Tasmanian Rural Community Nursing: Constructions Of Practice

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Abstract

Tasmanian rural community nurses practice in a role which encompasses both direct or domiciliary care and health promotion. This study uses narrative analysis in order to explore some of the boundaries which exist in the constructions of their practice. Stories told by the participants focus on the areas of; the boundaries between rural community nurses' personal and professional lives, professional boundaries, and the concept of community.

Acknowledgments

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Statement of Authorship

This thesis contains no material published elsewhere, except where reference is made in text of this thesis. Nor has material been extracted whole, or in part from a thesis or project presented by me for another degree or diploma.

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Jane Mills .....

Prologue

From where I sit at my desk, I look out to the sea. It glitters and winks at me in the sunshine, its colour changing from aqua to lapis lazuli. As I watch the water swell and abate, rushing up on to sands that will never again know the kiss of that same ripple of water, I am reminded of the 'Ocean of the Streams of Stories'[1]: a place where stories are found as different currents, currents which are all different colours, a breathtaking rainbow always fluid and always changing.

Storytelling is a fundamental way to give shape and meaning to the telling of our culture. Through the stories we tell, we describe, illustrate and paint pictures in our own and others' minds. The following thesis is a series of stories. Some of the stories you will read are told by me, and some are told by others. Each chapter has a different focus and the style in which the stories are told reflects that. There are stories about storytelling itself; there are stories about rural Australia and what it is like for those people who live there and the nurses who work there. Most importantly, there are the stories told by rural community nurses. These are stories about their lives and their practice. Wending through all of these bright sparkling streams of stories is my own story, always running next to another in this ocean of notions.

Together these stories meld to tell about how rural community nurses locate themselves on the terrain of rural health care. As the storytellers speak, we see that the spaces that these nurses create for themselves, both as practitioners and as community members, are influenced by many different things. The stories

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[1] Found in 'Haroun and the Sea of Stories' written by Salman Rushdie.

that this thesis contains are selective, partial and diverse, only able to touch on a few threads of a complex life, and yet hopefully they will allow the reader to gain a glimmer of insight into the world of rural community nursing.

A Place To Begin

Who are those who tell the practice stories from which this study attempts to make some meaning about rural community nursing? There are six women who tell stories of practice in the chapters to come, including myself. In the next few paragraphs, I will introduce each of the participants to you, in an attempt to give you a sense of their lives as women and nurses.

Bebe

Bebe has worked for the community nursing service for ten years. Over this time she has been based on both rural and metropolitan rounds and she is currently working in town, even though she lives in a rural environment. Bebe has a partner and two small children and she works part-time. Over the past two years, Bebe has completed her Bachelor of Nursing as a post-registration student, having originally trained in a Tasmanian teaching hospital.

Grace

Grace both lives and works as a part-time community nurse in a country town; she also has a partner and two children. Grace recently completed a Bachelor of Nursing degree via distance education. Born in America, Grace completed her training in a large American metropolitan teaching hospital. Travelling to Australia for a working holiday, Grace practiced in acute care before moving into Tasmanian rural community nursing practice.

Shona

Shona has been a long-time Tasmanian rural community nurse. Shona has lived and worked in a country town similar in size to Grace's for ten years. A single mother of three, Shona works full-time and is yet to fulfil her desire to undertake tertiary studies because of family commitments. Shona grew up in Tasmania, completing her training here before moving to 'the mainland' for several years before returning to practice in the community.

Claire

Claire has a very long history as a Tasmanian rural community nurse - over twenty years. Most of this time, has been spent working in a medium-sized rural town, not far from a major rural city. Claire works full-time as a rural community nurse, is single and has no children. Claire's early years as a nurse were spent on 'the mainland', where she completed her hospital training in a rural base hospital.

Fiona

Fiona has worked as a community nurse, mainly in a metropolitan setting, for eight years. Throughout this time, though, Fiona has spent time in rural community nursing settings, and was able to reflect on those experiences in this study. Having recently completed her Bachelor of Nursing degree, Fiona works full-time, is single and also has no children. Fiona trained in a large teaching hospital outside Melbourne and worked on 'the mainland' before coming to Tasmania 10 years ago.

Jane

My history as a nurse also began in a large teaching hospital, the Royal Hobart Hospital. After travelling and working in the United Kingdom, I have spent the past seven years working in Tasmanian

remote and rural community settings. In 1993 I commenced my Master of Nursing Studies, having completed my Bachelor of Nursing degree the previous year, also at the University of Tasmania.

Over the past three years, my thesis has been my most consistent and constant companion. It has been with me through a romance, courtship, wedding, five months of morning sickness and now maternity leave.

Not only this, my thesis has moved house and job with me. Together we have gone from a renovator's delight, inner-city cottage and a job working with a combination of metropolitan and rural community nurses to a large stone house on a property which encompasses the North-East tip of Tasmania, and a job managing rural community nurses, home helps and handymen, all of whom live and work in an area covering nearly one quarter of our State.

The pictures which illustrate this text mainly depict my home at Cape Portland, Tasmania. Hopefully they will provide a visual representation of my personal location and perceptions of rurality.

Women's Words, Women's Stories: Method And Methodology

Why Stories?

My nursing life has always involved chasing new horizons. This need to travel and seek new experiences in my work has led me from the redneck and isolated West Coast of Tasmania to the glamour and glitz of the Royal Opera House in Covent Garden. As you might imagine I have spoken with many nurses in vastly different circumstances. Through all these various conversations, though, there has been one constant thread, and that has been a compulsion to tell stories of practice.

These stories of practice have been tragic, sad and joyful. In nurses finding a way to speak of these moments of poignancy there was often an attempt to find some humour, stemming, I believe, from the old adage that "if you didn't laugh you would cry" at some of the situations we have found ourselves in.

But why the compulsion to tell these stories? What end does the telling hope to reach? I believe that the compulsion to tell is symptomatic of the complexities of nursing culture, a culture that is intrinsically gendered female and is dependent on the traditional orality of female interactions (Anderson, Armitage, Jack & Wittner 1991) to affirm nurses' own constructions of practice.

Storytelling and nursing practice are inextricable in this way. With an audience that possesses the inside knowledge to question and critique as well as affirm, the act of telling is integral to the act of cultural meaning-making. This generation of a deeper understanding of the meaning of practice then adds to the layers of understanding of which the culture of nursing consists. '[I]n the 'will to understand' their lives, nurses' narrative rememberings become the archives of a culture' (Walker 1995:157).

This cultural construction through the act of storytelling or narrative and the subsequent making of meaning which comes

through the sharing of stories can only be a fleeting moment because of the oral nature of nursing culture. Often these moments of cultural transformation are lost in time, unable to be shared by others, and so contribute to the image of invisibility which nurses continue to promote through their lack of a united visible voice, the voice of the written word (Street 1992:18).

This dependence on narrative to express the stuff of nursing culture means that with every telling, a recreation of events occur which will never be the same as the previous telling. This leads to another creation of meaning which is often dependent on the audience for whom the story is told. It is this question of for whom and with whom which adds impetus to the quest to undertake research with those who provide these narratives of nursing (Walker 1995).

Several years ago, during a class on research methods, we were asked by our lecturer to think about our underlying assumptions about the world. I remember this question for a couple of reasons, mainly because I wasn't really all that sure what this person was asking of me. I immediately started to think of what the right answer may be, without really knowing at this point that there was no right answer to give. As the other class members started to express their viewpoints, I realised that the question was all about what I believed. What were the most important lessons I had learned so far in my multitude of lives? When I think about that moment now, I know that one of my underlying assumptions is that there can be profound differences in each gender's view of the world and that this thought always needs to be taken into account, in all of my lives.

How this sense of difference explicates itself in my nursing life weaves its way through the everyday. Nursing has a long history of patriarchal influence which reaches back to the middle of the 19th century and the entrance of Florence Nightingale into the arena of health care. Nightingale created a turning point for the

image of nursing: from an occupation which had been regarded as that of a servant to the creation of a nurse who was well educated in the 'art' of caring for the sick and dying.

During this historical revolution of nursing, however, Nightingale also tied us to the coat tails of medicine with her 'strong insistence on the hierarchical relationships with nursing superiors and doctors [which] were designed to legitimate nursing as a good profession for women' (Street 1992:5). It is the how and why of this domination by physicians and scientists (who were traditionally men) which provides the basis for some of the structures of oppression which render nurses and their practice both silent and invisible. Nursing culture has perpetrated this sense of domination by subscribing to these dominant groups' norms and values (Roberts 1983:26), those of science and objectivity. Our own oral culture has been subjugated to medicine and science's (male) value system which holds up objectivity and generalisation in opposition to the subjectivity and individuality of the narrative form.

I would argue that nurses have only ever superficially engaged with science as a way of knowing and meaning-making in practice. Instead, they have instinctively resisted the reductionism and documentation of science in the ways in which they have constructed their methods of communication and practice around the female tradition of orality. As a female culture, we are immersed in our worlds and covet a closeness which is rejected in the male value system of standing back in order to truly know something. As women and nurses, I believe, we prioritise the intimacy and interconnectedness which is lived out through the act of storytelling.

How our own specificity of cultural practices is valued by others outside nursing can then be debated. Evelyn Fox Keller in her explication of the relationship between gender and science, states that the opposition between gendered ways of knowing is

congruent with the dissimilarities which exist between the genders themselves. This leads to a circular process of reinforcement in which what is scientific, and also male, is given even greater prestige, whilst that which is feminine, 'be it a branch of knowledge, a way of thinking or woman herself', becomes even further devalued by the comparisons at work (Fox Keller 1994:54).

Nurses' modes of practice also reflect this devaluation of our ways of knowing, as thinking outside the paradigms of objectivity and science is valueless to the dominant others who subscribe to science. Nurses' storytelling has then to translate into another form of doing in order to legitimise itself. The thinking involved with telling stories becomes a subconscious, natural adjunct to the telling (Street 1992) or doing. One of the most common examples of this is the tradition of the handover. In this telling of patients' lives nurses enshrine talking as a form of doing, a task which goes little way towards valuing this particular way of knowing.

Walker extends this argument around the tensions which exist between thinking and doing in nursing when he states that,

> nurses' efforts to position 'doing' as more important than thinking in clinical nursing culture are a consequence (rather than a cause) of their resistance to the worth we generally attach to intellectual work in Western society and are based on an assumption that 'hands-on' care draws on knowledges necessarily different from those which drive what is, at one level, legitimately intellectual work (scholarship, research and so on) (1997:5).

This powerful combination of what can be seen as anti-intellectualism and a gendered framework which devalues women's ways of knowing, leaves the genre of storytelling in a greatly unrecognised position in the realm of legitimate ways of knowing the world.

Post - Positivist Research And Narrative As Methodology

So where then, in a theoretical sense, can the importance of narrative to nursing culture be located? Lather talks about a place called post-positivism, a place where there is a 'loss of positivism's theoretic hegemony in the face of the sustained and trenchant criticisms of its basic assumptions' (1991:6). Over the past decade, there has been an adoption of various theories by authors who have undertaken such a critique and moved into a space beyond the traditional tenets of positivism. Examples of such works are Lather's use of critical theory (1991), Weedon's work posited in the post-modern (1987) and Stanley and Wise's reworking of their original feminist text to more clearly reflect a post positivist position (1993).

The use of narrative has generally been seen as a method for the collection of data, usually in ethnographic studies or those that are action-based in intent and generally founded on post-positivist theories of research. Narrative analysis is only now emerging as both a method and a 'methodological imperative' for understanding in nursing research (Walker 1995:156).

