

An unusual occupation

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ABSTRACT

A number of single nurse remote clinics exist in Australia in remote Indigenous communities, fly in mine sites or small isolated towns. Included in this category are privately employed and State Health employed nurses. Work issues including safety, provision of acute care, trauma, and chronic diseases leave little time for primary health or preventative care. The practice is marked by issues of education, distance from referral centres and limited access to medical assistance. The study was a study of social justice, inequity, shortage and burnout. This paper reports on the social impacts of single nurse clinics in relation to job satisfaction and the impacting factors and outcomes.

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INTRODUCTION:

Home at 1930, numb, emotionally dehydrated, physically exhausted, nothing left to give, who next, sick last week, now today, need help, funeral, heated my curry, bed at 2300, sleep escaped me, obsessed by my own demons tonight, unhappy, that's my dog, restless, spent most of the day locked up, no walk, happy if someone locked me up, maybe just drive away now, sort of dancing the tarantella was pulsating music, commanding me, keep dancing, faster, faster, spinning forward until you drop

We recently observed what happens when a Government takes it into its head to act without consultation of key stakeholders in relation to health in remote communities throughout the Northern Territory. In remote Aboriginal communities there is a potent mix of extreme need, paucity of resources, moral imperatives and political rhetoric (Dade-Smith J. 2004). 'Pressures to do more and to find 'quick fix' solutions to complex, long standing social problems from within and outside the organization often means that morale can be tenuous' (p139). In Australia, seventy percent of RANs work in Indigenous communities constituting over 85% of the health workforce (CRANA 2006). They work with Indigenous Health Workers (IHWs) to provide primary health care with extended roles, normally performed by doctors and allied health professionals.-Not new information to any of you.....

Every Australian, irrespective of culture, environment, ethnic background or place of residence, has a right to *affordable, accessible* and *appropriate* (sic) health care. This is based on the principle of human rights as it conceptualizes health as a fundamental right as a individual and community responsibility (Mc Murray 1999). In light of recent Government imperatives this is particularly relevant today.

LITERATURE REVIEW:

CONTEXT

Australia's growing inequity has its basis in the changing structure of the labour market responding to the twin forces of economic globalization and rationalism(Gruskin *et al.* 2002);(Gutberlet 1999; Srinivasan *et al.* 2000) leading to the polarizing of the workforce into winners and losers.

We are looking in this study at two levels of exclusion, the remote communities from health care and RANs from the support of their own profession. Within health services a

tension then exists between ideology (the dominant view about how things should be done) and the way things are done in reality.

Nursing is often presented as an oppressed profession. Whilst at times this may have been true on the surface, this is somewhat simplistic and denies nurses as individuals any element of choice (agency) in their responses to situations in which they have found themselves. To ignore the impact of agency implies that these nurses themselves have had no part in what has happened to dis-empower some parts of the profession such as RAN. Other parts of nursing have experienced a different reality (e.g. mental health, some midwives in New South Wales and some of the South Australian women's Health nurses). These groups appear to have been able to mobilize their members in a way that RANs could not or at least for many years did not (Wicks 1999). Was it simply because geographically they were closer together than RANs, was it because they were experiencing a different reality of support or was it something else (Yuginovich 2000)?

For many years no one (including nurses themselves) appeared to publicly credit nurses with the ability to change things for themselves or indeed with a need to change anything in terms of power relationships with medicine or with rest of the health profession and legislators. This was particularly true of the public face nurses presented. Despite cries of oppression, patriarchy, subjection, abjection, closure, exclusion et cetera by RANs, publicly they were still being hailed as pioneers and builders of the nation or the strength of local communities (Pitt 1993). It remained the case until the late 1980's despite the formation of ATNA, two world wars in which women took on many so called male responsibilities, various depressions in the state and country and the beginnings of more active unionism within the ranks of nursing (Yuginovich 2000).

