UNIVERSITY OF ADELAIDE
2·12·02
LIBRARY

The professional working relationship of rural nurses and doctors: Four South Australian case studies

Ian Alasdair Blue, RN, RM, Dip. Teach (Nurse Ed), B.Ed. (Health), MEd. Admin., FRCNA

Submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy in the Department of Clinical Nursing – Faculty of Medicine, Adelaide University, 2002

Table of Contents

Chapter 1

The Context of the Research

1.1 Introduction 1

1.2 My own rural story 2

1.3 Developing the research topic 4

1.4 Past and present status of nurse-doctor relationships 5

1.4.1 A history of conflict

1.4.2 Domination of nursing by medicine

1.4.3 Rural nurse-doctor relations

1.4.4 Medical shortages in rural areas

1.4.5 Medical recruitment schemes

1.4.6 Rural nursing shortages

1.4.7 Communication and collaboration

1.4.8 The changing face of rural nursing

1.4.9 Collaboration between nurses and doctors

1.4.10 The need for greater understanding

1.4.11 The doctor – nurse 'game'

1.4.12 Nurses seek a new dimension to the professional relationship

1.5 Aims of the research 28

1.6 Summary 28

Chapter 2

The Nursing and Medical Workforce in Rural South Australia

2.1 Introduction 30

2.2 Rural South Australia 30

2.3 Defining what is rural 33

2.4 Characterising rural nursing and medical workforces in South Australia 36

2.4.1 Registered Nurses (RNs) in rural South Australia

2.4.2 General practitioners (GPs) in rural South Australia

2.4.3 Educational preparation for rural nursing and medical practice

2.4.4 Rural and urban practice differences

2.5 Summary 51

Study Design

3.1 Introduction 53

3.2 Study design 55

3.2.1 Overview of study design plan

3.3 The rationale for a case study approach 59

3.3.1 Selection of case study sites

3.4 Methods, strategies and techniques 66

3.4.1 Ethnographic techniques

3.4.2 Selection of key informants – participants

3.4.3 In-depth interview technique

3.4.4 Transcription of interviews and checking for validity & accuracy

3.4.5 Comparisons across case study sites

3.4.6 Convergence of data from observations, interviews and other sources

3.4.7 Additional data collection sources

3.5 Discursive exploration 85

3.6 Summary features of the study design 88

3.7 Ethics and other approvals to conduct research 89

3.7.1 Research proposal and human research ethics approval

3.7.2 Changes requested by the Ethics Committee

3.7.3 Participant information

3.7.4 Participant consent

3.7.5 Case study site approvals

3.7.6 Confidentiality

3.7.7 Secure storage of research information

3.8 Limitations of the research 97

3.8.1 Case study sites

3.8.2 Selection of key participants

3.8.3 Exclusion of other than nurses (RNs) and doctors (GPs)

3.8.4 Sample size and generalising of results

3.8.5 Rural location of study

The Case Studies 102

Chapter 4

Sea Town

4.1 Describing Sea Town 103

4.1.1 Physical characteristics

4.1.2 Socio-economic characteristics

4.2 The health service description 105

4.3 Profile of nurses and GPs 106

4.4 Nurse-doctor interactions 108

4.4.1 Overview

4.6 Summary 123

Chapter 5

Valley Town

5.1 Describing Valley Town 126

5.1.1 Physical characteristics

5.1.2 Socio economic characteristics

5.2 The health service description 128

5.3 Profile of nurses and GPs 130

5.4 Nurse-doctor interactions 132

5.4.1 Overview

5.4.2 Examples of interactions

5.5 Summary 145

Chapter 6

Bridge Town

6.1 Describing Bridge Town 148

6.1.1 Physical characteristics

6.1.2 Socio economic characteristics

6.2 The health service description 150

6.2.1 Bridge Town Hospital

6.2.2 The accident and emergency area

6.3 Profile of nurses and GPs 152

6.4 Nurse-doctor relationships at Bridge Town hospital 154

6.4.1 Accident and emergency observation

6.4.2 Communication issues

6.4.3 Nurse-initiated treatments

6.4.4 Building trust and respect

6.5 Summary 162

Chapter 7

Silo Town

7.1 Describing Silo Town 165

7.1.1 Physical characteristics

7.1.2 Socio-economic characteristics

7.2 The health service description 168

7.3 Profile of RNs and GPs 171

7.4 Nurse-doctor relationships at Silo Town health centre 173

7.4.1 Constructions of the social relationship

7.4.2 Nurse-doctor roles in a visiting GP consulting session

7.4.3 Policies influencing nursing-medical relationships at Silo Town CHC

7.4.4 Nursing autonomy and its effect on the relationship with GPs at Silo Town

7.4.5 Building trust and rapport between visiting GPs and nurses

7.5 Summary 188

Chapter 8

Discursive exploration

8.1 Introduction 190

8.2 Perspectives of the relationship across rural case study sites 191

8.2.1 Similarities and site-specific features in the relationship

8.3 The rural nurse-doctor relationship rubric 194

8.3.1 Introduction

8.3.2 Explanation of the rural nurse-doctor relationship rubric

8.4 Major characteristics shaping the relationship 197

8.4.1 Credibility, Respect, Trust and Interdependence

8.4.2 Professional and Personal Giving

8.4.3 Mutual Sharing of Responsibility in Practice

8.4.4 Historical and Traditional

8.5 External factors influencing the relationship 242

8.5.1 Political Action

8.5.2 Rural Community Values

8.5.3 Governance

8.5.4 Rural Practice Preparation

8.6 Distilled meanings of the relationship 249

8.6.1 Meaning of the relationship for rural RNs

8.6.2 Meaning of the relationship for rural GPs

8.7 Summary 255

Chapter 9

Conclusions

9.1 Introduction 256

9.2 Relevance and standing of the relationship 257

9.3 Essential features of the relationship 258

9.4 Factors that build or weaken the relationship 259

9.4.1 Personal factors

9.4.2 External factors influencing the relationship

9.5 Recommendations 262

9.6 Critique of the body of work 273

9.7 Future directions 274

Epilogue 275

References 277

Appendices

Appendix A Rural and remote area classification systems 286

Appendix B Plain statement – Information sheet for patients 287

Appendix C Letter to in-depth interview participants requesting validation of transcript 290

