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Remote area nursing in Western Australia: An examination of a conceptual model for practice

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REMOTE AREA NURSING IN WESTERN AUSTRALIA:
AN EXAMINATION OF A CONCEPTUAL MODEL FOR PRACTICE

BY

Anne Magee. RN, RM.

A Thesis Submitted in Partial Fulfilment of the
Requirements for the Award of

Bachelor of Nursing (Honours)

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Edith Cowan University

Supervisor: Adrienne Montgomery

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USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

ABSTRACT

The intent of this research was to explore the phenomenon of remote area nursing in relation to a theoretical framework, the SUN Conceptual Model. A Theory-Research-Theory strategy was chosen in order to modify, refine or redevelop the model. Using a descriptive, interpretive design, a sample of eight Remote Area Nurses (RANs) in Western Australia were asked to describe their experiences of remote area nursing. The data were collected by telephone interview. Themes were extrapolated and categorised according to key concepts of the previously developed model. Common components of significant statements were identified in order to gain understanding of the meanings of responses. Analysis revealed that some overlap existed between the original key concepts of the model which were subsequently regrouped or made redundant. This process culminated in a revision of the original model. The revised SUN Conceptual Model was thus considered to be a useful theoretical framework for reflecting the reality of remote area nursing, as supported by the literature. Study findings point to the need for more research to further examine the model as a theoretical framework for RAN practice and to identify factors which contribute to the effectiveness of RANs. The study provides a contribution to the knowledge base of RANs while moving towards the development of a theoretical framework which may be included in education programmes and ultimately practice.

DECLARATION

"I certify that this thesis does not incorporate without acknowledgement, any material previously submitted for a degree or diploma in any institution of higher education; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text."

Signature.

Date...15/6/92.....

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Chapter 1

Introduction and Purpose

The study reported in this thesis was an attempt to examine a conceptual model in order to test its applicability to the education, practice and research of Remote Area Nurses (RANs). A few conceptual models exist which are relevant to remote area nursing, but none encompass the complexity of the RAN's practice and life experience. Earlier work by the present researcher resulted in the development of a conceptual model aimed at providing a framework for remote area nursing practice. The SUN Conceptual Model was devised using concepts from Leininger's "Sunrise" model (Wenger, 1985, p. 304), "Concepts of Rural Nursing" developed by the Montana State University College of Nursing (M.S.U.C.N.) (Long & Weinert, 1989) and other related concepts identified in the literature. The current research study collected data on remote area nursing from practising RANs in Western Australia in order to substantiate, refute or modify the conceptual model.

Theory Development

Theory development is purported to arise from practice, utilising one of four major strategies: theory-practice-theory; practice-theory; research-theory or theory-research-theory (Meleis, 1991). The Theory-

Research-Theory process represents the strategy of choice to fulfil the present study objectives by taking theoretical concepts of the model and attempting to demonstrate their usefulness. This strategy involves the selection of a theory or theories compatible with the area of nursing under study and the redefinition and operationalisation of the concepts through research, the findings of which are used to modify, refine or develop an original theory, or develop a new theory (Meleis, 1991). A descriptive study design was used to gather the data because it was the most appropriate way to provide the rich detail necessary to adequately describe RAN practice. This entailed asking informants about their experiences as a RAN, which could then be examined in relation to the existing model.

It is the overall purpose of this study to implement the "research" phase of this theory-research-theory strategy in order to attempt to lay claims for validation of the SUN Conceptual Model, by identifying necessary modifications, refinement, or redevelopment of the existing model (see Figure 1).

"SUN"

CONCEPTUAL MODEL FOR THE REMOTE AREA NURSE

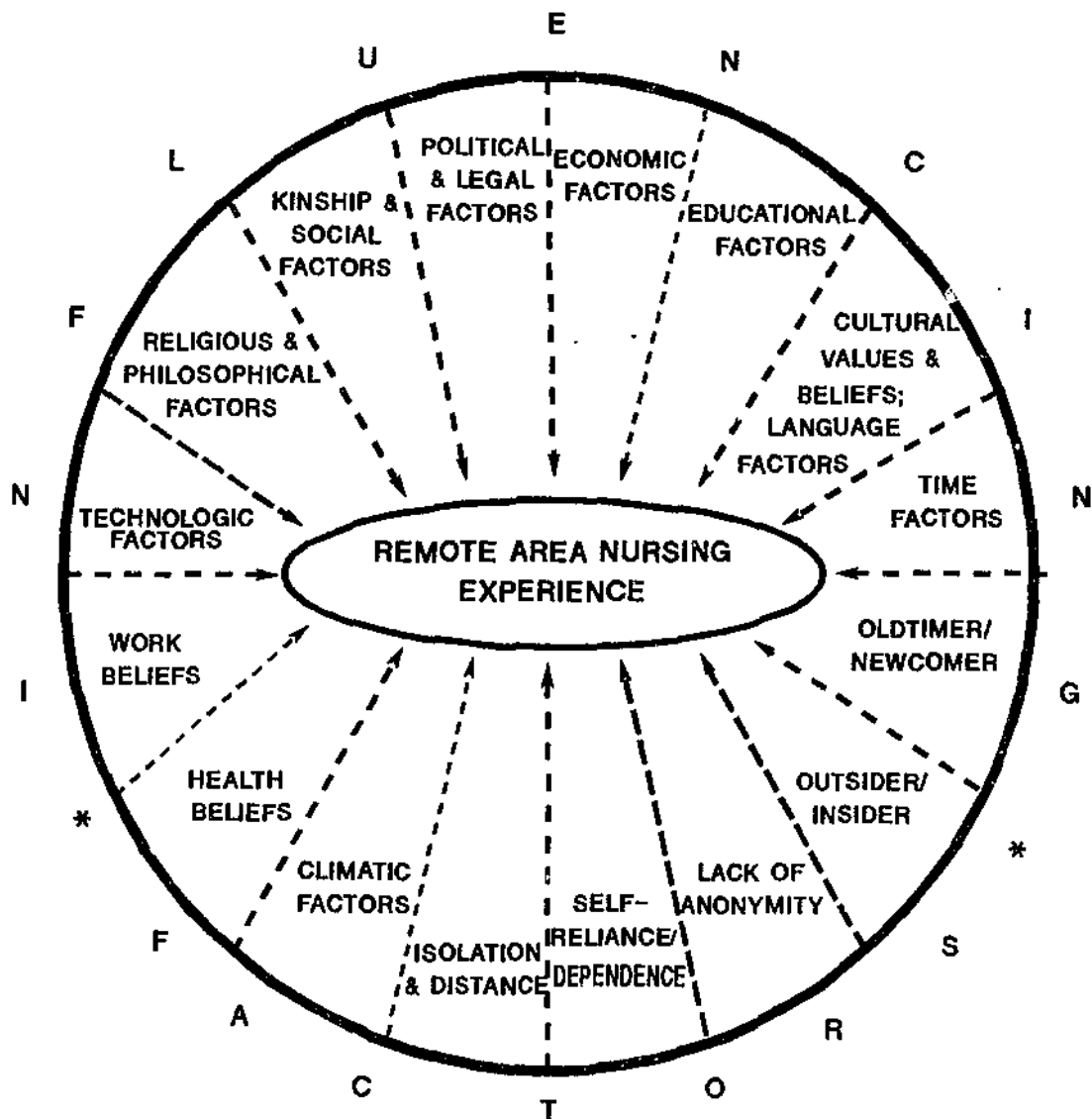


Figure 1.

ADAPTED FROM:

1. Long, K.A. & Weiner, C. (1989) Rural nursing: developing the theory base. *Scholarly Inquiry for Nursing Practice*, 3(2), 113-125
2. Wenger, A.F.Z. (1985) Learning to do a mini ethnographic research study: a doctoral student's experience, in Leininger, M. (Ed.) *Qualitative research methods in nursing*. Orlando: Grune & Stratton Inc.

Anne Magee
29 July 1991

Background

In an attempt to achieve relevant educational preparation for practice, several research studies have been conducted into the educational needs of RANs. Kreger (1991) asserts that RANs "practice in a context significantly different to that for which urban-based education courses prepare nurses in Australia" (p. i) and that:

remote communities are characterised by values, beliefs and behaviours, social and health status, and resource provision dissimilar to those usually encountered in urban areas. (p. i)

Kreger (1991) further notes that it is essential to provide RANs with a realistic view of their role including all of the dilemmas they are likely to face. Many of the anecdotal accounts of RANs themselves reflect that the nurses did not know what they were getting themselves into when they took up a remote area post. Many nurses write of the ambiguity of their role, frustration, lack of support and education, isolation and lack of privacy.

Two nursing models were perceived by the researcher to be closely linked to remote area nursing practice: "Concepts of Rural Nursing" (Long & Weinert, 1989) and Leininger's "Sunrise" model (Wenger, 1985, p. 304). The M.S.U.C.N. has been developing a theory base for rural nursing, recognising that there are differences in life and health care needs in the rural area. The M.S.U.C.N. researchers have identified seven concepts which influence the health and lifestyle of rural dwellers (Long & Weinert, 1989). These relate predominantly to the local definition

of health, difficulties obtaining services and to dualism in the nursing role. Leininger's work on transcultural nursing provides a basis from which to draw out factors relevant to the RAN, as 80% of RANs work largely with Aboriginal clientele (Cramer, 1989). According to Leininger, cultural factors are implicit in a person's health needs and as such must be identified as important when nursing people of other cultures. Some of these factors are related to education, family relationships, ways of running the community, and the potential language barrier. The SUN Conceptual Model for RANs was developed by the researcher as an extension of these two theoretical frameworks which were identified in the literature. The development of this model will be further discussed in the review of literature.

The present study is thus built on the premise that a synthesis of both of these models has the potential to provide a basis for an appropriate conceptual model to guide education, practice and research of the RAN. The aim is to broaden the knowledge base concerning the context of remote area nursing in conjunction with a previously developed conceptual model.

Research Questions

1. What are the common components of the experience of remote area nursing as identified by RANs?
2. Is there correspondence between the key concepts in the SUN Conceptual Model and those components identified by RANs?
3. Is the SUN conceptual model a useful model for guiding RAN education, practice and research?

Research Objectives

1. To study a sample of RANs in order to extract from the data the nurses' perceptions of their experiences as a RAN.
2. To examine RAN's perceptions of their experiences of remote area nursing in relation to a model of RAN practice.
3. To make claims for the validity of the SUN Conceptual Model.

Structure of the Thesis

This chapter has outlined the rationale for this study and the approach used. Chapter Two of the thesis introduces a discussion of the current issues and state of knowledge of remote area nursing, the development of the SUN Conceptual Model and the theoretical definitions of key concepts. Chapter Three provides the theoretical framework of this study, including a discussion on defining theory and theory building. Chapter Four describes the methods and procedures adopted for conducting this research while Chapter Five provides details of the findings and analyses of these data. The final chapter, Chapter Six, presents the conclusions of the study, the operationalised definitions of the key concepts and recommendations for future research, practice and education.

Chapter 2

Review of Literature

This literature review has a dual purpose: to provide an insight into the current issues and state of knowledge relevant to remote area nursing and to discuss the background to the development of the SUN Conceptual Model.

There are 217 documented RAN posts in Australia, of which eighty per cent are based in predominantly Aboriginal communities (Cramer, 1989). It has been recognised that remote area nursing is very different to nursing in the urban and/or hospital setting where the majority of nurses have been trained or gained much of their experience. Many skills are required of the RAN, and the remote area - with its complexity of cultural influences (both rural/remote and with a large Aboriginal population) - offers particular challenges to the RAN (Blackman, 1985; Cramer, 1984; Klotz, 1983; Lambeth, 1985; Nathan, 1983; Potts, 1990).

The Remote Area Nurse

The literature pertaining to remote area nursing is limited largely to focussing on the role of the RAN, not on the RAN as an individual. With the exception of Harris (1991), little is documented about the day to day life and experiences of the RAN.

There has been a growth in awareness of the plight of RANs, particularly with regard to educational needs. Research concerning remote area nursing has been limited to investigating these educational needs (Cameron-Traub, 1988; Kreger, 1991; Munoz & Mann, 1982) and has repeatedly

identified inadequate preparation for their extended role. Each of these studies indicated the necessity for a specific course to prepare RANs. An investigation of RAN training needs conducted by Munoz and Mann (1982) found that:

although the nurses providing this highly demanding level of health care should be among the best prepared within the nursing profession, this survey indicated the contrary. (p. 39).

Blackman writes of:

the poor educational foundation to prepare nurses for their remote area roles. There is little orientation to their work and inservice education is at best, scanty. (1985, p. 6)

Cameron-Traub's (1987) study indicated that a majority of essential skills were acquired mainly by trial and error and textbook instruction, after commencing work at a post. However, RANs indicated a preference for learning by supervised instruction and special courses. Harris (1991) emphasises the need to keep education and skills for RANs at a level appropriate to that speciality. Several curricula are under development or currently in place throughout Australia specifically to meet the needs of RANs; for example, at the University of Southern Queensland (Toowoomba) and the Health Department of Western Australia (HDWA).

It is well documented that nurses are the main providers of services in the remote area (Cramer, 1987; Kreger, 1991; Watson, 1987). According to Kreger (1991),

In the absence of other health, and welfare professional and ancillary personnel, RANs participate in an exceptionally diverse range of activities expanded well beyond the usual scope of nursing practice in Australia. (p. i)

Kramer (1985) highlights the difficult period of transition for nurses, between receiving nursing education and practising in the workplace, with her concept of "reality shock". This refers to the differences in "ideals, values and culture" (Kramer, 1985, p. 891), between what is taught in the nursing school/university and the realities in the workplace. This conflict has led to ambiguity of role, where nurses are unable to bridge the gap between classroom ideals and the actualities of practice. According to Kreger (1991), the RAN's:

inability to fulfil conflicting, unrealistic and unreasonable expectations contributes to role conflict and ambiguity, contraction of actual nursing practice and ineffectiveness and inefficiency in remote area health delivery. (p. i)

The Committee of Enquiry into Health Services in South Australia (1973), found that:

many nurses, while technically competent, suffer considerable mental and physical stress whilst adapting to and gaining experience in the outback. (cited in Kreger, (1991, p. 8)

This situation is partly due to the fact that these nurses are expected to practise clinical skills outside their professionally defined role (Blackman, 1985; Cramer, 1984; Klotz, 1983; Lambeth, 1985; Munoz & Mann, 1982; Nathan, 1983; Potts, 1990). Reality shock may be a factor contributing to this finding.

Klotz (1983) highlights the legal dilemmas of nursing in isolated areas of Australia:

I would say at the moment there are no **safe** practices because no one is adequately trained to work in isolation. Legally we are in a very grey area. (p. 30)

Thornton (1991) identifies the legal implications of RANs practising outside the role they were educated for, the confusion over employment contracts and job descriptions, and the absence of an award specific to RANs. Other legal concerns of practice are raised, with concerns regarding the administration of drugs, responsibility over health worker practices, the standard of care in sometimes substandard conditions, with understaffing and poor equipment and the extended practice of RANs not covered by legislation (Cramer, 1984; Kreger, 1991). This issue is currently being addressed by the Staff Development section of Community Health Services (C.H.S.) in Western Australia with the formulation of a new education curriculum and plans for establishing protocols for nursing practice. This will aid in relieving the current ethical and legal dilemmas facing RANs.

According to Kreger (1991):

Negotiation, clarification and formal recognition of the scope of remote nursing practice is a prerequisite to appropriate RAN education (p. 60).

Kreger (1991) identified the need to provide RANs with an "understanding of the remote area context, expectations and dilemmas that are likely to confront them in practice" (p. 60). She proposes that insight into the context in which RANs work would provide a realistic understanding of nursing practice and associated educational needs.

Harris (1991) explains that "anything more exotic than salt and pepper" has to be acquired outside the community. A reduced selection of goods and services is provided in

the community, but at an inflated price. Potts (1990) describes the need for RANs to adapt:

to powdered milk, frozen bread, fresh fruit and vegetables every second week, week old news and weekly mail during the dry season. (p. 13)

In the wet season, the availability of goods and services is further reduced (Harris, 1991). Unreliable postal services create difficulties in undertaking studies (Kreger, 1991). The effects of weather on unsealed roads complicate the evacuation of patients, for which "roads and airways are vital" (Cramer, 1989, p. 23). Problems of unreliable radio and telephone communication are identified as resulting from atmospheric conditions and organisational situations (Cramer, 1989; Gehling, 1979; Harris, 1991; Kreger, 1991).

A major source of concern is the requirement for continuous on-call work. The community expectation of a 24 hour service places unrelenting demands on the RAN, posing a threat to his/her personal and professional well-being (Cramer, 1984; Gray, G. 1982; Harris, 1991; Kreger, 1991; Lambeth, 1985; Potts, 1990). According to Cramer (1984), "the stress [of fulfilling a medical role] is compounded by unrelenting community demands and chronic fatigue" (p. 29). Communities reportedly display "insensitive attitudes toward...[the RAN's] privacy, rest and recreation" (Lambeth, 1985). RANs mention factors such as feelings of burnout, stress, frustration, dissension, helplessness, ambiguity of role and lack of anonymity (Campbell, 1982; Cramer, 1984; Kreger, 1991; Lambeth, 1985; Potts, 1990) and

a sense of just "filling the gaps in the service delivery" (Kreger, 1991, p. 29).

According to Cramer (1989), "nurses become casualties of the health services they provide" (p. 29), and possess no control over personal time (Cramer, 1989; Lambeth, 1985). Cramer (1984) asserts that the unpredictable work demands make organisation difficult to achieve, and as a result "feelings of exhaustion and futility ensue in time" (p. 41). Cramer (1987) identifies RANs as at risk due to the overwhelming pressures on them, with isolation from peers, "detached from the central organisation" (cassette recording) and as the most constantly available person for any crisis or trivial demand. Aggression and threats of violence against the RAN are identified as an existing problem, threatening their safety (Cramer, 1987; Harris, 1991; Kreger, 1991; Lambeth, 1985; Thornton, 1991).

Difficulties of isolation are evident in various forms. Potts (1990) identifies geographic, social (cultural), professional and psychological isolation experienced as a RAN. This was supported by other authors (Harris, 1991; Kreger, 1991).

The multiple role of the RAN is described by several authors, ranging from changing tyres on the four wheel drive, to practising advanced clinical skills (Cramer, 1989; Harris, 1991; Lambeth, 1985; Nathan, 1983; Potts, 1990).

Harris (1991) asserts that "the first 12 months is always the hardest for a remote area nurse" (p. 100), as it encompasses a wide range of concepts (for example, public

health) and diseases foreign to most nurses. She describes her experience of becoming part of the community, and the advantages of an informal atmosphere which promotes trust with clients, explaining, "I think that trust improves the outcome of your care tenfold" (p. 102). This same closeness achieved with the community creates difficulties when social problems such as sexual assault occur. This aspect of social/role conflict is also identified by Kreger (1991). Harris (1991) explains that "with extra effort" (p. 103) an active social life can be enjoyed by RANs.