For RANs in single nurse clinics the work is often physically demanding with continually heavy demands for pity, sympathy and compassion. Persons working continually under such circumstances find chronic stress can be emotionally draining and can lead to burnout (Gruskin *et al.* 2002). Managers may fail to recognize the suffering of these employees. The Gruskin *et al* (2002) study undertaken in Britain poses many points of similitude for Australian RANs in single nurse clinics where the role is a continual mix of accident and emergency (The Council of Remote Area Nurses of Australia 2006), acute

medical and sometimes surgical nursing all of which escalate stress levels predisposing to burnout. Traditionally, this role often caused the scope of practice, to cross traditional boundaries, of legislation for registered nurses (Bushy 2002; Dade-Smith J. 2004; Dade-Smith J. *et al.* 2002; Yuginovich 2000); reports the situation in Australia reflects that of Canada.

The more remote the location, the more difficult it is to recruit and retain nurses and other health professionals. Common issues include; professional development, locum relief, spouse employment, professional isolation, on-call demands, family and schooling once children reach a certain age ((Buckley *et al.* 1993) (Strasser 2003);(Dade-Smith J. 2004). Given that RANs are mostly female, working on call and live alone, safety and the risk of personal violence are triggers to leave employment according to Smith (p.127). (Buckley *et al.* 1993). (Fisher *et al.* 1996) identified that of 310 respondents, 86 percent had experienced aggression and 43 percent had experienced abuse. It is significant that nothing has changed since then. The literature review identified the following concepts as major issues impacting on the ability of RANs to deliver primary Health Care in remote communities.

PRIMARY HEALTH CARE

There are three issues to be actively managed in remote Primary Health Care.

1. Reconciling expectations of consumers and staff with funding and other constraints of the practice context.
2. Reconciling ideologically acceptable rhetoric about community control with requirements for a skilled, expert workforce including the need for high levels of technical knowledge for decision making.
3. Reconciling the competencies of health status determinants include historical, political, and economic factors with the need for clear progressive and bounded organizational vision(Wilson 2001).

Not all researchers view the situation as hopeless. The experience of the Nganampa Health Council is that measurable significant health improvements can be achieved and sustained (Van Haaren *et al.* 2000).

SOCIAL JUSTICE AND POVERTY

Issues of social justice are crucial to those who are most vulnerable in society. Health, housing and education are the basic human rights of every Australian. Poverty within many of Australia's remote communities is primarily concerned with distributional issues, such as the lack of resources at the disposal of individuals, whereas social exclusion focuses on relational issues of inadequate social participation (Gutberlet 1999) p.222-3). In December 1994 The National Aboriginal Health Strategy (NAHS) Committee found that the strategy had never been effectively implemented and that remains the case today. All governments had grossly under-funded the remote initiatives, there was a lack of accountability and a lack of political support. They advocated a Human Rights approach to be adopted for funding and to meet the backlog in housing and essential services in remote and rural areas (*cited in* Dade-Smith 2004 p.112).

Equity in health is influenced more by an individual's perception of inequality rather than their actual economic circumstances (Eckersley 1998). (Srinivasan *et al.* 2000) concur suggesting collective action is needed within the framework of social justice to reduce the effects of these factors. Clients already dealing with pressures of poverty may lack the assertiveness, sophistication or time to deal with the complexities of the health system and consequently may forgo needed care (p.164) as in remote Australia's indigenous, and small isolated rural communities which have high levels of unemployment.

Social exclusion is an extreme form of marginalization and can be understood as 'one or more dimensions of non-involvement or participation in that society' (Townroe 1996 p.187). Not only do excluded groups suffer the negative consequences related to poverty, they are also prevented from being citizens, in the sense of having access to social services and basic infrastructure. They are disadvantaged in terms of access to adequate health and childcare, education, sanitation or welfare assistance and are characterized by isolation, cultural diversity, socioeconomic inequality, health inequality, resource inequity, and a range of climatic conditions. In other words Social justice is denied them (Beugre 2002; Parsons *et al.* 2003). (Gill 1986);(Rawls 1971);(Di Bartolo 2001) suggest a socially unjust society equates to a violent society, particularly violence in the home. The issues raised

concerning social justice apply equally to Indigenous communities as well as the RANs who live with them providing health care in less than optimal conditions (Dade-Smith 2004).

