaly for nursing practice was seen in nurses' perception of practice in the remote area as 'unregulated' or 'self-regulated'. Individual nurses attempts to comply with the formal regulations of nursing practice were thwarted by a lack of structural controls to support them. This appeared to lead to nurses' frustration, self-doubt and sometimes a feeling of despair. Anomalous practice was entrenched in the system of health service delivery in the remote area and viewed by nurses as beyond their individual capacity to resolve effectively. These feelings were portrayed in the following quote:

You don't even have the autonomy to say no, if I don't agree or don't approve or I don't think it is the right way to do things as a nurse. So when it's a serious issue, like whether it's ethical to go out to people's homes, gathering people up, asking for urine specimens or for blood specimens or whatever, you don't feel that you have any control over practice then.

In *beyond the nursing domain* nurses felt that they were unable to control their practice and, furthermore, that this practice also appeared to be uncontrolled by the authorities. In this situation their accountability for nursing care was a fundamental problem.

Accountability for practice

The notion of practice in the remote area as 'unregulated' or 'self-regulated' appeared to be associated with a lack of external accountability for acute care as well as for routine day to day care. At a meeting held in Warburton with a visiting Australian Nursing Federation officer the issue of accountability for remote area practice was discussed. During this discussion, most nurses acknowledged the difficulty of their accountability for practising outside the scope of nursing. Fewer nurses, however, appeared to appreciate the essential nature of nursing care together with their independent accountability for all the care they administered. The latter concern was illustrated in this quote:

I can't be held responsible if there is no alternative but to undertake a client treatment outside the scope of nursing.

Later that day this nurse confided, 'the matters raised at the meeting were quite stressful for me'. A glimpse of the hidden costs for consideration in a practice *beyond the nursing domain*, both for nurses and for nursing practice, was revealed in this nurse's remark about her professional predicament:

I felt stressed thinking about what I should do, whether I'm prepared to put my nursing future on the line. Not only may I not gain anything by staying, but I may lose everything.

In the perception of several nurses a lack of external accountability was a dominant issue. These nurses attributed this difficulty to their isolation as well as to the Aboriginal clients lack of awareness of their rights to health care. A nurse expressed this point of view as follows:

Accountability out here is a big worry because we are so isolated. I believe that these people [Aboriginal clients] deserve the same treatment, the same accountability as we [nurses] would give anybody else anywhere. And that's not happening. But these people don't question their rights.

Nurses tended to vary in their attitudes towards accountability for practice. Some nurses appeared to believe that circumstances in the remote area sanctioned them to practice autonomously and *beyond the nursing domain*. In contrast, others expressed feelings of vulnerability for censure especially when not practising within the domain of nursing. These difficulties of practice that emerged in the theme of *beyond the nursing domain* revealed another facet of *amorphous practice*

Beyond the nursing domain and amorphous practice

The theme *beyond the nursing domain* encompassed dimensions of a practice in the remote area that were considered alien to nursing practice. In this sphere of misty outlines, where the boundaries of nursing were stretched beyond the limit, practice was seen by nurses as 'unregulated'. The cultural terms, 'overstepping the bounds' and 'crossing boundaries' in routine remote area practice conveyed their sense of movement away from formal nursing parameters and across to a medical substitute role. The theme *beyond the nursing domain*, together with the themes of *detachment* and *diffusion*, are inter-related and seen as contributors to the overall theme of *amorphous practice*. A clue to the theme of *amorphous practice* as revealed in the culture of remote area nursing was given in the expression 'doing your best' as a way of practice.

Amorphous practice: 'doing your best'

The amorphous shape of practice in the remote area setting was depicted in the recurrent expressions of 'doing your best' such as, 'You do your best' or 'I can only do what I can do'. Each nurse 'does their best' as they perceived it to be in a context of isolation, with a lack of resources and where nurses were on their own as health care providers. That is, nurses compromised their individual professional limitations and the parameters of nursing practice in a belief that 'you do your best' and 'do whatever you can do' in order to provide a service. The following quotes were an

expression of the nurses' reality:

- I had a head injury situation. So you are on your own and wondering if you can do an assessment alright and get it right and hope that things go smoothly. And when you don't you are a bit more nervous. Like when, for example, you have to put a drip in that you have never done before and it doesn't go in. That's when it gets a bit nerve racking, because you feel everyone is relying on you. So you have to do your best, but it can be a bit nerve racking
- It (nursing) is a very - it's a hodge-podge. That's all I can explain it as. Wherever I have been as a remote area community nurse it has always been a hodge-podge. You go to work expecting to do one thing and someone walks through the door and takes eight hours and then it's next day. Everything has to be flexible. I guess the mind-set you have to get yourself into and work with is so totally different. It's a mind-set where you will have plans but those plans are almost timeless. If it doesn't happen you don't berate yourself. You know there have been extenuating circumstances. It's the nature of the game. You have to have a coping mechanism. If your coping mechanism is rigid, I'm sure that rigidity gets broken down because that's just the way it is. And you just have to keep up with it, do your best and whatever you can do. And you still have to maintain in your mind that what you are doing is as legal as you can make it and as ethical as you can possibly make it.

The notion of 'doing your best' was influenced by each nurse's attitudes and abilities as well as their divergent perceptions of the nursing role within the remote area context. The sub-conscious meaning of 'doing your best' was that remote area nursing was what each nurse could make of it according to their individual capabilities and conscience and with the limited resources available to them. It intimates nurses deep-seated feelings of inadequacy and disquiet where, in providing care under less than ideal circumstances, they would say, 'doing my best was all I could do'. 'Doing your best' was also expressed to rationalise ways of practice that nurses knew, or ought to have known, may be legally indefensible (Staunton 1992).

The care of clients depended on the varying abilities and the ingenuity of individual nurses and their interpretations of what was required. Such a practice was amorphously shaped and difficult to evaluate because it was inconsistent. This, in

turn, was due to a lack of adherence to predetermined standards, or the non-existence of relevant standards. Nursing practice appeared to be devoid of a plan or an objective system of nursing responsibility in a remote area. Nurses did not have a shared professional knowledge base or conceptual understandings of what remote area practice ought to be.