Cramer (1987) asserts that:

few administrators have knowledge of the total demands and complexities faced by field workers in remote areas [and are] seldom willing to listen and learn from RANs. (cassette recording)

She alleges that nurses are left alone for indefinite periods, with inadequate orientation and inservice, where job descriptions and staff appraisals are either unrealistic or non-existent. She describes administrators as being "uncomprehending/indifferent to the workload of RANs" and that support or intervention is either unreliable or does not occur, reflecting not only neglect of the nurses, but also of the community. Cramer also takes the view that it is "not the responsibility of the nurse on site to state limits of service".

It is apparent that the experiences of RANs in Australia are comparable with those of Canadian RANs. Hodgson (1982) highlights the difficulties of working with people of other cultures, both in practice, and in the sense of being isolated in a community culture foreign to

one's own. She identifies similar demands and challenges to those already described. She cites Goffman (1961), who coined the concept of "total institution", defined as:

a social arrangement in which the barriers separating the three main spheres of life - work, sleep and play - have broken down, so that all three are carried out in the presence of others in the same location and according to a single rational plan. (p. 110)

Hodgson likens this to the situation of RANs, living, working and socialising within one area, with communal housing, and a resultant lack of privacy.

Many positive attributes of the remote area nursing experience are identifiable in the literature, including experiencing the wet season, personal and professional growth, the sunsets, the isolation and beauty of flora and fauna (Cramer, 1984; Harris, 1991; Potts, 1990). Potts (1990) explains that "the good things make up for the bad" (p. 14) and Cramer (1984) identifies the opportunity for RANs to "gain rare insights into the [Aboriginal] people's beliefs and values about life" (p. 29).

Another educational aspect of fundamental importance is the apparent absence of an appropriate theoretical framework on which to base nursing education/practice and research in this area. McFarlane (1976) stresses the need for a theoretical frame of reference as "an expression of professional need" (p. 443). The Australian Nursing Federation (A.N.F.) Position Statement (1991) on remote area nursing noticeably does not comment on this item, and yet it is accepted that nursing practice, education and research require some theoretical frame of reference (Fawcett, 1984; Meleis, 1991). Reid (1983), cited in

Blackman (1985), maintains that RANs have no "conceptual frame of reference from which they can work" (p. 6), causing confusion of role and failure to individualise care. Blackman (1985) asserts that the primary health care model is one way to define and guide the role of the RAN, but this conflicts with the findings of Kreger's (1991) study which found that "the immensity of demand for curative services impinges on the preventive efforts of RANs" (1991, p. 7) and that the overall emphasis of practice is on:

acute illness and trauma...[the community] expects a clinical service...[with] actual resistance by community and health workers to primary health care principles of illness prevention and health promotion through community development and self reliance (p. 23).

This is supported by other authors (Campbell, 1982; Gehling, 1979; Glover, 1986; Potts, 1990). The reported resistance to preventive measures by community members and the tremendous workload which enforces a priority of acute care, indicates that the health promotion and PHC models are not adequate to cover the realities of practice.

Blackman (1985) highlights the high turnover rate amongst RANs where "over 50% stay for one year or less" (1985, p. 6). This is supported by other studies (Kreger, 1991; Percival, 1986). Percival (1986), in her study on staffing levels in Western Australian country areas, explains that:

poor staffing levels have the potential to seriously affect the delivery of safe, acceptable standards of health care to rural communities. (p. 1)

This has deleterious effects on both staff morale and workloads, with "emergency staff [used] as stopgaps" (Percival, 1986, p. 1). The use of temporary staffing is costly both financially and in disruptions to staff and clients.

Cramer (1986) suggests that administrators are prepared to finance relief staff, rather than attend to the problems facing RANs already in the field. Kreger's (1991) study identified indications of the high turnover and insufficiency of staff, creating difficulties in implementing primary health care principles.

The Client Population of RAN Practice

It is reported that the Australian rural population is disadvantaged in the provision of health services and possess lower levels of health than their urban counterparts (Kellehear, 1988). The Aboriginal population experience even lower levels of health:

Internationally, the expectation of life at birth for Aboriginals...is comparable with levels reported in India, Indonesia, Haiti and Kenya (Australian Institute of Health. [AIH], 1990, p. 31)

In almost all disease categories, Aboriginals rate higher than non Aboriginals, with mortality rates two to four times higher and life expectancy 12 to 20 years less than for the non-Aboriginal population (AIH, 1990). In remote areas, these health problems reflect the poor physical environment and it is suggested that social and economic inequality are contributing factors (AIH, 1988). While inroads have been made into the improvement of Aboriginal

health overall, great problems still exist and cause concern for the achievement of the World Health Organisation goal of health for all by the year 2000. Health problems of Aboriginal people include: low birthweight, undernutrition, increasing rates of lifestyle diseases, infectious diseases, sexually transmitted disease, parasite infestation and anaemia (AIH, 1990, Gehling, 1979; Glover, 1986; HDWA, 1990).

Kellahear (1988) highlights the difficulties [or impossibilities] of changing the lifestyle behaviours "associated with social and geographical positions" (p. 3) of people in the rural area. He argues that "lifestyle, to the extent that it is determined by social positions, is rarely chosen" (p. 3) and that:

cultural values and resistances are shaped by the rural requirements of independence and "toughness" imposed upon such people by the social and geographic features of their isolation. (p. 4)

According to Edwards (1988), "it is now impossible to observe traditional Aboriginal societies in their pristine state" (p. vii). This illustrates the process of change occurring within this culture. Holland (1991) adds to the discussion, by providing a list of factors which contribute to the current problems facing Aboriginal people:

loss of identity
loss of culture
loss of land (belonging to)
loss of social culture
loss of independence
loss of hunting grounds (bush tucker)
loss of citizenship (given back 1967)
loss of language
institutionalisation (welfare)
enforced removal of children
poor education
poor health and poverty. (p. 89)

According to Cramer (1989), "the intrusion of western ways has eroded traditional sacred laws" (p. 30). Kreger (1991) found that the community's health beliefs and behaviours were influenced by diverse social, economic, historical, cultural, environmental, educational and political factors. Nathan (1983) highlights the incongruities between Western medicine and Aboriginal medicine, which "organises cultural experiences and social cohesion around the sickness of community members" (p. 40). This is supported by Gehling (1979), who stresses the contrasts between Aboriginal and European attitudes concerning health and lifestyle. She relates her experiences of one community's use of traditional healing methods. Glover (1986) contributes further to the discussion, identifying various taboos, beliefs and practices concerning midwifery. Campbell (1982) offers insight into other aspects of Aboriginal life, including the indifference of Aborigines to age and birthdays, and that "tablets are rarely taken" (p. 2022). Nathan (1989) proposes that all people working in Aboriginal communities should undergo rigorous orientation prior to commencement of duties.

Difficulties confront the RAN in making decisions, because of the incongruities of RAN and community beliefs (Cramer, 1984). Hodgson (1982) stresses that community expectations may relate to the traditional attitudes and practices of health care which were holistic in nature, and hence the nurses orientation may be different. She asserts that:

asking a nurse to handle social, religious, and even economic duties may seem perfectly logical to anyone subscribing to this extended or multifaceted definition of "healer". (p. 109).

Nathan (1989) highlighted the differences between western medicine and "indigenous medicine, which organises cultural experiences and social cohesion around the sickness of community members" (p. 40). She further proposes that all people working in these communities should undergo rigorous orientation prior to commencement of duties.

Communities reportedly have little appreciation of the demands placed on the RAN with continuous 24 hour call, seven days a week (Kreger, 1991).

The Aboriginal health worker is described as a "cultural broker" (AIH, 1988, p. 121). The support and knowledge provided by these workers assist the RAN greatly (Gehling, 1979; Nathan, 1983) and in fact health workers in some areas assume greater responsibility for health care than their counterparts (Glover, 1986). However, problems exist due to the need to avoid certain people which can hinder their role (Gehling, 1979). Kreger's (1991) study indicates some unreliability of health workers to attend work.

Blackman (1985) asserts that Aboriginal customs differ dramatically from European practices and beliefs and that "most nurses have little or no skills in understanding the aboriginal culture or language" (p. 5). This is supported by the studies of Cameron-Traub (1988), Kreger (1991) and Munoz and Mann (1982). Nurses report "an absence or paucity of transcultural practice preparation" (Kreger,

1991, p. 50), creating difficulties in the delivery of service.

Development of a Conceptual Model for Practice

No single theoretical framework has been found to be of use for the RAN. This investigator has previously developed a conceptual model by integrating/adapting two theoretical frameworks ("Concepts of Rural Nursing" and concepts from Leininger's Transcultural Nursing Theory) with the inclusion of other relevant concepts found in the literature on remote area nursing in Australia.

Concepts of Rural Nursing

The MSUCN have been undertaking research into health care issues concerning rural dwellers in sparsely populated, rural areas of Montana, in an attempt to develop a theory base for rural nursing. The impetus for such a study came from the assumption that:

How people define health and illness has a direct impact on how they seek and use health care services and is a key concept in understanding client behaviour and in planning intervention. (Long and Weinert, 1989, p. 121)

This research, as yet incomplete, was undertaken in the belief that urban models of health care were inappropriate for rural areas:

Health care needs are different in rural areas from that in urban areas...and all rural areas...[have] some common health care needs (Long & Weinert, 1989, p.115).

Long and Weinert (1989) reported that certain common key concepts were appearing from these data. It was found that

rural dwellers defined health primarily as the ability to work, to be productive, to do usual tasks. Little emphasis was placed on the comfort, cosmetic and life-prolonging aspects of health. Pain was often tolerated for extended periods so long as it did not interfere with work. Rural dwellers were seen to be present-time and crisis orientated. Rural dwellers in Montana were found to be more self-reliant than urban dwellers, resisting health services from those seen as outsiders. The new nurse in the area was likely to have difficulty as he/she is seen as a newcomer. Health care providers experience a lack of anonymity during and out of work hours. Nurses in Montana identified a sense of professional isolation. Health workers experience much greater role diffusion, with an inability to separate the activities and behaviours of certain roles. Rural nurses are expected to perform a vast array of tasks (Long & Weinert, 1989, p. 120). Another concept identified was that of insider/outsider, where it can take many years before health professionals are accepted into a community.

It would appear that those concepts identified to date do have possible application to the RAN. One of the assumptions underlying this reported study is that the rural nurse is "the front-line health care worker" (Nichols, 1989, p. 129), which is comparable with the Australian remote area situation. It is reported in Australia that community members resist efforts of health promotion and prevention of illness, but demand emergency/clinical services (Kreger, 1991). Differences in

health status are noted between urban and rural areas.

RANs in Australia experience professional isolation, with an absence of access to mentors, role models and professional networks (Kreger, 1991, Potts, 1990).

Australian RANs reportedly experience social/role conflict, a lack of anonymity, poor resources and inadequate support systems (Kreger, 1991).

The key concepts that have emerged from the Montana study to date are: work beliefs; health beliefs; isolation-distance; old-timer/newcomer; self-reliance and lack of anonymity (Long & Weinert, 1989, p. 115). These were the first concepts to be included in the SUN Conceptual Model.

Concepts from Transcultural Nursing Theory

The culture concept is derived from anthropology, where health and illness are studied within the cultural context (Leininger, 1990, p. 54). Leininger's anthropological studies have shown that the cultural beliefs, values and social systems of a group determine their health care needs (Leininger, 1979, p. 21).

Leininger's emphasis is on giving culturally congruent care, without which health care is undermined and inappropriate (Leininger, 1984, p. 43). She asserts that:

every nursing care situation has transcultural caring behaviors [sic], needs, and implications [and that] caring behaviors [sic] and functions vary with social structure features of any designed culture. (Leininger, 1988a, p. 11).

Many assumptions are postulated in this theory including that care, health and culture are closely linked (Leininger, 1979). Care, according to Leininger (1988b, p.

134), is fundamentally cultural, with each cultural group having their own "emic" values, beliefs and practices, but these vary from one culture to another. Societal systems are said by Leininger (1988a) to influence these and health care needs. According to Leininger (1987), the "etic" view is that of the profession, who also have their own values, beliefs and practices. If the "emic" and "etic" views differ greatly, stress and incongruent care will result (Leininger, 1987). Care is multidimensional with psychological, spiritual, environmental, physiological and cultural aspects (Leininger, 1988a. p. 5). "Culture is... the blueprint for determining human decision making and actions" (Leininger, 1984, p. 42), therefore the nurse needs to consider cultural factors even for basic nursing care. All cultures have their own folk (health) care practices (Leininger, 1985, p. 209). Because the folk-care system and practice is different from the Western health-care system and practice, Leininger (1984) believes that it is essential for the nurse working with people of other cultures to have knowledge and understanding of these. For the nurse to give holistic and comprehensive nursing care it is necessary to have knowledge and understanding of the culture of that individual or group. Nursing care must be culturally congruent with the client to be holistic. This, it is asserted, will also result in increased client satisfaction, better promotion of health, and quicker recovery from illness and disability (Leininger, 1984, p. 42). Nursing care that is not culturally congruent will result in problems of nurse-client relations and a failure

for the client to benefit from health-care with signs of client displeasure, lack of cooperation, refusal to comply with treatment and difficulty in achieving therapeutic goals (Leininger, 1978a, p. 11).

The theory of transcultural nursing is particularly relevant to the practice of the RAN as approximately 80% of RANs "work in predominantly Aboriginal communities" (Cramer, 1989, p. 26). The three Australian surveys of the educational needs of the RAN have identified cultural factors as requiring attention (Munoz & Mann, 1982; Cameron-Traub, 1987 & Kreger, 1991). RANs report encountering cultural differences with Aboriginals and other cultural groups. They report an "absence or paucity of transcultural practice preparation" (Kreger, 1991, p. 50). The RAN is limited due to inadequate knowledge of cultural values, beliefs and behaviours (p. 50) and communication difficulties arise. Several more experienced RANs spoke of conflicts between Western health practices and those of other cultures.

Reinhardt and Quinn (1973) assert that:

to be effective, nurses in the community must consciously design and implement their services, giving much thought to the indigenous people's health values, norms, attitudes, and behavior [sic]. They must take the people's health beliefs and practices into account, integrating health services with the culture's health practices (p. 47).

The Aboriginal kinship system is known to be complex (Edwards, 1988). The RAN requires some knowledge of this system to anticipate/avoid difficulties. For instance, the Aboriginal health worker may not be able to speak to and hence treat a son/daughter-in-law.

Leininger's "Sunrise" conceptual/theoretical model of cultural universality and diversity (Wenger, 1985, p. 304) was developed by her in order to guide the data collection relating to clients of various cultural groups. The seven key concepts of this model are: technologic factors; religious and philosophical factors; kinship and social factors; political and legal factors; economic factors; educational factors and cultural values and beliefs. These concepts were also added to the SUN Conceptual Model.

The "SUN" Conceptual Model for the Remote Area Nurse

The SUN Conceptual Model for the RAN has been devised by adapting Leininger's "Sunrise" theoretical/conceptual model of transcultural care diversity and universality: a theory of nursing (Leininger, in Wenger, 1985, p. 304), concepts of rural nursing (Long & Weinert, 1989), and other factors identified in the literature. The developed model was named the "SUN" Conceptual Model, to indicate that it potentially reflected the broadest view of the experiences of RANs available. The factors potentially influencing RANs' experiences were situated within the sun-shaped model. Each key concept was divided by interrupted lines, to depict the belief that there were interrelations between, and overlapping of, factors. Once the model was devised its applicability could be evaluated with respect to descriptive information provided by RANs, with resultant claims for validation or further development of the model.

Although the concepts identified by the MSUCN and Leininger were originally designed largely to reflect or

obtain data on (potential) clients and communities, the researcher's belief was that they could be utilised in a different perspective, that is, to elicit and categorise data on factors influencing the RAN's experiences and perceptions of the community. In this way data could be elicited about what the RAN experienced and what his/her views or perceptions were on various aspects of the community.

Australian RANs' practice involves working with people in the rural area with their specific health needs, and also with different cultural groups, particularly Aborigines. It is proposed that the combination of Leininger's Theory of Transcultural Nursing and Concepts of Rural Nursing could serve as a valuable framework on which to base remote area nursing practice/education.

Several other concepts pertinent to remote area nursing in Australia were identified in the literature, which were included in the SUN Conceptual Model. Australian literature points to Aboriginal people having a problem of dependency, where the patriarchal influences of the past have led to a lack of both initiative and self-determination (Edwards, 1988; Holland, 1991; Kreger, 1991). RANs have reported that Aboriginal health workers sometimes relinquished their responsibilities, often seeking a second opinion, due to "stress, cultural/social pressures, [and] a history of dependency" (Kreger, 1991, p.23-24). This being the case, "Dependence" has been added as an alternative to the concept of "Self-reliance" in the model.

"Time" was another factor identified as having an effect on RANs. This concept has been related in the literature in several ways. The health worker could not always be relied upon to be present during normal clinic hours and keeping to a schedule was not always valued (Kreger, 1991). RANs reported not have enough personal time or sufficient hours in a day to complete, or even sometimes to attempt certain tasks, such as health promotion and preventative health. The extended length of time needed for travel to evacuate clients and send correspondence by post have been identified, and time of day was crucial to the evacuation of clients (Cramer, 1989). "Time Factors" were thus added to the model.

The use of language other than English was identified as a barrier to communication by RANs (Cameron-Traub, 1987; Munoz & Mann, 1982) and was not deemed by the researcher to be explicit enough within the key concept of "Cultural Values and Beliefs". This was therefore modified to read "Cultural Values & Beliefs; Language Factors".

Climate was a concept identified as affecting RANs in that it created communication difficulties in bad weather. Transportation, both aerial and road, was susceptible to problems, particularly due to floods (Cramer, 1989, Kreger, 1991). A lack of adequate air conditioning in extreme heat was identified. Therefore "Climatic Factors" was also added to the model.

The writings of RANs mention such factors as feelings of frustration, helplessness, ambiguity of role and lack of anonymity (Campbell, 1982; Cramer, 1984; Kreger, 1991;

Lambeth, 1985; Potts, 1990). This researcher believes that this is partly due to an inadequate understanding and appreciation of the cultural and rural factors applicable to living and practising in this area.

Conclusions

From the preliminary investigation prior to commencing the study, it became clear that the broader milieu of remote area nursing had not been studied in detail or linked to theory. The researcher proposes that a thorough understanding of the context of life and practice in remote area nursing, with emphasis on (Aboriginal) cultural and rural factors, would have benefits for the RAN, and the client. The SUN conceptual model for the RAN can be viewed as a potential foundation on which to base practice, education and research for the RAN.

Chapter 3

Theoretical Framework of the Study

The debate persists amongst nursing scholars as to the distinction between various theoretical structures used to describe nursing practice. This chapter presents the current schools of thought on defining these and presents the researcher's orientation for the purposes of this study. Theory development is discussed with a particular focus on exploring the significance of descriptive theory.

