Remote Area Nursing: Bush or Bushed?

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I have been asked to frame my paper around what has happened to remote area nurse education in the past, what were the strategies developed, comment on the problems and offer solutions/strategies for the future.

To do this I think it is important to identify who a Remote Area Nurse (RAN) is and what this nurse does to distinguish them for other nurses. To answer the first part of the question - what is the nurse? - a RAN is a person with a registered nurse qualification. Today, the emphasis is on levels of competence rather than years of experience. This of course has not always been so. Employers used to, and some still do, state that it is highly desirable to have some years of nursing experience, and presumably life experience accompanies this, incorrectly equating time with competence. Midwifery training was also highly desirable.

There were no further qualifications to achieve.

There has been considerable change in the past 15 years, and sadly too many similarities. I choose 15 years as that is the period I have been involved in both rural and remote area nursing and am familiar with. Anecdotal, personal communications and CRANA conference presentations have given us some insight into the times prior to that of my own colleagues.

Then (15 years ago), as it is now, there were no post graduate courses to adequately prepare a nurse to work in a remote setting. I did not have any colleagues who were embarking on an Aboriginal Studies course, Public Health or Primary Health Care (this was not surprising as the Alma Ata declaration was made in 1978). Unlike today when most colleagues are furthering their education in some form, most of these were not accessible to us or did not exist. A community health degree that was perceived to have an urban focus was all that we were aware of.

So, as I said, a RAN was a nurse with a basic hospital qualification. The nurse also had some personal qualities, a sense of exploration, adventure and some confidence, a mix of social justice and sometimes paternalism, demonstrating our efforts to come to terms with the complex issues involved in remote area health care and what we now understand as the Primary Health Care model. These may or may not have been well founded, but were usually present.

The education, or lack of it, does not match up with the role of the RAN but may explain how the role has evolved. This an important point. This is a role that is often described as an expanded nursing role that includes elements of medical practice. I argue that the remote area nursing role is perhaps one of the oldest forms of nursing in Australia today and that we do not perform areas of medical practice but rather, as I define, them as remote nursing practice. This is what makes us unique. We are not medical substitutes and neither are we in competition with other practitioners. There are so few doctors resident in the remote areas of Australia, and those are part of the multidisciplinary team in that setting. The roles of the team are both equal and complementary, although this is not reflected in remuneration.

Since nurses first established health services, moving with the population into the remote areas, our practice has been comprehensive.
I reflected on Florence Nightingale's view in her *Notes on Nursing* first published in 1859, encouraging us to ensure we take a holistic approach to our profession. 'Nursing (the term) has been limited to signify little more than the administration of medicines and the applications of poultices. It ought to signify proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet, all at the least expense of vital power to the patient.' What she is describing here are the foundations for Primary Health Care, the model we strive to use.

The rapid development of sophisticated technology requiring highly specialised skills has forced nursing to be more defined, specialised and prescriptive. Legislation has followed but not kept pace with this. Marry this to population growth and dispersion in this country and the broad issues that impact on health can get overshadowed. Rural issues in general are poorly understood by our urban neighbours, remote even less so. The activities of the bush go relatively unnoticed. Tjaka (that's the way it is).

Improved communication, transport and technology have assisted remote area nurses to develop professional networks. We have taken collective responsibility to develop standards of practice, identify the needs and to lobby for appropriate education to ensure our profession can minimally meet our standards of practice. In this process we have been pressured to legitimise our practice. It has become clear that few outside of remote area nursing have a functional understanding of what it is we do, what our values are and what it is we believe should be done.

For example, as remote area nurses were are committed to supporting Aboriginal health worker education. Aboriginal health workers are the linkages between community and health service. Some are the health service with limited support from mobile RANs. A remote area health service cannot function properly in their absence. Yet few RANs in this country have had any opportunity to develop the adult education skills required to foster and support the education of our colleagues.

Our roles may change in the future, the community will determine that. Today our role is as described. The fostering and maintenance of an individual's and community's vitality is what makes our role so comprehensive. As Primary Health Care workers we are not isolated in an illness management centre. The communities in which we work are generally small and geographically isolated, hence our health services are very people focused and consequently influenced. This aspect of our work is highly regarded by us. It is what often attracts and keeps nurses in the bush. We are mindful that this is something our city brothers and sisters cannot enjoy. Community development, health promotion and education activities, as well as a clinical service make up the whole.

In the past it has been easy to criticise RANs for being poor collaborators, having few opportunities for professional development or even contact, because of the enormous distances and poor communication technology between practitioners. In conjunction with this was the overwhelming morbidity in the communities. High morbidity and poverty have been accepted as the norm in Australia's bush.

The statistics are well known, particularly to you, and so I will not repeat them here except to remind us that rural people are said to have a worse standard of health than city people and remote people, of whom the majority are Aboriginal and much worse off than their rural counterparts. The enormity of the task and the apparent acceptance of the status quo may have influenced the various state and federal authorities' responses to the standard level of health service supported in the bush, eg only now in Queensland is there an Aboriginal and Torres Straight Islander health workers education program. I believe these are important contributing factors, but the issues are more complex.