Nurses, in a context of isolation and under conditions which merged their private and work life, 'do their best' and 'do whatever they can do' to provide health care. They acted as substitutes for medical practitioners, pharmacists, other social and health care providers and service managers who were not usually available in the remote area. Nurses individually 'do their best', 'coping' with a seemingly improbable (to an outsider) array of demands and expectations in a context where they lacked the organisational and professional support needed to safely and effectively provide client care. They did what they believed was 'their best' amidst a practice situation that appeared to be irrational.

The pervasive notion of 'doing your best' was also found to characterise the outlines of remote area nursing practice in other written documents. For example, Philp (1988, p1) summarised remote area nursing as follows:

Remote area nursing has always been one of 'do the best you can' situations with staff expected to cope with a wide range of duties and at times a number of almost impossible situations with a greatly depleted reserve of facilities, staff and knowledge.

As another example, at an address to a State nursing conference a remote area nurse recounted her experience before the law courts for alleged professional misconduct (Heathcote 1991). The nurse concluded with this statement:

When we are doing our best with very little and often with little support from our superiors, please recognise how much responsibility we have on our shoulders, as RANs (remote area nurses) are quite useful.

The expression 'doing your best' and similar sayings in the culture of remote area nursing summed up the overall theme of *amorphous practice*.

Summary: amorphous practice and its tributaries

The contributors to *amorphous practice* in the remote area were revealed in the three distinct cultural themes of *detachment*, *diffusion* and *beyond the nursing domain* (figure 9.1, p283). These themes were inter-related and seen as tributaries of *amorphous practice*. Each tributary had distinctive characteristics and revealed a different aspect for explaining the phenomenon of *amorphous practice* as it occurred in the setting. Isolation emerged as the main underlying feature influencing the culture of remote area nursing.

In *detachment* nurses felt that ‘no-one sees’ their practice. They experienced a sense of alienation in their transition and adaptation to the isolated setting. At the same time they also learned to accept the variant rules of remote area practice. *Detachment* was further revealed in the lack of oversight or control by the employer, or the profession, for the enactment of practice in the remote area. To deal with *detachment* nurses themselves interpreted what their practice could or should be for client care. The practice, therefore, changed according to individual nurse’s attitudes, motivations and abilities and the situation. It was also influenced by expectations that were communicated to a nurse in interactions with other health carers and/or clients. These features of the theme of *detachment* were seen as contributors to *amorphous practice*.

The theme of *detachment* was inter-connected with another theme termed *diffusion*. Isolation together with a lack of control or direction ‘allowed’ a *diffusion* of the nurses’ role to happen. *Diffusion* described the indiscriminate spread of practice in the remote area. Assertions such as, ‘I am it’, ‘It all falls on me’ and ‘There is no cut off point’ revealed the relationship of work performance, space and time to the all-encompassing nature of care. The theme of *diffusion* also illustrated the irregular and broad parameters of nurses’ responsibility in remote area practice. In this context the nurses’ actual practice was stretched to the limit. How nurses in varying individual ways responded to unwieldy, and often unrealistic, role expectations was an important factor in the making of *amorphous practice*. The themes of *detachment* and *diffusion*

linked together with the theme of *beyond the nursing domain*.

The contributing theme, *beyond the nursing domain*, revealed how nurses in the remote area felt compelled as well as had the opportunity to exceed the boundaries of nursing practice in the manner of day to day care they provided. This theme was encapsulated in nurses' assumptions of their practice such as, 'overstepping the bounds' or 'crossing boundaries'. It implied that their role was stretched beyond the limits of their professional boundaries into an obscure realm, outside the domain of nursing and beyond the scope of nurses' control. There was also a perception amongst nurses that the practice focus was medically orientated, 'unregulated' and lacked external accountability. This feature as revealed in the theme of *beyond the nursing domain* was a major contributor to the unstable and inconsistent nature of *amorphous practice*. In a context of isolation, *amorphous practice* was characterised by nurses' cultural value of 'doing your best' to provide a health service with limited resources and according to their individual knowledge, attitudes and abilities.

The substantive theory of *amorphous practice* together with the tributary themes of *detachment*, *diffusion* and *beyond the nursing domain* provided an explanation for how nursing was practised in the remote area. In doing so, it also revealed an insight for understanding why nursing in the remote area appeared to be so different from nursing as it is generally practised in other settings.

CHAPTER 10

CONCLUSION

*Our... conclusions must stand the test of empirical reality, but
we should make good use of the knowledge we accumulate*

Robert Elias (1986)

Introduction

In this ethnographic research the researcher described, explored and analysed nursing as it was practised within a remote area setting. The exposition was a portrayal of the everyday reality as experienced by remote area nurses and the meanings it had for them in their practice. A narrative account described the setting and how nurses learned to practice, their decision making and the organisation and implementation of care. The overall theme that emerged from this naturalistic inquiry was *amorphous practice*. The theme of *amorphous practice* encapsulated the changeable shape of practice. Contributing themes, termed *detachment*, *diffusion* and *beyond the nursing domain*, explained how this practice was formed within the setting.

The practice of nursing was made visible through a prolonged observation of the day to day practice of nurses as it was ordinarily performed. The knowledge uncovered in this study has allowed a deepened understanding of what it meant for nurses to practise in the context of a remote area, isolated from professional and organisational structures. This study provided a way of seeing beneath the surface that tends to be 'more than mere perception allows' (Clough 1992, p41).

This in-depth study has revealed the potential, as well as the anomalies and contradictions, for nursing practice in the remote area setting. Nurses were seen to play the pivotal role in day to day care delivery. Working with Aboriginal people in a remote area tended to be a rewarding and satisfying experience for these nurses, in spite of the shortcomings and difficulties encountered. As seen in this study, however,

the recurrent discrepancies between formal nursing practice and the expectations of practice in the remote area were a major barrier to nurses fulfilment of their professional duty of care. By the same token, the rights of clients to a reasonable standard of professionally competent care were also jeopardised.

The findings from this study are a stimulus to broaden the inquiry into the practice of remote area nursing and its part in health care delivery to isolated Aboriginal communities. The central question is where to proceed from here? In this concluding chapter the implications of the study and the significance of its findings for nursing practice are discussed. Finally, further research is proposed to investigate more fully some of the basic problems evident from this study for professional nursing.

Implications for nursing

The findings revealed in this study have major implications for the integrity of nursing practice to predominantly Aboriginal populations in remote areas. Accordingly, pertinent questions need to be asked. The questions posed are relevant to nurses, to the nursing profession, to clients, to other health care members, to health authorities and to governments at a state, territory and national level.