Defining Theoretical Structures

The issue of defining "theory" can be divided into two distinct schools of thought: (1) those that mandate strict, specific criteria in order to justify the title of "theory" and (2) those who maintain a more pragmatic approach. Within the ranks of the first viewpoint, McKay (1969) suggests that a theory is "a logically interconnected set of confirmed hypotheses" (cited in Chinn & Kramer, 1991, p. 63). Fawcett (1989) maintains that a theory focusses quite specifically on particular phenomena and requires emphasis on the interrelationships of concepts by means of propositional statements and generation of hypotheses. The second school of thought offers more flexibility with a broader interpretation. This includes defining theory as a way of thinking about and structuring concepts; an organising framework to guide research, practice, interaction and education; a means of relating concepts and as the powerhouse of substance to illuminate phenomena (Barnum, 1990; Bush, 1979; Chinn & Kramer, 1991; Ellis,

1968; Meleis, 1991; Ray, 1991). Dickoff & James (1968) maintain that theory may range in complexity from simple to more elaborate.

It is argued that the major difference between a theory and a model is the level of abstraction, conceptual models being more representative of reality (Meleis, 1991; Fawcett, 1989). Conceptual models have been viewed on the one hand, as precursors to the development of theory (Fawcett, 1989; Meleis, 1991; Wilson, 1989) and on the other, as similar to or synonymous with theory (Barnum, 1990; Meleis, 1991; Wilson, 1989). Chinn and Kramer (1991) define conceptual framework/model and theoretical framework/model in similar terms as a "structure comprised of concepts related to form a whole" (p. 197). In relation to the research process, Wilson (1989) offers no distinction between the identified theoretical structures:

a theory, conceptual model (paradigm), theoretical framework, or model serves to provide parameters for the study, guides data collection, and provides a perspective for interpreting the data, enabling the scientist to structure the facts into an orderly system. (p. 277)

The SUN Conceptual Model in the context of this study is a precursor in the development of a theory for remote area nursing.

Theory Development

Meleis (1991) offers several methodologies to advance theory development. One of these is the "Theory-Research-Theory" strategy. The process of this strategy involves selecting a relevant theory, defining concepts for the

purposes of the research and utilising the research findings to either improve the original theory or generate a new theory (Meleis, 1991). The initial stage of such a process may be purely descriptive. While descriptive theory is the first level of theory development, it is also the most important, because "it determines what entities will be perceived as the essence of the phenomenon under study" (Barnum, 1990, p. 4). From this, descriptions may evolve regarding the salient parts of the theory (Barnum, 1990). Dickoff and James (1968) regard this as a necessary step on the road to prescriptive theory.

Barnum (1990) identifies the three structures of theory: context, content and process. This research study attempts to lay claims for validity of the SUN Conceptual Model as potentially providing the theoretical "context" part of the theory structure for remote area nursing practice. Barnum (1990) explains that:

context is the environment in which the nursing act takes place...and in some cases, describes the nature of the patient's world. (p. 59)

The data collected in order to meet the purposes of this study will also add to the "content" of the SUN Conceptual Model. The "content" of a theory provides "the main theory building bricks that give the theory form but are not the moving forces" (Barnum, 1990, p. 61).

Summary

This study was guided by the "Theory-Research-Theory" strategy suggested by Meleis (1991). A descriptive approach to theory development was adopted. The SUN Conceptual Model was the framework used to categorise and structure the data. The study design and methods used in this study is detailed in the chapter to follow.

Chapter 4

Methods and Procedures

This chapter describes the study design, procedures for obtaining the sample and method of data collection. The section on the treatment of data includes a discussion of ways to enhance methodological rigour in qualitative research and the method of data analysis used in this study. Ethical considerations are highlighted and assumptions held for this study are listed.

The Descriptive Study

A descriptive design was considered to be the most appropriate for this study. Burns and Grove (1987) contend that such studies "attempt to achieve a clearer picture of the phenomenon" (p. 243) under examination. Seaman (1987) claims that such a design uses "whatever method of data collection is the most helpful" (p. 181) and that although such methods are basic, they are "essential for providing information upon which later studies may build" (p. 181). A qualitative, interpretive method, a relatively new approach used in nursing research, was selected to guide data collection and analysis for this study. In most qualitative studies data collection and analysis take place simultaneously. Barnum (1990) explains that the underlying assumption of qualitative studies is that "things must be known in their entirety rather than by reduction to their parts" (p. 165). One way to approach this task is to investigate phenomena from the research participants' perspective. In this case:

individuals are viewed within an open perspective in that they are active agents, interpreting their own experience and creating themselves by their inner existential choices. (Munhall, 1988, p. 22)

Munhall (1988) further explains, that, in exploring phenomena from the participants' perspective:

the subjective experience of the individual and or groups is valued and described. Meaning comes from the source and is not presumed, assumed, or assigned. (p. 23)

In such studies, objectivity is defined differently than it would be in a quantitative study, for:

objectivity itself, can be viewed as a subjective discovery, and perception of it's own. (Munhall, 1988, p. 23)

This study was guided by the "Theory-Research-Theory" strategy suggested by Meleis (1991). A descriptive approach to data collection and analysis was adopted.

Assumptions

The following assumptions were held for the purpose of this study:

1. Informants will tend to report their perceptions and/or activities honestly and to the best of their ability;
2. A person's present experience will be understood in the context of past experience;
3. Informants' self-reported perceptions will provide information which will enable the refutation and/or further development of the SUN Conceptual Model.

Sample

The population of RANs in Western Australia is 24-25 (Payne, A. personal communication, September, 1991). A sample of eight RANs was drawn for this study, from those

volunteering to describe their experiences. These nurses practice in four community health regions (see Appendix B). The study sample included only nurses who possessed at least six months experience as a RAN, to ensure that a sufficient period of time had passed to enable informants to adequately evaluate their experience. Directors of Community Nursing in each region were sent introductory letters seeking permission to approach RANs in their respective areas to participate in the study (see Appendix C). Permission was granted by them and the name, address and contact telephone number of suitable RANs was obtained. Each nurse was sent a letter inviting his/her participation in the study with an accompanying consent form (see Appendix D). These RANs were requested to return the consent form signed if they were willing to participate, unsigned if they preferred not to join the study. The first four letters were sent by mail, which proved to be a less than optimal way of communication as the mail process was lengthy, both in the RANs receiving the letter, and in the researcher receiving the reply. At the suggestion of other Directors of Community Nursing, the remaining five letters of introduction were sent by facsimile (fax). This method prompted a maximum three day turn-around, from sending the fax to receiving faxed replies from the RANs. One RAN to whom a letter was mailed, failed to return the consent form, so a target sample of nine was reduced to eight. The responses from the remaining RANs indicated an enthusiastic attitude towards participating in the study.

Data Collection

Data were collected using an interview technique. Because of the expected high cost to arrange face to face interviews, a telephone format was selected. A semi-structured interview was conducted with each of the RANs in order to maintain flexibility, to enable the use of questions to elicit information not forthcoming and to allow for clarification of answers or descriptions. A selection of guideline questions were used to structure the interview (see Appendix E). These were generated by the researcher with the assistance of an interview/survey expert who checked for ambiguity of wording and bias of questions. A practice interview was conducted with an expert in remote area nursing, to test the interview and recording technique and to gauge the length of time required for the interview.

Procedure

The researcher made initial verbal contact with the informants via telephone from Perth, on receipt of each signed consent form. At this time, arrangements were made for a convenient appointment time with each RAN, ensuring that sufficient time was allowed for completeness of data collection. These initial calls took approximately ten minutes, during which time the expected length of interview was discussed and consent for taping the interview obtained. The interviews were conducted over a six-week period. Informants chose a quiet room within the clinic or their own residence for the interview. The researcher

conducted the interviews from her private residence. Several RANs voiced the concern that the interview could be interrupted by clients seeking treatment. Fortunately, no interruptions occurred and the interviews flowed easily. The main interviews took between one and one and a half hours. A relaxed and informal manner was used, to put the researcher and informant at ease, and to aid in establishing rapport. It was evident that the initial introductory phone call also aided in this pursuit.

The interviews were conducted using a conference telephone and a tape recorder was utilised to record the verbal data, after authorisation was obtained from the participants. No objections were raised by the informants regarding this.

Basic demographic data was elicited (see Appendix E) in order to gain an overview of the informants and their environments, and to facilitate better researcher/informant relations. The interviewees were asked a range of questions from broad, overview inquiries to a more specific line of questioning. If relevant information was not forthcoming, open-ended follow-up questions were used.

The informants were asked permission for the researcher to telephone them at a later date if any confusing or ambiguous answers were discovered during analysis.

During the interview sessions the informants were asked to describe and explain their experiences as RANs.

Ethical Considerations

Participation of informants in this study was voluntary, and this was made clear in the letter to participants (see Appendix D). Informants were advised that they could withdraw from the study at any time, and could refuse to answer any questions without repercussions. Written consent was obtained from all participants. Verbal consent was obtained from informants for tape recording the interviews. These data were stored in a secure place at the researcher's home when not in use. Access to these data was limited to the researcher and her supervisor and each was destroyed or erased following the completion of analysis. The identity of participants was protected by the use of a coding system. Any identifying information was kept separate from the coded data. Permission to conduct the study was given by the Edith Cowan University Nursing Research and Ethics Committee. Approval was given by the Western Australian Health Department's Senior Nursing Policy Officer, and the regional Directors of Community Nursing.

Attaining Methodological Rigour

Guba and Lincoln (1981), cited in Sandelowski (1986), claim that qualitative research can attain methodological rigour by establishing the following four criteria: (1) truth value, (2) applicability, (3) consistency and (4) neutrality,

(1) Truth value is evaluated by "credibility", which is described by Sandelowski (1986) as:

Such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize it from those descriptions or interpretations as their own. (p. 30)

(2) Applicability can be evaluated by "fittingness", where the study findings can be related to contexts outside the study and readers can see the findings as meaningful and applicable in terms of their own experiences. The findings should be grounded in the life experiences including common and atypical cases.

(3) Consistency can be ascertained by ensuring "auditability", where steps in the research process are detailed in a logical and clear manner so that another researcher could follow the steps of decision making and conclusion drawing used by the investigator and could arrive at similar, not opposite, results.

(4) Neutrality, can be judged by "confirmability" (Guba & Lincoln, 1981, cited in Sandelowski, 1986), which is established when truth value, consistency and applicability have been achieved.

Triangulation is a research approach that serves two main functions: confirmation of results and as a way of enabling "a more complete, holistic, and contextual portrayal of the units(s) under study" (Jick, 1983, cited by Knafl & Breitmayer, 1989, p. 211). It involves the combined use of "multiple methods, sources, theories, and/or investigators" (Knafl & Breitmayer, 1989, p. 212). Although triangulation is espoused by many authors (Burns, 1987, Guba & Lincoln, 1981, cited in Sandelowski, 1986; Knafl & Breitmayer, 1989; Miles & Huberman, 1984b), this

study was too limited in time and budget to undertake these types of comparisons to any great degree. However, single researcher interviews ensured consistency and the informants' responses were compared with the findings in the literature following the analysis of data.

Treatment of Data.

The tape-recorded data were transcribed onto computer discs following each interview, using the Microsoft Works programme at Edith Cowan University. Each informant was coded with a number corresponding to the order in which the interviews were conducted. Subsequent to this, all data from every source was correspondingly coded. Thus, informants' data were coded from one to eight. Where a quote was used verbatim from the source, it was referenced as (IN 1), for instance, for data obtained from interview/informant number one.

The researcher possessed a personal understanding of the experiences of RANs because of prior knowledge and experience. This included having practised in rural areas, knowing several RANs personally, reading widely about the subject and having visited several remote communities, attending medical clinics periodically. The researcher was alert to the possibilities of biasing the data collection by asking leading questions, as well as manipulating data to satisfy personal convictions. Therefore, a process was used, whereby the researcher attempted to suspend "previously acquired knowledge, beliefs, and opinions" (Powers & Knapp, 1990, p. 16) about the experiences of

RANs. This was exercised both in the questioning technique used, and the logical sequencing of the analysis process, described later. The interview consisted primarily of general inquiries and open-ended probing questions. Care was taken not to intimidate or lead the informants. The researcher attempted to maintain neutrality in verbal and non-verbal responses. This was difficult at times due to the unexpected nature of some of the responses. For example, one informant described the relative homogeneity of the community and her feelings of vulnerability:

I'm the only caucasian right in the middle of the community (IN 1).

The investigator questioned further, "How does that make you feel?" The reply was:

Well,..two weeks after I got here a drunk tried to rip the cyclone screens off the windows and doors to get in and murder me [and it] made me feel unsafe (IN 1).

A further unexpected response was:

"Days of Our Lives" probably affects us more than anything else - you cannot get someone to come down [to] the clinic because "Days of Our Lives" is on (IN 8).

The researcher's immediate response was that the nurse was joking, but the informant was actually explaining a serious problem in the community.

Validity

Validity can pose a potential problem for the single researcher (Burns & Grove, 1987). In order to overcome the threat of biased interpretations, the researcher audited the data for researcher effects. Weighting of evidence was

continually checked by looking for outlying and discrepant data (Miles & Huberman, 1984a). For example, seven of the informants experienced some effect from climatic factors, but one interviewee explained:

That's been a surprise to me, inasmuch as they [climatic factors] don't affect me at all (IN 4).

The researcher audited for consistency within and between responses and used probing questions if any inconsistency appeared in responses. For example, when auditing the data, the researcher noted that one informant was of the belief that:

Work would be basically the same wherever I was - whatever culture I work in - I mean it's no different working with Aboriginal people than it is working with blacks in South Africa or the Maoris and Pacific Islanders...or Pakistanis in Britain (IN 1).

However, when this informant was later asked, "What effect does culture have on your practice?", the informant replied:

Mostly it's been...gaining the confidence and trust of women particularly, to tell me what I must and must not do...they're not used to telling white people, especially sisters what to do (IN 1).

Method of Analysis.

The approach to data analysis was devised primarily from combining the method developed by Colaizzi (1978), as utilised by Riemen, (1986, p. 94), and the methods espoused by Miles and Huberman (1984b). Riemen (1986) completed the analytical process in her study by giving "an exhaustive description" (p. 95) of the phenomenon in question, in her study of "caring". However, the current researcher did not perceive that such a step was possible for this study, as

the area of concern was too diverse and broad to allow such a description purely from one study. Similarly, it was not within the scope of this study to check the analysis of data with the informants due to time and budget constraints and logistical problems of distance from the informants.

The following steps were undertaken after the transcribing phase:

1. The tape recordings were again listened to in conjunction with re-reading the transcribed material, in order to enhance the researcher's understanding of the data.
2. The data were reduced manually, by eliminating all data which was not relevant to the remote area nursing experience.
3. The remaining data were clustered according to the key concepts of the original SUN Conceptual Model (Figure 1), using the definitions displayed in Appendix F as a guide.
4. Under each key concept, significant statements of each description, sentence or phrase were extracted.
5. From the significant statements, common and outlying or discrepant descriptions, phrases or sentences were identified.
6. Meanings were formulated from the data under each key concept. These were further grouped into "emic" - the RAN's perceptions of the views/beliefs/practices of the community and/or employing agencies - and "etic" - the perceptions of the RAN him/herself.
7. The meanings were then re-examined in order to detect

any overlap between the key concepts. Key concepts were reidentified following this process and meanings were further categorised according to the revised SUN Conceptual Model (Figure 2).

8. Original statements in the transcripts were re-examined to ensure the meanings were in keeping with the context of the original message.

It was intended that categorising the data according to the key concepts of the original model would represent a process of guided thematic analysis. This enabled the researcher to identify areas of overlap and thus allow the refinement of key concepts and recategorisation of data.

Summary

This chapter has presented the assumptions held for this study, the sampling technique, research design and procedures used to obtain data, including ethical considerations, the strategies used to attain methodological rigour, the process of data treatment and an overview of the method of analysis. The following chapter presents the findings, analysis and discussion of these data, with an examination of the findings in relation to current literature on remote area nursing.

Chapter 5

Findings and Analysis of Data

This chapter presents the demographic data and gives examples of the common explanations and descriptions given by RANs in the interviews. As outlined in the previous chapter, significant statements were clustered under the reidentified key concepts in consideration of the definitions formulated from the literature in Appendix F. Common, outlying and discrepant responses were extracted, grouped together and meanings identified. These are further arranged under "Emic" and "Etic" categories. More extensive examples of common responses and their meanings for each key concept are given in Tables 1-6 (see Appendix G). Demographic information is presented, followed by the findings, analysis and discussion of these data and how they relate to the literature as the source of the original model.

Demographic Data

Demographic data were obtained in order to give an overview of the informants and their environs. The sample of eight consisted of five females and three males. The posts occupied by RANs were largely Aboriginal communities, but included small mining towns, some requiring the RAN at the community to take responsibility for outstations. All communities were populated largely by Aborigines. Populations were difficult to estimate because of the mobility of community residents. Approximate main community populations were given, ranging from 100 to over

500 residents. Outstation (see Appendix A) populations given ranged between 20 and 60. Over half of the population of any community was Aboriginal; these representing up to 93% of the total population at one community. The length of service at the current post ranged from six months to eight years, with an average of one and a half years. Most RANs had extensive acute and emergency experience, but other nursing experience varied greatly. Previous remote area and country nursing within Australia was common and some informants had worked in New Zealand, Britain and Third World countries. Community, public health and other non-hospital experience was common. Other areas of experience included psychiatry, geriatrics, obstetrics, gynaecology, the intellectually impaired and disabled, paediatrics and nursing management. Their years of nursing experience ranged from 3 to 29 years, with an average of fifteen years. All RANs were registered midwives. Other nursing education included certificates in ICU-related specialties, occupational health, psychiatric nursing, maternal and child health, geriatrics, community health, paediatrics and first aid. Several RANs either had or were working towards some tertiary qualification in nursing. The age range of informants was 28 to 54 years, with an average age of 42 (the age of one RAN was not obtained).

Work Beliefs

As can be seen in Table 1 (see Appendix G), analysis of the significant statements grouped under this key concept elicited numerous meanings.

Etic meanings.

Nurses espoused a community health philosophy and encouraged community independence and self responsibility. This was illustrated by several RANs:

Clinical takes up a lot of your time, but your thrust has to be community development (IN 8).

And another nurse reported that RANs were:

trying to lose the paternal role (IN 4).

RANs approached client and health worker education by ensuring relevance, teaching basic hygiene, promoting health and preventing illness. This was illustrated by the following statement describing how:

all the time [I'm] trying to educate a little bit more...every opportunity that I have with a client (IN 5).

Another important role of the RAN identified was that of provider of primary health care and emergency care. The following statement indicated this:

We are the primary health contact (IN 7).

Autonomy was experienced by the majority of RANs in terms of independence and freedom of practice. As one informant explained:

Make your own policy, enact it, prove it successful (IN 1).

Remote area nursing offered many positive attributes to nurses. One informant stated:

It's the most challenging form of nursing that a clinical practitioner could ever do...it's got everything (IN 1).

Remote area nursing offered a greater depth of nursing and life experience than the hospital system. This was summarised in the following example:

I've learned more in a year than I learned in ten years in a hospital (IN 3).