Appendix D Participant consent form 291

Appendix E Patient information and consent form 292

List of Figures and Tables

Figure 2.1	Location of employed RN-GP workforce in South Australia, 1996 (Australian Institute of Health and Welfare 1997)	37
Figure 2.2	Weeks incorporating rural placements, 1998 (from Bridgewater 1998, figure 1.1, page 7)	47
Figure 3.1	RN and GP participants in the study	76
Figure 3.2	Ages of RNs and GPs	77
Figure 3.3	List of contents of the application and research proposal lodged with the university Ethics Committee in 1997	90
Figure 3.4	List of information provided to participants	93
Figure 4.1	RN/GP profile in Sea Town	107
Figure 5.1	RN/GP profile for Valley Town	131
Figure 6.1	RN/GP profile for Bridge Town	153
Figure 7.1	RN/GP profile for Silo Town	195
Figure 8.1	Rural nurse-doctor relationship rubric	195

Table 1.1	Summary of major research studies examining the relationship between nurses and doctors – 1966~1999	5
Table 3.1	Study design main phases	59
Table 3.2	Case study fieldwork plan	63
Table 3.3	South Australian rural & remote health service profile	63
Table 4.1	Socio-economic cluster characteristics for the Sea Town Statistical Local Area	104
Table 5.1	Socio-economic cluster characteristics for Valley Town Statistical Local Area	128
Table 6.1	Socio-economic cluster characteristics for Bridge Town Statistical Local Area	149
Table 7.1	Socio-economic cluster characteristics for Silo Town Statistical Local Area	168
Table 7.2	Range of local & visiting health services in 'Silo Town' Community health centre	169
Table 8.1	Comparison of the RN-GP relationship across case study sites	192

Abstract

This study describes the professional working relationship of registered nurses (RNs) and general practitioners (GPs) who are practising together in a rural context. This history of nurse-doctor relationships in Australian and internationally is one of conflict, subordination of nurses by doctors, division of labour based on gender and 'game playing' by nurses and doctors to achieve objectives. No detailed research has been conducted in Australia examining the professional working relationships of nurses and doctors in rural health services.

This study used a case study method to examine four rural health services and described the nurse-doctor relationship in each setting using ethnographic techniques of in-depth interview and non-participant observation. A total of 10 nurses and 6 doctors (n=16) participated. The study is essentially an inductive enquiry conducted in three phases. Phase one included an extensive literature review of research and published information about nurse-doctor relationships. Phase two provided descriptive narratives of the four case study sites and the day-to-day interactions between rural nurses and doctors. Also included is an analysis of the four case studies and the data emerging from observation and in-depth interviews. Common patterns and features are described and emergent themes identified. Questions are posed about why certain behaviours were undertaken and explanations given. Finally, phase three is a discursive exploration of issues and features revealed in the previous phases, and refers to other studies and contemporary discussion about factors influencing the rural nurse-doctor relationship.

The final chapters of the study bring the various discourses together and along with analysis of the themes and sub themes capture a snapshot of time and place for rural nurses and doctors in the case study sites. The resulting confirmation of the traditional aspects of nurse-doctor relationships but also the unique characteristics of how the relationship operates in a rural context is interesting and challenging. Other rural nurses and doctors reading the thesis will find many familiar aspects but also some unique ones that make the relationship either strong and viable or limited and dysfunctional. Finally the thesis suggests how the core features of the relationship can be improved and in some cases radically altered. It concludes with recommended strategies for building effective professional working relationships between rural nurses and doctors for their mutual benefit and the rural communities they serve.

Declaration of Originality

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to this copy of my thesis, when deposited in the Adelaide University Library, being available for loan and photocopying.

Signature of Candidate

Date_____

Acknowledgments

In a work of this kind the final outcome is only made possible with the support, guidance and assistance of others. The author acknowledges, with deep appreciation:

- the individual rural nurses and doctors who participated so willingly in the observation and interview components of the research
- the four case study rural health service sites who gave their permission for the research to be conducted and for their hospitality during the fieldwork
- guidance, direction and support from my primary supervisor, Dr Mary Fitzgerald, Department of Clinical Nursing, The University of Adelaide.
- advice and suggestions on study design received from Professor Alan Pearson, Head of the Department of Clinical Nursing, The University of Adelaide.
- scholarly debate, encouragement and friendship from fellow PhD students and staff at the twice yearly PhD Research Schools I have attended since July 1996.

To

Melva, Malcolm, Graham (deceased), Roderick,

Judy, Damian, and Rowan

For the values they have instilled in me and the

Everlasting demonstration of perhaps that most important

of relationships ~ family.

Chapter 1

The Context of the Research

1.1 Introduction

To appreciate the background of this study some personal explanation is required. There are two reasons why I embarked on this journey. The first is an academic and scholarly one and the second is a genuine belief that the quality of rural health care delivery can be improved if the professional interactions between rural nurses and doctors are better understood and, where possible, improved.