SAFETY

RANs have noted for many years they often live and work in unsafe environments and suggest the inclusion of another RAN would lessen isolation and feelings of lack of safety (Dade-Smith J. *et al.* 2002); (Fisher *et al.* 1996); (Gillespie 2003); (Beugre 2002; Buckley *et al.* 1993); Gill, 1986 #22). For example; when there is need for the RAN to have time off from being on call; the occurrence of health concerns with family/close friends particularly following serious acute illness/trauma; personal-either physical or verbal abuse suffered by the RAN or family member/s; when emergency leave is required e.g. RAN becomes sick and has to leave the community (Yuginovich 2000).

Based on the literature review, the above major issues must be addressed in relation to staffing levels for RANs in remote Australia. This study is crucial for adequate health service provision in remote Australia as well as being most timely for a new approach to retention of remote area nurses in that it provides yet again a voice by those least listened to.

METHOD

Phenomenology drove the collection and interpretation processes for this (in-depth interviews) part of the study. The recording of details reinforced the importance of the research question in order to explore the meaning for participants within a critical paradigm. The researchers' understandings about the context being researched, enabled the asking of questions which explored RANs experiences in single nurse clinics as the conduct of critical research needed to be guided by the critical moral imperative of human emancipation and social justice (Smith 1993 p.215 & 242). (O'Brien 2004) states that phenomenological researchers should be able to reflect on what it means to be a person in the world, and explore the researcher's own understanding of a phenomenon, to think beyond proving the facts to a desire to explore the experiences of self and others of a phenomenon in a particular context. Such an approach is according to O'Brien interpretive

from beginning to end. A two stage process of data collection within this framework was utilized for the study including;

- i) a mail-out to all CRANA members
- ii) in depth interviews with RANs

Sample:

Typical case sampling was utilized (Llewellyn *et al.* 1999) and required the researcher be familiar with the typical patterns (in this case workplace, context and conditions of work) of the participants. Given that both researchers are familiar with these criteria, this need was well satisfied. An opportunistic sample (Jackson *et al.* 2003) was selected for initial surveys due to the transience of this population of nurses. The target population was RANs in various locations around Australia in order to compare their experiences of single nurse clinics. The sample was accessed initially via a mail-out to all CRANA members via the quarterly “*Outback Flyer*” and at the CRANA Conference in Darwin in September 2005. Following this a random sample was identified from the respondents for in-depth interviews conducted by the researchers.

Ethics:

Ethics approval was obtained from the relevant authorities prior to proceeding. Prospective participants were provided with a plain language statement informing them clearly of the study, their ability to refuse to participate or withdraw without penalty at any time and the offer of access to the results from the study once it is concluded. Data is stored according to NHMRC guidelines in a place only accessible by the principal researcher. Participants are anonymous, with no identifying characteristics of their employment posts or as individuals being included in results.

Significance of the Study

Recruitment and retention of staff and poor standards of health of Indigenous communities are ongoing issues within remote areas of Australia. At risk is the health of many small communities who are vulnerable to a variety of factors impacting on their health. Particularly vulnerable are indigenous communities. Community expectations within these communities are for comparable access to health care with the remainder of Australia.

Limitations:

The opportunistic, cross-sectional nature of the sample meant that some RANS who had left this practice were unable to be contacted or included in the study. The large distances involved made it necessary to interview by phone rather than face to face as the preferred option.

FINDINGS & DISCUSSION

Concerns about support and safety were expressed 194 times. 69.8 % of respondents identified that they work 24 hour call, 73.3 % identified that they never have emergency relief, 30% identified that they are never able to leave the community. High correlation was noted between the number of days worked without relief, ability to meet the needs of the community and the personal health of the RAN. This was related by RANs to the number of days on 24 hour call (sometimes up to 100 days without relief) and the RAN's ability to undertake further study.

Lack of relief or time out was cited as being a major contributor to burnout and inability to provide care. The longest period on call with no break was 100 days. Such lack of support poses great threats to the well being of RANs and community members as well as the safety of practice and reflects findings by others(Fisher *et al.* 1996);(Strasser 2003); (The Council of Remote Area Nurses of Australia 2006); (Gruskin *et al.* 2002); (Baddock1995).