The positive aspects of remote area nursing were coupled with demands, frustrations and the fact that work dominated the life of RANs. One RAN commented that:

if you do this work, then there's nothing else (IN 5).

Another reflected that remote area nursing was:

rewarding but terribly draining and frustrating...It's hard to balance all of these different things out and make sense of them (IN 6).

However, one informant gave a discrepant response to this and stated:

I work to live and not live to work (IN 7).

The need for the RAN to set down rules was evident, particularly in relation to working after hours, but also to enhance his/her own safety. One informant set the following limits:

I would not attend drunks who injured themselves while drinking and fighting...anybody who abuses me or assaults me or threatens me or frightens me will be charged - anybody who damages Health Department property a) will be charged b) will pay for the repair and c) they'll be lucky if I ever speak to them again - [I] only had to [say that] once and it [the violence] stopped (IN 1).

RANs assumed a multiple role undertaking a diverse range of functions and activities. This was illustrated by the following comment:

You're everything else as well - you're the undertaker, and the police, the community counsellor (IN 1).

Work for the RAN was dependent on what was going on in the community. As one informant explained:

people are very mobile...how much grog's come in or funerals - really affects how much you can do (IN 8).

It was evident that with time, RANs became more confident in the effectiveness of their work, as illustrated by the following informant:

The first year is a learning year, [the] second year you start to do things (IN 2).

The need to set realistic goals and team-work were important aspects identified, as the following comments illustrate:

Don't try and change the world (IN 2).

You're the doctor's eyes and ears (IN 3).

Job satisfaction was attained by the style of practice offered, the close client contact and seeing positive change. One informant explained how:

I can see the change, so I'm getting job satisfaction (IN 3).

Another described job satisfaction in terms of client contact:

You've got a much more continuous relationship with people - you're actually seeing people before they're born, through to when they die and all the bits in between (IN 8).

However another nurse disagreed:

There isn't a lot of job satisfaction at this community because the same problems keep reoccurring and often on the same people (IN 5).

Measures perceived to influence the health and attitudes of the community included promoting self esteem and

progressive improvements in health. These were being achieved through the intervention of the RANs. As one nurse suggested:

Their health has really improved and their taste in food is changing - [now they] will eat porridge, weetbix and fruit (IN 3).

The RAN was not pressured by time constraints, but had difficulties keeping to a schedule. The following examples illustrate this:

You're not tied to [a] rigid timetable - you can have busy times, but you can have time to think and time to actually talk to people - you can sit down and actually be with people (IN 7).

[You] can't keep [your] time schedule rigid - I attempt to get through a certain volume of work in a month...because you never know what might happen during the day (IN 1).

Most of the informants experienced a sense of professional isolation. As one informant explained:

Even here with two RNs you're still isolated because we try and respect each person's time off...sometimes I really just wish that I could have a second opinion before I call the Doctor and describe things properly over the phone (IN 5)

Another RAN commented that:

Especially in single nursing places you haven't got that sounding board...that other professional to bounce ideas off (IN 6).

Nurses reported having to be self-reliant, resourceful and self-disciplined to cope with the isolation. One informant gave the following example:

I had a lady mauled by a crocodile - there was no way we could get her out at night - so we just had to live through it...even though you're the only person, you've got to start stabilising that patient before you can start ringing up for advice (IN 7).

Emic meanings.

Communities seemed to have an expectation that the RAN would be constantly available, even for non-emergencies, and as one informant explained, this created a certain amount of pressure:

I am here to serve them...to help them - to work for them and do what they want - "Get the car out!" - "Drive me here!" - "Drive me there!" (IN 3).

Another commented that:

the demand on my time can be overwhelming (IN 3).

Cultural Values and (Health) Beliefs; Language and Kinship Factors

Within this key concept a number of identified meanings were elicited as seen in Table 2 (see Appendix G).

Etic meanings.

Negative influences on the health of the community included long distances travelled, and lack of motivation.

Environmental factors, lifestyle diseases and gambling were emphasised as key health issues. One RAN described the problems as:

Chronic overcrowding - all these basic problems - sewerage, water, housing - all the social problems and the gambling thrown in (IN 6).

Culture shock on arrival at a community was experienced by a number of RANs. One nurse described this as:

like being dumped in hell...it was a major shock and it probably took me four months to come to terms with (IN 8).

A further cultural difference between the nurse and client involved the nurses having to accomodate to what one

described as a "Blaming Syndrome" in the community, a phenomenon which made education difficult. One informant gave an example of this. An Aboriginal burial ceremony was underway and there was not enough dirt to bury the dead. The Aborigines response was that it was:

"Whitefella's fault!" (IN 3).

RAN's attempted to adopt a realistic and accepting approach to Aboriginal culture, in order to live and work with these people. The following is an example given by one informant:

I've encouraged a dynamic situation where they can express their feelings to me without fear of reprisal...they give me a list of demands and I have to consider them as well - so it works both ways (IN 1).

RANs respected the community beliefs and collaborated in various customs. The following highlights examples of the types of participating activities undertaken by one informant:

Don't mention [the] name of [the] dead person, collect all photo's, edit all videos with that person on them [and] collect hair and shoes (IN 1).

Emic meanings.

The first of these was the incongruity between the beliefs of the RAN and those of the community. Health and illness prevention were viewed differently by the community as illustrated by the following example:

If someone doesn't feel sick, has no pain, isn't bleeding - then they consider that they're healthy - [they] may be diabetic or hypertensive but because that doesn't affect directly how they feel at the time - they would perceive themselves as having good health (IN 8).

Health was given a low priority by community members as explained by this informant:

Health is way down a list which starts with housing, moves onto land rights, outstations, cars (IN 1).

People within the community were dependent on the RAN for their health as depicted by the following example :

People still see that if anyone's got any sort of problem at all it's up to the clinic sister to fix it...they really perceive an injection's the way to go for most things (IN 8).

Health workers also had a different view of health matters from the RAN. One RAN described a situation where an elderly diabetic client with multiple health problems suffered a stroke. Despite having had the disease processes explained at length, the health worker believed that the cause was a "stick in the client's neck" (IN 2). One RAN commented that the impact of the strong bonds of the community with their own law and culture was that the community:

always attribute improvements in health/infection to the Marban man (IN 3).

English was the second language in some communities and certain European concepts were not understood. This created communication difficulties and educational problems. This was highlighted by several RANs:

[they] don't understand white mans' language, [are] very tribal [and] have strong Language - people don't comprehend simple English (IN 3).

There's a lot of people here - they're not quite sure where all the money's coming from, or what it's all for - it's just money (IN 7).

Informants reported that Aboriginal community members had different priorities to the RAN and were suffering from a

loss of cultural tradition as the following examples illustrate:

These people don't have watches/clocks. Time is just different to them (IN 2).

Traditional life here has gone down the plughole - extremely so (IN 6).

The Aboriginal people in some communities were very superstitious and also believed in and practised "payback" (see Appendix A). This was evident in one informant's description of the reaction of the community to people that died out in the desert:

Spirits were after them, it was payback, the featherfoot was after them (IN 3).

RANs reported that a kinship belief system existed, where family grouping was manifest and contributed to the fluidity of housing arrangements, mobility of the community and inter-family conflicts. The following examples illustrate this:

Because of the family grouping some houses have two people living in them and some three bedroom houses have 40 (IN 1).

If you're not in the family group there's a lot of infighting (IN 5).

A lot of people move between here and [the outstation] and some spend an almost equal time at each place (IN 8).

Informants highlighted the great importance placed on death and the surrounding ceremonies by the Aboriginal communities. One RAN remarked that there seemed to be a funeral every week (IN 3).

Political, Legal and Educational Factors

A number of meanings were elicited within this category as seen in Table 3 (see Appendix G).

Etic meanings.

The role and responsibilities of the RAN far exceeded those of most nurses and were likened to the work of general medical practitioners (IN 2). Informants utilised medical officers for legal backup (IN 3). They were largely self-educated, learning many of their skills "on the job", because of perceived difficulties of gaining access to education (IN 6). Obstacles included lack of employer support, the demands of the job, and the recent HDWA budget restrictions which had, according to one RAN, made inservice a "non-event" (IN 7). Nurses voiced concern that a generic educational course for RANs was difficult to achieve as each community was different (IN 7).

RANs reported experiencing unrealistic demands and pressures from management, particularly in relation to implementing health promotion programmes. This was explained in the following example:

It's okay for our superiors to say you will do this...it's got to be the right time to put it into the community (IN 7).

Law enforcement was dependent on police, the community itself, or a combination of these. As one informant explained:

Some [police] encourage payback - some take them miles out of town and just leave them - others lock them up (IN 3).

Another RAN described the situation in her community:

When things get unsettled, often some of the senior men will go along and try and sort it out - it depends who's around as to what happens - but there is no formal law out here (IN 8).

Emic meanings.

Most nurses reported that communities were self-governed with an elected Council, however one nurse reported that:

[The] Council...doesn't seem to exert administrative or authoritarian power or influence over the community (IN 4).

Inequality in wealth and power was evident. One nurse explained that the:

[Councillors and Chairman] get all the goodies, such as all the new houses [and] they'd get the Toyotas - people at the bottom wouldn't get these (IN 2).

Philosophical Factors

The data within this key concept revealed a number of meanings as seen in Table 4 (see Appendix G).

Etic meanings.

The overall conditions within the communities were compared with the Third World, as the following statement highlights:

I have never experienced in the Third World what I experience here (IN 3).

Moral, Christian and professional ethics were motivating factors for RANs as described by this informant:

The way I work is affected by professional ethics socialised in nursing and religious beliefs. No matter how unpleasant the client or the situation - I seek to do a good job (IN 4).

Informants possessed an acceptance of life in the remote area and looked upon remote area nursing as an enriching experience. This was alluded to by one informant, who explained:

I'm very happy, I couldn't complain...I lead the hidden life and that's alright - I've chosen that (IN 3).

Another described the experience of remote area nursing as:

Probably the most rewarding period of my working life - it's made me change both personally and the way I look at the world (IN 8).

However, the job also brought its ups and downs for RANs.

One informant explained that:

It can be extremely frustrating, it can be violent, it can be rewarding, it can be very sad (IN 6).

Emic meanings.

No meanings were determined within this classification.

Social and Economic Factors

A number of meanings were elicited from the data within this category as depicted in Table 5 (see Appendix G).

Etic meanings.

Social life and recreational opportunities were limited for the RAN and life was fairly simplistic. One informant described this predicament:

There's really nowhere to go here...I'm quite happy going out to the bush...but there's not much around here (IN 5).

Another described that on a typical day off she:

Might go out for a cup of coffee [or] go walking -
so it is fairly quiet (IN 8).

Social and psychological isolation presented difficulties
for nurses as the following example illustrates:

[You] have to make friends with whoever's around
(IN 1).

It was perceived that informants had to be resourceful in
order to attain an acceptable personal/social life. One
nurse commented:

I run aerobics twice a week (IN 2).

Another suggested that:

you need things that you can do in your spare time
(IN 5).

Participation of RANs in community activities and the
opportunity for family life were evident. As one informant
explained:

I find my life actually includes my [spouse] and
[child] a lot more than it did when I was needing to
spend so much time travelling to work (IN 4).

The analysis of the data categorised within this key
concept elicited one significant statement which was
discrepant with the remaining data. This related to the
limited social and recreational opportunities. The
informant commented that:

time just seems to fly by, in fact, sometimes I think
I can't really afford to go anywhere at the moment
because I've got too many things to do at home (IN 7).

Nurses reported experiencing a lack of privacy. An example
of this was given by one informant who explained:

There is no separation between the two units so you
can hear what the other person's doing (IN 5).

Informants reported that sleep and rest were encroached upon by his/her close proximity to the community and the constant demands on his/her time. One informant described this problem:

If there's a disturbance in the community, I fear I'm going to be interrupted, and I don't sleep well (IN 1).

Some RANs suggested that it was in their own interest to perpetuate distance to keep relationships on a more professional level with the community. This was illustrated by the following description:

It's very much a business-like relationship...that's how I actually prefer it for my own sanity (IN 8).

It was widely viewed that RANs with more experience settled in more easily. This was apparent in the following statement:

You find that when you've worked in these places for a while that you settle in much more quickly (IN 2).

The high cost of living and the deficiency of facilities or resources were identified as facts of life living in the remote area. One informant made this comment:

There's limited supplies in the store (IN 2).

Another explained that:

Every phone call I make is an STD [subscriber-trunk dialling] (IN 3).

However, remote area nursing offered economic incentives to RANs. One nurse described these as:

Good wage, good work conditions [and] benefits (IN 1).

Informants reported that climatic conditions interfered with their comfort and well-being, health and recreation.

For example, one nurse commented that:

[It] gets a bit hot for recreation/walking (IN 2).

Yet another suggested that:

The flies'll drive you crazy - and you've got to really like the heat...Heat [is the] main difficulty about life in [the] remote area (IN 3).

The response of one informant was discrepant to that of the remaining informants. This RAN commented that:

Climatic factors haven't affected me at all - I thought they would (IN 4).

Emic meanings.

RANs perceived themselves as a "target" within the community. This was illustrated by the following explanation:

I find that sometimes to vent their anger - you mightn't be involved in something, but they'll come and vent it at you - especially at the clinic, because you're there 24 hours a day - so you're a good target - if they're angry or drunk (IN 7).

The RAN was viewed by the community as a problem solver.

Because of this:

You'll often have people come and want you to solve... personal problems or whatever - and I don't want to do that when I'm not on duty (IN 8).

A lack of understanding on the part of people outside the community of the conditions in which the RAN lived and worked was experienced by RANs. This was illustrated by one informant:

[They show a] lack of understanding of the kinds of conditions involved in working with Aboriginal people (IN 4).

The RAN was viewed as an "outsider" from the Aboriginal and non-Aboriginal community to varying degrees. The following explanation was given by one informant:

You're the minority out here - you're the odd one out - you're not the blackfella in a sea of white faces, you're the whitefella in a sea of black faces and you're on their turf and their country and their culture (IN 6).

Another nurse explained an ongoing problem, where:

[We] want to participate in community meetings [but the community is] reluctant to have nurses attend (IN 4).

Yet another RAN related how:

The police, the shire and the school is all clicked together. I'm not married [and] I think if I had a [partner] it'd be different, [but] if they have little dinner parties, they don't include me (IN 3).

Nurses were viewed as more of an "insider" with increasing time and experience as a RAN. One informant explained that:

In an Aboriginal community, if you know somebody, or you're related to somebody, you're accepted...more readily than a total stranger (IN 6).

RANs reported abuse or misuse of resources, such as inappropriate community housing and that members of the community were living in poverty. One informant explained:

they're breaking up the houses because they're flash (IN 3).

Another suggested that:

money just gets poured in, but it just gets spent on vehicles and generally wasted (IN 7).

And yet another described the poor standard of living:

a lot of people here don't have houses, they don't have running water - they don't have toilets here some of them (IN 2).

The final meaning derived from this category was that violence was a part of life in the community. This was exemplified by the following example:

Warring and fighting is a real way of life (IN 3).

Isolation and Distance

Analysis of the data within this key concept resulted in the identification of a number of meanings as can be seen in Table 6 (see Appendix G).

Etic meanings.

The effects of isolation and distance on the availability of goods and services was alluded to by most RANs. One informant explained:

You're a long way from the dentist...things as simple as lentils [you] may not be able to get (IN 5).

Another illustration of this was:

If you've got a problem [it] takes police three hours to get here (IN 8).

Halfways - where the RAN and client meet hospital transport at a point approximately half way between the community and the hospital to effect quicker transfer to hospital - were a necessity due to the distance of the communities from hospitals and assisted the RAN by reducing driving time. The increased time required for the delivery of goods and services was alluded to by most nurses. One informant elaborated on this:

Between ordering stores and receiving takes six to eight weeks (IN 8).

Climatic factors reportedly added to the delays in obtaining goods and services, affecting roads and contributing to breakdowns in equipment.

Time was an important variable in the evacuation of clients. The following example illustrates this:

If anything happens, it takes time to get planes out here (IN 2).

The isolation and distance of communities was surpassed by that of outstations. This was commented on by one RAN who reported that:

Outstations [are a] long way from hospital by road (IN 1).

Once stationed at the community, logistical reasons made it difficult to leave. As one informant explained:

There are dirt roads all around - [there is] no allowance for travel time. If you don't have a vehicle you can't get out except fly to Perth [three days a week]...I thought it would be less isolated here...but in fact, I'm more because we have no option (IN 5).

In the absence of other permanent health workers, the RFDS, the community health office and the regional hospitals provided expertise and support to the RAN and community. Examples of the types of support services available included dietician, health promotions officer, and nursing supervisor.

Communications were noticeably improved from previous years, however problems were still experienced with equipment. One informant commented that:

Telephones have made things a lot easier because you can present the case a lot better (IN 7).

Another revealed that the telephone doesn't always work.

Three nurses reported no hardship related to isolation, and one suggested that isolation and distance could be to the benefit of the RAN:

Solitude [is] a bonus - plus the quiet (IN 3).

Emic meanings.

No meanings were determined within this classification.

Discussion

The origins of the SUN Conceptual Model (Figure 1) were factors elicited by the MSUCN in their research endeavouring to build a theory for rural nursing, factors from Leininger's Sunrise Model and other concepts identified in the literature on remote area nursing. Through the analytical process it became clear that the amalgamation of the two models had resulted in some duplication of key concepts and meanings within them. However, this was not illuminated until a rigorous process of analysis and reexamination of key concepts and data was undertaken.

Re-examination of the meanings categorised under the sixteen key concepts of the original model, illustrated the overlapping of some of these. This was evident in the themes within "Lack of Anonymity". Factors such as lack of privacy and constant demands on the RAN's time were categorised under this key concept, but there was overlap with the category "Social Factors". The themes originally grouped under "Economic Factors" related to other key concepts - community poverty, and economic incentives for

RANs were more applicable to "Social Factors", whereas the high cost of living and lack of (access to) resources was associated with the "Isolation and Distance" key concepts, while family grouping/housing was more related to culture. No data or meanings were lost, but they were regrouped in a way which made some of the key concepts of the original SUN Conceptual Model redundant altogether and other key concepts, having overlapping meanings, were regrouped together. An example of this was the regrouping of "Cultural Beliefs, Values; Language" with "Health Beliefs" and "Kinship" (originally part of "Social and Kinship Factors"). Many of the themes within "Health Beliefs" were in fact pertinent to the "emic" category or RAN's perceptions of the community's beliefs regarding health. All of these - for example, prevention as a foreign concept, and the belief that feeling well is well - were found to be related to culture. They were recategorised under "Cultural Values and (Health) Beliefs; Language". It was also found that the meanings related to "Kinship" and "Religious factors" (originally grouped with "Philosophical factors") - such as family grouping and the significance placed on death and ceremonies - were primarily culturally related. Therefore "Kinship" was split from "Social Factors" and regrouped to form "Cultural Values and (Health) Beliefs; Language and Kinship Factors", while religious matters were considered to be inherent within "Cultural Values and Beliefs".