For feminists, the importance of women's words in uncovering the structures of oppression which exist in the everyday has meant a reconceptualisation of narrative as a key to unlocking meanings which have been previously hidden and excluded by the 'science of research' (Sandelowski 1991:161). I will use storytelling as a method for data collection and narrative analysis as my methodological imperative in the quest to uncover some of the why of rural community nursing practice.

Narrative And Feminism

Feminist researchers have embraced the use of narrative as a way of garnering greater understanding of the issues which are important to women. Often their questions arise from a much

more personal basis than can be subjected to quantitative analysis which seeks to know the object of study. Instead feminists have 'experimented with ways of 'identifying with' the other in order to 'know' the other' (Reinharz 1992:233).

Engaging in storytelling cannot ever be a one-person affair. Rather there is the storyteller (participant) and the listener (researcher, in my case). Even though the story told supposedly belongs to one person, there will always be interaction and dialogue, and what 'emerges and develops through dialogue are issues - the chaotic and problematic process of two humans thinking and communicating' (Minister 1991:36). Stories then belong to no one as they are always the outcome of people's interactions with others who can also tell the story as their own. Our investment with the stories that we tell is great, though, for storytelling is the way in which we make sense of our worlds, and so we tell these stories as though they belong to us, and us alone.

It is in this way that an oral interview offers to storytellers the chance to put into words their experiences, allowing both a sense of ownership of thoughts and ideas, and a chance to reflect on the meaning of those experiences to them (Anderson et al 1991). The data is personalised and individualised as it consists of the narrator's words. As Hale states when discussing feminist methodology:

> A woman (interviewee, narrator, oral historian of her own life, autobiographer) should always be encouraged to be herself in the sense not only of being honest but also of not remaining anonymous to be the subject of her own life to reinvent history (especially: to interject herself into history) and to act. Her answers will not always fit his questions, nor 'ours' either' (1991:125).

Through the researcher inviting the participant to speak freely with no constraints there is a chance to produce insights which are non-standardised, 'exploring people's views of reality and allowing

the researcher to generate theory' (Reinharz 1992:18). I think, though, that it is important to note here the importance of the chance element involved with the invitation to speak freely. Throughout this piece of research, my position as a clinical nurse consultant (CNC) in relation to the community nurses who chose to tell their stories of practice was always one of other, even though that was not my choice. How to break down the formal constraints created in situations such as mine eluded me, as it has other researchers. I will later discuss the strategies I undertook to minimise this power relation when I talk about the process of data collection.

For Hilary Graham, a feminist writer, 'the story marks the boundaries of what the individual is prepared to tell' (in Reinharz 1992:30), and that is what I found. By allowing the teller's story to 'wend its way where it will', the focus quickly shifted to how the narrator (participant) saw herself in relation to community members with whom she practised. My original idea for a research question was founded in my own concerns as a CNC, but the importance of this notion was quickly dispelled by the storytellers whose own priorities were played out in the stories they were prepared to share.

Narrative As A Methodological Imperative: Issues and Concerns

Storytelling and narrative have been a part of our lives since the beginning of time. Our histories are created through the stories which are passed on from generation to generation. Sometimes stories are passed on in a written or pictorial form, but more often they are told using the spoken word. Stories are a 'source of learning about the world, about what it means to be human' (Anderson, 1994:40). Manning Clark, writing on his development as a historian, describes the effect of storytelling as 'increasing wisdom and understanding, making people aware of what has been seen previously "through a glass darkly"' (in Anderson, 1994:40).

Sandelowski considers storytelling a threshold activity, capturing the narrator's momentary link between the present, past and future. She goes on to explore the structure of narratives, stating that they are 'composed of a story or fabula, comprised of actions, happenings, characters, settings, discourse or plot, the way the story is communicated' (1991:162).

To extend this description of the structure of narrative another step, I think it is worthwhile considering Anderson & Jack's (1991) perspective of narrative as a methodology. They put forward the notions of meta-statements and the logic of the narrative as necessary to narrative analysis.

Meta-statements are places during a narrative where the speaker reflects back on her own words, pausing and commenting about something just said. These reflective moments are indicators of when the speaker has sensed a contradiction in terms of individual beliefs and expected beliefs. 'They inform the interviewer about what categories the individual is using to monitor her thoughts' (Anderson & Jack 1991:22). Subconscious adherence to dominant norms is apparent through the use of language and these moments of reflection can potentially be seen as moments of resistance for such women, especially if the reflective thought actually negates the individual's initial comment.

Continuous with this line of locating moments of resistance in narrative pattern or structure is the need to examine the language used for 'internal consistencies or contradictions' (Anderson & Jack 1991:22). This is termed the 'logic of the narrative' and combines with the concept of meta-statements to help the researcher identify oppressive cultural norms in narrative tellings.

For a beginning researcher, narrative, as a research methodology, provides some murky water to tread. As an insider to community

nursing practice, I feel sure my identification with both the storytellers and the stories they had to tell led me to a deeper insight and understanding of the things they wanted to talk about. Segura believes that the 'quality of the interview data and their reliability is enhanced when the researcher is knowledgeable and integrated into the community under study' (in Reinharz 1992:26). This thought, though, is tempered by the need for the researcher who is an insider to the research field to hear other stories and prevent the possibility of generalising from personal experience (Reinharz 1992).

When I think about my insider status in the research I undertook, I know that this also undoubtedly created many lost opportunities throughout the period of data collection. My own inexperience as a researcher, and yet considerable experience as a community nurse, meant that I missed many cues which might have yielded much more insight into the topics under discussion. Such is the nature of narrative, a temporal notion, a moment in time, that these mistakes cannot be lived out again. My familiarity with the field meant that I often glossed over the obvious, missing the chance to ask the storyteller what she meant by a detail of her story. It is in the everyday of nursing practice that the structures and relations which shape nursing culture are best explicated, and it is in the detail of 'telling it like it is' (Walker 1995:160) that these locations are to be found.

Living out of a feminist position in my nursing life is for me fraught with the pitfalls and problems created from my own background, which was strongly influenced by the scientised, hospitalised culture in which I was trained. Avoiding placing myself in a position of controller in the researcher/participant relationship was something I strove for when thinking about the doing of my data collection, and is something I strive for in the everyday of my practice as a CNC.

Upon rereading the data, however, I can see how I subconsciously avoided or even blatantly ignored, at times, leads given to me by a storyteller which ran contrary to my own ideas. Instead of offering affirmation or encouragement through either verbal or non-verbal feedback, I offered a verbal prompt which led to that thought's demise! This has led me as interpreter of the data to try later to reconstruct where the storytellers train of thought might have been going.

It is this notion of reconstruction or interpretation that I would like to now consider in some depth, for it is at this juncture between analysis and the stories of the tellers that I realised the implications of the politics of interpretation.

The Politics Of Interpretation In Narrative Analysis

Interpretation for me will always be a site of conflict. This conflict arises from the question of ownership: whose words are they that we as researchers are attempting to interpret? As a feminist, I believe that the intent of the words spoken belong to those who have spoken, the teller of the story, the participant. The use of those words by myself as researcher then becomes a site of conflict between the storytellers original perception or intent and my interpretation of their meaning in the bigger picture of my analysis.

As we move from the problems of interviewing to those of interpreting the resultant text, the oral history process seems progressively to efface the original storyteller and diminish her control over her own words. Once the tape has been converted into a text, what at first might have appeared to be an immediately accessible account of a life or an episode, with the speaker as the ultimate authority, becomes a site of interpretive conflict (Gluck & Patai 1991).

Fiona Kelly, explaining how she conducted research which maintained a feminist ethic, pointed to the need for the return of transcripts to participants. This provides an 'opportunity for each woman to read her transcript, and correct, qualify, or add anything she want[s]' (in Reinharz 1992:57). I decided against returning the entire transcript to each of the participants in favour of producing a discussion paper which incorporated chunks of data. This had implications for my methodology because of the way my ideas about what I wanted to write about in the final data analysis chapters changed over time. By not returning the entirety of the transcripts to the participants, I lost the chance to live up to some of my feminist ideals and in doing so closed off the avenue for any one of the stories told to be discussed by the tellers.

Borland discusses her own experiences of interpretive conflict and offers some consolation when she asserts that as her 'consciousness has been formed within a different social and historical reality, I cannot restrict my reading [of the data] to a recuperation of original authorial intentions' (1991:70). This, however, does not address the uncomfortable feeling that I have, that my interpretation could be seen as an attack on the participants' constructions of their practice as community nurses. I can only seek to reconcile these feelings with the knowledge that an interpretive research design hinges on the researcher's explication of data shared by the participants in order to explore for deeper meanings - in my case, the broader picture of rural community nursing. All the people involved in this thesis - myself, the participants, or my supervisor - came from diverse backgrounds, and each has contributed differently because of that. Ultimately, though, this is my piece of work, and so I have to assume responsibility for the interpretation of the data used.

Research Methods

In order to find participants for my proposed research project, I decided to ask each community nurse personally through the use of a flyer which I distributed to all staff. This described my general intent and outlined how much commitment would be asked of each participant (that was to attend both an individual interview and a focused group discussion). In addition, I spoke to as many community nurses as I could, inviting them to join my study. From this process I recruited five female community nurses, three of whom practised in rural communities and two in urban communities.

The majority of the participants had known me both as a community nurse (ie when I was one of them) and also as a CNC, which was the role I was in when undertaking the data collection. My rapport was stronger with those alongside whom I had practised, with those nurses often referring to me during the interviews through comments such as, "you remember" and "you know what I mean".

For those community nurses I had not worked with as a peer I needed to offer much more reassurance that no one else would be privy to their transcripts and that I was not there to evaluate them but rather just to listen to them. Helping my credibility in being able to do this was a practice of mine as a CNC. I routinely went out with nurses on what I call clinical practice visits. These were not times of formal assessment (I refuse to audit nursing notes) but rather times of sharing stories, problems and goals through meeting clients and talking to the nurses while out on the round, thereby establishing a stronger rapport.

All the participants had the option to choose the venue in which the individual interviews were conducted, which led to a

variation from coffee shops to homes, to my home, to health centres. The focused group discussion was held in the home of one of the participants, with a large afternoon tea being provided by myself (our tapes are filled with the rattle of cups and saucers, a fairly typical noise to be heard when nurses are telling stories).

Each of the interviews and the focused group discussion was taped and transcribed. The transcripts of individual interviews provided me with the ethical dilemma which I have previously addressed. Because of the bulk of the individual transcripts, I decided not to return them to the participants in that form - rather I wrote, as I said earlier, a discussion paper which incorporated large chunks of the data. This discussion paper formed the basis of the focused group discussion. The main purpose of holding the focused group discussion was to try and generate more stories around the main themes I had isolated from the individual interviews.