The first of these reasons stems from my need to demonstrate a scholarly capacity that is both rigorous and adds a new perspective to existing knowledge and the second is to ensure that the topic chosen for this research is one of relevance. That is, relevance to me as a student and to the rural nurses and doctor participants under study and their individual and professional lives.

A further motivation to conduct research of this kind has arisen out of my own history and association with rural South Australia and the people who live and work there. As a young child I lived in Adelaide; but because my mother's brother and my grandparents owned and operated a mixed crop and livestock farm on the Eyre Peninsula, I spent a great deal of my school holidays living and working with these relatives. These times are amongst the most treasured of my early life and have left me with a strong affinity with all things rural.

Some 40 years have passed since I first travelled as a ten year old boy by bus from my city home in Adelaide to what became commonly known in our household as 'the farm'. The memories of many happy days spent there are still fresh in my mind. The 550 km bus journey to the farm was a long one. After eight or ten hours on the road, the last part over rough gravel, the welcome by my grandfather, who always drove into the small rural town to meet me, often late at night, was a mixture of relief and anticipated excitement for what lay ahead. My younger brother, Graham, and I often made this trip together and I remember feeling quite anxious about the bus not stopping at our town when it arrived at night. I need not have been concerned; the bus driver always stopped and, reassuringly, my grandfather was always there to meet us.

My grandparents' farmhouse was a big stone home with a veranda surrounding all four sides. It was called *Four Winds*, a name given it by my mother. Positioned overlooking a shallow valley, it lived up to this name. In the late 1950s and early 1960s when I first visited the farm, the house, if judged by modern standards, had limited facilities. A 32-volt diesel generator supplied power and light. This meant most household appliances were specially adapted for this low voltage electric current which relied on a bank of batteries to give light when the generator was not operating. The household refrigerator ran on kerosene and had a very small freezer, with just enough room to hold two trays of home made ice cream. Rainwater for household use only was always rationed very carefully due to its short supply. Hot water was only available when the wood chip heater in the bathroom was 'fired up' or from the large wood fuel stove in the farm house kitchen.

The bathroom chip heater was a thing of both terror and fascination. After a fire had been built under its boiler and sustained by feeding small chips of wood, the cold rainwater tap was turned on over a funnel, which lead into the heater. Furious 'chuff, chuff' noises emanated from the heater as it belched and hissed hot water from another tap extending out over the bath. In winter this experience was very pleasurable, as the fire in the chip heater would warm the whole bathroom from heat radiated by its boiler. Many times I lay in the bath, lost in my own thoughts with the crackle of the fire and chip heater accompaniments in the background. It was strangely soothing.

These and many other memories of life on the farm and in the nearby small rural town of around 500 residents are part of my history and in part explain why rural living and rural people are woven through my personal and professional life. These early childhood experiences led me as a young man in the late 1960s to seek employment as a share farmer on Eyre Peninsula and later to work as an agricultural adviser in Papua New Guinea before taking a different career direction in the early 1970s when I commenced nursing. After spending 15 years training and working as a general nurse, midwife and nurse educator in Adelaide, I again found myself returning to those early experiences of rural life.

1.2 My own rural story

In 1986 with my wife and two primary school aged children I left Adelaide and moved to a northern South Australian regional rural town. There I joined a small team of nurse educators who provided a continuing education service to rural and remote nursing staff in the Northern and Far Western parts of South Australia. The region covered 86% of the state's landmass and contained many sparsely populated rural and remote outback communities.

During this time the delivery of health care was becoming increasingly complex with new techniques, treatments and equipment being used by both doctors and nurses in these areas. At the same time the relative well being and wealth delivered by high rural commodity prices had lulled many rural communities into a false sense of security and there was a reluctance to accept that things were about to change.

From mid to late 1980s, the first cold winds of economic rationalism started to blow over rural South Australia. For the first time in the history of the state rural towns faced the real possibility that their local hospitals would be closed. This was a bitter pill to swallow as many of these hospitals had been financed and built with money raised by the community through bequests, donations and community fundraising. During this period and into the early 1990s tensions were high, and many public meetings between local rural communities and the 'messengers of doom' sent by the Adelaide health bureaucracy ended in acrimony.

One of the unintended consequences of the decade 1985-1995 was the bringing together of previously separate factions, including doctors and nurses. They were forced together in a common defence of their health services. Rural nurses knew that if their local hospitals closed they would likely loose the town doctor or doctors. This in turn meant work practices would be affected and at worst, lost altogether. The de-skilling of rural midwives is a good example of this. As more rural hospitals lost or had their obstetric services downgraded, either because the doctor stopped delivering babies or an external review had concluded the risk of deliveries in a particular rural town was unacceptable. So the ability to maintain skill through practice was lost.

It is difficult to find published evidence where nurses and doctors collaborated together to fight for the retention of their health services. My own experiences of talking to many during this period left me with the strong impression that nurses and doctors found they had more in common and therefore it made sense for them to work together more closely on the political level to achieve the desired outcome. Certainly during that period I attended many public meetings where the voices of both nurses and doctors were in concert when it came to closure or restriction of health services.

1.3 Developing the research topic

Throughout much of the decade 1986-1996 I was in close touch with rural health services and professionals as I travelled extensively through rural and remote South Australia. I had occasion to witness first hand the professional working relationship of rural doctors (GPs) and nurses. The relationship struck me as being one that was pivotal to both these professionals, the health service in which they operated and the community they served. There were situations where the nurses and doctors got on very well together, but there were others where the evidence pointed to that not being the case. Questions started to form in my mind about the relationship and how it worked.

