ORIGINAL RESEARCH

Doctors and nurses in outback Australia: living with bush initiatives

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ABSTRACT

This qualitative in-depth study investigates the work and life experiences of 18 female doctors and nurses in remote Australia. The study begins to unravel some of the events and relationships in the women's lives that keep them working and living in remote areas. The study also examines social and working conditions that cause the women to leave, and concludes that action must be taken at both government and local levels to support female health professionals who work in remote locations. This may be achieved by the means of a health promotion action model to underpin such initiatives as the 1999 Commonwealth Government 'fly-in-fly-out' initiative, in which sessional female doctors provide women's health services in remote areas.

Introduction

In 1999 the Commonwealth Government of Australia allocated $2 million to $2.1 million to be spent annually over the following 4 years, in order to establish 'fly-in-fly-out' female general-practitioner services for women living in rural and remote areas without access to a female general practitioner (GP). These services were implemented nationally to provide primary health-care interventions (such as cervical cancer screening and breast examination) and other preventative care for rural and remote women. The services were also intended to identify and provide necessary interventions for other complex conditions, such as cardiovascular disease, diabetes, psychosocial problems and

conditions related to the reproductive system and/or sexual health[1]. The Royal Flying Doctor Service was the national administrator of this initiative and it was envisaged that the process would include a complementary drawing together of health services in each chosen location.

Barriers to integrated care

Women's health clinics in Queensland have been providing a service similar to the Commonwealth fly-in-fly-out initiative since November 1994. In fact, the fly-in-fly-out program was based on the Queensland model. However, a final report to the Commonwealth about the project used such statements as 'unclear communication' across a number of service areas and 'barriers to achieve a truly integrated service'[2] . In another report, the nature of and reasons for these barriers were suggested by the recorded concerns of local medical practitioners about the introduction of 'imported' medical care because of issues such as continuity of care, lack of access to patient records and tests, reduced income in smaller communities, and a variation and fragmentation of referral practices[3]. In the same report it was indicated that tertiary health-referral stakeholders, such as nurses and allied health practitioners, believed that their services would also be bypassed and/or duplicated.

In addition to communication and boundary issues as barriers to achieving integrated services, of further concern are the consequences of limited-time funding in the context of the absence of a safety net of local goodwill and service support. This raises the issue of longterm sustainability of such health initiatives in rural and remote areas. The evolutionary factors that drive these agendas derive from a hierarchical model in primary healthcare, obstetric and gynecological care, general physician care and other specialist care, which under certain circumstances can foster fragmentation and dislocation of services. Such split systems of care may be difficult to integrate in the holistic and inclusive settings of rural or remote health models.

Retention of health professionals

Retaining doctors and nurses in rural and remote Australia is not just a function of recruitment. It has been suggested that part of the dilemma of retention includes issues such as the assimilation of health practitioners into a community. This process has been identified as playing a strategic role in not only retaining doctors and other health professionals in a remote area, but also with their own and the rural community's satisfaction with the health professional's practice role[4,5].

Remote towns and communities are small and close knit. Patient-practitioner inter-relationships are unavoidable and are layered within a social culture of the common knowledge within each community. The 'culture of practice' of a practitioner in a rural area is extremely important and affects the use of that practitioner. Patronage of a rural practitioner is not always a gender issue and the practitioner's communication skills may also play a part[6]. In fact a rural population's behavior regarding their healthcare can be directly related to the value people place on a particular service or service provider[7] and the 'fit' of the provider with the culture of that community.

It is therefore important to acknowledge the expectations, events, practices and processes that make up rural and remote communities, and how an individual's (particularly a woman's) perception of a community may influence their decision to stay or leave.

Methodology

The research was conducted as a qualitative study that focussed on the experiences of a sample of women doctors and nurses across Australia involved in remote-area health clinics, practices and health programs.

The methodology has been adapted from the hermeneutic approach of analysing individual experience. This is based on the premise that behind all exegetical activity that governs the way activity is carried out, lies a complex web of theories, principles, rules and methods[8]. The proposed activities of investigation are initially foundational, and

enquiry was initiated by beginning in people's experience of the actuality of their own lives. The aim was not to explain people's behavior per se, but to explain how their life's experiences are related to socially organised powers and cultures in a particular setting or community, and how their own activities contribute, embody and maintain them in this environment[9].

Method

Participants

There were 18 participants in total, nine female general practitioners and nine female registered nurses from the Australian States of Queensland, Northern Territory, South Australia and Western Australia.