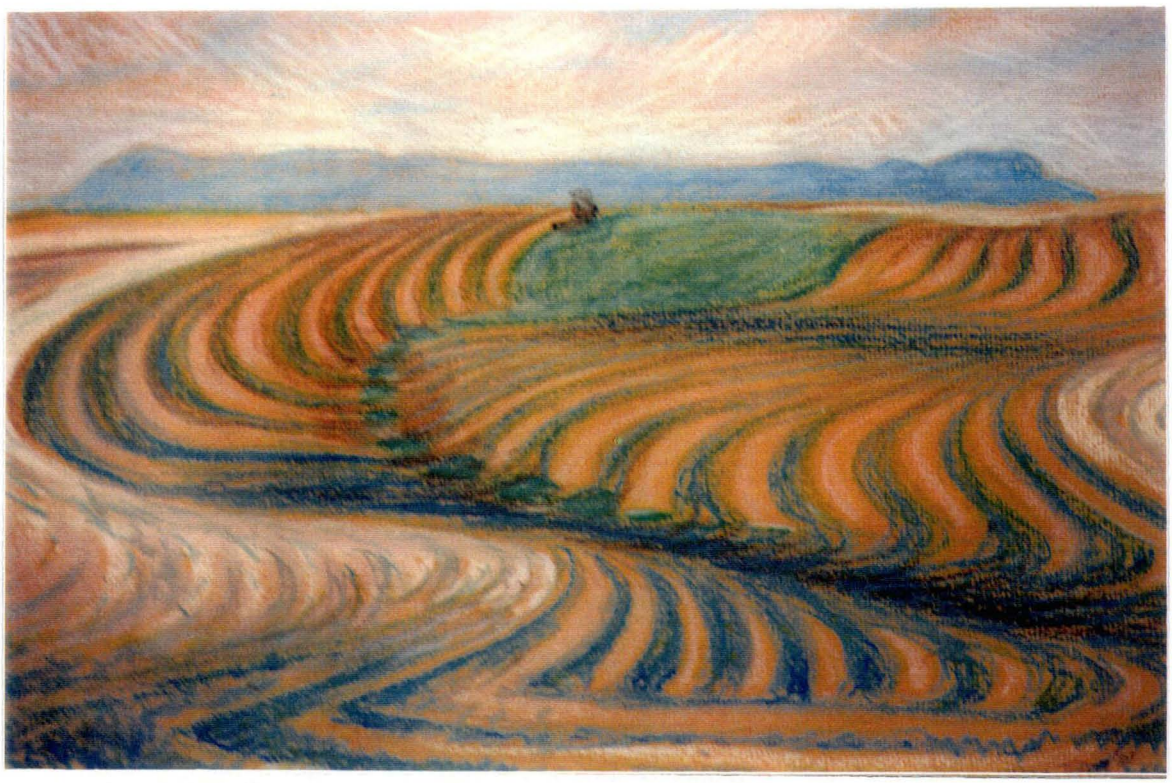
Each of the participants had this paper for a fortnight before the group discussion. Attendance at the focused group was, of course, voluntary, and two of the participants decided not to come. Apologies and reasons for their non-attendance were given freely, but, I am not sure if this was a reflection of time constraints, a lack of interest or a fear of reliving in a group situation the topics they had spoken about on an individual basis. I didn't pursue this, trying not to invade those nurses' privacy, and so can only speculate on the cause. Sulimar Reinharz makes a point which all researchers need to be mindful of in a situation such as mine, where time is given on a voluntary basis. 'Multiple open-ended interviews are well suited to understanding how a woman develops her ideas. They can be done, however, only among interviewees who have time to invest in the process' (1992:38).

The focused group discussion was a lot of fun. Those who attended all participated in clarifying ideas that I had presented and refuting points that they had originally made in their individual interviews. The stories that were told were complex and reflected

a feeling of safety within the group atmosphere. My choice to use a focused group as a forum to hone my ideas supported my decision to use narrative in opposition to the written word as a method of data collection. Rather than relying on a written response to either transcripts or my formal paper, I wanted to continue to listen in the tradition of women's and nursing's oral culture.

Textures, layers, visions, context, meaning, a cacophony of voices - this is the stuff of women's words, women's stories. Plumbing the depths of the stories told is like diving into the swirling surf, tumultuous and always surprising. Together we speak, our words often overlapping, mixing and making meaning of the lives which we live out as rural community nurses and rural women.

A Story About Identity: Tasmanian Rural Community Nurses



Such is the nature of a literature review that there are many stories to be told by many voices. These voices of 'experts' compete to create a story which is at once full of contradictions and tensions and yet provides a foundation for future stories to be told. This is a story about rurality and identity, a story of definitions.

Tasmania: A Rural Community

Tasmania, Australia's only island State, is also this country's smallest and poorest. This is reflected in several social indicators - for example, Tasmania experiences consistently high levels of unemployment at over 10% of the population, Australia's highest suicide rate (Rothwell 1997:1) and one of our nation's lowest median weekly income levels at $257 (approximately $13,364 p.a.) (Australian Bureau of Statistics (ABS) 1997:1).

Tasmania also has a large ageing population with 33.3% over 45 years. In addition, the 1996 Census found that many of the Statistical Local Areas (SLAs) 'with the highest median ages were situated in outlying areas across the State' (ABS 1997:2), indicating that a high level of the ageing population live in rural areas and will potentially require a higher level of health care and social support.

Generally Tasmania has a substantial proportion of its population living in rural areas. At the time of writing, the 1996 Census (ABS 1997) information was only beginning to be released and the official calculation of how many Tasmanians lived in rural areas was not available. To give some contextual detail for this study, though, I was able to perform some rudimentary calculations based on available information.

I set three goals in this: to approximate the number of Tasmanians who live in rural or remote areas; to calculate the number of Tasmanian-registered nurses who are based in rural or remote areas and to ascertain how many of these registered nurses worked

in the field of rural community nursing. I did not include enrolled community nurses, as there are only a very small number of these positions in the State. In the Northern Region where this study was undertaken, there is only one.

The Commonwealth Department of Human Services and Health's Rural/Remote Areas Classification (RaRA) (1994) criteria for classifying SLAs in rural and remote areas in Tasmania, as either Rural Other or Remote Other, is that the 'population approximates 14,000 (or 7000 and 30 or more per s.q. km)' (1994:4).

I decided to exclude the RaRA Rural Major criteria (14,000-75,000) from my definition of Tasmanian rurality. As Hegney states that it 'is the lack of support services which influences the scope of (rural community) nurses' practice' (1997b:22). Later in this chapter I will argue that, because of the nature of the centres which are included in Tasmania's Rural Major category, the community nursing services delivered there are essentially of an urban orientation.

Using this as a measure of what could be constituted rural or remote in Tasmania, I turned to the 1996 Census information. Here I encountered a problem. SLAs are unrelated to Local Government Areas (LGAs), so several SLAs can be included in one LGA. This is indicated in the ABS Census data by a bracketed alpha figure after the SLA's name. Even though the census data is provided using SLAs as a measurable unit, these SLAs have never been broken down into postcodes, which was the only way I could gather information on rural community/registered nurses. Postcode information was only available by LGAs (ABS Private Correspondence).

This meant that the most specific correlation I could calculate on rural community/registered nurses was by LGAs with a population less than 14,000. This excluded the LGAs of Launceston, Clarence, Hobart, Glenorchy, Kingborough,

Devonport, Burnie, Central Coast and West Tamar. However some of these LGAs do have small rural components, which I acknowledge will skew my figures slightly.

The total population of Tasmania in 1996 was 459,659. The number of people living in rural or remote LGAs with a population of less than 14,000 was 150,836, or 32.8% of the total population (ABS 1997).

According to the Nursing Board of Tasmania's (NBT) 1997 registration figures, there are 5800 Tasmanian registered nurses with a current annual practising certificate (NBT Private Correspondence by Letter). The total number of registered nurses in Tasmania who lived in rural or remote LGAs with populations of less than 14,000 was 1591 or 27.43% of the registered nurse population.

How many, then, of these registered nurses work in rural community settings? The most recent labour force statistics collected by the Department of Community & Health Services (DCHS), Tasmania, in 1995, indicated that there are 75 registered rural community nurses in Tasmania who live in the LGAs I have nominated as rural or remote (DCHS Private Correspondence by Letter).

Because the methodology for this project is not quantitative, I decided that in order to tell the story of rural community nurses in Tasmania, I would use this somewhat inadequate statistical data. What we can tell from this information is that there are very few Tasmanian rural community nurses. Altogether they make up only approximately 1.3% of the State's total registered nurse population. Their small numbers, combined with the isolation they experience in practice means that they are a group of Tasmanian nurses whose concerns and issues are often not heard but rather taken for granted. Their insignificance on the greater

health landscape is reflected in the paucity of literature about Australian rural community nursing in general.

Defining Rurality

Throughout the literature, there is much discussion of the difficulties in either defining the term rural nurse or adequately describing the role (Buckley & Gray 1993). This confusion only reflects the disparities that exist around the definition of rurality (Humphreys & Weinard 1989, Humphreys & Rolley 1991, Kreger 1991, Malko 1992, McDonald 1994). There are four classifications of rural which have been nominated by Australian government departments and tertiary institutions (Hegney 1997b), of which the RaRA classification is one.

The dubious applicability of these prescriptive, competing definitions has been well illustrated in the introductory telling of this story of identity. The relevance of the confusing reductionist definitions of rurality which seek to map and thereby control sectors of our society is questionable. Without some form of consistency and common language about the word rural, people who speak about rurality do so in different tongues, creating potential obstacles for the advancement of rural health care as a whole.

Several authors have pondered the appropriateness of using population-based, numerical measures to differentiate what is meant by 'rural' as compared with 'urban' and 'remote' (Huntley 1991, Buckley & Gray 1993). Buckley and Gray, studying the needs of registered nurses who worked in rural and remote areas, found that the terms, 'rural' and 'remote' were self-defined by the registered nurses they worked with. They took into account the individuality of their areas and the support network which surrounded it, thereby creating a contextual definition.

Huntley continues this theme, discussing the need to consider context in relation to the definition of what constitutes rural or remote health care provision. Factors which need to be included are 'distance, time, cost, physical barriers, structure and ease of provision of both human and tangible resources' (1991:14).

The National Rural Health Alliance also recognised the problem of defining rurality at its Winter Manifesto (1995) and further developed one of the initial recommendations from its third National Conference, at the same time incorporating relevant proposals from the National Rural Health Strategy (1994). Recommendation fourteen states that:

> There is a need for a redefinition of 'urban', 'rural' and 'remote' places. The new definition should account for local and regional variations in distance, population and culture and include recognition of specific local anomalies which affect access to high-quality health services (1995:7).

This statement portrays a sense of conflict between the need for definitional guidelines and the acknowledgment of contextual variation between similar areas. The National Rural Health Alliance's Winter Manifesto's 14th recommendation discusses a scope of definition which would necessitate a consideration of community members' perceptions of their own isolation and how this can be communicated effectively to those who make policy decisions affecting health care.

A dimension of the discussion on defining rurality, which Humphreys identified early in the literature, was that any definition of rurality involved making a 'value judgment' (in Huntley 1991:14). To make a value judgment involves an examination of knowledge based on personal, contextual experience. For people who live in country areas, an answer to the question of defining rurality is very clear; for those policy-makers who are based in urban environments, their definitions

are clearly insecurely grounded in actual experience of living within a rural area (Stasser, Harvey & Burley 1994).

The Rural Community Nurse: Defining An Identity

Desley Hegney, in her analysis of the discourses of rural nursing in Australia, 1991-1994, concluded from her data analysis that rural nursing can be defined as the practice of a nurse:

- in a rural hospital without a full-time medical officer employed in the health service (a resident doctor). This excludes a medical superintendent who has a right of private practice;
- who works in a community health or district nursing service in a town located outside capital cities and other major urban environments (that is, populations less than 80,000) (1996b:249-50).

Pivotal to this two-part definition is the high level of autonomy in decision-making which is inclusive in these rural nurses' scope of practice. I do, however, have a problem with the second part of the definition which relates to rural community nurses. Hegney quantifies her definition of rurality in relation to community nursing, stating that those who work with populations of less than 80,000 would be defined as rural community nurses. In Tasmania, this would designate all cities outside Hobart, the capital, as being rural.

Hegney is the first Australian author to fully acknowledge rural community nurses as requiring definition in their own right. When expanding on this point, Hegney concluded from her data that rural community nurses identified three main differences in their practice, as compared with nurses working in metropolitan areas. If we relate these to Tasmania, it becomes clear that community nurses who work in the three cities other than Hobart, do not experience these differences as do community nurses working 'in the country' (Hegney 1996b:253). The differences were: working with a community which they knew and in which they

were known; the long distances they needed to travel to deliver service; and the broad knowledge and skills needed for practice regardless of the lack of support services and professional isolation (Hegney 1996b).