What made the relationship good? What made it bad? Did it really matter? Were nurses and doctors really interested in working towards a harmonious relationship? Was the relationship different from that in urban practice? What was the real essence of the relationship and how was it formed and maintained? These questions started to interest me and the beginnings of a longer-term plan to examine the issue started to form.

In thinking through these questions and my ability to find answers to them I contemplated my own biases and prejudices. Could I, after 25 years of being a professional nurse, conduct a research study that examined the professional working relationship between nurses and doctors? Like all nurses, I have formed a general opinion of doctors and also how nurses interact with them. Just how objective a researcher could I be?

I answered part of my own question by acknowledging that having this experience was in itself a good starting point. It would allow me to understand the subtle nuances of the relationship that other non-nurse, non-doctor researchers would not look for, or, if they saw, would not recognise. In addition, there is the need in all research to apply a rigorous approach to the gathering of the data and the interpretation of it. If I recognised and accepted my own biases and prejudices as reality, but equally could demonstrate a clear and traceable path from premise to conclusion in the research, then I would be true to the desire of most researchers: to investigate a phenomenon and present it in as uncomplicated a form as is possible and in a way which gives rise to new meaning.

Before embarking on this task it was important to learn all I could about the way nurses and doctors worked together. In particular, to examine the published literature about the relationship and its past, present and future developments.

1.4 Past and present status of nurse-doctor relationships

While there is an abundance of published articles by authors commenting on nursing-medical relations, only one Australian published research study could be found which examined the professional working relationships between nurses and doctors in a detailed way. The study by Deidre Wicks was conducted during 1997-1998 in an acute metropolitan general hospital setting in NSW (Wicks 1999). There are, however, several key studies that examine collaboration between nurses and doctors internationally. These span a 30 year period from mid 1960s through to the end of the twentieth century. Some of the more significant ones are summarised in Table 1.1 which shows a progression of research studies involving nurses and doctors in a variety of countries and settings. All of the studies are located in large or small urban acute hospital environments and there are no studies that specifically examine the relationship between nurses and doctors in practice settings that would be regarded as being rural, at least by the Australian definition.

Table 1.1 **Summary of major research studies examining the relationship between nurses and doctors – 1966~1999**

Author	Hofling, Charles; Brotzman, Eveline; Dalrymple, Sarah; Graves, Nancy; Pierce, Chester (1966)
Location	Midwest – USA, 1965
Method	Research conducted in a public and private hospital in medical, surgical, paediatric and psychiatric wards using a false drug order by a doctor to nurses over the phone to gauge their reaction. A third control group answered questions on how they would react to a similar situation. The researchers constructed an artificial circumstance in which a doctor telephoned an order to administer a dose of medication (a placebo), which was obviously excessive and not listed on the ward stock-list and therefore cleared for use.
Conclusions	A rather curious form of research entrapment which would be regarded as somewhat unethical today, the results of the research revealed that out of 22 ward based nurses (12 public and 10 private) only one nurse did not comply with the 'bogus' doctor's request. In other words, the overwhelming majority of the nurses complied with the telephone order to administer the drug despite them not being familiar with the doctor caller or the drug. About half of the nurses did, however, question the telephone order dosage and what the correct dosage on the package stated. Those in the control group were much more circumspect and claimed they would not have given the drug at all. The researchers acknowledged the danger to patients of unresolved difficulty between the nurse and doctor even when there is little or no friction. Patients reasonably expect both doctor and nurse to act using their combined intelligence. This experiment demonstrated nurses blindly following a doctor's order, despite the potential dire consequences on themselves and the patient. It also showed nurses trust doctors to be correct and generally wish to please them. In this case by agreeing to break regulations and their own professional judgement to administer a drug which was of a higher than normal dose, the nurses left themselves open to claims of being passive to the doctor's wishes.

Author	Stein, Leonard (1967)
Location	USA, 1966
Method	Report of participant observations by three doctors (of which Stein was one) and two nurses about the relationship between nurses and doctors.
Conclusions	The interactions between nurses and doctors, where nurses make recommendations to doctors about the treatment of patients, are unique in character. Stein describes this process as a 'game model' in which the players use certain behaviours or rules to play out their day-to-day work activities. The object of the game for nurses is to take the initiative and make significant recommendations to the doctor in a way that does not cause the doctor to believe they are being told or directed to do something. Open conflict or disagreement must be avoided at all costs. The nurses use hints or disguised questions and likewise the doctors. Good 'game players' learn how to preserve the importance of the doctor and the valuable contributions of nurses or the acting out of stereotypical roles of men and women. There are rewards and penalties and a successful 'game' outcome is one in which the doctor uses the nurse's skill and experience and the nurse receives respect and admiration from the doctor. In this way the doctor-nurse team is seen to be efficient and effective. Stein recognised the limitations of the model: the inhibitory effect it has on open communication and the anti-intellectual level it operates on. He urges attitude change – in both professions.

Author	Prescott, Patricia; Bowen, Sally (1985)
Location	USA, 1981-1982
Method	Research data collected from physicians and nurses in 15 hospitals across six cities. Units included medical, surgical, intensive care and medical-surgical special care units. The study included interviews with 264 nurses and 180 physicians and questionnaires from 1044 nurses and 536 physicians.
Conclusions	Physicians and nurses were questioned regarding the nature of their relationship, the areas of disagreement about patient care and how such disagreement was resolved. 70% of the doctors and 69% of the nurses in this study described the relationship between them as mostly positive. There were four main areas of disagreement. The main one related to the patient's care plan, with more doctors (65%) than nurses (53%) reporting competitive approaches by the two professional groups when conducting treatment. The other three areas of disagreement included: the nurse wanting something from the doctor (in order to prevent a problem); the doctor disagreeing with the nurse (nurse has taken initiative outside nurses' scope of practice); and lastly the doctor wanting something from the nurse (assistance with a procedure or changed approach to the patient). Most of the disagreements were settled, not resolved, using a medical chain of command with the doctor generally having the final say. Four elements of a positive relationship emerged. These were: mutual trust and respect, open communication, willingness to cooperate and help each other and competence in performing one's role. The first of these was of most importance to the nurses. Very few examples of joint problem solving (collaboration) were seen in the study.