Themes within the original "Economic Factors", "Time Factors", "Climatic Factors" and "Technologic Factors" were

all related to "Isolation and Distance" and hence were recategorised under this key concept. Meanings within "Education Factors" were recategorised; for example, the RAN's attitude of maintaining relevance in client education was more appropriately grouped as a "Work Belief", while lack of access to education and "on the job" training created legal dilemmas and so these meanings which remained within Education factors were regrouped as "Political, Legal and Education Factors".

With regard to the key concept of "Self-reliance/dependence", the researcher decided to remove "Dependence" from the model as it was found to be superfluous. The initial rationale for its inclusion as an alternative to "Self-reliance" was that the literature pointed to a problem of Aboriginal dependence on the various services, including health care provided by RANs. Elements relating to this dependency problem appeared to be more appropriately categorised under other key concepts, for example, "Cultural Values, (Health) Beliefs; Language and Kinship Factors". The meanings of resourcefulness and self discipline elicited under "Self-reliance" were recategorised more appropriately under "Work Beliefs" and "Social Factors". Self-reliance was a meaning derived from the data which was also included within these categories. Of the sixteen original key concepts, only "Work Beliefs" remained unchanged.

Relationship of the Findings to the Literature

The following discussion seeks to present the relationship of the literature to the reidentified key concepts. Meanings within each key concept were compared with what was found in the literature in order to enhance the validity of the findings. This will be conducted using the major headings of the key concepts to facilitate clarity.

Work beliefs.

Many of the meanings elicited under this category are found in the literature. The multiple role of the RAN is well documented (Cramer, 1987, 1989; Gray, H. 1990; Harris, 1991; Nathan, 1989; Potts, 1990). Harris (1991) describes having to perform venepunctures on chickens, to monitor the potential levels of Murray Valley Encephalitis and of fighting bush fires. She also asserts that with increasing time and experience on the job the effectiveness of the RAN is enhanced. While community development, health promotion, illness prevention and public health concepts are widely discussed in relation to the role of the RAN (Blackman, 1985; Harris, 1991; Lambeth, 1985; Nathan, 1989; Worrell, 1991), an emergency and primary health service is also a key function (Harris, 1991; Kreger, 1991; Munoz & Mann, 1982; Potts, 1990). Inherent in these concepts is a need to provide a service which is congruent to the lifestyle and culture of the communities in which the RAN works (Glover, 1986; Harris, 1991). Several authors assert that the emphasis of nursing care is on medical or clinical

services (Kreger, 1991; Potts, 1990). Kreger's (1991) study indicates that the community is more interested in a medical service than a preventive one. Several authors have perceived a community expectation that the RAN represents a service and as such is available at all times, regardless of their own needs (Cramer, 1984; Hodgson, 1982; Kreger, 1991). Cramer (1989) asserts that the perception of RANs as all giving and dedicated is detrimental to the health and wellbeing of RANs and is the result of unrealistic expectations. Potts (1990) takes the view that the RAN must set realistic goals. Autonomy and independence of practice are attributes enjoyed by RANs (Cramer, 1989; Harris, 1991; Hodgson, 1982), however, professional isolation is a recurring theme in relation to this practice (Blackman, 1985; Cramer, 1987; Gray, H. 1990; Harris, 1991; Thornton, 1991). Remote area nursing is seen as a challenging career - demanding - but also offering a wide scope of experience and an informality not easily found in any other area of nursing (Harris, 1991; Hodgson, 1982; Lambeth, 1985). Potts (1990) actually describes it as a "challenge to survive" (p. 14). While Cramer (1987) claims that the onus of responsibility is on the employer to stipulate the limits of service, Harris (1991) regards self enforcement of the emergency only after hours convention as a necessity. This is in keeping with the informants' views that the RAN needs to set rules of service.

Cultural values and (health) beliefs; language and kinship factors.

The meanings derived from the analysis of this study are comparable with those in the literature. Klotz (1983) asserts that RANs are "not used to working in the cross cultural situation" (p. 89), where health is linked "to spiritual, religious and ceremonial matters" (Nathan, 1989, p. 39). Many authors acknowledge the differing needs of Aboriginals in communities where traditional concepts of health care remain and are practised and causes of illness and other events can be attributed to many sources, including sorcery, environment and superstition (Broome, 1982; Campbell, 1982; Gehling, 1979; Hodgson, 1982; Kreger, 1991; Nathan, 1989; Read, 1990). These authors infer that these beliefs contribute to a resistance to Western/medical health care. Glover (1986) suggests that the existence of the spiritual dimensions with regard to conception and birth for instance, account for inadequate or absent antenatal care. Moodie (1973) is of the opinion that this contributes to late presentation for illness. He further proposes that it should be expected that Aboriginals possess divergent health standards and goals because their lifestyle and attitudes are different from other Australians. Nathan (1989) asserts that "profound differences in Western and Aboriginal belief systems" (p. 39) exist. This is seen to lead to difficulties in providing culturally congruent care as the RAN provides a western medical service while the community desires traditional treatment (Gehling, 1979). Gehling (1979)

suggests that the health concept is seen differently by
Aboriginals. He further explains that:

health prevention in our terms is a foreign
concept...hygiene, diet and safety precautions are not
[believed to be] directly associated with disease
origins (p. 29).

This is the cause of failure to comply with antibiotic
treatment and failure to return for appointments (Campbell,
1982; Gehling, 1979). In Aboriginal terms, a lack of
symptoms means wellness. Nathan (1989) states that
traditional Aboriginal healers practise illness prevention
and promotion of health. This is in contradiction to
Gehling's (1979) view that the Aboriginal communities have
no concept of preventing illness. This would also appear
to contradict the informants' views in this study.

Aboriginal culture is seen to be undergoing some
turmoil, with a loss of tradition (Edwards, 1988, Gehling,
1979). Cramer (1989) asserts that "the intrusion of
Western ways has eroded traditional sacred law" (p. 30).
Several authors point to a loss of independence with the
adoption of dependent and demanding attitudes and
behaviours (Broome, 1982; Lambeth, 1985). Broome (1982)
explains that resistance to Western ways and intrusion is
manifest in violent behaviour and alcohol abuse. Salvage
(1982) suggests that racism is widespread.

Several authors suggest the existence of a language
barrier where English is not spoken or is the second
language used (Campbell, 1982; Gehling, 1979; Read, 1990;
Salvage, 1982). This is seen to affect health care
provision.

According to Broome (1982), kinship "provided a mental map of social relationships and thus behaviours" (p. 16) with specific behaviours expected in every kinship relationship. Other authors support this belief and acknowledge the existence of special relationships between certain members of that group, and suggest that avoidance is sometimes practised (Blackman, 1985; Cramer, 1984; Moodie, 1973; Nathan, 1989). Aboriginal communities are known to be mobile (Harris, 1991; Moodie, 1973) and this is often in order to attend ceremonies or visit other members of the family group. This kinship system promotes the sharing of dwellings with other kinfolk and contributes to a lifestyle where environmental health problems, including overcrowding, poor hygiene, the spread of infectious diseases and poor health status flourish (Glover, 1986; Kellahear, 1988; Moodie, 1973; Nathan, 1989; Salvage, 1982). An inability to budget sensibly leads to a situation where finances are directed toward vehicles not food (Gehling, 1979). Glover (1986) also comments on the association of the socioeconomic environment with ill health.

Aboriginal food and name taboos associated with death are also reported in the literature (Glover, 1986; Moodie, 1973).

Several RANs write of experiencing culture shock at communities where they have been stationed (Gehling, 1979; Potts, 1990). Potts (1990) warns prospective RANs of the phenomenon of reverse culture shock where returning home can be a most unsettling experience.

Political, legal and educational factors.

Meanings elicited from these data within this key concept are also found within the literature. RANs are the main health care providers in the remote area communities (Kreger, 1991; Watson, 1987). In particular the extended role of RANs has been hotly debated, where the RAN practises as a GP, providing medical services without adequate training or legislative backup (Blackman, 1985; Cameron-Traub, 1987; Cramer, 1987; Gray, G. 1982; Harris, 1991; Hodgson, 1982; Klotz, 1983; Kreger, 1991; Menere, 1991; Munoz and Mann, 1982; Nathan, 1989). Thornton (1982) asserts that RANs have difficulty accessing education. Menere (1991) suggests that the current routine of drug dispensing and prescribing by RANs is not lawful. Cramer (1987, cassette recording) is of the view that RANs bear the brunt of "irrational demands", are "detached from the central organisation" and are "jeopardised by practises which do not meet state regulations". She asserts that administrators are "notorious for evading responsibility" and equates the neglect of staff to neglect of the communities in which they work. Cramer (1984) states that the RAN "has to undertake unfamiliar procedures and take responsibility for the outcomes" (p. 41). She suggests that the exhaustion commonly experienced by RANs creates a question of fitness to work and maintain effective and safe clinical and decision making skills. Inadequate training and "extreme work conditions" (Cramer, 1984, p. 41) make the legal implications a dilemma for these nurses with

little legal protection. She calls for increased employer responsibility.

On the job training and learning by trial and error have also been criticised as inadequate means of learning or attaining skills. Klotz (1983) suggests that there are "no safe practises because no-one is adequately trained to work in isolation" (p. 39).

Harris (1991) describes as a necessity, telephone contact with the doctor for each patient presenting in response to the involvement of other RANs in legal proceedings over services provided. She describes RANs as being vulnerable.

Kellahear (1988) claims that although RANs service a large number of patients, they suffer from a chronic shortage of funds. Broome (1982) suggests that as Aborigines represent only one per cent of the Australian population, they have no political power.

Several authors comment on the existence of community Councils (Harris, 1991). Moodie (1973) states that Aborigines have their own legal system, and Campbell (1982) claims that tribal punishment is regularly practised.

Philosophical factors.

The meanings derived from the data analysis with regard to this key concept are confirmed in the literature. A number of authors described their own remote area nursing experiences as enriching, rewarding and fulfilling (Cramer, 1984, 1989; Harris, 1991; Hodgson, 1982 ;Potts, 1990)

although according to Harris, "life has its ups and downs" (p. 99).

Social and economic factors.

Several authors discuss of the difficulties of having to cope alone, the demands, stress and fatigue of being on call night and day and the constant lack of privacy (Cramer, 1989; Gray, G. 1982; Harris, 1991; Hodgson, 1982; Lambeth, 1985). Potts (1990) describes her experience of finding a resourcefulness she never knew she had prior to taking up a post. Some suggest that it is necessary for the RAN to "know when to draw the line" and actively protect their privacy by maintaining more professional relationships with clients or other community members (Hodgson, 1982; Lambeth, 1985). Hodgson (1982) suggests that although many RANs choose their work in order to get to know the people, they often find that they have little in common with them.

A number of authors acknowledge the existence of or potential for violence (Cramer, 1984, 1987, 1989; Harris, 1991; Lambeth, 1985) where RANs are regularly the target of aggression, physical assaults or threats of violence.

Several reports are made with regard to personal isolation experienced by RANs (Blackman, 1985; Gray, 1990). Kellahear (1988) suggests that rural communities have difficulty accepting newcomers. Harris (1991) describes enjoying an active social life, particularly with other itinerant workers within the community, which is not in keeping with the reports of the informants in this study.

She also comments on the high cost of living associated with living in the remote area.

Isolation and distance.

The literature supports the findings of this study in relation to the meanings identified under this key concept. Kreger's (1991) study indicates that "geography and climate affects access to hospital, medical and other crisis services" (p. 4). The fragility of communications, roads and transport with delay or failure of supply of goods and services are frequently reported (Cramer 1989; Gray, H. 1990; Harris, 1991; Klotz, 1983; Potts, 1990). Potts (1990) gives the example of mail being regularly delayed. A number of reports are evident concerning the unreliability of roads due to flood (Harris, 1991; Munoz & Mann, 1982). Difficulties are experienced in relation to evacuating clients - if the roads are out, then the RFDS cannot usually land as the airstrip is also often unusable and delays are unavoidable (Harris, 1991; Munoz & Mann, 1982). Klotz (1983) reports that evacuations are dependent on communications and the availability of medical personnel. Kreger (1991) claims that although communications have improved over recent years telephone and radio transmission remains unreliable. This creates difficulties as medical expertise is provided using this technology (Harris, 1991).

Kellahear (1988) maintains that rural populations are disadvantaged by a lack of provision of services. However,

Harris is of the view that isolation "can be a curse but is also a bonus" (p. 100).

Summary

This chapter has provided information concerning the demographic variables of the informants and has presented the analysis of the study findings. Examples of the common and discrepant data elicited from the significant statements of informants were also provided, with a discussion on the analytical process and subsequent results. A comparison was made of the meanings derived from these data and the relevant literature in an attempt to enhance the validity of the findings.

The Meleis (1991) strategy of selecting a relevant theory, testing it in practice and then relating the findings to modify, refine or develop the original theory or develop a new theory was the process adopted for this study. In the light of the findings of this study the original SUN Conceptual Model was found to be inadequate in that some of the key concepts within the model overlapped. As previously discussed, through the analysis of the findings, the key concepts were reidentified and the meanings recategorised accordingly. The modification of the original model has resulted in the formation of the revised SUN Conceptual Model (Figure 2).

"SUN"

CONCEPTUAL MODEL FOR THE REMOTE AREA NURSE

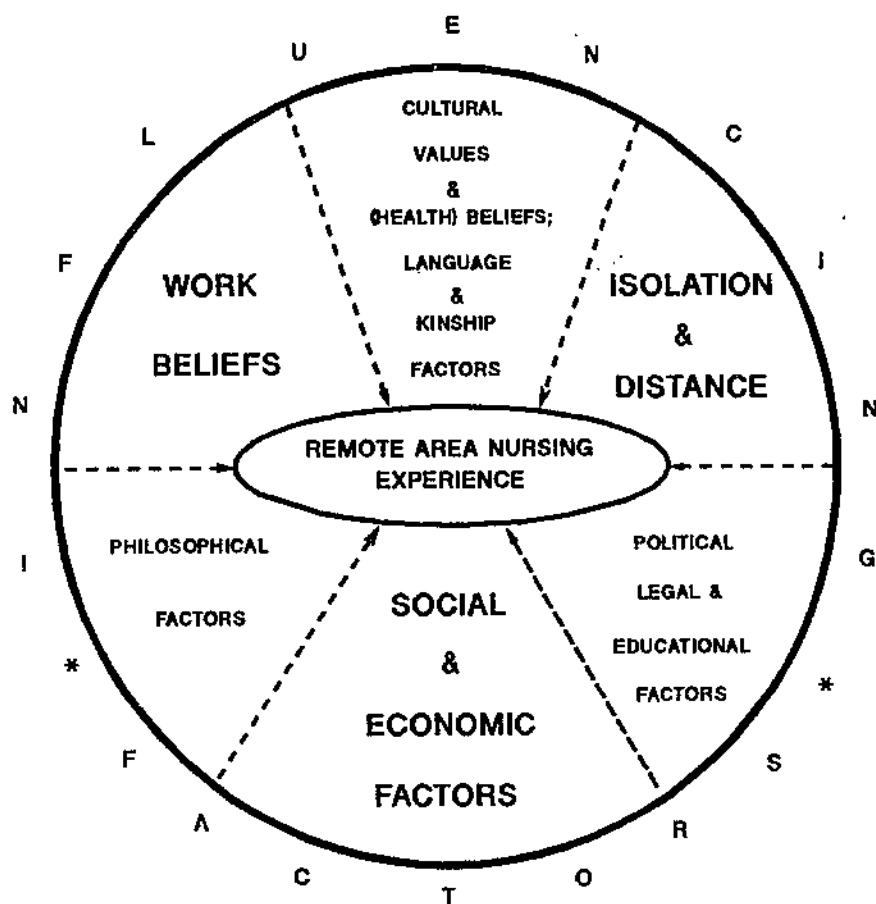


Figure 2.

ADAPTED FROM:

1. Long, K.A. & Weinert, C. (1989) Rural nursing: developing the theory base. *Scholarly Inquiry for Nursing Practice*, 3(2), 113-125
2. Wenger, A.F.Z. (1985) Learning to do a mini ethnographic research study: a doctoral student's experience. In Leininger, M. Ed.) *Qualitative research methods in nursing*. Orlando: Grune & Stratton Inc.

Anne Magee

Revised

01 June 1992

Chapter 6

Conclusions, Implications and Recommendations

This study was an attempt to relate a previously developed model to the experience of remote area nursing. The "Theory-Research-Theory" process was adopted as the strategy to examine the SUN Conceptual Model. The purpose of the study was to refine the existing model or develop a new model or theory. A descriptive research approach was used to gather data from eight practising RANs. These data were analysed using the model as a guide for the categorisation of significant statements from the informants and the meanings identified. A rigorous process of analysis was used in order to inhibit the overlapping of data within the original key concepts. This exercise led to a need for reidentification of the key concepts, as some of these were found to either overlap with other key concepts, or become redundant as the identified meanings were recategorised.

Theoretical Definitions

Meleis (1991) proposed that through research, the redefinition and operationalisation of concepts within the theory under examination could be achieved. The findings of this study lead to a revision of the key concepts within the SUN Conceptual Model. This being the case, although redefinition of the concepts has been achieved, these remain at a theoretical level. Using the research data collected from the informants participating in this study, the researcher arrived at the following theoretical

definitions of key concepts in the (revised) SUN Conceptual Model:

Work beliefs.

The RAN's perception of the following, or factors which impact upon these: philosophy of practice; role as a RAN; attributes of remote area nursing; intrinsic demands of practice; ability to maintain a schedule; job satisfaction; professional status and professionalism; the RAN's influence on the community; effectiveness as a RAN and culturally congruent health care.

Cultural values, (health) beliefs; language and kinship factors.

Culturally derived factors which the RAN perceives to exist or exert influence upon themselves or the community, such as: spiritual beliefs and practices of the community as perceived by the RAN; incongruities between RAN and community views and beliefs; health beliefs of the community and the priority given to health; traditions; effects of law and culture on health beliefs; aspects inherent in culture that impact upon health status; loss of independence; attitude towards people of another culture; value placed on money and other concepts divergent from cultural traditions; family grouping and relationships; actual or potential communication barriers; mobility and culture shock.

Political, legal and educational factors.

Factors which the RAN perceives to impact on himself/herself or the community such as: law enforcement; hierarchy of community or employing agency; equality; positions of power; legalities of remote area nursing practice and relevant legislation; adequacy of educational preparation and access; specific educational needs of RANs/community and departmental budgeting.

Philosophical factors.

The RAN's reflections on life in the remote area and life experiences as a RAN.

Social and economic factors.

Factors impacting upon the lifestyle of the RAN and community as perceived by the RAN, such as: the availability of social/recreational opportunities; the dynamics of the community; the remote area lifestyle; overall living conditions in the community; social/psychological isolation; lack of anonymity/privacy and demands on personal life; level of wellbeing; the presence of other itinerants; levels of interaction within the community; the attitude of the community to the RAN; the level of understanding by outsiders of conditions in the remote area; previous remote area nursing experience; the cost of living in the remote area and economic incentives to the RAN.

Isolation and distance.