Community nurses working in larger population centres such as Hobart, Launceston, Burnie and Devonport have considerably different environments in which to practise than those elsewhere in country Tasmania. The level of support services available to clients and community nurses in these cities is far more sophisticated. Examples of these services are podiatry, physiotherapy and women's health. As well, the services offered by the community nurses themselves are more comprehensive. Examples of these differences are the weekend and after-hours services routinely offered in each of these cities by community nurses.

Because of the recognition of rural community nurses and the conditions of difference which they experience, Hegney's definition is the one which I have chosen to adopt for this study, excluding her numerical qualification of rurality.

The Rural Community Nurse: Building A More Complex Profile

Many of the studies, reports and conference papers which bear some relation to rural nursing make comment on the dearth of writing on the topic itself (Kreger 1991, Harris 1992, Buckley & Gray 1993, Gale 1993, Hegney 1993, 1996a, 1996b, Pearson 1993, Evans 1994, Keyzer 1995). Although this situation has improved in recent years comparatively a great deal has been written about remote area nursing (Pearson 1993:215). Often this term is coupled with rural, giving us comment on the rural/remote area nurse, thereby adding to the confusion.

In 1992, Harris conducted a comprehensive national survey of rural health workers which included 780 nurses. Using RaRA,

Harris found that 73% of nurses surveyed fell into a rural nursing category as compared with 21% in remote and 5% working in Aboriginal communities (1992). Buckley and Gray's study on rural and remote nurses also supports this finding. 'The data indicates that the majority of nurses working in areas which are classified as rural or remote are working in rural settings' (1993:37).

Why so much has been written about the small proportion of the nurses working in remote areas of Australia is an interesting question. Their isolation and the often extremely difficult and dangerous situations they face, combined with the red expanse of the romantic Outback, probably make for more exciting reading. Rather more pragmatically, though, remote area nurses mobilised themselves in the political arena much earlier than rural nurses with the establishment of the Council of Remote Area Nurses in the 1970s (Buckley 1997).

Buckley and Gray assert that to some extent, 'rural nursing practice is camouflaged by the belief that doctors and facilities are accessible' (1993:1). This, tied in with the plethora of rural nursing needs, makes their issues less clearly identifiable than those of remote area nurses, and may answer in part the question of why there has not been more discussion of rural nursing.

Rural nurses practise in a diverse range of roles. They work in areas ranging from district hospitals which maintain an acute focus of care to nursing homes, hostels and, most importantly for the purpose of this paper, in the community.

The Rural Nurse Is Almost Always A Woman Aged Over 35 Years

Throughout the studies on rural nurses which I reviewed, there was strong evidence that approximately 81% to 96% of the rural nursing workforce is female (Blue 1995:61, Buckley & Gray 1993, Burley & Harvey 1993, Harris 1992, Hegney 1997b, Huntley 1991:98). With respect to the average age of rural nurses, Hegney,

Pearson & McCarthy (1997) found that the mean age of nurses in their study was 38 years, with 53.8% of rural nurses over 44 years of age. These findings confirmed other studies which have found that the rural nursing population is ageing (Hegney 1997b).

The Rural Nurse Is Almost Invariably Born A Rural Woman

Both Huntley (1991) and Harris (1992) found that a large proportion of rural nurses had either been born into a rural setting or had spent considerable amounts of time in the country. Huntley found that 69% of nurses whom she surveyed when completing a cross-professional study on rural health professionals had been born in a rural community (1991). Harris's findings confirmed this, noting that 'the rural/remote nursing workforce is very significantly rural in upbringing, with two in every three rural/remote nurses reared in the country' (1992:122). Sturmey & Edwards also quote the rural origins of health workers as being a determining factor in the ability of health agencies to recruit and retain staff (1991). Hegney's writings also confirmed that a major reason for nurses working in a rural area was that they 'were born in the area or had family there' (1995:11). Confirming previous findings, Hegney et al found that 54.2%. of rural nurses studied had been born in a rural area and that 55.17% had grown up in a rural area (in Hegney 1997b).

The Rural Nurse Is A Member of Her Local Community

Many of the studies I reviewed showed that a large proportion of rural nurses live and work in the same community. Harris (1992) found that 87% of the nurses he surveyed were in this position. Blue confirms this proposition, also stating that approximately 75% of rural nurses work in the town in which they live (1995). Lampshire and Rolfe gave some snapshot quotes from rural community nurses on the reasons why they chose to find work in their own communities. These told of: the need for flexibility and convenience in working hours; and the shortage of work for

nurses in rural areas which often meant a rural community nursing position was one of a limited few available (1993). Employment of partners in the same district was found by Hegney et al to be a significant factor for rural nurses living and working in the same area (in Hegney 1997b).

The Rural Nurse Has Usually Only Minimal Formal Qualifications For Practice - Most Are Hospital Trained

Lampshire & Rolfe's study of district, or rural community nurses, revealed that 8% held undergraduate degrees, with 5% holding post-graduate diplomas. At 28%, midwifery was by far the most usual post-graduate qualification (1993).

This finding was verified in the national studies of rural registered nurses that I examined. Harris found that only 12% possessed a post-graduate qualification, but 48% of the registered nurses questioned possessed a nursing certificate (1992). Buckley & Gray found that 53.6% of respondents held a midwifery qualification but only 3.2% held a Bachelor of Nursing (1993). Blue states that fewer than 4% of rural nurses hold tertiary education qualifications (1995), while Huntley found that 38% of her sample possessed post-general registration qualifications. However, on closer examination the majority of these were midwifery certificates (1991). Hegney et al found that approximately 89% of rural nurses were hospital-prepared (in Hegney 1997b).

Hegney, in her study of rural nurses, found that only a small percentage of nurses surveyed felt that they were adequately prepared for practice (1993), while Buckley & Gray's study revealed that only '3.1% of respondents felt that their nursing education had prepared them adequately for rural nursing practice' (in Hegney 1993:115).

The complexity of the rural nurses' role is such that more than a minimal level of education is required of nurses in order for them

to practise confidently. The question of why more rural nurses have not undertaken post-registration education can be partly answered by considering the problems related to living in a rural area. The tyranny of distance is great, especially when the need for further education has to compete with family, finances, lack of access to courses, no relief staff and lack of employer support (Hegney et al 1997).

Reflections On A Superficial Image

There are inherent dangers in trying to do something such as build a profile of a rural community nurse. Obviously there are exceptions to all generalisations and I believe it is important to note this when reading information such as that which I have just presented. Rather than a definitive profile, I have formed only a superficial image of who a rural community nurse is, or rather might be. It is in the exploration of practice that the complexity of the person is able to be revealed - a task that only a small handful of authors have attempted to undertake in the field of rural community nursing (Lampshire and Rolfe 1993, Hegney 1996b).

Community As Context

The literature story about rural community nurses would not be complete without some reflection on the word 'community' itself. For it is 'community as context' which creates a sense of difference for rural community nurses as compared with their other rural nursing contemporaries.

Butler and Wintram, writing about the concept of 'community', call this idea both a 'myth' and a 'chameleon'. As they state,

> it is assumed that a single definition of community exists, transforming it into an ideological tool. Hillery (1955) discovered ninety-four different definitions of community, and that was over thirty years ago, so no doubt there are more to be found! (1991:30).

Lest we become too cynical, though, Petersen reminds us that the 'positive connotations of the word 'community' have nonetheless become firmly established, at least in many Western societies' (1994:109). And it is those people who have used a sense of community to their advantage to whom I now turn. As Petersen goes on to explicate, when a clearly identified group's goals are defined and shared, this sense of community can be a 'useful rallying point for political struggle' (1994:109).

It is when the 'tables are turned' and others are speaking of groups in our society using the term community as an authoritative summation that the risk of individual oppression is greatest. As Pettman suggests,

> 'community' is often used to mean a 'target group' identified for government management of difference and provision of services. It can facilitate state or racists' divide-and-rule strategies (in Petersen 1994:109).

So how, then, can we define the word community, or rather can we define the word 'community' at all? I believe that there is no answer to this question, rather there are the possibilities raised by individuals who have a shared sense of community with others, be that based on ethnic background, locality, age, a feeling of belonging or any one of a multitude of commonalities.

Other Contextual Influences On The Experience of Rural Community Nursing

Further exploring the literature around the story of rural community nursing's identity, I will now examine some more specific contextual influences on the rural nursing experience.

The relationships which rural community nurses form with clients and carers are often difficult to separate from friendships, family connections and relationships formed at a community

level (Sigsby 1991, McMurray 1993, Burley & Harvey 1993, McDonald 1994, Gale 1996, Hegney 1996a, 1997b). Bigbee suggests that 'knowledge based on close relations influences the provision of health care in rural communities' (in Congdon & Magilvy 1995:19), while Busby states that rural people value 'taking care of our own' (1991:127).

Lampshire and Rolfe, in their study of district/rural community nurses, found that some rural community nurses did not object to performing unpaid work out of hours because they felt that they

> were a part of the local community, that it was their duty, and saw it as an inherent aspect of being in a 'helping' profession. For others, however, the burden of the community expectations provided an extra pressure (1993:55).

This sense of connection influences the way in which rural community nurses can view their communities. Sometimes this may mean a delimitation of their practice outside normal working hours; for others it may mean confrontation and anger from community members if they choose not to be available after hours. However, for most rural community nurses, 'because of this interconnectedness, most patients are not strangers: rather, patients may be friends or neighbours. Rural nurses are visible and respected in the community' (Congdon & Magilvy 1995:21). Anonymity, however, is forgotten and the rural community nurse becomes, in some respects, public property (Thornton 1988).

Because of how different members of the community relate to 'the nurse', rural community nurses often face increased pressure in their personal lives. The difficulties which arise while trying to separate their roles in the community can increase the stress they experience related to work.

In her study, Huntley found that 'rural nurses said they felt stressed by not being able to absent themselves from work during their time off' (1991:139). Burley & Harvey also comment on the

personal stress which can be generated from community expectations of the rural nurse. This is especially true in smaller communities where volunteer numbers are dwindling, placing even greater expectations on rural community nurses in times of crisis such as when a person chooses to die at home (1993).

Lampshire & Rolfe discussed the issue of unrealistic community expectations and demands on district/rural community nurses at length. They found that 'living and working in small communities often leads to demanding expectations for the district [community] nurse to be all things to all people at all times' (1993:40).

The need for support for rural nurses in situations where they have to care for friends or relatives was also discussed by several authors (Carey 1993, Gale 1996, Hegney 1996a, Sigsby 1991, Sturmey & Edwards 1991). Nursing friends, neighbours or relatives is not an unusual occurrence for rural nurses and, as Hegney notes, can be 'a negative and/or positive influence on how nurses deliver care to their clients' (1996a:5). How rural nurses experience this situation is an indication of their own sense of self, as will be explored in a data chapter to come.

Rural Nurses: Practising In An 'Extended' Role

Much has been written on the 'multi-skilled' or 'extended role' of rural nurses which in part applies to rural community nurses (Burley & Harvey 1993, Evans 1994, Hegney 1996a, 1996b, 1997, Thornton 1988, 1992, Wade 1995). Hegney, however, rejects this notion of describing the complexity of rural nursing practice through the use of words such as 'extended', 'expanded' and 'multi-skilled', stating that,

> the generalist advanced practice role of rural nurses must be legitimised to avoid continued subjugation of this knowledge to the more dominant discourses of medicine and allied health. This isolated advanced practice role is the distinguishing

feature of rural nursing practice (Hegney 1996b:320, emphasis added).