Author	Keddy, Barbara; Jones Gillis, Margaret; Jacobs, Pat; Burton, Heather; Rogers, Maureen (1986)
Location	Nova Scotia, Canada
Method	A grounded theory method that interviewed 34 older nurses who had worked and trained in Canada during the 1920s and 30s.
Conclusions	This study revealed nurses who had a different relationship with doctors from nurses of today. Some 50 years after the 1920s and 30s the older nurses in the study reported doctors having a much greater input into the education process of nurses. This included lectures and in some cases exams set by doctors. Doctors, in the experience of these older nurses, also had the power to decide who got work and who did not. Nurses who were 'selected' by doctors to work for them enjoyed a special status. Doctors from that era had clearly defined expectations of nurses. This generally meant doing exactly what the doctor dictated. In return the nurse earned respect. Doctors accepted nurses, not for their prowess in patient care, but for their efficiency. Fifty years ago the role of the doctor was an all-important one. Nurses only related to the doctor on a superficial level and only gave her opinion when asked for it. Nurses in the study reported that doctors were upset when the generally accepted rule that they should stand when a doctor entered the room was stopped. These old ways of the relationship promoted ineffective communication, mistrust and resulted in disputes over power and territory. There was a recognition that change must continue and that nurses must fight harder to establish their credibility through education and acceptance by the public that nurses were more than 'temperature takers with small brains and big hearts' (Leduc 1979).

Author	Young-Hee Kim, Esther (1989)
Location	Philippines, 1988
Method	A study of interpersonal relationships between doctors and nurses, their professional performance, the quality of patient care and links between these concepts. A survey of 100 nurses and 100 doctors by questionnaire at the Philippine General Hospital.
Conclusions	The study set out to answer the questions: Is the relationship between nurses and doctors related to quality of patient care? And is the performance of nurses and doctors directly related to quality of patient care? The findings of the study show there is a direct correlation between the status of the relationship between nurses and doctors and the quality of patient care. The performance of both nurses and doctors in giving such care is also affected by the status of the relationship. Psychosocial elements of care such as kindness, gentleness and a friendly nature in approaching patients were ranked highly by both nurses and doctors as a quality indicator. Nurses rated physical elements of care such as meeting comfort needs and symptomatic relief more highly where doctors valued hydration and elimination needs. Interpersonal relationship factors identified by both nurses and doctors included: communication, recognition, respect, cooperation, confidence, understanding and friendliness. These correlate with the perception of quality of care provided to patients for nurses and doctors in the study. The researchers called for strategies that brought nurses and doctors closer together to share definitions, expectation and meaning around interpersonal relationships. Quality patient care will not be achieved in organisations with no mechanisms or educational programs designed to improve interpersonal relationships.

Author	Porter, Sam (1991)
Location	Belfast, Northern Ireland, 1990
Method	Participant observation of nurses and doctors in an intensive care unit and general medical ward in an acute hospital setting.
Conclusions	An examination of the nurse-doctor power relations and how they operate in a hospital setting. Four types of interaction between nurses and doctors were derived from the literature and tested against empirical data gathered by the author as a nurse participant observer. The four types of interaction by nurses were: unproblematic subordination, informal covert decision making, informal overt decision making and formal overt decision making. Findings were that nurses were less dependent on subordinate modes of interaction than thought but that formal overt decision making (although officially encouraged) was used infrequently. More senior nurses used informal overt strategies to involve themselves in decision-making sequences. Use of such strategies reduced but did not eliminate the power differential between nurses and doctors.

Author	Jones, Rebecca (1994)
Location	USA Midwestern metropolitan county hospital
Method	Descriptive study that used a random mail survey of 59 nurses and 67 doctors to determine collaborative practice.
Conclusions	The 126 subjects in the study completed a nurse or doctor communication scale (adaptation from the Weiss & Davis Collaborative Practice Scales), a practice spheres and goal checklist. Nurse-doctor collaboration was defined as a process characterised by four indicators: mutual power-control; respect, recognition and acceptance of separate and combined practice spheres; mutual safeguarding of concerns; and common patient goals when nurses and doctors work together. Findings revealed nurses and doctors were the same on the power-control and concern indicators, but were inconsistent in their perceptions of responsibility for practice spheres and patient goals. The study showed both nurses and doctors perceived that doctors initiated a greater number of communications than nurses. This challenges previous studies that suggest doctors exercise power and control over nurses. Collaboration is more likely when high levels of assertiveness and cooperation are perceived. Nurses and doctors in the study did not agree on whether the responsibility for an area of practice rests solely with one provider or should be shared.

Author	Svensson, Roland (1996)
Location	Sweden 1995
Method	A study that included interviews of 45 nurses from 14 medical and surgical wards in five Swedish hospitals. Two of these were city based and three were in district county areas.
Conclusions	Interviews focused on themes surrounding the nurse-doctor relationship. These were: nurses' opportunities to influence decisions, division of labour, exchange of knowledge and information, ethical attitudes and potential conflict situations. This research builds on the theory that negotiation is fundamental to an understanding of social organisations. It also holds that the conditions governing the negotiations between nurses and doctors have changed significantly over the past decade. A 'negotiated order' exists in the wards between the nurses and doctors as a result of a continuous negotiation between the two professionals. The study demonstrates the importance of analysing the structural basis of negotiations and its knowledge context in order to appreciate the interplay of doctors' and nurses' opportunities for exerting power in their work. Nurses who had worked between 15-20 years noted that there had been a noticeable improvement in the working relationship in the past 8-10 years, claiming they could convey their ideas and opinions to doctors who in turn would listen and take account of what they said. Nurses in the study reported they had increased their influence on decisions taken by doctors about patient care.