It needs to be asked whether the phenomenon of *amorphous practice* is peculiar only to Warburton. Could it also occur in other remote areas of Australia as well as overseas where there are indigenous populations? Why is it that Australian literature presents only the fringes of problems encountered by remote area nurses, such as educational needs, lack of support and expansion of their role, whilst the fundamental issues of actual nursing practice are mainly overlooked? (Cameron-Traub 1987, Philp 1988, Kreger 1991a, 1991b, 1993, Brown 1991, House of Representatives Standing Committee on Community Affairs 1992, Buckley & Gray 1993, Cramer 1993, Australian Health Ministers' Advisory Council 1994, Australian Nursing Council 1994, Baker & Naphine 1994, Nurse Education Review Secretariat 1994, Bell, Chang & Daly 1995, Siegloff 1995, Nursing Review 1997, 1998). More importantly,

why has this practice remained hidden for so long? Is it because remote area nurses have remained silent, or silenced? Could it be that the extraordinary complexity of practice and its difference from nursing as it is customarily performed made it too difficult to unravel and for a more complete portrayal to be written? Could it be that the extensive time involved in observing day to day practice of nurses within the remote area setting has prevented this knowledge from being revealed? Or to a more fundamental question, why does nursing practice in a remote area need to be revealed?

Other authorities as well as the nursing profession have a public responsibility for remote area health care. There is a need for a concerted effort by health care professionals, government authorities as well as Aboriginal groups to investigate the complex problems of service delivery within a remote area. Significantly higher rates of morbidity and mortality among Aboriginal people in remote areas, in comparison with the general population as well as in comparisons with other Aboriginal population groups in Australia, have been documented repeatedly over an extended period of time (for example, Tatz 1972, Moodie 1973, House of Representatives Standing Committee on Aboriginal Affairs 1979, Royal College of Ophthalmologists 1980, Lincoln et al. 1983, Thomson 1984a, 1984b, Munoz et al. 1992, Veroni, Rouse & Gracey 1992, Bhatia & Anderson 1995, Mathers 1995, Plant, Condon & Durling 1995, Somerford et al. 1995, Australian Institute of Health & Welfare 1996, Australian Bureau of Statistics 1997). Paradoxically, whilst this extensive documentation reveals a pattern of high morbidity and mortality, there remains a poor knowledge or evidence of scrutiny of the health care given in remote communities and its outcomes for Aboriginal people. The questions prompted from the substantive findings of this study indicate a pressing need for further inquiry into these and other 'core problem' areas of health care practice and its structures as advocated by Alford (1975, pp247 & 259).

The nursing profession is challenged by the knowledge revealed in this study to reassess the adherence to statutory nursing duties, philosophical principles and

professional codes of practice in a remote area. These declarations are fundamental to the legitimacy and accountability of nursing practice and to the nursing profession's obligations to protect the public (Gordon 1985, Affara 1992, Percival 1992). If this practice as revealed is to continue, how long will it survive and with what consequences? Why do nurses acquiesce to the present mode of practice? What is the nurses' professional and moral obligation for care delivery in remote Aboriginal communities, independent of what others see? How long will nurses alone assume complex health care responsibilities in a remote area for which others should also be accountable? How are the moral dilemmas for nursing and the accountability of nurses to clients addressed within a remote area context? Is it possible for the professional integrity of nursing in remote areas to be upheld or defended in the current system?

In this study the medical substitute role of remote area nurses was found to influence their clinical decision-making. Why has the medical profession ignored nurses routine performance of a medical role in the remote area? Is it because of a tacit acceptance that in their absence or unavailability to provide medical care nurses have unofficially been 'allowed' to perform their role? Is it because nurses in remote areas, regardless of what they do or the outcomes of their practice, present no problems to the authorities or to the reputation or power of medical practitioners (Johnstone 1994)? Is this a case where medical dominance and control continues (Willis 1989, 1994)? In terms of medical control, could it be that the practice of medicine in remote areas is dependent upon nurses collusion with this role substitution? If so, what are its ramifications for nurses and for nursing practice? These questions on the consequences of an unauthorised medical substitute role need to be investigated.

The phenomenon of *amorphous practice* in remote areas has implications for the professionalism of nursing. To start with is it assumed that, irrespective of the anomalies for nursing care delivery in remote areas, nurses are able to practise morally, safely and effectively? Could it be that the normalisation of practice as it is revealed in the isolated setting has made it acceptable and therefore allowed it to be ignored? Are nurses under an illusion that they should take not only calculated but

uncalculated risks in the practice of nursing under the guise of providing a service? Is it because *amorphous practice* is hidden, isolated and within a socially marginalised group away from the public eye? Is it because of expediency that such a system is condoned? If so, why is it so? How is this modality of practice sustained by the system? How can such practice be in the best interests of clients and to the credibility of nursing? If not, then in whose interests can this form of practice be perpetuated?

Aspects for further research

The findings of this ethnographic study of nursing practice in a remote area poses many other questions that are worthy of in-depth inquiry. The following suggestions for further research relate to those questions arising from this study that are considered relevant to knowledge for professional nursing practice in remote areas. This research has revealed the phenomenon of *amorphous practice* in remote area nursing. As a first level exploratory inquiry into nursing practice in a remote area Aboriginal community the study exposed areas that raise concern and areas for further research. Topics include the recruitment and orientations of nurses, evaluation of nursing practice and the development of a model for remote area nursing.

A major concern that was evident in this study was the problem of recruitment and orientation of nurses for their placement at a remote area nursing post. Research into this longstanding problem has been recommended by other researchers (Percival 1986, Sturmey 1989, Sturmey & Edwards 1991, Kreger 1991b, Buckley & Gray 1993, Cramer 1993, Bell, Chang & Daly 1995, Overton 1996). Accordingly, it is again proposed that the problem be examined at a state, territory or national level. Relevant questions for such a study could be: What are the strategies and selection processes used for the recruitment of remote area nurses? What motivates nurses to work in the remote areas? How are nurse recruits orientated to remote area practice? Or, how should they be orientated to remote area practice?

The rationale for such research can be seen in the consequences portrayed in this aspect of this research study. For example, a high turnover of nursing staff as well as the employment of short term staff in the remote area appeared to be a barrier to the stability, consistency and continuity of client care. This problem was exacerbated by the variability of qualifications and experience of nurses who were recruited to the remote area as well as the mix of nurses who were employed at any one time. In this research, the previous experience of most nurses who were recruited to the remote area was in an acute care hospital setting. Moreover, as described in this study, the information communicated between the employer and the nurses at their recruitment was often found inadequate to make a rational decision to accept employment. These factors, therefore, also appear to be pertinent to an inquiry into the recruitment and retention of nurses in remote areas.