Reflecting on Hegney's assertion, it would be useful at this point to clarify the terms, generalist, specialist, advanced and practitioner in relation to nursing practice. All of the following definitions are found in the National Nursing Organisations Draft Glossary of Terms (1997).

Generalist Environment: Nursing practice not identified or limited by focus on any specialist area.

Specialist Nurse: A registered nurse who has undertaken formal graduate nursing education in a nursing speciality.

Advanced Nurse: Demonstrate advanced abilities across a broad range of contexts, not defined by speciality but by advanced generalist competencies.

Nurse Practitioner: An advanced or specialist nurse who seeks to be credentialled in order to practice autonomously.

As the following discussion reveals, though, the literature until now has really only focused on the way in which rural nurses have 'taken on' others' roles, rather than providing an acknowledgment of an advanced level of rural nursing practice (Hegney 1997a).

For most rural community nurses, the concept of health care provision in an 'expanded' role relates to areas such as podiatry, physiotherapy, care of the diabetic client, social work and counselling (Humphreys & Rolley 1991:56). Allied health provision (such as physiotherapy, podiatry etc.) is scarce in rural communities and the cost and inconvenience of travelling long distances in order to access it means that it is often the rural community nurse who fills a need (Lampshire & Rolfe in Hegney 1996b, McMurray 1993, Thornton 1988).

Pearson sums this issue up, stating that,

> access to health services in rural areas is dependent upon the presence of a health professional who is able to meet the needs of individuals and communities rather than the presence of a full multi-disciplinary team which is normally expected and provided in major population centres (1993:214).

The concept of advanced rural nursing practice hinges on the establishment of the education, training and credentialling or registering of nurse practitioner roles in Australia. Rather than expecting all rural nurses/rural community nurses to continue to provide a level of care for which clearly they can be ill-prepared, legitimising the advanced rural nurse practitioner role would create an avenue for appropriately prepared and credentialled nurses to take on the complex and demanding practice mantle often expected of them.

The debate over the nurse practitioner role in Australian health care is only just beginning. 'Roberts states that medical practitioners are resisting a formal acceptance of the role, particularly with regard to diagnosis and prescription' (Seigloff 1997:55). Paradoxically, the need for the establishment of a role such as that of the advanced rural nurse practitioner is due in part to the declining number of general practitioners who are prepared to practise in rural Australia.

This shortage of general practitioners has long been recognised. 'The maldistribution of the medical workforce is not a recent phenomenon, since reliable reports from as early as 1961 point to the problem' (Harris, 1992:5). This issue originally prompted the call for a restructuring of national policy regarding rural health status (Humphreys & Murray, 1994) and the establishment of several current initiatives such as the General Practice Rural Incentives Program, the Rural Health Research Education and Support Program and the establishment of Rural Health Training Units (Patterson 1996). These strategies have eventually incorporated the full spectrum of rural health workers and have

instigated developments in addressing rural health issues surrounding education and training.

Even though skill development for rural health workers has improved, the availability of and access to health care provision itself is still a major concern. Malko believes that 'because of access issues, they [rural areas] are seriously deprived from a social justice perspective' (1992:34).

In a paper discussing the National Rural Health Strategy, Humphreys and Murray (1994) identified characteristics of rural areas which form a common basis requiring a national response. One of these is the vast distances in rural Australia which create problems of accessibility to health care for potential consumers. As well, there are the issues of isolation and remoteness which create problems for rural health care providers in terms of support from colleagues, locum relief for continuing education and recreation, and difficulties for spouses and families. The social and geographical diversity in rural Australia means harsh living conditions, and additional transport and living costs for health care providers. Finally, a need for special orientation and training courses in order to practise in ways consistent with the cultural requirements of indigenous peoples often prevents the appointment of appropriate health care personnel (Humphreys & Murray 1994:28).

All these characteristics of rurality combine to create an environment which can be problematic for both the consumers of rural health care and those who are trying to provide it. At Federal, State and local government levels the complexity of the question of rurality and what that might mean for health care for the people who live in rural areas is only now being recognised by those who write public health policy in Australia.

A Story Of Identity, A Story Of Struggle

Tasmanian rural community nurses are representative of rural community nurses who live and practise all around Australia. Their struggle to create identities as rural community nurses, rural women and rural community members is one which, to some extent is shared with other rural nurses.

Throughout this story we have heard many voices who have described the tensions which exist for these women. Tensions which are both personal and political and which identify some of the sites of oppression on which this struggle takes place. The challenge is there for all health care workers to create and sustain a deeper level of debate than has been exemplified in the literature so far. Greater co-operation and communication, especially about the question of defining rurality, is essential if we are to all contribute optimally to improving health outcomes for rural Australians.

Stories From The Field

Choosing The Stories To Tell

Back in the dark ages of 1995, I was faced with the thesis component of my 'Masters'. Like most students, my immediate thought was to find something to research which would reflect a contemporary issue or problem in the workplace. As most students find, though, these things do not always go according to plan, and my research question developed in a far different direction than I had originally forecast.

It is my own personal transition from urban woman to rural woman, urban community nurse to rural community nurse which is reflected in the choice of participants stories that I eventually analysed. As I read the data through and through, the story fragments which appealed to me most were those which related to the culture of rurality which affected these women's practice. I wanted to look beyond the superficial writing and thinking which has been characteristic of previous works concerning rural community nurses, rural women such as myself, and to search for greater depths and dimensions in their thinking, in their stories.

Instead of seeing these women as 'victims' of the tyrannies of distance, isolation, poor access to education and support, I wanted the reader to see them as nurses experiencing their practice differently from those who live in urban environments. Rural community nurses are more than just the victims of circumstance or the heroes of isolation that the literature portrays them as. They are women who experience their nursing practice differently from others; the question for me is, what might those differences mean for them?

A Story About Personal And Professional Boundaries

Early in the 1940s in Tasmania the Bush Nursing Service was established to service remote and rural populations (McLean Private Correspondence). These nurses were sole practitioners who offered a 24-hour-a-day service which combined emergency care, community nursing and family and child health. Over time, the legend of the bush nurse has developed in a way which is similar to that of the country doctor, a caring professional who is available to serve their communities at any hour of the day or night.

Tasmania's rural community nursing service has evolved, in nearly all of these communities, into a far different service from what was provided in the early days. Many of the members of these communities, though, still believe that they have in effect a licence to access their rural community nurse, born out of the history of the bush nurse. In the 1990s, personal and professional dilemmas are bound to arise from this legacy.

More often than not, these nurses live and practise in the same rural areas, and this impacts on their lives outside work. They have to balance community members' constructions of their role with their own sense of what it means to be a community nurse, and what it means to be a parent, friend and member of many of the groups which develop in small regional areas. This chapter is based on three story fragments, each of which will examine a different way in which rural community nurses construct their sense of self.

Bebe's Story

Leading up to the story Bebe tells today, we had been discussing the differences she had experienced while working in both metropolitan and rural settings. These centred on examples of how the rural community nurse is much more accessible and visible within a community in which she both lives and practises.

Bebe's rejection of this as an acceptable practice environment can be clearly heard as we listen to her story.

Bebe: *Kathy 'does' the New Norfolk round, and when she was appointed to the round, she came to me and she said she couldn't believe that she had got the round - she felt sure that I'd want it, because I lived down there too. And I said, 'No, thank you'. As I said, 'You will now go into the supermarket in New Norfolk and you're not anonymous any more'. You know, on your off times. Now that's fine if that's the way Kathy wants to do it. I could see it happening to me, though, and I said, 'No, thank you, I just want to stay where I am 'out there' [a metropolitan round] for the moment' You would lose your anonymity straight away - people would know you straight away. You're the nurse - it's a small community, New Norfolk. I come from New Norfolk, my family live at New Norfolk - I didn't want to be a part of it in a nursing role.*

Rural Community Nurses And Their Sense of Self

Bebe uses the word *'anonymity'* several times in her story. It is this loss of anonymity which she fears and which was the reason for her not accepting a position as a rural community nurse closer to her home. In her story, she equates the loss of anonymity with the capacity for people to *'know you'*. It is this idea of how people know you which I find interesting and believe is worth exploring.

Bebe is typical of most rural community nurses in that she trained in a large metropolitan teaching hospital. It was in this environment that her sense of self as a nurse was developed initially. The culture of such institutions was such that the need to be objective and removed, to be detached, was a part of what it meant to be a good nurse. The boundary between personal and professional roles was very clear.

Demonstrating this need to be detached, Bebe is quite explicit in her preference to work *'out there'*, meaning a metropolitan round far removed geographically from her home and family. In order to construct boundaries for how clients *'know me'* , Bebe reduces the possibilities for contact with clients outside her eight-hour working day. As Bebe states, she was born in New Norfolk, her family live in New Norfolk but she did not want to be a *'part of it in a nursing role'*.

Bebe, like all of us, has many ways of constructing her sense of self. Her relationship with her clients assumes a professional status; her role in this sense is one of expert, able to perform the many tasks of nursing, with a sense of personal detachment. The separation of her personal and family self from this role is important to her, and something which she has obviously thought about and prioritised.

The smallness of the New Norfolk community also plays a part in how she wishes to construct this image of a self to know within her home town. The boundaries between professional practice and personal life are difficult to transgress given the nature of nursing work, which is often 'dirty' and difficult for people outside the health care arena to understand. It is this way that people come to know you as a nurse which Bebe is anxious to avoid in her home community, thereby protecting her personal relationships with these people.

Bebe's story is interesting in that it raises concerns that most rural community nurses have and then describes how one community nurse has managed to avoid them. Few have the luxury, though, of being easily able to work outside the area in which they live, mainly because of the long distances to be travelled to find other nursing work. Bebe argues for a clear delineation between her role as a community nurse and her role as a member of her home town. It is the sense of confusion created through being unable to construct this model of role delineation that we will explore next.

Grace's Story

Before Grace told the story that she will relate to you here, we had been discussing the implications, for rural community nurses, of living and working in the same country town. Grace's story begins with her origins of birth and goes on to tell of her position of marginalisation as she attempted to assimilate into a country town.

Grace: *I'm not a local girl - I'm from America. Most of the other rural community nurses were born in this community and so the clients would tend to call them first. Like my job sharer gets phoned up an awful lot, because I tend not to give my phone number out.*

Jane: *No, I wouldn't either.*

Grace: *But I know the other girls do and they don't seem to mind to be contacted, but I don't particularly like my privacy being invaded.*

Jane: *So is there a sense of family as far as they're concerned because they grew up here?*

Grace: *I don't know whether it would reflect on them as well if they didn't respond to the phone call and said 'no I'm not on duty, phone my job sharer'. I've had my job sharer phone me up on her days off saying "Mrs So-and-so has just phoned me, can you go and visit her?" Instead of phoning here [the office], they phoned the nurse at home and she would have gone to visit but perhaps she's got family commitments that day. Otherwise she probably would have gone to visit them on a non-working day.*

Jane: *Do you think she documents that information?*

Grace: *No. I mean, I live out 12, 13 km, way out in the bush, whereas my job sharer lives right in the community. So that's a bit different and as I said I don't give my phone number out, apart from the 'palliative cares' I'm starting to be asked for it now - I haven't been asked for it much, but a lady asked me for it today actually.*

Jane: *Did she? What did you say?*

Grace: *Well, I didn't come out with a straight answer, I sort of fobbed around and then the subject got changed. But she will bring it up again next week, so I'll have to tell her I don't want her to have my number or to phone here [the office].*

Jane: *Do you think that makes a difference to how people view you in the community? Do you think they see you differently?*

Grace: *I don't know... I'll have to - yeah, well, that's it, isn't it. There's the feeling that you want to be liked and you want to be accepted and so you go ahead and give out your phone number, just so that you're liked.*

Grace's story is full of conflict. There is a sense of confusion, and in some ways despair, over her position of difference within the rural area in which she lives and works. Initially the reader is given the idea, *'I'm not a local girl I'm from America'* upon which to found this marginalisation. Even though this might have initially promoted a different approach from clients, because she hadn't grown up before their eyes, it is not this which continues to create conflict within her situation. Rather it is Grace's reluctance to fall in with the other rural community nurses in their 'open door' approach which provides the greatest impediment to her acceptance as one of them.