Factors impacting on the RAN and community as perceived by the RAN, such as: the availability of goods and services (including communications and in particular ability to evacuate patients); variables that impact on the availability of goods and services, for example, climate and the availability of technology, expertise, backup and support.

Response to Research Questions and Objectives

The research questions for this study related to: (a) the identification of common components of the experiences of RANs; (b) determining whether the key concepts of the model corresponded with these; and (c) the usefulness of the SUN Conceptual Model for guiding RAN education, practice and research. In relation to (a), the common components of the experiences of RANs is presented in summary in Appendix G. These are categorised according to the reidentified key concepts. As can be seen, a substantial amount of data regarding the common experiences of RANs has been generated. In relation to (b), significant statements from the interview transcripts were grouped together using a process of guided thematic analysis. This involved grouping data in consideration of the theoretical definitions adopted for this study, under the appropriate key concepts in the model. As previously discussed, the amalgamation of the two models (Concepts of Rural Nursing and Leininger's Sunrise model) and other concepts previously identified in the literature, resulted

in some duplication. This was addressed within a re-examination of the identified meanings under the original 16 key concepts with a resultant regrouping of overlapping key concepts and derived meanings and the elimination of other key concepts which were found to be redundant. Having reidentified the key concepts, correspondence between common components (meanings) and these key concepts was able to be achieved. In relation to (c), the utility of the model can be related to the broad scope of commonly occurring data on the remote area nursing experience categorised within each of the key concepts. Information relating to remote area nursing could be stored in an organised way by using the key concepts as a framework for categorising data and as a system for information retrieval, as suggested by Ellis (1968). The model provides a beginning theoretical framework for RANs and educators from which to address the "context" of nursing in the remote area, particularly with new staff, and to impart knowledge relating to the components within each of the key concepts. Information gained by nurses could be used in the remote area practice setting. The model, or components of it, could be used as an organising framework for future research related to remote area nursing, to guide the research questions, data collection and analysis. At present, aspects of the model remain at a generalised level many components of which could be related to any professional working in the remote area. In order to attain exclusivity to RAN practice, hypotheses could be generated from components within each key concept for

testing, in order to definitively relate the model to remote area nursing practice.

The objectives of this study related to: (i) eliciting RANs' perceptions of their experiences; (ii) examining these in relation to an existing model of RAN practice; and (iii) making claims for the validity of the model. The findings of the study indicate that the objectives were largely met. In relation to (i), insight into the perceptions of RANs regarding their experiences was gained from the analysis of interview data. In relation to (ii), these data were related to the SUN Conceptual Model, in order to identify the adequacy of the model. Analysis has led to the revision of the original model (see Figure 2) as previously discussed. In relation to (iii), analysis of these data has allowed the researcher to confirm that the reidentified categories within the model are useful as a primary step in formulating a theoretical framework for describing the experiences of RANs. In recognition of the fact that the model is in a rather primitive state, no claim can be substantiated for its validity.

It is the researcher's belief that the contribution of this study represents a beginning step in theory development for remote area nursing practice. Kreger (1991) recommended that:

practising RANs gain a broad and objective perspective regarding influences on their current practice. They require understanding of the remote area context, expectations and dilemmas that are likely to confront them in practice. (p. 60)

The study has attempted to contribute towards achieving this aim. It was evident from the interview data that some

negativity existed amongst the study informants towards some aspects and conditions of their job. Most of these RANs when questioned as to their expectations prior to taking up their first posting, responded that they had little/no idea of what this career choice entailed. All of the informants commented that it took time to settle in, to "soak up" the people and the needs of the community, before achieving effective practice. It is the researcher's belief that, with a more realistic orientation prior to commencing practice in this environment, the time lag between commencing at a post and the onset of increasing confidence and effectiveness in that role could be reduced.

Limitations of the study

It is not usually possible to generalise findings in qualitative research studies, as they are thought to be unique to that study (Burns & Grove, 1987, p. 37). In qualitative research, each experience is assumed to be personal and a "once only", never to be repeated. Difficulties are encountered in replicating such studies, as the setting and circumstances are difficult if not impossible to reproduce. Although the findings of qualitative studies are not able to be generalised in the same sense as quantitative studies, Denzin (1978) asserts that "any subject belonging to a specified group is considered to represent that group" (cited in Sandelowski, 1986, p. 31). It is postulated that RANs have some experiences which are common to all RANs, whilst each in all likelihood have unique experiences. The researcher

asserts that information gained from this study will have implications for all RANs, particularly in Australia. This is partly justified by the ability to find similarities between the data obtained in this study, and reports in the literature.

Researcher bias was inevitable to some degree, but this researcher endeavoured to carefully describe all steps of the research process, showing the rationale for decisions and statements.

The sampling technique adopted to access the informants created the possibility of bias. Most of the eight informants were shortlisted by their Directors of Community Health as potential candidates as they each possessed six months or more experience as a RAN. However, in one region, the Director put forward only those who were assumed to be willing participants. It was possible that only the most articulate or outspoken were presented and as such their perceptions may have been divergent from the broader RAN population.

Recommendations

The following recommendations are derived from the findings of this study.

* That further research be conducted:

1. To identify which factors contribute to the effectiveness of RANs, both in terms of coping, and as a health service provider in the remote area.
2. To further examine the SUN Conceptual Model as a theoretical framework for RAN practice.

- * That the model be trialled as a guide for RAN orientation prior to taking up a post, and that its usefulness be evaluated.
- * That the findings of this study be made available to RANs in order to enhance the existing knowledge base on remote area nursing.

Conclusion

This research study was undertaken in an attempt to relate remote area nursing to a previously developed theoretical framework, the SUN Conceptual Model. From the findings it would appear that this model has application to assist in the advancement of the theory development, education, practice and research of RANs.

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APPENDICES

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APPENDIX A
GLOSSARY OF TERMS

Community/post/town.

Near-synonymous terms referring to the RAN's place of work and residence and/or the people within the allotted work setting.

Community Development Employment Programme (CDEP).

Commonly referred to as CDEP, this is a major form of employment for Aboriginal people living in communities. An agreement is reached by the CDEP work supervisor and a community member to perform certain jobs around the community, such as rubbish collection, or working as a health worker in the clinic, in exchange for Social Security payments.

Community health philosophy.

"The goal of community health nursing is primarily promotion of health and prevention of illness, rather than treatment of illness" (McMurray, 1990, p. 10).

Council.

Elected body which governs each Aboriginal community, headed by a Chairman, with Deputy Chairman and Council members or councillors.

Featherfoot.

Part man, part spirit form believed to be involved in payback and other Aboriginal spiritual/cultural beliefs and practices.

Gadiya.

Non Aboriginal/European/white person.

Language.

Dialect spoken by traditional Aboriginal people.

Law.

Aboriginal cultural and spiritual ceremonies, beliefs and practices.

Marban/Waman man.

Traditional Aboriginal medicine man.

Outstation.

Breakaway Aboriginal community, which may be many kilometres from the original or main community.

Payback.

Traditional form of punishment where one wrong deed is met with some form of retaliation from another person/s or spirit.

Remote area.

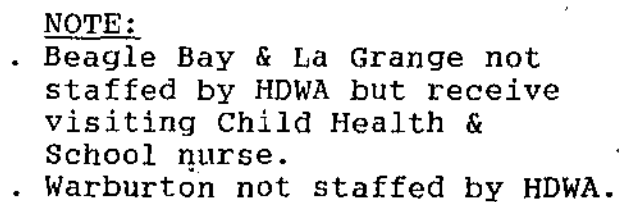
Places which are geographically isolated from public amenities, community services, acute hospital facilities and (usually) medical practitioners (Kreger, 1991).

Remote area nurse.

A Registered Nurse (RN) employed as the health care provider on a 24 hour basis in a community that is isolated from hospital and medical facilities (Kreger, 1991). This may include RNs at multiple nurse posts, as 24 hour on-call work is still required, even if intermittently.

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Remote Area Locations (Underlined)



APPENDIX C

The Director of Community Nursing

----- Region

P.O. Box ---

Town, Post Code

Address

9/8/91

Dear Ms ---,

I am an Honours student at Edith Cowan University, Churchlands, undertaking the Bachelor of Health Science (Nursing). I am at the thesis stage of this course and propose to conduct a descriptive study of five to ten Remote Area Nurses (RANs) in order to describe and explain their lived experience.

I have developed a conceptual model, which I believe comes close to reflecting an accurate account of life as a RAN. The data collected from interviews will be related to the model in an attempt to validate and develop it for use in curriculum development. Permission has been granted by the Nursing Research and Ethics Committee at Edith Cowan University to undertake this project.

This study has the potential for promoting the professionalism of the RAN by providing a theoretical frame of reference for education, research and practice, and the creation of a greater understanding of the role of the RAN.

This communication is to seek permission from you to approach RANs to participate in this study. Ethical considerations will be maintained and stringently upheld, including voluntary participation and confidentiality.

Your consideration of this matter would be greatly appreciated and I would be pleased to discuss the study with you, should you require any further details.

yours sincerely,

(Miss) Anne Magee

APPENDIX D

Address

27/8/91

Dear Participant,

I am a Bachelor of Health Science (Nursing) student at Edith Cowan University, Churchlands, and I am proposing to undertake research on the typical experience of the Remote Area Nurse (RAN). Permission has been given to me by ---- to approach you for this study.

During my time working as a midwife at Derby Regional Hospital and a short term at Fitzroy Crossing Hospital, I visited several communities in the area with Community Health Nurses and Doctors. It is from this experience and further reading, that I developed an interest in your field of work.

I have developed a model which potentially reflects your circumstances well, but in order to validate and develop the model for use, I intend to interview RANs about their experiences. I would like to invite your participation in this study. This is of course voluntary, but I would appreciate the opportunity to interview you by phone, to gain a greater understanding of your role, and to substantiate my model. Your privacy is respected, and confidentiality assured.

I would like to allow one hour for the interview, at a time which is convenient for you. Ideally, I would like to talk with you in early September, but this is flexible. If you would like to participate in the study, please fill in the consent form attached, and send it to me in the self addressed, prepaid envelope enclosed, so I can make the necessary arrangements. If you decline participation, please return the consent form blank. I appreciate your consideration of this matter, as your time is valuable. Thanking you.

yours sincerely,

(Miss) Anne Magee

Please sign the form below if you are willing to participate in the study and return to sender in the envelope provided. If you are not willing to participate, please leave the form blank and return to sender in the envelope provided.

I am willing to volunteer to participate in your study as a telephone interviewee. I understand that I may withdraw at any time, and reserve the right not to answer any questions at any time.

Signed.....

Please print name underneath signature.

Please indicate which time and day/date would be most suitable for you in early September (this can be flexible if necessary). Due to the cost of STD calls, if at all possible I would prefer to speak with you at low peak periods (Sat 6pm to Mon 8am and 10 pm to 8am daily represent the cheapest times, then Mon to Fri 6pm to 10 pm). But your time and experience is valuable and any other day or time that is more convenient to you can be arranged.

Day/date

Time of day

APPENDIX E

DEMOGRAPHIC DATA

Size/type of community; length of service in that community; other nursing experience; years in nursing; age; and nursing educational experience.

SAMPLE QUESTIONS

- * Why did you go remote area nursing?
- * What did you think of remote area nursing before you started this work?
- * Have your expectations been met?
- * What does remote area nursing mean to you?
- * What are the most important aspects to you?
- * What are the best parts about life in the remote area?
- * What are the best parts about practice in the remote area?
- * What is life like as a remote area nurse?
- * Tell me about the type of life you lead as a remote area nurse?
- * Tell me about your worklife?
- * Apart from those things what elements influence your life?
- * What elements influence your work?
- * How are these things important to you? [elements influencing your life and work].
- * Tell me how you think and feel in relation to these elements.
- * What are the difficulties about life in the remote area for you?

- * What are the difficulties about practice in the remote area?
- * Tell me what it was like when you first arrived.
- * How do you feel now?
- * Would you choose to work in this station again knowing what you now know? If yes, why? If no, why?
- * What advice would you have for new nurses going remote area nursing?
- * How should nurses be prepared to cope successfully with remote area nursing?
- * If you could describe your experience as a remote area nurse in one or two sentences, what would it be?
- * If you could describe your work as a remote area nurse in one or two sentences, what would it be?
- * Is there anything else I haven't asked you about that you think is important for me to know?

Should "specific" questions be required to elicit data regarding eg. cultural influences, examples of questions might be: What effect does culture have on your practice?

What effect does culture have on your life?

APPENDIX F

Theoretical Definitions

Work beliefs.

attitudes toward work and the priority given to that work by the RAN, administrators and/or client/community member.

Health beliefs.

the personal definition of and importance placed on health by the RAN and/or client/community member, including time orientation. For example, a client seeking health services only in emergency situations would indicate present-time orientation.

Climatic factors.

atmospheric temperature, rain, flood, humidity, cyclone, dust, the wet season, the dry season and any other atmospheric conditions.

Isolation and distance.

any form of personal, recreational, academic, professional, social or family seclusion; seclusion from medical, welfare, allied health and other services and facilities; sparseness of population. Distance refers to the vast spaces: between communities/towns/cities; from services, facilities and administrative support/services.

Self-reliance/dependence.

the degree of client/community member/community reliance or dependence on the RAN and/or other services; the degree of self determination and initiative shown by the RAN and/or community members.

Lack of anonymity.

relates to the client/community seeing the RAN as a constant provider/caregiver out of working hours; the inability of the RAN to work or undertake recreational or social activities without constant recognition by client or community; lack of privacy; combination of personal and professional relationships between the RAN, the client and community.

Outsider/insider.

the RAN taking on his/her role in a community as a foreigner to that community, while the members of that community know each other well and have the feeling of belongingness.

Old-timer/newcomer.

clients/communities where the residents have lived a long time and see visitors or health professionals as novices, who do not receive the same respect or have the same authenticity as members of the community. This connotes that the RAN must reside at that community for many years before being fully accepted.

Time factors.

the meaning of the concept of time and schedules for the RAN and community member; the insufficient time available for the RAN to complete work; the long hours spent at work, seven days a week, on call 24 hours a day; lack of uninterrupted breaks; the increased length of time needed to travel for any purpose; the increased length of time for delivery of postal and other items; and the time of day/night.

Cultural values and beliefs; language factors.

culture is "the sum of the learned knowledge and skills that distinguishes one community from another and which, subject to the vagaries of innovation and change, passes on in a recognisable form from generation to generation" (Lewis, 1976, cited in Edwards, 1988, p. 13). This refers to the meanings given to aspects of life, such as atmospheric conditions, the land, folk tales, health, the sexes, spiritualism, folk health practices, the importance placed on material and non-material goods, the importance placed on health-related practices, foods, taboos, hunting practices, ceremonies, rituals, hygiene practices; form of communication/dialect spoken (Leininger, 1985, p. 36).

Educational factors.

differences between cultures in types of knowledge, learning needs, schooling, level of knowledge; the adequacy of educational preparation of the RAN for his/her role; undertaking formal studies.

Economic factors.

factors such as employment, housing, financial status and budgeting within the community; the state of maintenance of infrastructure in the community/clinic; payment in wages and overtime; the cost of temporary staffing.

Political and legal factors.

legislation, standards of practice, duty of care, responsibilities and the expanded practice of the RAN; the internal forces governing aspects of life and practice; law enforcement; clerical duties/paperwork.

Kinship and social factors.

ways of interaction and relationships, family structure, living arrangements, recreation, socialising and community structure.

Religious and philosophic factors.

spiritual beliefs and practices;
reflections concerning life and death.

Technologic factors.

includes all types of technological equipment and expertise; attitudes toward technology; the presence/absence of necessary equipment.

Appendix G

SAMPLES OF INFORMANT SIGNIFICANT STATEMENTS

N.B. Asterisks mark discrepant data

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Table 1

Work Beliefs

Identified meaning	Examples of significant Statements
1. Community health philosophy	<p>preventive health; altering community lifestyle - promoting good health (IN 1)</p> <p>Every time you see a client you're educating (IN 2)</p> <p>More family involvement/holistic (IN 4)</p> <p>Keen on the community health aspect (IN 5)</p> <p>district nursing - good, cost effective method (IN 7)</p> <p>Programme doing regular mass treatments and screening for hookworm (IN 7)</p> <p>Health promotion is in every client you see (IN 2)</p> <p>All the time trying to educate a little bit more...and every opportunity that I have with a client (IN 5)</p>
2. RAN approach of maintaining relevance	<p>Health workers trained for community's needs (IN 1)</p> <p>Seek to educate health workers as relevant health [promotion] and resource person for local people (IN 4)</p> <p>Teach them to buy cordial, not cool drink - buy economically (IN 3)</p> <p>reinforcing healthy ways, healthy</p>

lifestyle, healthy practices and the basics...washing hands, cleaning teeth, brushing your hair, trying to wear clean clothes - trying to make an informed decision about what type of food they buy with the money they're given and to teach the kids to look after their sores, how to clean them and how to dress them (IN 6)

Opportunistic - we grab someone as they come in and we talk to them one to one, rather than do too much in groups or set something up more formal (IN 8)

I encourage bush medicine (IN 1)

3. Promotion

of

Community involvement in decision making (IN 1)

self-

I try and encourage [community]

responsibility

responsibility (IN 7)

Educating community to voice concerns (IN 1)

Getting people to take responsibility - and to become independent (IN 8)

I'm constantly trying to put the emphasis for health back onto parents (IN 6)

4. Provider of

primary

First aid only (IN 1)

Health

Most time spent with sick people (IN 2)

and

Delivering the odd baby (IN 7)

identifying illness and treating (IN 4)

Emergency	Really into assessment (IN 5)
Service	stitching people up...minor ops...
	treating shark bites and crocodile bites
	- road accidents (IN 6)
	We are the primary health contact (IN 7)
	Pretty well our practice is traditional
	medical practice (IN 8)
5. Autonomy	very little interference (IN 1)
in	free to practice my own form of nursing,
nursing	provided the results...are good (IN 1)
practice	independence (IN 2)
	Autonomy (IN 4 IN 8)
	You use your nous (IN 6 IN 7)
	You get freedom (IN 6 IN 7)
6. Challenge	Challenge (IN 1 IN 2 IN 8)
	ultimate (IN 1 IN 5 IN 6)
	Never boring (IN 1 IN 4 IN 5 IN 6 IN 8)
	Interesting (IN 1 IN 5 IN 6)
	Variety (IN 1 IN 2 IN 3 IN 4 IN 6 IN 8)
	Busy (IN 1 IN 6)
	Enjoyable (IN 2 IN 5 IN 6)
7. Depth	Personal contact with people is very
of	different to hospital contact (IN 2)
experience	Don't do anything in hospitals - never
compared to	reflected in hospital about treatment or
hospitals	care - Go to Dr for advice (IN 3)
	More meaningful relationships than in
	hospital (IN 4)
	Hospital system rigid (IN 4)