Recruitment and selection

Selection was based on the length of time participants had lived and worked in remote areas of Australia. A process known as 'snowballing', or 'bush networking' was used to find current and past practitioners who worked in remote areas of Australia. This is a long, hard process of seeking information and linking up with relevant people. The usual processes of recruiting people with a specific information base are not efficient or successful in the bush. There are no regular paper deliveries and sometimes no radio reception, so timely contact must be otherwise negotiated.

Participants must have lived and worked for at least 6 months and up to 25 years in remote locations, or had visited locations and delivered services over a number of years. If they had only provided visiting services, they were required to have stayed on location from 2 days to 1 week at any given time.

Interviewing

The majority of the health professionals were interviewed by telephone because of the wide geographical separation of their remote locations. When possible a meeting and interview was arranged at a location convenient to both parties.

This research was performed in conjunction with another study on the affect of geographical isolation on the health of 22 rural women[10]. Questions in the two studies were based on similar criteria and it was considered logical to formulate similar background prompt questions. The background prompt questions allowed similarities in or differences between women's experiences to emerge. The questions were left open-ended to allow each person to describe their own path and their own experiences. The questions focussed on the following: family/historical background; initial reason for move to remote practice/life; activities related to this process; supports, services and networks; health and wellbeing; self, family, and related experiences; good, bad and unusual experiences; personal change; reasons for staying or leaving; community, relationships and friendships.

Validation of data

In order to offer insight into the reflections and experiences of these women, excerpts of conversation from participant transcripts have been included in the Results section. The excerpts illustrate the concept presented in the participant's own words. The transcripts presented in the body of this article are those which best reflect and articulate a particular concept.

To validate the content of the data, the research results were presented to participants for their comment and feedback. Not all participants replied but those who did affirmed the themes in the final analysis.

Results

An enormous amount of information emerged from this study but three inter-related, significant phenomena recurred:
  1. For those who live there – loneliness.
  2. For those who fly in and fly out – always fitting in.
  3. In the workplace - being valued.

Loneliness

Working in a remote area usually means being separated from family and friends. Even though the women knew this would occur they were unprepared for the loneliness of this type of life. In such small communities the participants' professional and personal lives were easily enmeshed, and to avoid being compromised they often returned to an empty house, rather than joining in social activities. This increased their loneliness. An example of managing this kind of loneliness in a remote area is offered by this nurse:

> If you say you've got a dog, the nursing agencies will tell you that a lot of remote area nurses have got a dog. You go home to that dog, and the dog knows whether you've had a good day or bad day—the little dogs I've had do. It's just another presence in the house.

The participants were also unprepared for the assimilation process that occurred as they became part of a community. This process generated feelings of frustration and exclusion, especially in the work community. A number of the female doctors commented that when they were new to a practice or working part time they often were not included in the practice decision-making process. In response to this they felt isolated and less valued, as is illustrated by this comment:

> The biggest frustration is the feeling of being left out on the edge rather than being included as a valued member of the team. At the end of the day, that's the thing.

As well as the work community, the local (social) community played an important role in alleviating loneliness and influencing a health professional's decision to stay in a particular setting. Making friends was an essential element in the assimilation process. It also appears to be directly related to whether the women stayed or left. As this doctor suggested:

> I think probably the thing that kept me there the longest period of time was the community itself ... It was really the people from the community ... they supported us enormously within that community. They've had a major impact on the things that I've done.
>
> Do you think that being supported in the community is very important for doctors moving out [into the bush]? [researcher]
>
> For me, it kept me there for [a lot] of years...

When there is a feeling of inclusion and friendships are established within such communities, there is also a feeling of being understood, supported and belonging, as is illustrated in this comment from a nurse:

> I made some very good friends out there. The friends were community staff and teaching staff - people who I'm still in contact with. A lot of people didn't realise what life was like out there, but these people did. So we've got this bond.

This kind of bonding and friendship is essential for health professionals who work and live in isolation. Community support (both work and social) is essential to reduce loneliness, which is what appears to impact on women most significantly.

For those that fly in and fly out – always fitting in

Work practices are often different in remote health communities from those in metropolitan health practices or clinics. There are also often blurred boundaries between the professional roles of the various service providers and an informality that is based on filling a need with what is available for people with very few services options. This often takes new bush health professionals by surprise, but can also cause frustrations about work practices. In the end the successful health professional is able to assimilate local

knowledge and adapt their work practices to those most suitable for a particular community and environment.

The following examples show how difficulties can occur when metropolitan practice meets remote-area philosophy. From a nurse:

Their expectations are quite high. Some you could talk to and say, 'Me doing a BSL [blood sugar level] on every diabetic in this town isn't going to change their treatment and it's not going to do anything, so I'm not going to do it. I can give you a list and I can say that all these people have got high blood sugar.' That was one of the frustrating things - they were trying to get their programs running and having all these things that they could see, but it wasn't going to do anything for the patient.