The telephone is also significant in Grace's story. It is through the telephone that clients are able to access their rural community

nurse. The telephone number can therefore be seen as an instrument of power in that the rural community nurse can gatekeep this avenue of communication.

Grace compares herself in this sense to the *'other girls'*, the rural community nurses with whom she works. Unlike them, she does not make a practice of giving her telephone number to her clients, and she describes a situation where she *'fobbed around'* when asked for it by a client. Loath to have her *'privacy invaded'*, Grace only gives this information to the *'palliative cares'*. When I thought about why it was that palliative care clients would be different for Grace from other clients, I made the connection that rural community nurses are paid in order to be rostered 'on call' for these clients. So, the giving out of her telephone number to palliative care clients, relates to a paid form of nursing work.

Contrasting with this, Grace discusses how her *'job sharer'* will visit clients who telephone her on her days off from work, unless she has other *'family commitments'*. When I asked Grace if this rural community nurse documented her visits, she said no, which leads me to consider the blurring between home and work for many rural community nurses.

The implications for these nurses of not formalising visits to clients out or working hours are far-reaching. A duty of care given rests with these nurses, regardless of whether they are being paid for their actions. By virtue of their knowledge and skills as demonstrated by their registration, they are accountable for their actions regardless of the consequences. This site of conflict arises for rural community nurses who do not attempt to delineate their nursing role for other community members.

As I mentioned earlier, the legendary status of the bush nurse has become a part of the culture of rural community nursing, leading to unfair expectations being placed upon these nurses by both community members and themselves. Often these nurses are

their own worst enemies, marginalising those like Grace who say *'sorry, I'm not on duty'*. They live out the 'tyrannies of sacrifice and niceness' (Walker 1997:9), the seeds of which were sown and nurtured during their training as student nurses in a hospital setting.

Both Grace and Bebe have attempted to construct boundaries between their personal and professional lives. Grace, by simply not giving out her telephone number, hopes to avoid being placed in a situation where *'it would not reflect well'* if she did not respond to a client outside working hours; Bebe chooses not to live and work in the same rural area.

Grace's confusion over her interpretation of the role of the rural community nurse, of the boundaries between the personal and professional, culminates in the final paragraph of her story. The language she uses shows how she is torn between her sense of selves, Grace as rural community nurse versus Grace as community member. The trade-off faced by rural community nurses who choose to live and work in the same place is summed up when she says *'well, that's it, isn't it, there's the feeling that you want to be liked and you want to be accepted and so you go ahead and give out your phone number, just so that you're liked'*. Professional boundaries are sacrificed in the need and desire for community acceptance of all Grace's selves.

Shona's Story

The final story fragment, which continues the theme of personal and professional boundaries for rural community nurses, is told by Shona. Unlike Bebe and Grace, Shona discusses the pragmatics of transgressing these boundaries, and how this has shaped her practice.

Reading back over Shona's transcripts, it was very hard for me to choose a story for her to tell you. Much of what she had to tell me

was full of the complexity of rural community nursing practice. Shona's story is about what happens when you blur personal and professional boundaries.

Shona: *I had a very, very good friend for 18 years he died a couple of years ago. We were extremely close friends and that was difficult, when you're nursing someone that you're... I mean really close to, a really close relationship, so that's different.*

Jane: *So when you went in after hours and on weekends to see him, did you go as his nurse or as his friend?*

Shona: *Friend... sometimes I went... That was very, very different, we were very good friends. I went as both I asked him, actually we sat down and had a good talk and I said "do you really think this is a good idea?"*

Jane: *You being his nurse?*

Shona: *And he said he really wanted it. That can happen in a rural area, I suppose; at times it's a sheer impossibility if it's someone that is extremely close to you, and I suppose you do have the option then of getting someone else in from the adjoining areas, but that's not always feasible. It's something you have to deal with yourself. And that actually was good for me because dealing with it with Tim has made it easier for me too... it was actually great being with him so much at that time, so I could be with him as a nurse and as a friend.*

Jane: *So you actually set that up with him and got that straight in your head?*

Shona: *Yes, I didn't just do it for me, I said to them when he was in the hospital, "ask him whether he really wants me there" and they rang back and said "yes". I said "don't let him know I've asked, but just check it out, that he does want the friend as a nurse*

as well". Sometimes there's not that option in a country area for people. And sometimes when it is a relative or a friend, you [the rural community nurse] find you get more pressure from their other friends, because their expectation then is on you to do something [as their friend too]. I had a lot of anger from a couple of people. I'd say, "Tim, such and such is here to see you", and Tim would say "tell them I don't want to see them". And then later on they said "you stopped me from seeing him", things like that.

One of the strongest messages of Shona's story is that sometimes there is no other option, for either the rural community nurse or the client, as to who will be that client's nurse. Shona reiterates this on two occasions, considering the idea that it might be possible to find someone else to care for a friend who is a potential client and then rejecting the idea as not always *'feasible'*.

It is this stark reality which rural community nurses face on a regular basis. As we know from the literature, the majority of nurses who choose to work in rural communities were born there, grew up there or have chosen to move and live there as well as work there. This theme has been a constant through Bebe's, Grace's and now Shona's stories, with the notion of how the rural community nurse constructs her self, both as a nurse and as a community member central to the plot of each story.

Shona takes a different tack when dealing with the separation of professional nurse and friend. There is no doubt that Tim's meaning to her as a person was that of a *'very good friend'* - this is strongly emphasised throughout the story. As Shona says, this practice situation was for her *'very, very different'* because of her longstanding friendship with Tim. This leads me to think that like Grace and Bebe, Shona also usually attempts to create some delineation between her self as nurse and her self as community member and friend.

Shona then begins to explore the possibility of nursing Tim, her friend who is dying. Recognising that there is no space for separating her roles, Shona subconsciously begins to live out the hybrid role of friend and nurse, saying that *'I went as both'*. As she states, *'it's something you have to deal with yourself'*, this blurring of the boundaries between 'professional' nurse and friend.

The complex situation that Shona's hybrid role created actually gave her licence to be with her friend and establish a strong giving relationship with him at the end of his life. As Shona says it was, *'great being with him [Tim] so much at that time'*.

Since then, her thinking about her hybrid role has been *'good for me'* and has made it *'easier for me to...'* This is one of the moments of the transcript where I now experience frustration with my own abilities as a novice researcher to encourage further explanation. I don't know what Shona now finds easier because of this experience. Drawing on my own experience as a rural community nurse, I can only speculate that this experience of thinking through the need to perform a hybrid role will make it easier for Shona to recognise and accept this as a part of her rural community nursing practice.

There were, however, some ramifications for Shona from the way in which she played out her hybrid role. These are discussed in the final paragraph of her story when she describes how other community members, some of whom were her friends, reacted towards her. In carrying out the gatekeeper role that nurses so often perform for clients, Shona alienated and angered others who couldn't understand why she, as Tim's friend, a potentially equal status to their own, was able to access him more than they.

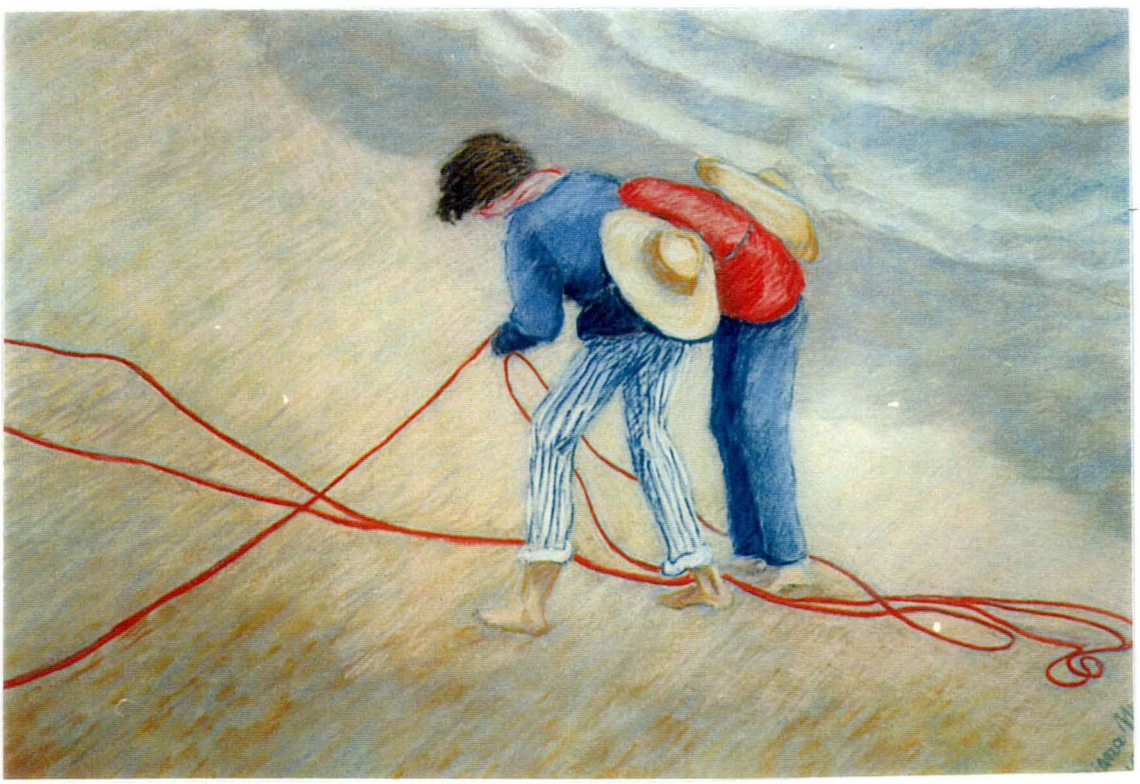
Even though Shona had subsumed her role as a rural community nurse into her hybrid role as friend and nurse, this was only so in her mind and maybe Tim's mind as well. The personal and professional dichotomy still existed in other community

members' minds, creating another site of conflict with which this rural community nurse had to contend. Those who had difficulty in conceiving of a hybrid role were outsiders to nursing and therefore had no experience or expertise from which to imagine the possibilities which could exist for both Tim and Shona at that time.

Questions Of The Self

All of us have many ways of constructing how we know ourselves. Rural community nurses are no different in this, as is illustrated in the three stories told in this chapter. The delineation between the professional and the personal is a mode of thinking inherited from the institutional training hospitals in which nurses were encultured for the greater part of two centuries. The ability to draw a line between the two is a part of what it means to be the, good nurse, as spoken about in the literature. The difficulty in achieving this status of, good nurse, constitutes a site of struggle for rural community nurses, as exemplified by Grace, Bebe and Shona. All these women felt impelled to discuss the tensions created between their professional and personal sense of selves. It is how these rural community nurses questioned and used their knowledge of the self which contributed to shaping the environments in which they practised.

A Story About Professional Boundaries



The relationships that rural community nurses sustain with other health care practitioners also help to create context for their practice. As we found in the literature, there is much discussion around the idea that rural community nurses take on the role of others and that this requires a greater level of competence than can be expected of a beginning nurse practitioner. This notion of nurses being multi-skilled, working in an extended role, in short, assuming responsibilities which have long been the domain predominantly of medicine, raises some interesting issues in relation to professional boundaries in rural areas.