Author	Wicks, Deidre (1999)
Location	Australia, 1997-1998
Method	Ethnographic study conducted in a general medical ward of a large teaching hospital with 20 nurses, seven doctors and four allied health professionals.
Conclusions	The relationship is based on a 'division of knowledge, power and authority which constantly threatens to overflow and bifurcate the essential experience of being sick and wounded or dying' (pg. xii). Contends gender 'enters into, constructs negates and shapes a large proportion of what happens and how it happens on a typical hospital ward' (pg. xiv). An 'unstable and contingent' dominance of medicine over nursing, evident since 19th century Britain, continues today. Balancing this view was the recognition by nurses of doctors who worked 'against the grain' of medically dominant behaviour and valued the knowledge of nurses, particularly in areas where medicine has taken less interest, such as palliative care. Nurses resist subordination to doctors and will challenge and in some cases override medical authority. Nurses and doctors can and do find common ground which enhances both practitioners (pg.175).
(Hofling 1966); (Stein 1967); (Prescott 1985); (Keddy 1986); (Young-Hee Kim 1989); (Porter 1991); (Jones 1994); (Svensson 1996); (LeDuc 1979); (Wicks 1999)	

1.4.1 A history of conflict

What these studies show is a history of conflict. The evidence shows domination by medicine over nursing whenever nurses have threatened the traditional power base of medicine. Hospitals and the patients who reside in them are considered to be the domain of doctors. Nurses play a largely subservient and supportive role in maintaining this status quo. The result has been a working relationship that is a contentious one and continues to be the focus of many debates. Surprisingly little research and other studies have investigated specific components of the relationship. Those that have been conducted characterise the relationship as being one of role confusion and overlap, mistrust, power struggles and open conflict (Warelow 1996; Dayton 1992; Turnbull 1992; Jones 1991; Weiss 1985; Weiss & Remen 1983; Weiss 1983).

When analysing the research undertaken in the nine studies summarised in Table 1.1 there is a wide divergence of methods. Most use qualitative strategies to explore the functionality of the relationship. Methods employed included: ethnography, interviews, grounded theory, participant observation, questionnaires and a pseudo randomised controlled trial. Themes examined included: compliance with doctors orders, behaviour traits displayed by nurses and doctors to establish rapport, the nature of the relationship in areas of agreement and disagreement, historical perspectives of nurse-doctor attitudes, the link between professional performance and the relationship, the types of interaction and their relationship to power, communication between nurse and doctor, relationship themes and negotiation around them, and interprofessional relationships between nurses, doctors and allied health professionals.

None of these studies examined the relationship of nurses and doctors in small work settings or the context of rural practice. Overall they have yielded significant results in terms of a greater understanding of the relationships and its complexities but have not presented a consistent perspective or a model to improve the relationship. In this study one objective will be to produce a model or rubric that explains the essential elements of the working relationship and their interconnectedness.

1.4.2 Domination of nursing by medicine

There is ample evidence to show medicine has constrained, controlled and confined the practice of nurses (Warelow 1996). This has resulted in considerable power struggles between the two professions, mostly resulting in nursing deferring to the more powerful and dominant medical profession. In more recent times nurses have begun to break the domination and control of medicine on nursing following the transfer of nursing education from the hospital based

apprenticeship system to universities, but there still remains a high level of control exerted by doctors over nursing work. This limits the scope of practice for nurses, prevents harmonious working relationships and stifles collaborative models of practice from emerging. Results from a number of studies over the decade 1985-1995 on collaborative practice between doctors and nurses consistently show the traditional status quo beliefs about the power and authority of medicine are more prevalent than fostering collaborative practice values (Weiss 1985, p.49).

1.4.3 Rural nurse-doctor relations

In rural practice the professional relationship between nurses and doctors is significant because of the interdependence each assumes in a clinical setting where doctors are not resident in the health service in the same way they are in metropolitan settings. Rural practice requires a greater level of autonomous practice and therefore a greater level of skills and added responsibility.

Both rural doctors and nurses experience professional isolation and the nature of rural health service delivery requires that they must work together effectively as a team. In a climate where there is equality, respect and appreciation of each other's professional skills it is more likely that an effective professional relationship will exist and flourish. If these factors are absent, the outcomes are poorer quality practice on the part of both professionals, higher risk of misadventure and lower standards of care provided to those patients receiving services from either doctor or nurse.

1.4.4 Medical shortages in rural areas

One factor that could reasonably be expected to impinge on the working relationship of nurses and doctors in rural areas is the shortage of doctors, particularly GPs, and the impact this has on nurses. By the late 1980s reports of problems with recruitment and retention of GPs in rural areas of Australia were emerging. In 1987 Professor Max Kamien's ministerial enquiry report into rural doctors in Western Australia showed there were significant barriers to retaining a well trained medical workforce. These included inadequate training for the work of a rural doctor, lack of professional support and insufficient educational and career support for doctors and their families (Kamien 1987).

Ten years later in 1996 the Australian Medical Workforce Advisory Committee (AMWAC) was established by the Australian Health Ministers' Advisory Council (AHMAC) to respond to the growing concerns about shortages of doctors in rural Australia. The AMWAC reported some significant findings about the characteristics of the rural and remote areas medical workforce. These characteristics are outlined below.