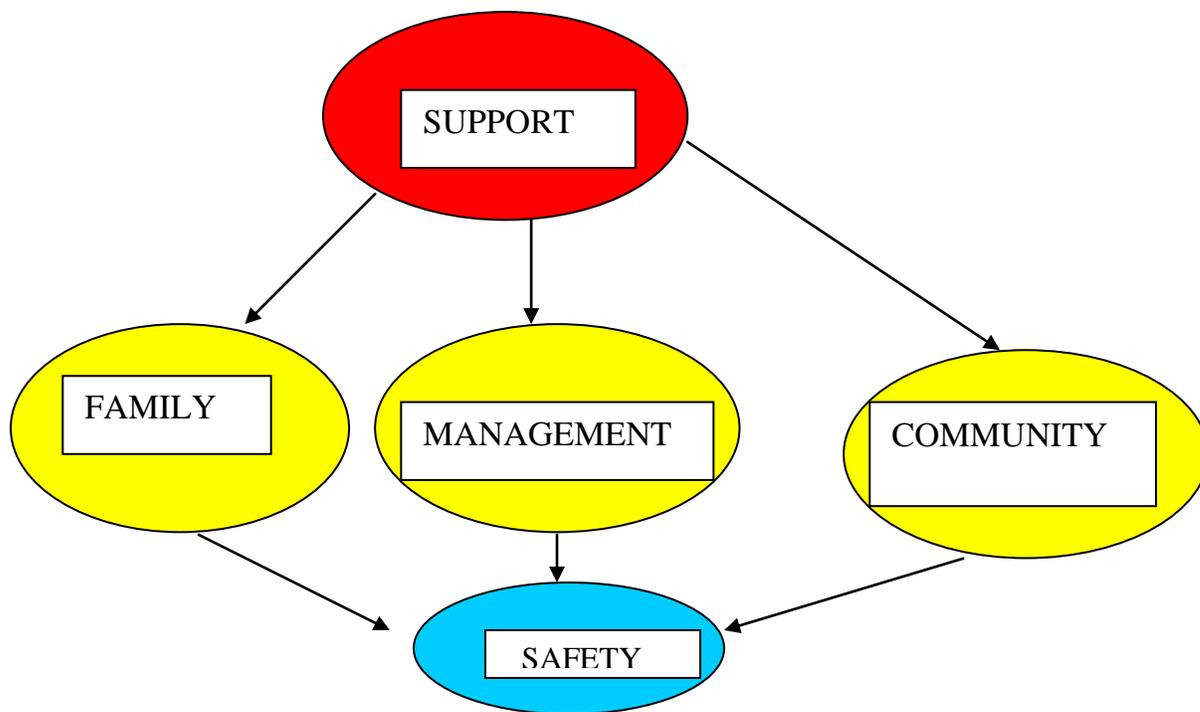


Figure1; Key concepts identified as impacting on safety for RANs

It would appear that even though scopes of RAN practice have been adjusted at State levels, little recognition is given at some District or Community levels in terms of funding to support RANs in all aspects of their roles-especially preventative health. Despite the fact that National Aboriginal Health Strategies and Federal Government priorities, place Indigenous Health as a national priority nothing is changing.

SOCIAL ISSUES

Issues identified by participants interviewed related primarily to community, personal, family, school issues and the absence of private time as well as safety.

Community: *very demanding people*

get disillusioned

impossible for a nurse to run a single nurse post and maintain their sanity

Personal;

Socially - it is sometimes very difficult because of the confidentiality side of

don't see me as a person

end up with burn out

being able to speak to another Caucasian who has similar cultural values

second person to be contactable would certainly increase your safety

*can never ever have any structure in life, day or night,
had to constantly share my accommodation
I get really great support both on a cultural level, a social level and a work level. So that
is really good
My family come and visit
accommodation
Having a block of time that was completely your own would be an enormous benefit
people I never got to have dinner with because you were always called out as soon as it
was on the table
He used to speak on the phone every single day. He would ring me every night without
fail.
It may become tiring, exhausting but never boring or unstimulating*

school: *the school only went to year 6*

private time; *knowing the community intimately, autonomy;
not enough time to get everything done,
interruptions by patients when needing to do some administration jobs.
social life left behind*