They came in with clinical stuff that, in fact, wasn't going to fit with how the culture worked there.

It wasn't going to do a damn thing for the person whose blood sugar was up there. I could spend time talking to them, or we'd go to the shop and see what the shop had that they could eat, instead of diligently getting someone to record their blood sugar every day for a fortnight and it's high all the time. Well, what have we done about it? So those kinds of things used to get to you.

In the outback the health professional will also become 'all things to all people'. Generalist they may be, but the following is an example not only of blurred practice roles, but also of what a remote community might expect of a health professional. From a doctor:

I remember one day getting to the next fella, and I said, 'You're next'. He said, 'Well no, it's my dog; you'd better see the next person'. So we saw the next person and then saw his dog.

Stitching up someone's dog is not an unusual occurrence in remote areas. It is expected and accepted because there is no one else to do it. Health professionals, however, are often

totally unprepared for such unique community expectations.

For both doctors and nurses, constantly working in different settings with different communities can also be very tiring and may eventually take its toll. From a doctor:

I was so, so tired of it. I'd think of not being at home and think of being in these two areas. There is a sort of 'use by' date…. But it is a very hard life when you're travelling all the time. It's not just the travelling. It's fitting in with people out there. I've found that's one of the hardest things - fitting in. Everywhere you go, the team is different and they have their own ways and their own problems and issues. You get tangled up in all that.

Obviously, continuity is preferable but not always possible for those who fly in and fly out of health communities. This lack of continuity, working in different communities with constant changes of staff, excessive travel and lack of support, ultimately impacts on female practitioners and they reach their limit - their rural and remote 'use by' date.

The workplace – being valued

The issue of being valued in the workplace continuously arose for female doctors who worked part time or flew in to relieve or conduct women's clinics. The participants who were in part-time medical practice experienced a lack of support locally from other doctors. A negativity within the medical workplace towards part-time female practitioners has seriously affected not only their recruitment, but also their retention in rural and remote areas. Women were made to feel a burden on the medical workforce, and that they should be apologetic for their role in medicine. This is so particularly for those who fly into a community to provide women's healthcare, especially when they are given the clear message that they are impinging on another practitioner's livelihood or 'patch' as shown in the following statement:

For example, some of the doctors in one of the small towns felt it was a threat to their livelihood. One accused the lady who went to this town of stealing all

his patients. But the problem was that those women didn't access him anyway.

We tried to get him to take them within his surgery so he'd have an ownership of it. That was one of our strategic approaches. He refused that. Because they were outside of it, he got paranoid. In actual fact, what was happening was there were two adjacent towns - one 120 km, and the other 240 km away - and his female patients were going to those two towns that had female GPs. So they were voting with their feet. When we pointed this out to him, he was very ungrateful.

This 'ownership' of patients is a real issue and is further highlighted in this example:

One of the difficulties to-date has been trying to overcome the problems of who's treading on whose toes and who's doing what and how. Okay, here's another service. Yes, I'm a GP, but I'm a GP with anonymity and some skills in an area that maybe a local GP hasn't quite developed. Or women prefer the anonymity, and so on. The frustration is losing this thing of, 'She's my patient; why won't she come and see me for a pap smear?' The things I've heard around that are ludicrous. And when I say this, I'm not talking about either of the locations I'm currently going to, but I've been told by a GP, 'Well, she needn't bother calling me for an emergency if she's not going to come and see me for the routine things'.

This is certainly not a pro-active approach in terms of patient care, but it does highlight the concerns of local medical practitioners who believe that continuity and their livelihood are affected by the introduction of imported medical care. Relieving practitioners are aware of their responsibilities, however, and want to work with local health professionals to do what is best for both the patient and the local medical service, as shown by this example:

I think it's no good to fly in, take a test, and then disappear. From a professional point of view, you

never know what you're doing if you're not following it up. But medico-legally as the person taking the test, you have a requirement. Equally, it's very important to follow that up with the local people on the ground. The worst case scenario would be someone with a major problem and the local GP knows nothing about it.

The women associated with the Commonwealth fly-in-fly-out initiative may unwittingly have been placed 'between a rock and a hard place'. Coming to some sort of agreement with the local medical and health community seems to be essential if relationships are to remain amicable and the 'fallout' of who owns whom is not to affect best practice for patient care. There is agreement about the dangers that may occur for patients as the result of lack of communication, but there is no agreement about amalgamating practices in order to avoid those dangers. Different health-service provision criteria in each State further exacerbates this problem. Many of the female practitioners felt they bore the brunt of the problems associated with the fly-in-fly-out health initiative, which like other government initiatives, was implemented before ground negotiations were completed. This placed the women in a continuous 'no-win' situation and perpetuated the female role in a male-dominated medical culture.