The how and why of the state of relations between rural community nurses and other health care practitioners, in particular general practitioners, was discussed in the focus group and provides the substance for this chapter. You will notice when reading this story, which was part of the wider group discussion, that as researcher I attempted to talk about *'rural allied health workers'* and *'primary health care providers'* and yet Shona, who provides the story fragment on which my argument is based, returned each time to discuss her relationship with general practitioners. This led me to believe that for these rural community nurses, the relationships between themselves and rural general practitioners create a contextual cornerstone of their practice.

A Story From The Focus Group

Jane: *How would you describe your relationships in the country with rural allied health workers? Do you work as a team, do you think, or do you all work separately?*

Shona: *Very much as a team. Students I've had have noticed that - they haven't seen the relationship before between doctors and nurses as such a consultative relationship. The same with the other allied health professionals. Because they don't want to have*

to come out unnecessarily. They're not going to come and visit the area if they can have a lot of their work done by us. And that's not them avoiding work, it's just a practical situation.

Jane: *Shona, where would you say you get most of your referrals from?*

Shona: *A lot of self-referrals, a lot through the GPs who just ring up and leave a name, no phone number - "Hi, Shona, can you go and see Ethel?" and you think "Yes, right". You do get them through the hospital system but not as many, mainly self-referrals I think, and GPs.*

What I have also found with the doctors is that if I find someone with a high BSL [blood sugar level], they ask if I'd mind managing it and if I think they need medication to forward them to them. And if someone has a sexual health problem, they will say, "I don't know how to deal with this, will you deal with it?" They tend to want to stay out of it [sexual health] if possible, and not take it on. Which is good. It means I can consult them when I need them instead of them... I usually tell them when their client has developed a problem like a high BSL, or something, but then they usually pass it back to me.

Teamwork: Rhetoric Rather Than Reality

What does it mean to be a team? The word 'team' is often associated with sport - a rugby team, football team, netball team; a group of people who interact in order to achieve common goals. How this group of people reach their goals is dependent on teamwork, or the way team members use certain tools to maximise their own and others' potential.

Some of the tools that a team has at its disposal are: being able to communicate clearly, be that through a written or oral medium; enabling accessibility to each team member's person, ideas and

skills; and acknowledging each team member's expertise, promoting trust, respect and reciprocity between team members. All of these are essential tools in creating an effective and efficient team.

A team, then, is a community of people who share a common vision. Within this team, or community, pre-existing boundaries are effaced by the desire to fulfil this vision, and so an egalitarian approach to the use of team members' knowledge and skills is used.

Throughout the story we have just read, the word *'team'* is used when describing the relationships between rural community nurses and the rural general practitioners with whom they work. What these women have really described, though, is a state of relations which is much closer to the traditional hierarchical model of health care than a flat teamwork approach to managing health care. Looking past the rhetoric of teamwork, what we have really heard is a story about the professional boundaries in rural health care and how different quarters exercise power over each other.

Gendered Division Of Labour: Playing The Doctor And Nurse Game

Nursing has long been a part of one of the strongest patriarchal hierarchies in the history of women in the workforce. The gendered division of labour allocates work into jobs which are defined as female or male. Within a patriarchal structure, jobs such as nursing, which are defined as female, are necessarily subordinated to male domination. The 'maleness' or 'femaleness' of a job is not inherent in the operation itself but in the ideological identification and distribution of tasks (Garmarnikow 1978).

Nursing and medicine are still fixed in this patriarchal, gendered division of labour. One of the most familiar motifs which has

been used to describe this has been the analogy of the family. The nurse-doctor-patient triad ties in neatly with the mother-father-child norm of white middle-class society with the nurse playing out the role of dependent and yet caring wife and mother, capably obeying everyone's commands.

Throughout the story told to us by these rural community nurses, there is very much a sense of that historically capable wife and mother. As Shona tells us early in the story, *'they [other rural health professionals] don't want to have to come out unnecessarily. They're not going to come and visit the area if they can have a lot of their work done by us. And that's not them avoiding work, it's just a practical situation'.*

There has been much discussion in the literature about moments just like these, when rural community nurses work in what has been called an expanded or multi-skilled role. Coping with a *'practical situation'* is only demonstrating a complicity with a culture which is trenchantly subordinate to others. This notion of rural community nurses being a part of a team of health care professionals is totally undone in the story told. Rather than describing a situation where people are working together to provide health care as a common goal, we hear a story of delegation and an arrogation of duty on behalf of the other members of the health care team.

Rural community nurses are complicit in this in that they agree that others can *'have a lot of their work done by us'.* By not challenging health care professionals who pass on their practice duties, rural community nurses open themselves up to performing in an unfamiliar role to a level which could possibly not be of an acceptable standard.

Thinking about the rural community nurse role as a 'jack of all trades, master of none', leads to the question of whether these nurses can be called advanced practitioners of rural nursing

(Hegney 1997a). Rural community nurses performing the work of others, in this submissive capable mother role, risk reducing their standard of care to the lowest denominator of care given. When discussing the need for greater workforce planning to meet the needs of rural Australians Moorhouse states that often,

> we find nurses and others doing the best they can - often remarkably well - to provide services that are technically and legislatively outside the terms of their registration. At best, they may be practising competently but at the very margins of their statutory authority to do so. Sometimes they will, under the various pressures, slip over one of those boundaries - statutory legitimacy or clinical competence. At worst, they may be putting people at risk. They are doing so... in the absence of any other health care options for people in their area. It's not ideal but it's better than nothing (Moorhouse 1998:7).

These are hardly the actions of an advanced practitioner who is confident and sure of her position in a health care team. For rural community nurses to achieve the best possible outcomes in their practice arena, there needs to be a cultural change which values so highly what nurses do as opposed to what general practitioners, social workers and podiatrists do that the idea of providing a service for which they do not have adequate knowledge and training is anathema. Returning to the literature relating to education, training and support for rural nurses, it is clear that this is an area of great need (Hegney et al 1997), leading me to suppose that these nurses are certainly not equipped to practice as substitutes for a plethora of others.

Some of the reasons why rural community nurses move outside the accepted boundaries of nursing practice are a manifestation of the characteristics of Australian rural life raised in the literature. Examples of these characteristics are isolation, distance to travel, reduced access to a wide range of health professionals and specialists, poor communication mechanisms and the rationalisation of rural services.

The blurring of the professional boundary between rural community nurses and rural general practitioners is more complex than can just be attributed to these characteristics of rurality. Shona contributes to the focus group story, telling about how the general practitioner with whom she works passes on to her the care of clients with sexual health problems saying, *'"I don't know how to deal with this will you deal with it?" They tend to want to stay out of it [sexual health] if possible, and not take it on'.* The rural community nurse in this story fragment has quite clearly marked out the area of sexual health as being hers, stating that the general practitioner wants to *'stay out of it, not take it on'.* This then leaves the rural community nurse in a position of control, exclusively possessing the knowledge needed to care for someone with a sexual health problem.

There is then a professional boundary or separation created by the nurse who enjoys the fact that *'I can consult them when I need them instead of them...'.* This reflective pause is illustrative of a moment of resistance to the usual scenario of the doctor and nurse relationship where the doctor is the one in charge, dominating the health-care trilogy of doctor/nurse/patient. In the story being told, it is the rural community nurse who chooses when to consult, who directs the patient or client's pathway of care.

The rural community nurses in this story have reinvented as teamwork these changes in the traditional power relations and professional boundaries which were created by our cultural history. This in part explains why the storytellers focused so strongly on their relationship with general practitioners, why it was so important to them to clarify their practice position in relation to that paternal figure, the doctor.

It is easy for rural general practitioners to allow these shifts in professional boundaries to occur. In the literature review, I discussed the shortage of general practitioners in rural Australia and the impact that this has on people's level of health care. These

movements in professional boundaries are only recognisable at a local level, though, as if they are symptomatic of a particular rural area's health care needs and the ability of existing health care providers to meet those needs. On a more formal level, the Australian Medical Association refuses to acknowledge the possibility of accrediting nurse practitioners with such licences as prescribing rights (in Duffy 1998). This exercise of power and cementing of another professional boundary contributes to the willing exploitation of rural community nurses who collude with rural general practitioners to provide an 'acceptable' level of overall health care in their practice areas.

Returning to my argument about the appropriateness of rural community nurses practising outside their scope of practice, the question of the quality of health care provided again arises. Rural community nurses and rural general practitioners both have their own agendas for shifting the professional boundaries of nursing and medicine - my concern is that their reasons are not always as client-focused as their practice standards demand.

The term 'advanced practice' as used to describe rural community nurses who work outside their scope of legitimate practice, be that constrained by either legislation or educational preparation, is a misnomer and can be seen as another site of struggle. The difficulties of adequately preparing rural community nurses for the complexity of their practice are well documented and yet there is a desire to call their practice 'advanced' by virtue of location alone. The introduction of a credentialled advanced practitioner role for rural nurses would clarify and recreate the scope of practice for these women - in turn giving legitimacy to the redefining of professional boundaries between medicine, allied health and rural nursing.

A Story About Community

Among rural community nurses, the word community is uttered probably 200 times a day yet there are many questions which arise around how rural community nurses interpret the word in their practice. Before anything else, our name rural community nurses indicates that we work outside the traditional sites of nursing practice - institutions. The following two stories describe how three of the participants in this study interpret this word in their practice, creating their own constructions of the notion of community.

Claire's Story

In the lead-up to the telling of the following story, Claire had been describing to me how important her role as an advocate for rural people was to her. The *'sessions'* she describes were part of a Community and Health Accreditation Standards Program (CHASP) review which the community nursing service participated in.

Claire: *I went to the sessions, to really represent rural people. I did feel strongly that with the questions that they had on the questionnaire, they needed to have more of a special explanation on rural areas. We do a lot of things that are applicable to an entire community. And their questioning was on, you know, how do you handle transport in your area? How do you run the Day Centre? Those were issues which appealed to me because we've done all that.*

Jane: *So you felt like you had some answers.*

Claire: *Had some answers and had some information that I could give. I think that it was repetitious for me [the questions asked]. I probably could have been gone for one day - that would have been enough. After the day finished, you thought, "well, I have spoken about that, that, that, that. I had spoken about all the issues that apply to my community".*

Jane: *So as a rural community nurse, then, you felt able to represent the community?*

Claire: *I think that I can competently say that.*

Jane: *Why do you think that is? As a rural community nurse, what makes you different, so that you are able to do that?*

Claire: *I think it is that I have had several years of experience I've been out here for eight years. And you don't learn this in one year. And you don't learn it in two years. Actually I was fortunate when I came here to Sorrel that there was no Day Centre and it all started for me then.*

I could see that there was an opening for a Day Centre and I had key people who were good in that area that I knew. So I was fortunate there and then I had the clients. Well, they hadn't seen one another for 15 years, some of them, and lived just around the street, you see. So that's what gave me the initial idea, that they were lonely and they needed to mix with their friends that they knew, had known years ago. So I was fortunate in the early years that set me going and I started to do the Day Centre. I realised then that this was very much a community thing. The community got behind it and they came from out of the woodwork really. So that's when I started to realise that, yes, it is different to the city round. Because in the city round, I mean, who gets the chance to start a Day Centre, for instance, and has a complete community that is prepared to back you?

My Community, Your Community: What Is A Community?

The word community has an almost self-explanatory acceptance within our society. As a word, it has taken on a life form, with bodily attributes such as a voice, feelings, visions and actions. Pausing to reflect on the possibilities of this amorphous entity, I

conjured up a list of words which might describe this creature called community. 'Mythical', 'magical', 'powerful' and 'interactive' headed this list, an entity to be reckoned with, a body which stands alone.