- There were only 20.8% of primary care practitioners (mainly GPs) out of the total Australian GP workforce providing their services to approximately 28% of the total Australian population living in rural and remote areas.
- In the 10 year period from 1985 to 1995 Medicare data revealed primary care practitioner numbers in rural and remote areas increased by 36%, but the proportion of total providers has remained around 22% and is slowly falling.
- The turnover of rural primary care practitioners was around 13-14%, which is similar to urban areas.
- The estimated shortfall of GPs for the rural and remote areas of Australia was estimated to be 445 FTEs or 511 actual and some 900 FTEs for specialist doctors.
- When compared with urban GPs, rural GPs treat more patients but see the same ones less often. They work longer hours and are on-call more often.
- Of the rural and remote GP workforce, female GPs made up 17% and, compared to males at 22.5%, were fewer in number compared to urban doctor male-female ratios (AMWAC 1996).

The identified problems of GP shortages in rural regions have continued through the 1990s despite considerable effort and funding by state and Commonwealth governments to overcome them. Many rural towns have lost the services of their doctor altogether or the number of doctors in the town has been reduced as the population has dropped or the local health service has been run down or closed. It is common for rural towns to spend considerable sums of money in an attempt to attract a doctor, and there have been examples where communities are still hoping to recruit a permanent GP after 10 years. Typical of the lengths to which some communities are prepared to go is Peterborough, a small rural town in South Australia, which in 1996 offered the following recruitment package to any qualified GP:

> Wanted: GP for country town. $200,000 practice with free surgery/office, accommodation, car, petrol, relocation costs, air tickets, meals cooked, linen supplied, entertainment and free set of steak knives! (Crouch 1996)

It is not that there is a national shortage of GPs who could take up such lucrative offers, it is just that they choose to live and work in urban areas and have shunned rural practice. Wilkinson (2000) in a study of the distribution of GPs in Australia noted that on average there were 920 people per full time GP in Australia and that Sydney had the greatest oversupply (63%) of GPs relative to the whole of New South Wales. Wilkinson listed one rural area in South Australia that had a ratio of 1731 people sharing one full time GP (Wilkinson 2000).

As the number of GPs willing to work in rural practice declines or the distribution of GPs remains urban centric, nurses will continue to carry the burden of health needs for the rural community they serve. Where acute or chronic shortages of medical services exist, nurses have had to step up and provide increased levels of service, not because they desire to practice medicine, but because they are forced into de facto roles for which they are often unprepared and unprotected by professional, educational and legal standards.

1.4.5 Medical recruitment schemes

In response to the general dissatisfaction of GPs in rural areas about their high workloads, lack of access to continuing medical education (CME), professional support and the increasing shortfall in numbers required to practice, there has been a broad range of initiatives put in place to overcome these difficulties. Federal and state government schemes such as the General Practice Rural Incentives Program (GPRIP) have injected up to $15 million per annum to attract doctors from metropolitan areas to rural practice. Introduced in 1993 the GPRIP incentives include non-taxable relocation grants of $20,000, training grants of up to $78,000 over 12 months for periods of intense training, and access to locum grants for GPs wishing to leave their practice for education and training or other leave.

In 1996 the GPRIP program had a budget allocation from the Commonwealth Department of General Practice of $15.1 million per year (Holub 1996). CME and locum grants offered $5 million each year to rural GPs across Australia to access training away from their practices. An additional $2.5 million per annum was provided for medical undergraduate initiatives designed to increase the number of medical students undertaking clinical rotations in rural areas and promoting rural practice as a viable alternative career path. By 1994 the 10 Australian medical schools had received this funding and were following the Rural Undergraduate Steering Committee (RUSC) report recommendations on how the funding should be used to include more rural content in medical curricula and expose more students to rural clinical experience.

Funding from the RUSC program has also supported the development of undergraduate student rural clubs within all Australian medical schools. These clubs have in some cases expanded to include nursing and allied health students in activities. However, these non-medical students have no funding support. In South Australia the three universities each have a rural club that forms part of the national network of rural student clubs. The Adelaide and Flinders University clubs receive allocations of funding from the RUSC program while the University of South Australia club does

not. This club consists of allied health students only and has not attracted nursing students as members. A primary reason for this has to do with insufficient funding for administrative support and the conduct of interdisciplinary activities.

Most medical schools now have active rural student recruitment programs and the numbers of students with a rural background have increased. This has included Aboriginal and Torres Strait Islander students, although not at acceptable levels. Programs, such as the John Flynn Scholarship Scheme introduced in 1997 are designed to encourage medical students to build a long term relationship with a rural or remote community in the hope that after graduation they will be recruited to that community or one like it. John Flynn scholars receive $2500 per annum or $10,000 over four years to assist with travel and accommodation costs while undertaking their two week placements each year (Norington 1996).

Rural nurses have pointed to the considerable gap between what medical students and graduates receive in the way of incentives for doctors to work in rural Australia and what is available for nurses. The response from the Federal government has consistently been that nursing is a state government responsibility and nurses should look to their state health departments for support. Such support is hard to find and bears no comparison to that offered to doctors. Nurses who live in rural towns and work alongside doctors who are the beneficiaries of these schemes might be forgiven if they were more public in their criticism of these inequities. That there is not more grassroots complaining by rural nurses about these social injustices has more to do with the concern nurses have about their own employment prospects and the perceived needs of rural communities for medical services above other health services.