A typical problem for beginning nurses in this study was their feeling of being totally unprepared for nursing as it was practised in the remote area. This was observed to adversely effect their role confidence and their ability to practise effectively. A lack of structured orientation meant that nurses were expected to acclimatise to an unfamiliar setting and to learn a modality of practice that was alien to nursing as it was known to them from previous nursing education and experience. In this environment, nurses tended to learn the skills expected for remote area practice by trial and error. Furthermore, their practice was unsupervised and without professional support. This manner of learning for remote area nurses has been reported in research over a long period of time (Munoz & Mann 1982, Cameron-Traub 1987, Kreger 1991a, 1991b, Sturmey & Edwards 1991, Cramer 1993). Nevertheless, the costs for these nurses and for nursing practice as well as for clients and for remote area health services have not been investigated.

With the high turnover of nursing staff, most nurses practising in the remote setting at any one time were inexperienced in remote area nursing. Their learning curve was at a steep stage and they had no-one to call upon for help. In the absence of a formal orientation, beginning nurses often felt ill-equipped for their new role. The tendency

then was for nurses to conform to the prevailing norms and role precedents. This presented a serious problem in terms of a lack of current research-based clinical nursing care. The implications of the manner of recruitment together with the inadequacies of an orientation process and its consequences are a facet of remote area practice that calls for further research and action.

Another area of concern is the inconsistent and changeable pattern of practice between nurses as revealed in *amorphous practice*. This variability in the practice of nursing has implications for the substantiation of care and for the accountability of nurses. The appropriateness of care actually provided by remote area nurses in their everyday practice has not been formally studied. What evidence is there to corroborate the care interventions used by remote area nurses? How are nurses in a remote area to know what is appropriate care? What are the outcomes of care? An evaluation study conducted within the natural setting that explores the appropriateness and effectiveness of care by nurses and the outcomes of that nursing care for clients is, therefore, recommended.

A recurrent problem for nurses was an inability to complete all the requirements for clients' care. The ongoing management of care, such as following up orders for a client discharged from hospital or monitoring a client on long term treatment, were often described by nurses as *haphazard*, *piecemeal* and *ad hoc*. Various factors were found to curtail the continuity of care, such as the frequent turnover of staff, lack of communication, the ability and attitude of the staff available and the volume of concurrent demands in the daily clinic. These problems have significance for establishing the outcomes of nursing care in the remote area and warrant further inquiry.

This study has portrayed how nurses independently assessed, treated and managed the care of a majority of clients who were seen each day at the nursing post. Their responsibility for medical care and treatment as delegated to them by absent medical practitioners also became apposite. Also revealed was a lack of controls or direction

for the performance of care. Furthermore, the validity, effectiveness and safety of assessment procedures and treatments used by nurses for client care were usually not reviewed. Such a scenario calls for research into the outcomes of care in remote areas.

Another point of concern pertinent to evaluation was a lack of guidance or feedback on performance. This tended to impact negatively on the confidence of nurses. Nurses frequently expressed feelings of uncertainty about the decisions they made. How this, as well as other recurrent stressors in the practice environment, effects the performance of nursing care in a remote area is still an unknown factor which poses another research question.

Nursing practice as seen in this study was often compromised by the problems of limited resources and gaps in the provision of health care. For example, the constraints to nursing care from a lack of organisational policies relevant to role performance, inadequate equipment, a lack of medical and pharmacy services, as well as the nurses limitations in meeting the demand for 24 hour care. The scope of responsibility undertaken by nurses in the remote area was increased because of these deficits in their practice environment. In addition, the resources that were available to them served to reinforce a medical focus of care, such as access to pharmacy, medical equipment and the Central Australian Rural Practitioners (1994) Standard Treatment Manual. These findings have major implications for the care provided by nurses. Thus, there is a need to evaluate how the availability of resources in a remote area influences nursing practice.

A further problem of concern was a lack of role clarity. This was seen, for example, in the wide-spread nature of practice and ill-defined parameters of responsibility for nurses in the remote area. The frequent overlap between the nursing and the medical domain illustrated the ambiguity of the nurses' role. Nurses routinely performed medical assessments and prescribed drug treatments according to their individual knowledge and abilities whilst knowing that they lacked the relevant educational

preparation and/or authority to do so. The assumption of a medical role by nurses was also seen to impact on nursing care, such as medical interventions often having priority over basic nursing care in the management of clients' health problems. The evidence from this study reveals that this aspect of remote area nursing could be worthy of evaluation.

Finally, another area of concern that was exposed in this study was the lack of a conceptual basis to inform and guide nursing practice in the remote area. Deficits in knowledge and skills relevant for practice in this setting, commonly found amongst nurses new to the remote area as well as the more experienced nurses, appeared to contribute to the variability of priorities and approaches to care. It is, therefore, proposed that a model of nursing that is specific to remote area nursing be developed. It should be reality orientated and within the parameters of a nursing context. To date, such a nursing model has not been attempted. Several questions pertinent to a nursing model have arisen from this ethnographic study. Examples of these questions include: How do nurses conceptualise nursing practice in a remote area? What are the boundaries of remote area nursing practice? What is the feasibility of a model for nursing as it is practised in the remote area?

The importance of formulating a nursing model is found in the cultural value of 'doing your best'. This notion signifies the nurses awareness of their inability to provide optimal professional care. It also indicates a need for nurses to establish a conceptual framework for their common goals for nursing practice together with the ideas, knowledge and values needed by nurses to achieve these goals within a remote area transcultural context.

In this study, nurses introduction to the remote area setting mainly focused on task orientated skills, such as being asked, 'Can you suture?' or being 'shown what to do'. In a setting where nurses usually felt estranged from their previous nursing education and experience, the nursing models that were familiar to them also tended to be disregarded. Nurses in this study frequently expressed, either directly or indirectly,

their uncertainty about what the aims and processes for care should be or ought to be in the remote area. An attendant problem appeared to be the lack of a shared understanding of what outcomes to expect from their care interventions in the remote area. These basic factors contributed to the changeable character of the management of care from nurse to nurse. It also contributed to a lack of consensus between nurses in determining the appropriate care for a client. Further research is recommended into the reasoning processes used by remote area nurses in making decisions for care.