In addition, female doctors believe they work an excessive amount of unpaid time. This is in order to ensure that they work responsibly and legally within their part-time rural and remote positions, but it is given little recognition:

It sounds like a lot of work for you. [researcher]

It is. There's another day's work when you come back—well, not a full day. But if I go to X for 3 days, get results back, collate them, write letters and contact people, I'm looking at another half-day's work, easily. That's with a very efficient system now in place - pre-prepared letters and so on.

In Australia, the attitude that women in medicine must give 'all or nothing' prevails, especially in rural areas. The

participants believed that this bias is often perpetuated by the very groups and associations that should be supporting them. They see these organizations as perpetuating male-dominant medical practices that reflect favor by leaning toward the male full-time procedural doctors, ignoring the needs of part-time female doctors.

Discussion

For individuals, every social setting is self-organising, has a character of its own and a social order[11]. It is, in fact, exactly the way a particular community setting is organised that will reflect the role and participation style for its members[7]. This is a process that occurs at the micro level of society and the medical/health community is no exception. In the present study, female health professionals were expected to play the woman's role in community health and practice settings. They encountered difficulty in assimilating into particular communities when micro-supports within these particular settings were unavailable to them. During the study a number of female doctors commented that when they were new to a practice or working part time they were not included in practice decision-making, nor in the social networks outside the workplace. This resulted in them feeling undervalued, frustrated and excluded, and caused them to retreat, which in turn increased their loneliness. It was at this stage they were most likely to leave the rural community altogether.

This exclusion and lack of social support was also experienced by nurses who became frustrated when their knowledge of remote-area communities was not included in medical program planning. This ultimately set them up (and their ensuing projects) to fail, because there was no community or cultural 'fit' to a proposed non-rural evidence-based care plan. In such a scenario the patient is the ultimate victim due to seriously reduced best-health outcome expectations. Lack of communication, and dissatisfaction with such exclusive patient planning processes caused their ultimate retreat from a particular practice environment. This micro-level support problem, however, is a reflection of a

much broader macro-level support agenda for women working in the outback that must be addressed.

At the macro-level it is somewhat paradoxical that women have been sought by the Commonwealth Government to achieve the current political agenda for a rural women's health initiative. Unfortunately, the current culture of medicine in Australia, and particularly that of the rural medical sector, has not been prepared or planned for and this compounds the 'climate' female health professionals find themselves in, which impedes their ability to implement best practice. This is an ambiguous situation that also leaves women open to criticism by their peers. As recently as 1998, Wainer et al noted this situation and wrote, 'Existing rural practice models do not encourage or even permit some of [the] different practice characteristics [of young women]' (Wainer J, Carson D, Strasser R, Stringer K, Bryant L, 'A life, not a wife', oral presentation, 5th National Rural Health Conference, 2001). In fact, there is still very little proactive effort being made to develop supportive working environments for women that allow them to live and work effectively in rural and remote settings. Effective health solutions will not be found in a system that perpetuates a model of reactive rural problem solving and reinforces ambiguous roles for women in an unplanned, unsupported environment.

Recommendation

Feelings of helplessness and lack of control within a social and workplace setting can cause opposition to change. Lack of consultation with the rural health community regarding the Commonwealth Government's fly-in-fly-out initiative created a negative climate and caused a resistance to female doctors, who are associated with what is seen as an imposed health initiative. In order to avoid these negative effects in future, it is recommended that attention is paid to positive 'climate' preparation, in both the pre-planning and planning phases of future initiatives.

Because public policy creates social conditions and contexts and shapes health environments[12], conceptualising a desired

climate into which public-health initiatives are launched should become an essential element of pre-planning processes.

Any political process that involves people in a community or a workplace, especially one as fragile as the rural and remote health environment, must also be cognisant of providing opportunities for community concerns to be voiced and accommodated prior to implementation. During the planning phase, then, climate preparation would include much broader and more timely opportunities for public consultation than was so for the Commonwealth fly-in-fly-out initiative discussed in the present study.

Conclusion

The key issue is how to appropriately structure a problem-solving process within such an economically complex and socially controversial context as the one portrayed in the present study. Problem solving and consultation are particularly relevant in such a setting, where the experience and wisdom of rural health-care individuals represents a valuable source of information.

Regardless of the difficulties, it is clear that both macro- (government) and micro- (local) support action must take place if female health professionals' difficult working and social conditions in rural and remote environments are to be addressed. If initiatives such as a fly-in-fly-out program are to be implemented, it is essential that the creation of conditions that will support, strengthen, and make feasible for women, the acceptance and adoption of such a health policy[13] are part of a preferred health promotion action model.

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