Some RANs cited marriage and personal relationship breakups as being directly due to lack of lifestyle options or work for spouses or partners. This serves to further compound feelings of powerlessness and isolation. It is easy to see why RANs burn out with no local professional support as might be provided by another RAN in the community. This is despite such services as the Bush Crisis Line (BCL) a 24 hour counseling support line provided to rural and remote communities by (the Council of Remote Area Nurses of Australia (CRANA)). Some identified they had no access to a hairdresser however though apparently a trivial issue this in fact is a symptom of a greater lack of social support systems in that they were unable to have a 'normal lifestyle', study leave, go out of community on days off or attend family occasions.

PRIMARY HEALTH CARE DELIVERY

RANs identified that they provide acute care in response to need without time for recall, follow up or initiating any primary health or preventative care in their communities which are surely the most disadvantaged. Many identified basic sanitation, hygiene, housing, and water as lacking and not having been addressed in many communities. Reasons impacting

on lack of ability to provide adequate/any primary health care included lack of management support, lack of staff, lack of support (see fig 2 below).

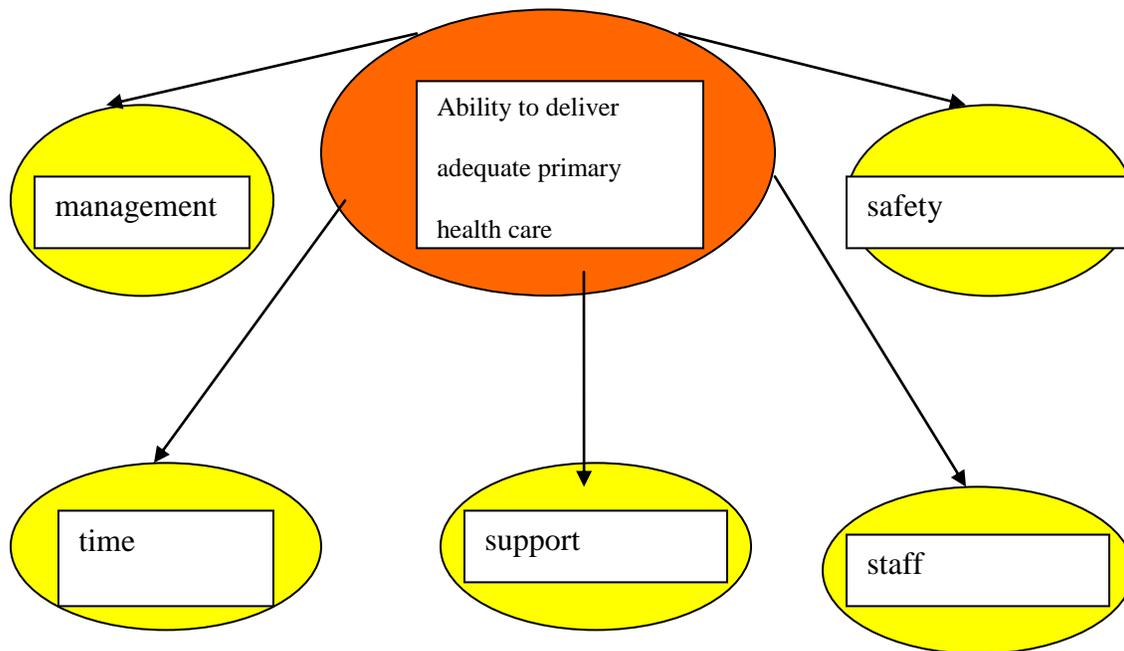


Figure 2; Issues preventing primary health care giving

MANAGEMENT

Style and type of management were seen to be the major factors relating to most issues relating to RAN life and burnout. There were 87 references to management and need for improved support by interviewees (see fig 3).

This is worrying partly explaining why turnover rates are so high and recruitment remains difficult. Fears for personal safety were frequently linked to levels of support by management. This is worrying partly explaining why turnover rates are so high and recruitment remains difficult.