Nurses in the remote area were also uncertain as to the parameters of their role. The wide open nature of the practice boundaries as well as the unfamiliar social and cultural environment added to their feelings of role insecurity. The relevance of a nursing model is that it can assist nurses in conceptualising their domain of practice and be used to guide their actions accordingly.

The different attitudes of nurses to their role and responsibilities as well as to their limitations were cause for concern. These individual interpretations of role requirements and the nurses' scope of practice in the remote area seemed to have an important influence on the nature of care they provided. A common expression of 'bandaid' care was used amongst nurses as well as with other health care providers. The symbolic significance of this notion has ramifications for the identity of nurses and for nursing practice as well as for the manner of care delivery in remote area Aboriginal communities.

Final conclusion

Remote area nursing practice in Australia is an area that is least researched at a substantive level. The research and articles previously written have provided important but superficial descriptions about various aspects of remote area nursing. The totality of the picture, however, together with unanswered questions and omissions of knowledge relevant to the performance of nursing still remains.

This ethnographic study has, for the first time in Australia, provided a detailed description and systematic analysis of the actual practice of remote area nursing from participant observation within the setting of an isolated Aboriginal community. A composite whole has been attempted in this research. Hopefully, it will act as a springboard for future expository research as well as for reform for nursing practice in remote areas. My foremost concern is that it is nurses who take up the findings of this study for rigorous inquiry. I believe that the continuing quest for knowledge through research in remote area nursing must be by nurses, for nurses and with nurses.

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APPENDIX 1:

**Protocol approval
Human Research Ethics Committee
Curtin University of Technology**

COUNCIL AND COMMITTEE SERVICES

MINUTE TO : Ms J H Cramer, C/- Assoc Prof A C Martins, Nursing
FROM : Cheryle Lister, Assistant Committee Services Officer, Ext 7004
SUBJECT : **PROTOCOL APPROVAL,
HUMAN RESEARCH ETHICS COMMITTEE**
DATE : 22 November 1994

On behalf of the Human Research Ethics Committee I am authorised to inform you that approval of the project "*Nursing practice in a remote area: an ethnographic study*" was granted on 17 November 1994.

Please find attached a copy of your protocol details, and the application form/cover sheet.

The approval number for your project is **HR222/94**. Please quote this number in any future correspondence.

Cheryle Lister
for Secretary
Human Research Ethics Committee

HREC DIR\REG94 HR222-94

Please Note:

If information about the authorisation of this project is required, the following standard statement is suggested for inclusion in the information to subjects section of the protocol.

This study has been approved by the Curtin University Human Research Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Council and Committee Services, Curtin University of Technology, GPO Box U1987, Perth, 6001 or by telephoning 351 3296.

APPENDIX 2:

Research Agreement

**Ngaanyatjarra Council (Aboriginal Corporation)
and
Warburton Community
and
Jennifer Cramer**

**Note: For copyright reasons Appendix 2 (pp396-404) has not been reproduced.
(Co-ordinator, ADT Project (Retrospective), Curtin University of Technology,
20.11.02)**

APPENDIX 3:

**Informed consent form
Health care worker**

**INFORMED CONSENT FORM
HEALTH CARE WORKER**

NURSING PRACTICE IN A REMOTE AREA: AN ETHNOGRAPHIC STUDY

My name is Jennifer Cramer and I am currently enrolled in PhD studies at the School of Nursing at Curtin University of Technology. The purpose of my study is to increase an understanding of nursing practice in remote area communities. The knowledge gained from this study will be of major significance to inform the nursing profession, educationists and service planners of the complexities of nursing practice within the remote area setting.

The study will involve nurses, other health team members, clients in the community and others who directly, or indirectly, interact with the nurse in the delivery of health care. Information for the study will be collected during fieldwork by participant observation and by formal and informal interviews. Data will be recorded in detailed field notes and tape recorded interviews. These interviews will take place at a time suitable to both yourself and the researcher. Interviews will need to be conducted over a period of time in order to explore the data and verify the accuracy of the data analysis. During the interview you may decline to answer any question and request that the tape recorder be turned off. No names will appear in the field notes or in the transcribed interview. Extracts of the interview may be used in the research report, however you will not be identified in any way. Participation is voluntary and you may withdraw at any time without penalty. Every precaution will be taken to protect your anonymity.

If there are any questions or concerns you have regarding this study, please do not hesitate to contact me on (09) 328 4550 (home). You may also contact my supervisor Dr Audrey Martins on (09) 351 2217 (work).

PARTICIPANT'S STATEMENT

I, _____, have read the above information on the study relating to a study of nursing practice in remote area settings. I understand the nature and intent of the study and have the opportunity to ask questions. I know where to direct future questions that I may have. I have received a copy of the consent form. I understand that my participation is voluntary and that I may withdraw at any time.

Signed _____ Health Care Worker Date _____

Signed _____ Researcher Date _____

APPENDIX 4:

Summary of research proposal

SUMMARY OF PROPOSAL FOR THESIS: DEGREE OF DOCTOR OF PHILOSOPHY
NURSING PRACTICE IN A REMOTE AREA: AN ETHNOGRAPHIC STUDY
Jennifer Cramer

Nursing practice in remote areas has been described as unique. Features of this unique practice are the service delivery by nursing posts, the physical distance of the nursing post from hospital facilities and the degree of autonomy by which nursing is practised in remote areas. In this setting nurses provide direct care to a mixed Aboriginal and non-Aboriginal population. Previous studies pertaining to remote area nursing have provided glimpses of their practice. No studies, however, have wholly portrayed the social world of nursing practice in the remote area setting. This stimulated the researcher to propose an ethnographic study to uncover the social and cultural pattern of nursing practice in a remote area of Western Australia.

The purpose of this study is to explore, describe and analyse nursing from the context of practice in a remote area community. An ethnographic method is chosen for this exploratory level of inquiry into the world of remote area nursing practice. Data will be obtained from field work conducted over one year in the remote area setting and will involve participant observation, interviewing informants and gathering material documentation. Data analysis will use the Developmental Research Sequence (Spradley 1980) format. This is concurrent with data collection in an on-going and cyclical process to discover the patterns and meanings of nursing practice within the remote area context. The reliability of the study will be enhanced by a detailed description of the social context of observations and a full disclosure of all phases of research procedures and the stance of the researcher. Validity of the study to portray observed reality will be achieved by constant comparison, synthesis and refinement of constructs through prolonged observation, verification with informants and explicit documentation of how the data is analysed. Approval and permission to conduct the study will be obtained from the University Human Research Ethics Committee, the regional health service organisation and the Aboriginal community. Confidentiality of informants will be assured.