In the absence of any other professions, RANs and Aboriginal health workers have demonstrated a willingness, however reluctantly, to adjust their role to the particular needs of the community, to search out a solution which may in the first instance require venturing into unfamiliar territory.
Fear is perhaps the single most significant factor that determines what a RAN does and how that RAN functions. If the educational foundation on which the nurse practises is deficient then naturally the situations do not disappear. Experience, trial and error becomes the school, leaving much to chance. The rapid change in technology and a change in both the community's expectations and the nurse's knowledge of what is possible have much compounded this.

There is another dimension to the reactionary learning process. If the RAN is practicing from a fear base, afraid of making a mistake, of the next procedure that may be required, of the consequences of attempting or not attempting procedures, of unfinished treatments or continued exposure to environmental hazards, what trauma will present next, etc. There is no way that nurse can, in the short or medium term, develop in partnership with health workers preventive and educative programs and/or a comfortable cross cultural relationship and level of understanding of what is important to that community. Very few RANs come from the bush, and so it cannot be assumed that a functional inter-cultural, in the case of urban trained nurses in rural areas, or cross-cultural understanding in both rural and remote areas, will settle on the nurse with the dust.

The combination of fear leading to clinical stress and cultural discomfort will directly impact on the power relationships, health service function and understanding of the community's and individuals' aspirations to health. This directly impacts on retention of both nurses and health workers and significantly affects further recruitment.

Both of these factors can be quite easily altered by good education at the right times. Undergraduate programs now contain a significant component of Primary Health Care and some offer remote area nursing electives. Student placements are exposing nurses to the profession. However, there is still some distance to go.

There have been some significant changes in mortality in remote areas in the seventies. I think we can all acknowledge there has been little change in the past ten years, and that there probably won't be. We have gone as far as we can on goodwill and the methods and technology we employed.

Mortality will not shift until we adopt the model of Primary Health Care across the country. This means having a good, safe, effective, culturally appropriate and scientifically sound health service that reflects the principles of community participation and intersectoral collaboration. Not just the rhetoric, but doing it.

The philosophical and political changes must come from the federal, state and local level, as well as the workers. The workers on the ground are ready. Leadership and role modelling from senior management are essential to support the reorientation required of health services. Many reports have been written on the health of rural and remote Australians. Recommendations have been made quite specifically about education for health professionals in these settings, including RANs in the following resources:

- National Aboriginal Health Strategy
- Aboriginal Deaths in Custody
- Remote Area Nursing: A Question of Education
- Enhancing the Role of the Rural and Remote Area Nurse
- WHO Alma Ata Declaration on Primary Health Care
- WHO Ottawa Charter on Health Promotion

The documentation is done. It is now time to move on the recommendations. Early this year a workshop was convened in Cairns by the Cairns and Toowoomba Rural Health Training Units as a follow on from a meeting with CRANA representatives in Brisbane where it was formulated, to 'develop a single, nationally accredited post graduate diploma for nurses working in rural and remote areas'.

The Cairns meeting had participants representing CRANA, the newly formed Association for Australian Rural Nurses (AARN), Northern Territory, South Australia, Queensland Health
Departments, Rural Health Training Units (QLD), James Cook University, University of Central Queensland, Northern Territory University, University of New England, Flinders University of South Australia, and the Queensland Board of Nursing Studies. Other groups invited, but unable to attend, included representatives from employer groups, the College of Nursing, other universities and the Queensland Nurses Union.

A joint group was formed between CRANA and AARN to further pursue developing a single, national core curriculum in conjunction with a university consortium, union and employer groups. This group has been unsuccessful in gaining funding and consequently has ceased to function.

CRANA strongly believes that the development of a national core curriculum - Remote Area Nursing, Primary Health Care practice is urgent, that it be developed by practice nurses in consultation with other RANs, employers, the university consortium and the Australian Nurses Federation. Experience has taught us that the course must contain a strong clinical skills component in an internship setting with clinical preceptors as well as cross cultural learning.

Other essential components have been well recorded. The curriculum will reflect differing political climates (by state and territory), various models of service delivery to remote area people, including historical models/methods: degree of community involvement in service development and delivery; aspirations of communities; comprehensive Primary Health Care as a philosophy, model and level of service provision.

Alternate modes of delivery need to include full time, for both nurses coming into the profession of remote area nursing and those on study leave, as well as part time and stand alone units. Distance education presents many problems for RANs. Scholarships and DEET support that reflects the complex nature of the training will be necessary to facilitate this process. Locum relief similar to that trialed in some rural areas will also be necessary.

The award will be a Graduate Diploma with a Graduate Certificate exit. The course will articulate into a Masters. Direct Entry in recognition of the RAN's existing experience is essential. We will be offering an award to many RANs for the first time who may well be intimidated by the process. Stand alone units will give them an opportunity to work at their own pace and develop confidence. Adequate professional and educational support will be essential to the success of the program.

There is no longer any need in this country to repeat our mistakes of the past. We are committed and very excited at the prospect of developing such a program. The benefits are obvious. The time is right. We don't want sympathy for whatever the circumstances RANs have found themselves in the past, or even today. We want to go forward. Right now and for some time in the future we are significant players in remote area health care, in some areas the sum of the service.

In summary, there is currently no coordinated approach to develop an education program that will adequately prepare a nurse for remote area practice. I have not mentioned orientation as I believe that is the employer's responsibility. Our priority is to see the development of this program, then we can move on.

References


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