One reason cited for poor management support was the perceived inexperience of District Managers who appear to lack understanding or recognition of the real needs of RANs. Comments related to issues such as pressures of varying and conflicting ideologies, unrealistic expectations and unmet needs suggesting as did Wilson et al (2001) that it only serves to distract from the key management tasks required to; (i) to establish and maintain

organizational focus (ii) recruit and retain quality staff, (iii) apply resources in a sustained fashion to achievable goals.

Responses included:

- management support, is something here that has been very poor.*
- they might pay lip-service to it, but they don't demonstrate any of those concerns at all.*
- haven't had a performance appraisal at all in the four years.*
- they could get us involved in learning and getting better health outcomes and giving us -- some sense of teammanship and those sorts of things I think would be really important.*
- all crisis management.*
- it's flawed and very difficult for the management structure to operate effectively under the guise of Queensland Health because kinships and family relationships interfere effectively with discipline.*
- a matter of cost*
- a lack of realistic understanding of the role by management for even basic resources to deal with very basic needs.*
- don't find that management is really supportive at all.*
- don't think they cover nurses. I think their expectation's that... nurses do this work, but they are not willing to cover them legally.*
- I don't think that they are doing their job properly. They are not really looking at what these nurses have to do*
- think there is the support and understanding of burn-out and stress and overwork especially when you have been dealing with a tricky situation.*
- I think it is probably improving. I don't imagine it's perfect, but I think it is improving.*
- The managers that I have had, have all been very inexperienced in management.*
- need managers that can manage, and they are managing a very unusual occupation. It is quite an unusual occupation when you think of all the multi roles of a RAN, especially a single post nurse*
- found management very helpful and understanding. In the time I was working with the Aboriginal Medical service the management had been remote area nurses themselves.*
- I felt that they understood the role and demands*
- The issues of finding appropriate staff and funding impact on how supportive management can be to the nurses on the ground.*
- no money for staffing level from middle management*
- This is talking about management and occupation health and safety issues, they are not supported. It is very ad-hoc.*
- up there in middle or top management, nobody has really made an effort, because of the increased workload, because of change in times, because of technology which takes up a lot of time,*
- nobody has really made the effort to look at the staffing levels. Nobody had really monitored that at all. They just expect you to continue as you were before.*
- management are only there to collect the facts and figures. They just don't understand -- they have no idea.*
- management really don't care what your skills are*