The significance of this ethnographic study is that for the first time a wholistic exploration, against a background of premises, interests and values concerning what it means to practice remote area nursing, will be provided. There is a lack of systematic description and analysis of practice from within the world of nurses in remote areas. This in-depth study will assist in the discovery of the complexities of nursing practice within the remote area setting in order to inform the nursing profession and others for the planning of nursing services in transcultural remote area settings of Western Australia.

Reference:

Spradley, J.P. 1980. Participant observation. New York: Holt, Rinehart and Winston.

APPENDIX 5:

**Statement of request to
Ngaanyatjarra Health Service
(Aboriginal Corporation)**

(name deleted)

1 McCarthy street
PERTH WA 6000

Telephone: (09) 328 4550 (h)
(09) 351 2638 (w)

9 December 1994

████████████████████
Manager
Ngaanyatjarra Health Service
P.O. Box 644
Alice Springs NT 0870

Dear ██████████

RE: Proposed study of nursing practice in a community

Further to our recent telephone conversation I am enclosing an outline of my proposal for your consideration. I understand that this proposal will be discussed with nurses in the Ngaanyatjarra communities. If the proposal is approved permission will be sought from the Ngaanyatjarra Council to stay in the Warburton community and undertake the study.

If you require information from the School of Nursing, Curtin University of Technology, please contact my supervisor, Audrey Martins (telephone (09) 351 2177). A detailed proposal for the study has been submitted to the university and is available to you if required.

I am happy to take short term relief nursing as a reciprocal arrangement.

I look forward to further contact with you

Yours sincerely

⤵
Jenny Cramer

REQUEST FOR PERMISSION TO UNDERTAKE STUDY
Jennifer Cramer

I am a PhD student at the School of Nursing, Curtin University of Technology. My proposed study is nursing practice in a remote area of Western Australia. I am seeking permission to undertake this study of nursing practice in a Ngaanyatjarra community, for example Warburton. I speak Pitjantjatjara which has similarities with the Ngaanyatjarra language. Previously I have worked as a nurse in Amata (1979 - 83) and at Aparawatatja (1985 - 86) in far North West South Australia.

The purpose of this study is to explore, describe and analyse nursing practice within the social and cultural context of a remote area community. The study aims to describe the delivery of nursing care from the perspectives of nurses, health team members and clients in the community. To achieve the aims of this study I will need to live in the remote community to carry out fieldwork where I can observe the work of nurses and discuss with them nursing practice in their setting. I will also need to talk with other health team members, such as Aboriginal health workers and visiting medical personnel about their perceptions of remote area nursing practice. I would like to obtain the views of individuals and groups within the community of the nursing care provided to them.

I will ensure that my presence is unobtrusive. Confidentiality of all health personnel and the community is assured. No names of person or place will be used in the study. The community will be consulted and informed of the purpose and nature of the study in order to obtain their approval.

The importance of this study is that it will provide a detailed portrayal of actual nursing practice within the reality of the remote area setting. To date glimpses of remote area nursing practice have been given by nurses in various journal articles and studies of educational needs, but there is no record of their total practice. Greater knowledge of the actual practice of nurses in remote areas is necessary in order to prepare nurses appropriately for their responsibilities. This knowledge will enable the body of nursing to evaluate the nursing care provided and be a basis to improve nursing practice in remote communities. As nurses and health care providers there is a duty to clients in remote areas to know what is entailed in nursing practice and to evaluate the care provided by nurses in the community. The study will also inform non-remote area nurses and others about the role fulfilled by nurses in remote areas. The planning of health services to the community can be assisted when it is more fully known what is involved in remote area nursing practice.

I enclose a summary of the formal proposal that has been accepted by Curtin University. The proposal has been approved by the Curtin University Human Research Ethics Committee.

APPENDIX 6:

Letter of acceptance

**Ngaanyatjarra Health Service
(Aboriginal Corporation)**

(name deleted)

Note: For copyright reasons Appendix 6 has not been reproduced.

**(Co-ordinator, ADT Project (Retrospective), Curtin University of Technology,
20.11.02)**

APPENDIX 7:
Royal Flying Doctor Service
A brief outline

ROYAL FLYING DOCTOR SERVICE A BRIEF OUTLINE

The Royal Flying Doctor Service (RFDS) of Australia is a non-profit organisation that was first established in 1928 by John Flynn, a Presbyterian church minister. It is funded by the Federal Government and charitable donations. Today there are Sections of RFDS in every State and Territory, apart from Victoria and the Australian Capital Territory.

Each Section is independently managed, however, there is also a Federal Council. A small fleet of twin-engined aircraft is owned and operated by each Section. The RFDS generally employs pilots, medical practitioners, flight nurses as well as management, administrative and aviation maintenance staff.

Its main purpose is to provide aeromedical evacuations as well as regular medical clinics to people living in remote areas. Primary transfers by RFDS are those evacuations of clients from isolated areas to a regional or metropolitan hospital. Secondary transfers are when a client is transported between hospitals. Whereas flight nurses accompany all aeromedical evacuations, medical practitioners accompany few of these flights, such as to multiple traumas or where clients require intubation and ventilation or where a nurse feels medical assistance is required.

The regular medical clinics are held in established remote locations, such as nursing posts, small communities and mining town medical centres. A medical practitioner always attends these clinics. In some areas flight nurses also accompany the medical practitioner, to conduct a child health clinic, for example.

The RFDS also provides a 24 hour communication system for access to medical aid via telephone or two-way radio for people in outlying communities and at remote pastoral properties. Medical chests, containing numbered pharmaceutical items, are also supplied by RFDS to use under instructions from a medical practitioner. These are made available in remote areas where there is no clinic with permanent nursing staff in residence.

The Warburton Nursing Post was served by the RFDS, Eastern Goldfields Section, based at Kalgoorlie in Western Australia. The service was available 24 hours a day for nurses to contact a medical officer and, in consultation with the medical officer, to arrange for an evacuation as needed. When the telephone lines were not functioning, a nurse then had to use the two-way radio to make contact with the RFDS base at Jandakot airport, Perth.