	Remote area nursing just isn't straightforward at all - especially compared to hospitals (IN 4)
	Using a lot more skills than in a hospital (IN 5)
	You're not a nursemaid - not running round in a hospital changing beds and giving out pills (IN 6)
8. Demands	My life consists of work (IN 2)
of	If you do this work, then there's nothing else (IN 5)
practice	Works against you if you're tired (IN 2)
	All the tremendous opportunities that come with remote area nursing come at a price (IN 4)
	community expectations are quite high and callouts at night can be quite frequent and I'm just feeling tired of getting up (IN 8)
	The social [disadvantages] evens that [interesting work] out (IN 5)
	Frustrating (IN 2 IN 3 IN 4 IN 6 IN 8)
	If you're looking for miles of gratification - forget it (IN 7)
	Sometimes it's very hard to keep going all the time (IN 7)
	[Although advantages] - it has other frustrations (IN 8)
	If your community is putting a lot of

demands on you a year can be an awful long time (IN 1)

Put pressure on self - personal determination to be right every time. High concept of the job I should be doing - wanting not to make mistakes (IN 4)

Pressure of having to deal with the prospect of a fairly horrible trauma being carried through the door (IN 4)
Every now and again you get these little panic attacks - what if that happens - what am I going to do? (IN 5)

I'm not going to try and educate clients about their diet if they're not interested (IN 4)

It's too much (IN 6)

9. Self

regulation

Made own rules for safety (IN 1)
you say "It's out of hours!" (IN 2)
clear on what to expend energy on and what not to get involved in (IN 4)
up to [health workers] to come and to learn (IN 1)

Emergency only out of hours (IN 5)

I've made rules - emergency only after hours (IN 6)

The big thing [for health workers] is to drive around in the [work] car - whoever gets to work with me walks (IN 6)

**10. Multiple
role**

Go way beyond the nursing role - you
tend to be policeman, the physio, the
town clerk, the adviser (IN 6)

**11. Dependence
on what's
going on
in
community**

I keep on meaning to get around to [STD
follow up] but there seems to be a
funeral every week...and then they had
this big Law meeting when I was going to
do it...so you can't get them down here
for that (IN 2)

Pay day/gambling day afternoons you just
do paperwork (IN 6)

Work's very dependent on what's going on
in the community...Days of Our Lives
probably affects us more than anything
else (IN 8)

Revolves around pay day and gambling
(IN 8)

TV affects how interested people are in
listening to what you've got to say
(IN 8)

Gambling/pay day affects our prevention
and health education (IN 8)

**12. More
effective
with time**

Need stable permanent nurse (IN 1)

Become much more effective with time
(IN 2)

You have to get to know the people first
and learn what they think is important
(IN 2)

Have to get to know people first - it's

- not like going into a white community,
because you're part of it (IN 2)
- 13. Teamwork** Teamwork important (IN 8)
- 14. Need to** I now know it doesn't matter how long I
Set stay [here] I'll never be able to make a
Realistic dent on the place (IN 5)
goals community and nurse have to accept
failures as well as successes (IN 1)
I don't think I'll see great changes
(IN 7)
- 15. Job** The longer you stay the more
satisfaction satisfaction (IN 1)
There's job satisfaction (IN 2)
Sometimes you actually get a bit of
positive feedback with your work (IN 6)
Very satisfying style of working (IN 8)
Like client contact (IN 1)
I enjoy the personal contact with people
- very personal thing. You get involved
with people and the whole community
(IN 2)
allows getting to know your clients
(IN 4)
- 16. Influence** Take every opportunity to praise
of the community and admire "our babies" -
RAN on (IN 1)
the With children I promote feeling of worth
community and self esteem (IN 3))
enormous reduction in STDS (IN 1)

people progressing - bring babies early when sick - no pneumonias/infant deaths, reduced admissions, only three or four severe gastro's - rest treated in community. Mothers able to treat them - they're very pleased being able to cope - can recognise it and take appropriate action (IN 1)

Diarrhoea - come before child very sick for gastrolyte. They are presenting earlier (IN 2)

At the beginning of the year every child had multiple sores...now you're lucky to find a dozen with sores - the kids know how to look after them (IN 6)

little kids...the mothers couldn't cope - managed to get them to survive on their own - they're doing okay now - that's a victory (IN 7)

17. Lack of restraints

You're not under pressure all the time...you actually have time to do the things that you want to do (IN 1)

18. Difficulty keeping to schedule

Can't keep to any sort of schedule as you never know what is going to happen - always plans get disrupted (IN 2)

19. Professional isolation

*We've got very good peer support group (IN 1)

Difficult to keep up (IN 2)

Isolation...from other professional

ideas (IN 7)

Some hospital staff look on you as pretty second rate - you're only out there because you can't cope in life or you don't have as much knowledge - "You're not really one of us", not doing a real job...condescending attitude (IN 7)

You're really professionally lonely because you're unsupported a lot of the time when things go wrong (IN 8)

**20. Have to
cope
alone, be
resourceful
and self
disciplined**

No one to help with IVs - just you (IN 2)

Times when I've said "I can't do this" [but] no one else (IN 3)

I've learnt to become more independent (IN 3)

I am the only one here - have to sit with patient if something wrong (IN 3)

There are a lot of times when you're on your own (IN 5)

You have to deal with it - you're the only one there - and you may have to deal with it for hours until someone's there - no secretary, so you have to do all the paperwork, all the filing (IN 6)

You're not going to have somebody holding your hand...so many times you are isolated by yourself...you've got to

do all the assessments yourself and have
a little bit of knowledge in every field
(IN 7)

No backup of other people (IN 8)

You have to be independent - help's not
always on hand (IN 8)

I need to impose structure on my day -
no one standing over me (IN 4)

You have to be motivated - self-
orientated - you have to have that
discipline to get in there and do it
(IN 6)

Stress of being the only person having
to deal with emergencies does get to you
after a while (IN 1)

Need to have self-confidence and belief
in oneself to deal with stresses (IN 4)

On your own - more stressful (IN 5)

Stress...you can't even be sick as a
RAN (IN 6)

When I ring the alarm, they know that
I'm in trouble and everyone clears off,
because they don't want to be in trouble
either (IN 1)

Help's two hours away - nobody to help
you (IN 1)

Difficult with emergencies - no pair of
hands helping - health worker disappears
(IN 2)

Remote area nursing is a neglected
subject...I really feel like we're just
sort of forgotten people - nobody
know[s] we're here (IN 3)

Table 2

Cultural Values and (Health) Beliefs; Language and Kinship Factors

Identified meaning	Examples of significant Statements

1. Incongruity between beliefs of RAN and community	<p>Community don't think of giving out panadol as work (IN 2)</p> <p>They're doing me a favour coming (IN 3)</p> <p>Things that you've done that whilst are very sound from a medical point of view - people may not necessarily like you for doing it (IN 4)</p> <p>the community want the medical service available - on the other hand they see us as interfering whites (IN 4)</p>
2. Incongruity between RAN and community definition of health	<p>No symptoms - healthy (IN 4)</p> <p>I think we're coming at things from different beliefs (IN 2)</p> <p>If they don't have symptoms causing their discomfort they're not interested in health (IN 4)</p> <p>what they think constitutes good health is probably not what I think constitutes good health (IN 8)</p> <p>No understanding of long term implications of disease processes (IN 4)</p> <p>Health is a state in which you exist when you don't have any symptoms - not too</p>

worried about their diabetes (IN 4)

They don't even think really about
illness...it's just very much today
(IN 5)

They think health is totally different
from what we do (IN 5)

A lot of them put up with health problems
that probably the average European
wouldn't - they just make do with it
(IN 7)

things that I would probably consider as
being unhealthy - like discharging ears
and children with runny nose are so
common they don't actually see that as
unhealthy either - they think that's
normal (IN 8)

Health worker beliefs quite different -
haven't got the background health
education - very basic understanding
(IN 4)

No understanding of disease processes
(IN 4)

**3. Preventive
health
foreign
concept**

No understanding of prevention (IN 3)

Can't understand why you'd take a tablet
for your eyes (IN 3)

Need for prevention but only come to me
with physical problems (IN 4)

[illness prevention] totally alien to
their thought processes (IN 5)

Don't have terribly much appreciation of the role of preventing ill-health (IN 8)
I'm trying to educate a client...people don't really listen because they're not too worried about their diabetes...sit down with me because it's less fuss (IN 4)

**4. Health
low
priority**

I think they're the same as our socially disadvantaged people - they don't think that health is very important either...I think health comes further up the ladder - you've got to solve your other problems first (IN 2)

I don't think health's important [to them] (IN 5)

This community doesn't put time into health (IN 6)

[Health] seems to be low down on their priorities (IN 7)

These people are very good at saying "Yes, yes!" and looking interested - they know how to look interested - and you know it's going right through them because they're not interested (IN 2)

**5. Dependence
on RAN**

They saw all health matters as being the responsibility of the sister and none of their own (IN 1)

Responsibility for health varies - some very responsible people - generally no

(IN 8)

expectancy of you to resolve things -
like a fairy godmother (IN 3)

The white system can solve everything
(IN 4)

hardly any input from community (IN 4)

Trying to lose the paternal role - often
resented (IN 4)

immense reluctance of clientele to take
this responsibility [for health] (IN 4)

No one will take responsibility to get
someone to [hospital] for an xray - no
one will volunteer (IN 5)

Community not prepared to transport
people...they actually see that we are
shirking our duties not driving (IN 8)
very little feedback from the community
or parents (IN 6)

People come as soon as they have the
slightest headache (IN 2)

"I cut my leg. Do something!" (IN 3)

Difficult to empower people to take
responsibility for their own health
(IN 4)

They see us as the safety mantle but they
don't care who's here as long as
somebody's here to take the responsibility
(IN 6)

[The client's view is that] if I go up to

the nursing post they'll give me tablets
and tomorrow I'll be fine (IN 5)

They'll bring their kids up covered from
head to toe in festering, weeping sores
eyes are running with pus nose is running
with mucus and lice - haven't had a bath
for three days - haven't had a decent
meal for days and then they'll expect you
to wave the magic wand and fix it (IN 6)
They want you to take the responsibility
of finding them and telling them "You've
got to come to the clinic...You've got to
do this" (IN 7)

at the moment people are very dependent
on all services (IN 8)

**6. Influence
of Law and
culture**

Great belief in Marban man (IN 2)

They're not really believing our medicine
(IN 2)

I said to an Aboriginal "You're putting
on too much weight" and he said "Well
I've got to sister, that's the way it
should be". (IN 2)

Funerals take precedence over STD
screening etc eg. women gather for Law
meeting but not interested in health talk
(IN 2)

Cause of death not considered in medical
terms, but might be considered in terms
of an inappropriate practice within the

- Law eg chronic alcoholic/diabetic, non-compliant with medications died at 36 years old - cause of death thought to be he skinned a kangaroo and ate it (IN 4)
- 7. English second language** English is their second language (IN 1)
for some of the people just over 40,
English is a second language (IN 5)
It was very difficult because a lot of people didn't speak English very well (IN 8)
People think they understand, but sometimes their comprehension is nil (IN 3)
- 8. Lack of understanding of European concepts** Abuse of money, alcohol - coke and chocolate (IN 3)
Different standards - they don't believe in washing (IN 2)
Use the store like a big pantry - haven't got concept of money (IN 3)
- 9. Different priorities** Money and Toyotas and new houses very important (IN 2)
people have told me over the years they respect me more because I'm full blood (IN 3)
You'll be able to scientifically reason something out - but their culture says no (IN 7)
All keen on cars - the Toyota trade is pretty big (IN 7)

- We fill our life up and they don't (IN 2)
 Not aware of basic hygiene (IN 3)
 School doesn't mean anything to them
 (IN 3)
- 10. Loss of culture** Here our mob don't seem to have any of
 that [tradition] (IN 7)
 the missions days...they were basically
 told what to do all day (IN 7)
 The traditional culture here is not so
 obvious - the outward forms of what I've
 seen at other places are breaking down
 here (IN 8)
- 11. Concept of time** Health workers difficulty meeting
 attendance regulations (IN 1)
different for They believe in the now (IN 3)
Aboriginals It's just very much today (IN 5)
 You can't plan a time for people to come
 back (IN 8)
- 12. Superstitious** Very superstitious...fearful (IN 3)
 people that died out in the desert
 "Spirit followed them into car and they
 killed them" - "sister doesn't like
 alcohol - people in car didn't - died
 because of that (IN 3)
 Believe that the featherfoot can see
 them and can't escape them (IN 3)
- 13. Payback** Beat up the mother whose three children
 died "Because if she had been a good
 mother she would have taken enough water

**14. Kinship
System**

for everyone because she knew they were drunk" (IN 3)

Payback results in nasty injuries - pretty vicious to us (IN 5)

Five families/tribes - five camps (IN 1)

Extended families (IN 1)

All related all over W.A. (IN 2)

They all live together...mothers, fathers, uncles - everyone (IN 2)

Grannies look after kids (IN 2)

Very strong extended family (IN 3)

They're very much family groups (IN 5)

all related to one of about five families (IN 7)

Extended family is fairly big...members of one family definitely living in the one house most of the time - you'll have drifters - they'll be living in one house for a while and another house for a while...most people here are interrelated basically and most families are actually related somehow (IN 7)

Very interconnected families between here and [interstate] (IN 8)

Community planned in clusters so people of family grouping could live near each other (IN 8)

20 people can be living in one house - there's a very fluid arrangement - most

houses belong to one person or one couple - other people tend to drift in and out of those houses and so people don't necessarily stay in same house - move between houses - usually relations (IN 8)

[Families] all have longstanding feuds (IN 1)

Constant conflicts (IN 6)

There's a lot of argument about who's a proper [original community] person and who's not (IN 7)

There is a few hassles [between families] (IN 7)

Housing big problem because if somebody dies they all move out (IN 2)

When someone dies people move out of that house (IN 8)

[They] travel for Law...mobile (IN 2)

Very mobile visiting relatives...for punishment (IN 3)

**15. Importance
of death**

Death very important - the older the person the more important, the more significant - exact opposite of the way we look at [death] (IN 1)

Seems to be a funeral every week and they're off in one direction and off in the other direction (IN 2)

superstitious about death (IN 2)

	Very scared of death - terrified (IN 3)
16. Negative	Self-destructive (IN 3)
Influences	Out on trucks - convince themselves child
on health	not very sick - biggest problems when
	they do long driving (IN 2)
	When travelling babies get dehydrated
	(IN 3)
	Alcohol; you're fighting against low self
	esteem (IN 3)
	Not aware of basic hygiene (IN 3)
	Environmental problems (IN 4)
	People living in creek - no ablution
	blocks - hygiene is really poor (IN 5)
	I don't think we're going to be able to
	improve the health status in this
	community greatly unless there's changes
	within the community itself - I don't
	just mean behavioural changes, but it's
	the way they think and relate to one
	another - that's got to change before we
	can start to improve their physical
	health - if they can't help each other,
	how can we improve other things? (IN 5)
	The community itself is a hovel equal to
	Third World, if not worse (IN 6)
	The apathy and just the attitude of the
	people (IN 6)
	Chronic gambling problem - people can
	play cards seven days for 24 hours a day

- there's chronic child neglect - not uncommon for children to only get one square meal a week (IN 6)
people are highly motivated for gambling ...not motivated to look after the kids - don't clean themselves or their houses - community attitude [related] to the [mission] history of this place (IN 6)
Trying to get them to comply - quite often I know damn well they're not going to take a full course of antibiotics - they're just going to tip them out (IN 7)
Gambling/pay day - they haven't got the money to buy medicine or food (IN 7)
Environmental factors - mangy dogs, unwashed kids (IN 8)
Gambling takes priority (IN 8)

**17. Culture
shock on
arrival**

[this community] is still a culture shock (IN 2)
Felt bewildered at the task ahead of me - Unpleasant surprise - no one actually welcoming us as a family to the community ...we had to invite other people to come to tea, or have a cup of tea with us, even though we were the new people in town (IN 4)
On arrival I was ready to turn around and leave...I thought "Am I going to be able to live here?" (IN 5)

First RAN post...I was amazed...a nurse out in the middle of nowhere ! (it's only 120 k's up the road) (IN 6)

it's a bit like ICU when you go there - the first few months you feel like panicking every time you hear a beep...six months down the track, you're wondering what you were busy with (IN 7)

I was fairly much knowing what to expect when I [started here] - the [regional] staff were very honest about what it was like and so they were very realistic and they didn't paint a rosy picture at all...I was quite pleasantly surprised driving in (IN 8)

**18. Blaming
syndrome**

Blamed me for water running out (IN 1)

"Gadiya fault!" (IN 1)

Blame everybody else for drinking (IN 2)

talk about drinking and blame everybody else for it (IN 2)

**19. RAN approach
to Aboriginal
culture**

Need to understand differences (IN 2)

*There's so much bloody culture that needs to be buried and burned and thrown away (IN 3)

I tell them I'm not related "I'm a full-blooded white..." (IN 3)

I try to learn as much as I can from the old people about plants and medicine and whatnot (IN 6)

I've seen people go overboard...go all out for Aboriginals...that's not the right approach I don't think. White people are white people and Aboriginal people are Aboriginal people, and never shall the two meet...we can't be like them and they can't be like us - you can't put our values and morals and expectations onto them and vice versa (IN 6)

We respect their wishes (IN 7)

I can never be Aboriginal and the Aboriginal can never be white...mindful of their cultural ways...two different cultures but we can live in harmony if we can work things out - it's a rocky way getting there (IN 7)

You've got to be mindful of what you say because you could insult somebody (IN 7)

We observe the taboos that we know about [and] try not to offend (IN 8)

20. Collaboration Never say dead person's name (IN 2)

of RAN

Try and get people out of community to die - smoke area (IN 2)

Political, Legal and Educational Factors

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- sleep...your decisions aren't good
(IN 7)
- 2. Doctors** Drs as backup (IN 1)
- legal backup** If a legal thing comes up the Dr will
- for RANs** always tell me what to do (IN 3)
- 3. Limited** Never feel you know enough (IN 2)
- resources** So often we don't know what's wrong
- (IN 3)
- You've got limited resources - make the
- best of them and do what you can (IN 7)
- 4. On the job** Drs teach procedures (IN 1)
- learning** On arrival had to learn to treat (IN 3)
- Continual learning situation (IN 3)
- I learn new things every day (IN 4)
- What I've learned, I've learned myself
- (IN 5)
- [Learned] mostly by trial and error
- (IN 7)
- 5. Difficulty** Difficult to keep up with current
- gaining** information - [medical details] for
- access to** nurses is very neglected (IN 2)
- education** Inservice not adequately covered (IN 5)
- Difficulty of access to education,
- inservice, study leave - no support
- (IN 6)
- 6. Demands of** Have to be organised with study - not
- studies** leave to last minute (IN 1)
- Very difficult working seven days for
- assignments - working on call, it's not

- very easy (IN 2)
- trying to study is not really practical
(IN 5)
- I'm having a hard struggle coping with
two units (IN 7)
- 7. Self**
education Advantage of being out here - able to do
some external study (IN 4)
- 8. Difficulties**
educating Educational needs depend on where you're
going (IN 2)
- RANs** Difficult to educate RANs...don't know
what makes a good one (IN 3)
- Hard to design a course because each
community is so different (IN 7)
- 9. Detrimental**
effects of Nurse three or four weeks helping out -
budget since the budget's come down [withdrawn]
(IN 6)
- [due to] Budget restraints [inservice
is] basically a nonevent (IN 7)
- 10. Extrinsic**
pressures Management demands are unrealistic
(IN 1)
- Pressure [from authorities] to implement
"wonderful" programmes (IN 2)
- you're expected to do all this health
promotion (IN 2)
- Management have no idea...what we face -
their demands are unrealistic...no
understanding that a remote area is a
remote area (IN 1)
- Pressure put on me from people in

town...expect me to do what they're doing...and I find this frustrating because what you can do in a white town and even with Aborigines...in...town are very different (IN 2)

They say they understand it [but] they keep pushing on health care as though it is appropriate for us (IN 2)

Outside agencies aren't able to understand or relate to what we're doing here...our authorities or our superiors don't really understand or relate to the kind of environment that we're in (IN 4)

Lack of understanding of the kinds of conditions involved in working with Aboriginal people (IN 4)

11. Law

enforcement

Police at community - law enforcement depends on police (IN 3)

There's quite a reasonable police force ...don't encourage payback (IN 5)

Bylaws drawn up by community and passed on as law. Breach of bylaws crime - [community] police own bylaws.