Reading back over Claire's words, I felt that this was how she interpreted the word community, for *'out of the woodwork'* came a *'complete community'* when the initial planning for the Day Care Centre was commenced. A little like the opening act in a play, the curtains are drawn back to reveal the creature community as the lead actor in a drama which the supporting actor, the rural community nurse, is trying to play out.

The projection of this bodily illusion only serves to disguise and devalue individual people working together with a sense of community, in this case in establishing an excellent day care facility for the elderly citizens of this town. Chordorkoff extends the discussion of people's sense of community when he states that

> the creation of a sensibility of a community the self identification of people with place, a sense of commonality, co-operation and a shared history and destiny is difficult to achieve, particularly in a social milieu which emphasises individualism, competition, mobility and pluralism. The growth of values like individuality rooted in community, co-operation, identification with place and cultural identity is antithetical to the thrust of the dominant culture (in Mills 1996:8).

Acknowledging that a sense of community is difficult enough to establish in our present-day society, dominated as it is by the division and isolation created in part by the technological age, brings me back to the problem of rural community nurses who choose to embody or enflesh and so insert the word community in their rural community nursing practice.

At the beginning of Claire's story, we are told how as a rural community nurse with *'several years of experience'*, she is able to

'represent rural people' on issues which are *'applicable to an entire community'*. Herein lies the danger of unintentional misrepresentation. If we agree that it is impossible for a community to be enfleshed as a whole, or one, but rather that it is the individuals who live within an area who have a sense of community, then how can one person, in this case Claire, respond on a community's behalf? Throughout her story Claire usually uses the word 'the' when nominating a community. If Claire had used the first person singular my to describe how she constructed her own sense of community, she would have only spoken for herself, and how she grounded herself within a collective of individuals who lived in the same area, or espoused the same beliefs.

The Politics Of Unintentional Misrepresentation

In both my methodological chapter and the previous chapter, I have discussed how nursing culture has been tied historically to a form of hierarchical and patriarchal thinking which promotes and endorses the domination of disciplines such as medicine and science. When I think about Claire's approach to speaking about the people with whom she works as a rural community nurse, I believe we can see an unconscious exercise of power which mimics the domination to which she has been subjected throughout her nursing history.

Language is a very powerful tool which has the potential to manipulate and mould the destinies of individuals, services and structures. Rural community nurses are often nominated as key political stakeholders in the country areas in which they work. They are seen as a source of information, representative of the community with whom they work, and the language which they use to describe others' thoughts and actions is very important. They can easily place themselves in a position of unintentional misrepresentation, rather than putting into context the views they espouse. For these words or views can only ever be partial,

selective and representational of the rural community nurse who speaks, or those who have directly nominated her to speak on their behalf.

When we listen to the radio, watch the television and read the papers, we find that people everywhere are participating in this potential misrepresentation and oppression of individuals' or groups' views. Politicians and bureaucrats are particularly fond of quoting the community with regard to their health care needs and wants. Questioning the accuracy of such statements is essential in identifying potentially oppressive norms which are being created through the use of this creature community, as opposed to the identification of the multiple realities which individuals live out.

Fiona And Shona's Story

The next story, told by Fiona and Shona, also dwells upon the idea of community, in this case the ability of rural community nurses to undertake community development, the building of individual and group skills within a community setting. Together Shona and Fiona touch upon how Shona, who lives in a rural community, has been able to create a network which enables her to action groups for the purpose of health promotion.

Fiona: *I think a lot of what we do is the same [rural and metropolitan community nursing], having worked in the same small area for so many years. You know how you were talking about, "you lose your anonymity", that the rural nurses do - I feel that I have out where I am. I can't walk down the street in North Hobart without getting stopped by everybody, so there's a similarity there, but it's that involvement in community development [Fiona has a problem with]. In the city, they don't have that sense of community, do they?*

But then I don't really know how to do all the other stuff. You know, they talk about all this primary health care stuff and being

involved, but you're never taught how to do it. I don't know how to set up groups.

Jane: *How do you think rural community nurses get those skills, Shona?*

Shona: *From being part of the community so you know the people that you're setting the groups up with.*

Fiona: *So you've got the support of the community?*

Shona: *Yes, they usually approach you and say "can you help us with this" and it grows from that. We've had a large number of people ring us and we know them all. So you'll say to someone, "I'm going to have a group", and they'll tell their neighbour and they'll ring us up at home sometimes in the evening, or at work.*

Jane: *Is that easier because they see you in other roles as well, Shona? For instance, they see you as a parent at the school, or they see you in the street, or they might see you as a member of a sporting team.*

Shona: *Yes, you're part of it so it's very easy then because you are a key person [as the rural community nurse] but you're a member of the community first. And they feel that they can tap into you. I suppose that's it. You're accessible for them and they'll utilise that.*

Again, the use of language and how it represents or misrepresents our actual meanings is very interesting and poses dilemmas both for those who have spoken or written and those who have listened or read and are trying to interpret. Listening to the conversation between Fiona and Shona once again, we can see the naming use of the words *'the community'*. The difference between this story and Claire's story, though, is that Shona speaks

of how as an individual she has become a part of what I read as being a community network.

Provoked by Fiona's statement that *'In the city, they don't have that sense of community'*. Shona explains how as a *'member of the community first'* her accessibility and approachability are increased for other people who are interested in groups she may be facilitating as a rural community nurse.

Because Shona is established in other roles in a small rural town, there has been the development of a sense of 'self identification with place, a sense of commonality, co-operation and a shared history and destiny' (Chordorkoff in Mills 1996:8). Shona's community network is firmly in place and enables her to take on a teaching role with other individuals who have shared interests. It is this sense of community which Fiona doesn't share with the people she practises with in the city.

How, then, do rural community nurses create positive possibilities for their work with the various individuals and groups who live within their areas? Before anything else, I believe that these nurses need to give some thought to their sense of self and how this impacts on the way they not only currently view their worlds but also how they act within these worlds.

When writing about feminist group work Butler and Wintram talk about how self-definition is dependent upon 'a woman's perceptions and assessment of herself within the context of the social roles she possesses and the impact of group relations on her' (1991:105). This message was revealed to us in the telling of Bebe's, Grace's and Shona's stories about how they saw others' constructions of their roles as rural community nurses.

Butler and Wintram go on to say that 'self definition also holds that women construct their own reality, are capable of understanding their own behaviours, and are able to

communicate this sense of self to others' (Butler and Wintram 1991:105). Stanley and Wise take this idea further when they postulate that reaching this state of consciousness or self-awareness,

> should be conceptualised as a 'process' *at the same time* that it is seen as a 'state'. It should be constructed as a process because differently situated and changing understandings underpin any 'state' of consciousness (1993:125).

For rural community nurses who are able to reach this state of current awareness, their ability to communicate with the individuals and groups with whom they practise takes on a greater sense of honesty and reality. Through engaging with others in this way, they are better able to work through common issues and problems which may promote social change and individual and group empowerment.

Thinking About The Question Of Who Speaks?

What might this all mean for rural community nurses, people who can be seen by others as 'key people', 'stake-holders' and 'holding a position of influence', in short representative of the communities with whom they work? By disclaiming the notion of the community as an entity and seeing this embodiment as an illusion, rural community nurses can find a place from which to speak. This place is one of our own or one which is shared with others who have the same sense of community as ourselves and may have nominated us to speak for them.

There are inherent dangers in speaking on behalf of another. As Petersen warns us, this 'problem of representation is especially acute for those who gain access to bureaucracy and are under pressure to speak for everyone from their presumed community' (1994:110). It is only when those who speak have some insight into their own sense of self and others' sense of community that they can bring clarity to the question of whom they represent. For

rural community nurses, the struggle to find this place from which to speak is a difficult undertaking, and yet one which is mandatory for their future credibility as primary health care practitioners.

Sites Of Struggle For Tasmanian Rural Community Nurses

Tasmanian Rural Community Nurses

Existing on the terrain of rural health care, these woman experience a multitude of struggles which influence their nursing practice. Common to all the stories told, though, has been their struggle for identity. History influences rural community nurses' identities in two main ways. Initially we heard how the culture of nursing has been influenced by the domination of medicine and science. Nurses have long been subjugated to doctors, especially in the institutional teaching hospitals in which all the participants trained. This has created a conundrum for rural community nurses in that we have been encultured into thinking of ourselves as practising under doctors' orders. Instead, the reality of today's rural community nursing practice demands that these nurses perform a scope of practice which is greater than our initial training has prepared us for and current legislation allows.

Our history as bush nurses provides a second way in which rural community nurses' identities have been formed. Pioneers in remote and rural areas, these women are the stuff of legend. The practice of these early rural community nurses was broad and designed to replace medical care in places which were too small or too remote to attract a full-time GP. These ancestors of rural community nursing created a precedent in a time where the legalities of nursing were not as well defined as they are today.

Current literature favours that we resolve this crisis by recreating rural nurses/community nurses as advanced rural nurses, but I would debate the appropriateness of this. When we listened to the stories in the literature, it was only too apparent that the education and training of today's rural nurses/community nurses is not generally of an advanced level. Creating new names for current practice goes little way to solving this crisis of identity. Rather we need to seriously pursue nationwide agreement for the registration or credentialling of advanced rural nurse practitioners. By defining a code of practice for these nurses, we would be

defining an identity by exclusion for rural community nurses. For those who wish to practise within a broader scope of practice, there would be an avenue to do so. For those who do not wish to practise in this way, there would be legitimate recourse to say no to other health practitioners who may wish to delegate their duties to the local rural community nurse.

The theme of identity as a site of struggle can also be seen in the stories from the literature which concerned the definition of rurality, which in turn concerns the definition of a rural community nurse. With no consensus at a nationwide level about how rurality is to be defined, a sense of confusion is apparent about who are rural. Research into the characteristics and needs of rural community nurses loses some authority when these competing definitions are used. This in turn can impact upon the allocation of a variety of resources to rural community nurses. Although the need for some uniformity of definition has been identified at all levels of government, little is being done to address this significant problem for all rural health care providers, including rural community nurses.

At a more personal level, the struggle for identity was equated with the struggle that rural community nurses need to undergo to find their own sense of self. From the stories about community, we heard of the different ways in which rural community nurses position themselves in relation to those with whom they live and work. Establishing their own sense of self and constantly reconceptualising this sense of self in relation to context was seen as the touchstone of honest and real communication with others and across their various communities. Thinking about their identities as rural women, rural community members and rural community nurses and what that might mean for others can create a whole new perspective for practice.

Pictures flash on our television screens: snapshots of anonymous men and women working with their stock, riding horses, wearing

Akubras - 'honest' images of Australian battlers. In early childhood, the stories of 'The Magic Pudding', 'Billabong' books and the legacy of May Gibbs were evocative of small animals and capable people, the colours of the bush. These rural images are cultural symbols, a part of our translation to the world of what it means to be a rural Australian.

Rural community nursing is a part of this rather romantic tradition of rural Australia. The reality which opposes this romanticism, though, has been somewhat explicated in the works which have so far been written about rural nursing and, as a part of that, rural community nursing. Releasing the shackles of our history, rural community nurses need to strive to legitimise and advance our practice. We need to raise our profile, and in so doing, more clearly define our current scope of practice. Tasmanian rural community nurses are a part of this struggle; the need to redefine our identities on the current health care terrain is no less urgent than that of our 'mainland' contemporaries.

The use of narrative analysis in this study has exposed only a small portion of the stuff of Tasmanian rural community nursing practice. There are countless stories to be told, and each one of these will add another layer to the culture of our practice. The challenge is there for others to attempt to make more meaning from new stories so that together we can change the future face of rural community nursing.

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Illustrations