Scheduled flights for medical clinics were conducted each Tuesday and Wednesday on a fortnightly rotation to nine communities in the area of the Ngaanyatjarra Lands. In the fortnight that Warburton was visited, a medical practitioner and a pilot usually arrived late on Tuesday evening and stayed overnight. The clinic was held on Wednesday morning. A monthly schedule was issued by the RFDS from Kalgoorlie. It named the medical practitioner on call, their contact telephone and paging numbers and the clinics to be visited in that period as well as the radio base call sign and other emergency service contact numbers.

APPENDIX 8:

Aboriginal health workers in remote areas

ABORIGINAL HEALTH WORKERS IN REMOTE AREAS

In Australia, Aboriginal health workers have played a role in health care delivery to indigenous communities since approximately 1970. This role has varied according to the locations and conditions of employment as well as the services in which they are employed (Saggers & Gray 1991, Torzillo & Kerr 1991).

In urban and provincial settings Aboriginal health workers have a predominantly educational and liaison role in a health team. These Aboriginal health workers are engaged in health promotion and health maintenance within Aboriginal communities. Their liaison role includes advocacy for Aboriginal clients as well as facilitating communications between these clients and health professionals (National Aboriginal Health Strategy 1989).

In remote areas, Aboriginal health workers have often been expected by their employer to assume a clinical as well as liaison and educational role. Here they are called upon to make clinical assessments and to provide care and treatment. In some remote areas Aboriginal health workers have undertaken this role alone. In most remote areas, however, they work with nurses who are resident in the Aboriginal community.

Ideally, Aboriginal health workers are selected by members of the community in which they live. The preference for trainees with a minimal level of literacy however, often favours the appointment of younger Aboriginal people. Their educational preparation is mainly provided at regional or metropolitan centres and is supplemented by distance education. A wide variability in their role expectations from State to State and by different employers has contributed to several training schools being established in each State and in the Northern Territory. Aboriginal health workers may also commence employment prior to undertaking an educational program and there is a lack of provision to ensure that a basic level of educational preparation is achieved.

At Warburton there were 3 full time equivalent positions for Aboriginal health workers. A total of nine Aboriginal health workers were employed over one year, with every one resigning in this period. Periods of absence and a lack of recruitment meant that on occasions Aboriginal health workers were unavailable at the nursing post. Only one of these had completed a course for Aboriginal health workers. Two had partially completed a course and the remainder had no educational preparation and minimal orientation. Nevertheless, they had requested an opportunity to undertake training.

The work undertaken by these Aboriginal health workers varied widely according to their experience and confidence. Their role also varied according to the expectations of nurses who were employed at the time, such as whether they were encouraged or discouraged from prescribing and administering drug treatments. The youngest Aboriginal health worker employed was 17 years of age. The Aboriginal health workers were mainly involved in clinical work, attending to and treating clients for minor complaints or learning to perform this role by working with a nurse in the clinic. In addition, two Aboriginal health workers were keen to develop health promotion programs, such as working with youth, but were not provided the support needed to implement their ideas.

APPENDIX 9:

**Ngaanyatjarra and Pintubi Lands
in a regional setting**

and

**Land tenure status of
Ngaanyatjarra and Pintubi Lands
and major communities**

(by courtesy of Ngaanyatjarra Council Inc)

Note: For copyright reasons Appendix 9 (pp419-420) has not been reproduced.

**(Co-ordinator, ADT Project (Retrospective), Curtin University of Technology,
20.11.02)**

APPENDIX 10:

Ngaanyatjarra Council organisational chart

(by courtesy of Ngaanyatjarra Council Inc)

Note: For copyright reasons Appendix 10 has not been reproduced.

**(Co-ordinator, ADT Project (Retrospective), Curtin University of Technology,
20.11.02)**

APPENDIX 11:

**Warburton Nursing Post
Nurse Staffing
June 1995 - May 1996**

WARBURTON NURSING POST

NURSE STAFFING JUNE 1995 - MAY 1996

Nurses	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
RN 1	_____] permanent / resigned											
RN 2	_____] permanent / resigned											
RN 3	_____] permanent / transferred											
RN 4		[] reliever										
RN 5			[]		[] reliever							
RN 6				[] probation / dismissed								
RN 7				[] reliever / resigned								
RN 8		permanent	reliever	[] resigned								
RN 9					[] reliever / resigned							
RN 10						[] permanent / transferred						
RN 11											[] reliever	
RN 12											[] reliever	
RN 13										[] reliever / resigned		
RN 14					probation / permanent	[]						
RN 15										[] reliever		
RN 16							permanent / resigned	[]				
RN 17									reliever	[]		
RN 18										reliever	[]	
RN 19											probation	[]

The basis and duration of employment for each of the nineteen nurses at Warburton during the twelve months of fieldwork.

APPENDIX 12:

Newspaper Advertisement

**for recruitment of
remote area nurses**

Note: For copyright reasons Appendix 12 from the following source has not been reproduced.

West Australian, Saturday April 13th, 1996. Classified index, p.36.

(Co-ordinator, ADT Project (Retrospective), Curtin University of Technology, 20.11.02)

APPENDIX 13:

**A nurse's letter of appointment
to
Ngaanyatjarra Health Service
(Aboriginal Corporation)**

(names deleted)

Note: For copyright reasons Appendix 13 has not been reproduced.

**(Co-ordinator, ADT Project (Retrospective), Curtin University of Technology,
20.11.02)**

APPENDIX 14:

Job Description

Charge - Nurse - Remote Area and Remote Area Nurse

Warburton Clinic

Note: For copyright reasons Appendix 14 (pp430-433) has not been reproduced.