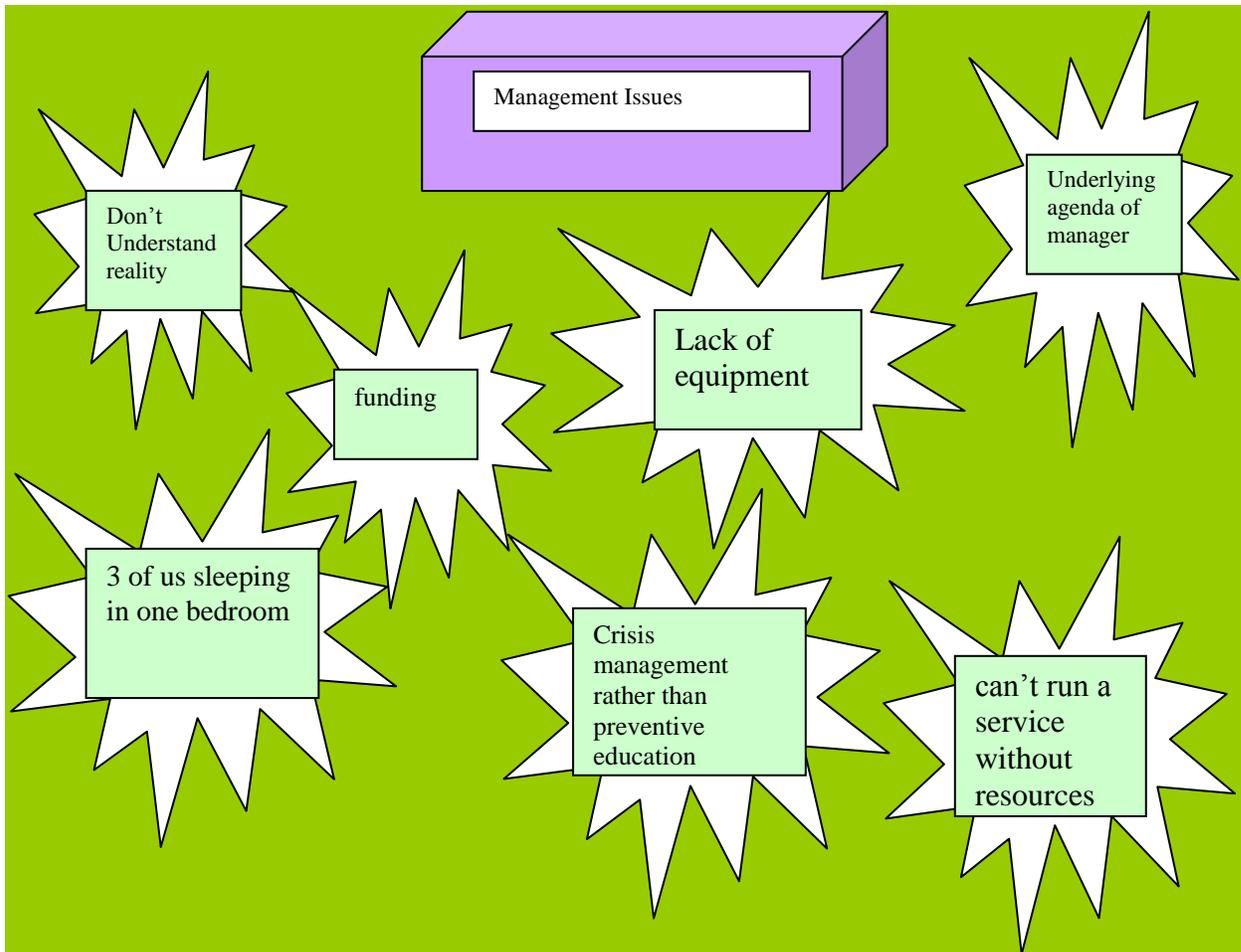


Figure 3; Issues arising from management models

The most common perception appears to oscillate on the one hand to saying it isn't the manager's fault as they are under-staffed, under-funded and under-prepared for their own roles to the other extreme of management really doesn't care as long as someone is there and willing to do whatever. RANs appear to reinforce this latter perception of management by the fact that because of their own sense of social justice they do in fact keep on doing more with less (in terms of time, equipment, resources, support and/or health or safety), thereby reinforcing management expectations/demands.

There are strong implications from this study for the safety of RANs in single nurse clinics in remote areas of Australia. Respondents discussed levels of violence within communities-especially those where alcohol is allowed identifying that as they were

unable to leave they were afraid for their safety at times. Such findings support views by researchers (The Council of Remote Area Nurses of Australia 2006);(Dade-Smith J. 2004) that poor health outcomes in remote communities reflect the social marginalization experienced linked with greater need for primary health care provision.

CONCLUSIONS

The findings in this study reflect that a socially unjust society equates to a violent society (Fisher, 1996 #24). This is evident in the Australian remote community lifestyle (Fisher, 1996 #24). It is of concern to note that RANs have voiced their concerns for many years (Yuginovich 2000) but little has changed. The link between community support and RAN ability to adequately fulfill their role in relation to Primary Health Care indicates the fragility of their positions and true lack of actual power within communities.

This truly is an unusual occupation; none of the information here is new but people still stay there in often untenable situations, being ignored for the most part when they ask for help and overlooked by Governments when they offer help to resolve issues in communities in their care as recently evidenced....yes a truly unusual occupation.

When you ask RANs why they do it they will give a plethora of answers mostly idealistic, romantic that only perpetuate the romantic notion-when we know it isn't the reality. Is the issue a State health one? Should we in fact be looking more closely to determine is it in fact intra-professional downward closure and how to reverse it? Should RANs ignore the moral imperative to keep on keeping on or should you in fact do as many RANs the Drs have done and express your dissatisfaction with your feet?

While ever this continues nothing will change. RANs will keep on keeping on until they burn out some never even really start or stay. We are not suggesting that people be left without health care but it begs the question; Why? What will happen to change it????????????? Yes a truly unusual occupation.....

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