Councillors keep charge list - illegal acts...call a councillor - charged and contact police (IN 1).

Work supervisor sorts out drunks (IN 1)

Law enforced old-fashioned way with a spear...[or] they're very fond of broken

arms...there's still the old way of a good beating up...police come up once a week or fortnight (IN 2)

Big punishment part of [tribal] Law (IN 3)

Not a lot of cultural Law (IN 5)

There is a bit of payback, but when that payback happens, the person then goes and reports it to the police (IN 5)

**12. Community
self
governed**

Two Councillors from each of five camps plus ten extra selected (IN 1)

New project officer Aboriginal (IN 1)

Chairman, vice Chairman...have a pretty good representation on the Council (IN 2)

they have very lengthy meetings, all talking about Toyotas and money they spend - may have special meetings if drinking problems...in which case they call a special meeting and...they generally do something about it - difficult as run out of ideas (IN 2)

*the advisor holds most of the power (IN 6)

they're looking for self determination (IN 7)

Community advisor, who really is not the decision maker, but is the coordinator or advisor (IN 8)

Chairperson also the ATSIC rep - there is a Council (IN 5)

elections every year for the Council members (IN 6)

We are run by a community Council and they are elected - headed by a community Chairman...we have people elected to the ATSIC council - it has been very hit and miss - there's been a lot of turmoil in the community and so they've been reasonably effective about decision making...I really haven't seen the Council as it should be run. 20

Councillors - they elect that many because they need to have a minimum to have a meeting and because they are so mobile, people are often missing, so they elect more councillors to cover that problem (IN 8)

**13. Unequal share
of wealth
and power**

looking after oneself...seeking to feather one's own nest...not...constructive for the community as a whole (IN 4)

Unequally distributed power (IN 6)

**14. Abuse or
misuse of
resources**

Would have been cheaper to make [mud bricks] up there [instead of shipping from Perth] - heaps of mud (IN 1)

Every time they get new houses, they move out of the ones they've wrecked

(IN 2)

They throw money around here (IN 2)

Abuse of money/alcohol (IN 3)

Use the store like a big pantry (IN 3)

Money just gets poured in, but it just gets spent on vehicles and generally wasted - misdirected. On pay day

[money] just gets gambled (IN 7)

There's loads of cars here (IN 8)

with control of drinking - money [spent on] food (IN 1)

Money spent on beer, not food (IN 1)

Housing...built in obsolescence [of] five years...fallen or knocked down [in five years] (IN 1)

They've just spend 1.5 million here and they've built houses...better houses, but have to teach how to wash (IN 3) everyone has got a house now - they're really not ready for the houses they built - they're breaking up the houses because they're flash (IN 3)

We've never had much success with the housing - it's still substandard - there's only two houses get anywhere near any standard - the rest you should put a bulldozer through (IN 7)

Table 4

Philosophical factors

Identified meaning	Examples of significant Statements
1. Moral satisfaction	I'm certainly doing a whole lot for my country (IN 3) I'm motivated from a Christian approach to work (IN 3)
2. Comparison with Third World	I always had the ambition to go overseas and maybe do a bit of work in a Third world country...I consider my experiences here in Australia just as powerful and fulfilling and relevant to my feeling of going overseas and doing that kind of work - that ambition's [satisfied] now - it's here in Australia (IN 6)
3. Life choice Enriching experience	RAN life enlightening (IN 4) [it's] been an extremely educating experience - valuable, even for the family (IN 6) We're fairly lucky to be able to have that experience...it's probably a bit of an honour - we're the more lucky ones (IN 7) I'm into a simple life and that's what I've got - pretty basic (IN 7) Life's okay - nothing earth shattering

(IN 7)

I do enjoy this life (IN 8)

**4. Ups and
downs of
life**

I've had hard times and good times

(IN 3)

Sometimes you get a lot of humour out of different situations that I guess - maybe it's just desperation ...they're the little things that happen that give you a good laugh and give you carry on fuel for a little bit longer...sometimes experiences can be really uplifting and so you go on for a bit further, and sometimes they can become drudgery and you just wait for the good things that keep you going for a bit longer (IN 5)

Table 5

Social and Economic Factors

Identified meaning	Examples of significant Statements
1. Social and psychological isolation	<p>Stress of isolation - nothing much to do (IN 2)</p> <p>Sometimes I think it would be nice to just walk down to the shops and buy what you want - hose fittings and things like that (IN 2)</p> <p>Isolated from white people - not married, don't drink (IN 3)</p> <p>Things...build up when you're out [here] all of these little things - you take them on their own and they're not a lot, but you put them all together (IN 5)</p> <p>If you start having trouble...it can get quite a strain on you (IN 7)</p> <p>you can't just nick down the shop and get what you want...Sometimes you just wish you could...go and look at the local KMART or Bunnings hardware shop or something like that (IN 7)</p> <p>A bit of pressure builds up (IN 7)</p> <p>Can be very lonely (IN 8)</p> <p>Problem of distance if you've got a problem - takes police three hours to</p>

get here (IN 8)

Communication can go out - electricity goes out reasonably regularly - not much alone but when you add them up they can make your life tedious (IN 8)
No social activities unless you drink (IN 5)

also a little bit separate from the non-Aboriginal people (IN 5)

**2. Limited
social
life and
recreation**

Recreation poor as gave undertaking that I would be available if there was an emergency (IN 1)

Recreational life conducted completely outside employment (IN 1)

Have to get on with whites there (IN 2)

I don't think it's terribly good for young people...Not much to do (IN 2)

Activities all revolve around grog and food (IN 3)

Life is not as relaxed because there's always a funny kind of mental/emotional "being on one's toes" phenomenon going on (IN 4)

People caught up in own problems - their own hassles - they find it hard to reach out in a positive sense, in a hospitality sense to others who are new, because it's all they can do to keep their own heads above water (IN 4)

I don't have a social life (IN 5)

The lack of suitable company...we're in a situation where you mix and work with people you would not necessarily choose to work with and that puts a strain on things (IN 6)

Social opportunities fairly limited (IN 8)

3. Simplicity

of life

in remote area

It's just a fairly normal type of life -it's just away from the sophistication of city life (IN 2)

I breathe fresh air every day. Best parts trees, sunsets, little children's faces (IN 4)

If not on call...go for run, play with son...cuppa with [my partner] or chat with the teachers (IN 4)

Best part of life outdoor lifestyle and country living (IN 6)

Fishing - that's my escape - I usually manage maybe once a week or fortnight to go out...you can get out and it's quiet and it's you and the bush (IN 6)

The countryside - even if it's desert - there's something spectacular about that - like it's a kind of addictive way of life (IN 8)

It's not a particularly wild social life, but there's a pleasant social

- life (IN 8)
- 4. Need some form of release** [Need] a good release somewhere - be it someone at the other end of the phone - or a punching bag (IN 5)
- You've got to have an interest out here - I like gardening - some girls like tapestry - you've got to come out and bring a few interests (IN 7)
- 5. Opportunity for family life** I think...the hardness and all the challenges...have made my [partner] and myself stronger - I think it's made my family even stronger (IN 6)
- 6. Participation in community activities** Attend and participate in social functions with community (IN 1)
- We have a music group (IN 2)
- Community involvement a benefit (IN 4)
- When there's a fight in the community, everybody comes out to watch...drag out the front of the bloody clinic all the time. I stand and watch too - it's entertainment (IN 7)
- 7. Violence part of life** a lot of violence - it is usually associated with alcohol (IN 5)
- The number of times I've been threatened with murder I can't remember - the number of extremely violent situations in the community - in the clinic - violent threats against myself, my family, my children - like

too numerous to remember (IN 6)

Only have flares of alcohol...I had to
[leave] it just got too violent here
(IN 7)

Outsiders from outstations/communities
cause problems in community (IN 2)

They come into [community] and bust or
drink and fight and cause great traumas
and then they go off again (IN 3)

**8. Benefits
for RAN**

One week leave every three months...

13 weeks leave altogether (IN 1)

The money certainly was a good
incentive. Accomodation comparatively
five star [to home in city] (IN 4)

*It's costly for me (IN 5)

I'm in a special area where I'm
entitled to one week every three months
(IN 6)

Things have really improved over the
last two to three years (IN 7)

Staff housing is absolutely brilliant
(IN 8)

**9. High cost
of living**

Cost of repairs enormous in remote area
and building maintenance (IN 1)

Housing very expensive here - \$300,000
per house to build (IN 1)

10. Poverty

[poor] standard of living (IN 2)

Living in poverty (IN 2)

Extreme overcrowding, extreme poverty

- of the people (IN 6)
11. Affect of
climate on
Recreation Climatic conditions play a big part for
recreation in the wet - floods and
cyclones - rain every day - you're
limited as to where you can go ((IN 6)
12. Lack of
time to
self There's no respite from the community
(IN 4)
Because I'm on call I leave a note
explaining where I am and how long I'm
expected to be away - quite often
they'll come and drag you back from
your family time or your time out to
come and see somebody (IN 6)
That gets me you know, you're always
standing up for your rights (IN 6)
13. RAN as
target Something I never realised about a
hospital - if you make a mistake or
they don't like you, or don't like what
their treatment is generally you just
go home and forget about it - whereas
you wear the responsibility - not only
of your decisions, but the things that
other people feel that you've done
wrong (IN 4)
Warning...for single ladies [RANs]....
you're fair game...you're the perfect
target, or maybe the only target for
the attentions of every lustful
Aboriginal male and white male...for

500 square miles and that can lead to big problems (IN 6)

Your life is at risk (IN 6)

They say "If something happens to this kid it's your fault" (IN 7)

What's going to be banging on the door next time - is there going to be somebody with a pickhandle? - which we've had before (IN 7)

**14. Lack of
privacy**

No sound-proofing in housing (IN 2)

**15. RAN seen
as problem
solver**

If something goes wrong, they come and see me (IN 3)

It's the pressure they put on you about other things not medical is often the tiring thing - the expectancy of you to resolve some things that they can't work out (IN 3)

People have got this expectation that you're super human and then they try and drag you into every situation that's happening (IN 6)

Nurses tend to be regarded as problem solvers (IN 8)

**16. Affect on
rest/sleep**

When you go out the first thing you do is sleep, because you know you're not going to be interrupted (IN 1)

I have on occasions been so tired I have refused to make a decision...I once took

a baby to bed (because I was too tired to do the drive up to evacuate it) so I could rehydrate it and sleep in between with an alarm clock set (IN 2)

Tremendous fatigue - exhaustion (IN 3)

You mightn't even necessarily get called out, but just being on call and having to be on edge waiting for whatever might happen (IN 5)

On a bad night, you can be up several times to callouts (IN 6)

Even when we're not on call, we're basically on standby for security (IN 8)
I'm just feeling tired of getting up at 1 o'clock because someone's been donged over the head by a drunk (IN 8)

**17. Exclusion
from
community**

we are quite symbolic...of previous white intervention in the community (IN 4)

I feel a fairly superficial part of the community - difficult to participate as white person...I can only become involved in a fairly superficial way - basically it's an Aboriginal community (IN 4)

definitely separate from Aboriginal people (IN 5)

You're the minority out here - you're the odd one out - you're not the

blackfella in a sea of white faces,
you're the whitefella in a sea of black
faces and you're on their turf and their
country and their culture (IN 6)

One thing I'm really disappointed in is
...I've asked on a number of occasions
if we can be notified as the health
centre staff of when the meetings are so
that we can come along...and just be
more a part of the community - it hasn't
happened...even though I've expressed
that to the health worker (IN 5)

*Involved with community events (IN 1)

Get on well with...Chairman, deputy
Chairman (IN 1)

Get on well with community especially
health workers...get on well except when
drunk (IN 2)

18. Purposeful

**distance from
community**

Feel part of community but a
professional part (IN 1)

I'm here to do my job and do it well -
be on call when I'm on call - but after
that I regard my job as finished and I
don't want to [work] or talk about it
(IN 8)

19. More

**experienced
settle in
more easily**

You find that when you've worked in
these places for a while that you settle
in much more quickly (IN 2)
When you've been around a few more

places it's not the culture shock that it is [otherwise] (IN 2)

People here - they've all known me from before - they've known my reputation from other places - I felt part of the place straight away (IN 6)

Moving from community to community... people know about me from [relations] (IN 2)

Being there...years - they tell me more private things - Law, secrets (IN 3)
having been here before - knowing the people...I did feel pretty well straight away part of the community (IN 6)

In an Aboriginal community, if you know somebody, or you're related to somebody, you're accepted...more readily than a total stranger (IN 6)

I've got a reasonable rapport with them over the years (IN 7)

They invited me to see stone removed... they wanted me to see that (IN 7)

Settling in not a problem - probably because I'd worked on other communities it's really just transplanting from one to another and although all communities are a little bit different, there were no real shocks in it for me because I knew...what to expect from people - I

knew a lot of what I could and couldn't
do in relationships...all those sorts of
things which are hard to adjust when you
first start, I actually already knew. I
didn't find it hard to settle in here
(IN 8)

Table 6

Isolation and distance

Identified meaning	Examples of significant Statements
1. Affects goods and services availability	<p>Affects length and cost of repairs (IN 1)</p> <p>Fruit and vegies once a week (IN 1)</p> <p>Mail out three times a week - dependent on Greyhound running (IN 1)</p> <p>Mail once a week (IN 2)</p> <p>Two hour drive to get fruit and vegies or get Dr to bring them (IN 2)</p> <p>Limited supplies in store - by the time it bounced down here [not in very good condition] (IN 2)</p> <p>No bus or anything (IN 3)</p> <p>Supplies difficult to get - getting things to town - only see Dr once a fortnight (IN 3)</p> <p>*No problem getting personal supplies - truck once a week (IN 3)</p> <p>Food supply sent in by plane - sent by mail, or if we're lucky the Dr will pick it up and bring it on the Flying Dr plane - so the difficulties are acquiring food (IN 6)</p> <p>Getting the specimens out can be a problem (IN 8)</p> <p>Getting stores and pharmacy out - make</p>

life a little more difficult (IN 8)

There's no real regular service of goods coming in - the truck only comes to the shop at irregular intervals - so...stores sent out on the [once a week] "Bomber" train (IN 8)

Mail comes in only once a week - gets picked up - goes missing...I get mine through the Health Department - that is very infrequent - once every three weeks (IN 8)

We can cash cheques at the shop - but not enough banking facilities - getting haircuts - just things that make you feel sane (IN 8)

Poor roads...single lane (IN 1)

Ran out of water (IN 1)

Lack of water - carted water in...can't water anything (IN 3)

Up until very recently there's been hardly any fresh fruit and vegetables in the shop (IN 8)

Unsealed road...not graded - treacherous (IN 8)

**2. Delay of
goods and
services**

No mail; fruit and vegies not arriving [in wet season] (IN 1)
because the roads are out...planes have got the added burden of other sections of the community...so those

- stores can wait for excessive periods of time at the airport waiting to get to you (IN 6)
- Mail takes long time (IN 5)
- 3. Need for halfways** Halfway to meet ambulance or RFDS (IN 1)
Halfways with ambulance to save full four hour drive (IN 2)
- 4. Difficult to get out** There's a long trip to go anywhere (IN 5)
Dirt roads all around - no allowance for travel time. If you don't have a vehicle you can't get out except fly to Perth [three days a week] - that just increased...I thought it would be less isolated here...but in fact, I'm more because we have no option [eg chartering planes to leave community] (IN 5)
Sometimes you just wish you could go out, or go somewhere (IN 7)
Once we're here, we're here for three months (IN 8)
Most of us don't have transport so can't get to [town] (IN 8)
- 5. Advantages of isolation and distance** I want to go somewhere even more [isolated] (IN 4)
Enjoying advantages of being at a distance from [hospital system] (IN 4)
I find far more plusses for it than negatives (IN 7)

6. Outstations Great distances to outstations (IN 2)
long way
7. Detrimental Road closed six weeks in wet season as
effect of washed out (IN 1)
climate Rain digs up roads - makes rough (IN 2)
on roads Cut off by road for six months of the
year (IN 6)
Weather affects road conditions. When it
rains, road gets cut up very quickly -
even in dry - a lot of bulldust.
Especially after rain [road] gets very
slippery - lots of accidents. Reasonably
frequently get cut off after rain (IN 8)
8. Time important Couldn't evacuate at night (IN 7)
for evacuation
9. Medical Doctor from [town] provides expertise
support (IN 1)
Drs at the hospital [resource] (IN 4)
Once the medico for the area figure out
that you're okay, or they're happy with
what you're doing, you get a fair
discussion with the medico...we discuss
a lot of the cases (IN 7)
10. Hospital [town hospital] provides technical
support (IN 1)
Dietician, health promotions officer,
nursing supervisor (IN 4)
You can ring up Pharmacy and get info on
drugs (IN 7)

11. **Communication improvements** Modern communication systems...have improved out of sight (IN 1)
12. **Problems with equipment** Power cuts (IN 1)
- FAX should be blown up - infuriating - people have to try three or four times - probably causes more trouble as it does help (IN 4)
- There's always things breaking down (IN 6)
- Especially in wet season, trying to radio hopeless (IN 7)
- System hooked up to phone and handpiece and when phone rings sometimes the system alarms so we then have to come back and turn it off, or just check whether it's alarming, because we can't tell from the handpiece if it's alarming or not (IN 5)
13. **RFDS support** RFDS monitor the radio on their own channel (IN 1)
- Service outstations and communities and offer expertise (IN 2)
- The Flying Doctor Service...provide our medical cover (IN 4)
- RFDS [clinic] days (IN 7)
- Flying Doctor evacuates (IN 8)
- *Never got support from supervisor...I have never, never had an answer to any question by a supervisor or...anybody in

authority on the nursing side - go to
doctors for advice or support - nurses
couldn't answer questions (IN 3)

Lack of support young doctors - no
understanding - didn't have the
experience (IN 3)

The times I've sought support from...
[superiors] it's not been forthcoming
(IN 4)