**(Co-ordinator, ADT Project (Retrospective), Curtin University of Technology,
20.11.02)**

APPENDIX 15:

Daily Patient Record

DAILY PATIENT RECORD

CLINIC _____ NAME _____ DATE _____

CATEGORY	RETREATMENT	AGE GROUP	MALE/FEMALE	EVACUATION

NAME	ILLNESS	TREATMENT
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		

1 = 0-5	A	B	C	D	E	F	G	H	I	J	K	L	O	Q	R	U	W	X	Z
RETREATMENT																			
2 = 5-16																			
RETREATMENT																			
3 = 16-40																			
RETREATMENT																			
4 = 40-65																			
RETREATMENT																			
5 = 65+																			
RETREATMENT																			
TOTALS INITIAL CONSULT RETREATMENTS																			

PROGRAMMES

NUTRITION	N	STD/UW	V
SCHOOL	S	TRACHOMA	T
0-5	P	IMMUNIZATION	M
DIABETIC	Y	OLDIES	00
RENAL	U	HEALTH ED	HE
WELL MEN	WM	WELL WOMEN	WW

- A - SKIN
- B - EAR
- C - RESPIRATORY
- D - DENTAL
- E - EYE
- F - FEBRILE (VIRAL)
- G - GYNEACOLOGICAL
- H - C.N.S.
- I - GASTRO/INTESTINAL
- J - TRAUMA
- K - C.V.S.
- L - MUSCULAR SKELETAL
- O - OBSTETRICS
- Q - PHYSCOLOGICAL
- R - PAEDIATRICS
- U - RENAL (URINARY)
- W - ENDOCRINE
- X - SOCIAL
- Z - MEDICATIONS

CLIENT MOVEMENT	1	2	3	4	5	6	7	8	9	10
REFERRAL										
EMERGENCY										
AGE GROUP										
CATEGORY										
DESTINATION										
ESCORT										
TRANSPORT										

DAILY TOTALS

: CLIENTS SEEN OUT OF HOURS
 : CLIENTS SEEN IN CLINIC HOURS
 : OUTSTATION VISITS

COMMENTS: -
 Visits: Specialty/Field Team

APPENDIX 16:
Individual Forward Planner

INDIVIDUAL FORWARD PLANNER

CLIENT:

URN:

DUE DATE

IMMUNISATIONS:

.....	/	/
.....	/	/
.....	/	/

INVESTIGATIONS:

.....	/	/
.....	/	/
.....	/	/

DEVELOPMENTAL 0-5 CHECKS/SCHOOL CHECKS:

.....	/	/
.....	/	/
.....	/	/

WELL WOMEN'S CHECK:

.....	/	/
.....	/	/
.....	/	/

WELL MEN'S CHECK:

.....	/	/
.....	/	/
.....	/	/

OLD PEOPLES CHECK:

.....	/	/
.....	/	/
.....	/	/

DIABETIC CHECK:

.....	/	/
.....	/	/
.....	/	/

SPECIAL TREATMENTS.

.....	/	/
.....	/	/
.....	/	/

APPENDIX 17:

**Central Australian Rural Practitioners Association (1994)
Standard Treatment Manual
2nd edition**

**Skin Infections
(pp145-146)**

**(Written permission from
Central Australian Rural Practitioners Association
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APPENDIX 18:

**Central Australian Rural Practitioners Association (1994)
Standard Treatment Manual
2nd edition**

**Stopping Labour
(pp168-171)**

**(Written permission from
Central Australian Rural Practitioners Association
12 December 1997)**

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APPENDIX 19:

Performance Indicators Monthly Report Form

PERFORMANCE INDICATORS

A. MONTH _____

CLINIC _____

Number of Consultations at Clinic _____
 (Do Not Count Clients on Programmes)
 Number of Clients Seen Out of Hours _____

Total of Clients Treated in Clinic and Out of Hours

B. PROGRAMMES

0 - 5 Years programme	Total Clients	_____
Antenatal programme	Total Clients	_____
STD / HIV programme	Total Clients	_____
Women's Health programme	Total Clients	_____
Old Peoples programme	Total Clients	_____
Chest / Athsma programme	Total Clients	_____
Diabetics programme	Total Clients	_____
School programme	Total Clients	_____
Immunisation programme	Total Clients	_____
Nutrition programme	Total Clients	_____
Health Education programme	Total Clients	_____
Trachoma programme	Total Clients	_____

Total of Clients on Programmes Monitored

Add total of **A.** (Clients in clinic and out of hours)
 To total of **B.** (Clients on programmes)

Total Client Consultations For Month

C. Medical Referrals to Alice Springs

	Adult	_____
	Child	_____
	Escort	_____
Medical Referrals to Kalgoorlie	Adult	_____
	Child	_____
	Escort	_____
Medical Referrals to Perth	Adult	_____
	Child	_____
	Escort	_____

Emergency Evacuations to Alice Springs	A	_____	C	_____	E	_____
Emergency Evacuations to Kalgoorlie	A	_____	C	_____	E	_____
Emergency Evacuations to Perth	A	_____	C	_____	E	_____

D. Number of Visits by RFDS _____

Number of Client Consultations With RFDS _____

Number of Specialist /Field Team Visits _____

Number of Days Visit Lasted _____

Number of People Seen _____

E. Number of Outstations Visited _____

Names of Outstations Visited _____

Number of Client Consultations _____

APPENDIX 20:

**Warburton Nursing Post
Pharmacy Account**

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APPENDIX 21:

**Poisons Permit (Industrial)
June 1996-June 1997**

**Issued to Ngaanyatjarra Health Service
by Health Department of Western Australia**

(names of manager, nurses and medical practitioners deleted)

Note: For copyright reasons Appendix 21 has not been reproduced.

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APPENDIX 22:

Pharmacy Imprest List

**Issued to Warburton Nursing Post (WB)
by Kalgoorlie Regional Hospital**

**Note: For copyright reasons Appendix 22 (pp450-462) has not been reproduced.
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APPENDIX 23:

Emergency Resuscitation Kit: "Parry Pak"

Operational Instruction

26 September 1995

Health Department of Western Australia

Note: For copyright reasons Appendix 23 (pp464-470) has not been reproduced.
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APPENDIX 24:

**Central Australian Rural Practitioners Association (1994)
Standard Treatment Manual
2nd edition**

**Chest Infections
(pp46-53)**

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Central Australian Rural Practitioners Association
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APPENDIX 25:

**Central Australian Rural Practitioners Association (1994)
Standard Treatment Manual
2nd edition**

**Alcohol Problems - acute
(pp21-22)**

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Central Australian Rural Practitioners Association
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APPENDIX 26:
Nurses Code of Practice 1995
Under Section 9
Western Australia Nurses Act 1992

Note: For copyright reasons Appendix 26 (pp479-481) from the following source has not been reproduced.

Government Gazette, WA, 28th April, 1995, pp 1463-1465

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APPENDIX 27:

Registered Nurse Competencies

Division 1

Nurses Board of Western Australia

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