1.4.6 Rural nursing shortages

A considerable amount of attention has been focused on the doctor shortage in rural Australia. Just as important is the effect of rural doctor shortages on rural nurses. Where doctors have left rural areas or contracted their consulting time, nursing services have tried to continue to meet community health demands.

Nurses form the largest group of health professionals working in the provision of health services. As rural health services have had to adjust to changes, including the shortage of medical staff, the way nurses practise and their role and function have adapted also. How the rural nursing workforce is to respond to a falling number of rural doctors, changes in the way health services

are delivered, and their own changing profile is not the central focus of this study. It is likely, however, that the working relationship between rural nurses and doctors will be effected as both groups suffer a loss of experienced workers.

Studies conducted since 1991 show some alarming trends in the rural nursing workforce. Rural nurses are ageing, with the national average for rural nurses in the mid 40s (Blue 1993; AIHW 1997; Stephenson 1999). Rural nurses are becoming de-skilled due to changes in rural health services and have a low higher degree postgraduate participation rate than other groups of nurses (Buckley 1991; Blue 1993; Stephenson 1999). Some studies suggest that rural nurses are undervalued by the communities they serve (Hegney 1997).

Rural nurses working in towns where the number of doctors have fallen or from where doctors have gone altogether are faced with the task of expanded practice roles and added responsibility. Keyzer (1997) refers to nurses who perform medical roles as 'surrogate doctors' and acknowledges this occurs not because the nurses choose to practice this way but because there is little or no choice (Keyzer 1997). The fact is nurses in rural practice where there is a chronic shortage of doctors have to provide a level of health care service that meets the needs of their community. They cannot say to a mother who brings her child to the local hospital accident and emergency room with breathing difficulties: 'Sorry, I can't treat your child because the doctor is out of town and the treatment I may give is medical and not nursing'. On the contrary the nurse is more likely to make a thorough assessment of the situation and implement appropriate action, but in doing so is exposed to professional risk in undertaking procedures for which the nurse may not be trained or authorised to perform.

Evans (1994) conducted a study at a 42 bed rural hospital in NSW on an extended skills education program for nurses. The skills tested were intravenous cannulation, adding of medications to IV flasks, simple wound suturing and cardiac defibrillation. Nurses in the hospital were asked to record these procedures if they completed them during the one month survey period. It was found that although nurses had access to training on these four extended skills, they only performed four IV cannulations and doctors performed the overwhelming majority of these procedures (Evans 1994). Evans pointed out the cost charged for an after hours IV cannulation by a doctor is $122.00, and noted that if the same procedure were performed by nurses the cost to the community would be much lower.

Whether or not the nurse undertakes these procedures is determined by a number of factors, only one of which is the pressure placed on them by medical shortages. The outcome of these interventions by rural nurses depends heavily on the professional working relationship between the nurse and the doctor. In cases where the doctor knows and trusts the clinical knowledge and proficiency of the nurse, the nurse treats patients without the doctor being present and may not even consult with them. In other cases, the professional relationship is such that nurses are actively discouraged from taking any initiative without first referring to a medical opinion. Nurses operating in these circumstances are more likely to hesitate when faced with emergency situations where no doctor is present and may not be able to deal with an emergency in time. Depending on the seriousness of the emergency, hesitation by the nursing staff because they either lack confidence or skills can result in adverse patient outcomes, which further erodes the professional relationship between the two professionals.

Rural nurses have not entered nursing to practice medicine. They want to practice the best quality of nursing care they can. The identified barriers to this are an ageing rural nursing workforce, de-skilling due to health service changes and increased pressure to perform extended practice roles due to overworked or increasingly vacant medical personnel positions in rural areas. These identified stresses on rural nurses are in addition to the ones experienced when poor communication and collaboration with medical personnel exists.

1.4.7 Communication and collaboration

Poor communication and collaboration result in poor health outcomes. As long as the numbers of rural doctors continues to fall, age or suffer stress from high workloads, the important professional working link between nurses and doctors will face as yet unknown stresses. A deeper understanding and knowledge of the relationship can provide a foundation on which to build a more comprehensive and equitable interaction and improve the quality of patient care outcomes as a result.

The burden of poor or inadequate patient treatment resulting in death or iatrogenic illness is increasing in rural areas at a time when the health status of rural people is already below that of urban people (Humphreys 1992). Apart from distinctions in health status between urban and rural people, there are cases where an obvious flaw in the professional working relationship between the rural nurse and doctor or vice versa results in deaths and misadventures.

Death through misadventure. Tragic deaths of rural patients like the one described by Kriven (1994) highlight the potential for disaster when the relationship breaks down completely. In this case a 30 year old woman died of an overdose of drugs in a small rural hospital because the on-call doctor refused to attend and instructed the nurse to 'watch her' when the nurse called him at 1am in the morning. After an extended period of vomiting by the patient the nurse again contacted the doctor and was instructed to administer an anti-emetic drug. Finally the doctor did attend the patient at 4am but at 7am the patient had a cardiac arrest and died. During the Coroner's inquest that followed it was revealed that the nurse and doctor had been married but had separated. It was also found that both of them had failed in their communication with each other about the case and had made fundamental errors of judgement, which had contributed to the death of the patient (Kriven 1994). It is likely in this case that the personal and professional relationships of the nurse and doctor contributed to a sad outcome for all concerned.

Where the relationship is poor between nurses and doctors or collaboration is lacking, rural nurses bear the brunt of this dysfunction. Nurses working in rural towns where the doctor/s are hostile towards the nurses or regard them as their personal assistants are often reluctant to confront the offensive behaviour because the doctor may threaten to leave. Communities faced with a choice between supporting the local doctor or the nurse in a conflict may align themselves with the doctors because they reason that nurses are easier to replace.

Sophie Heathcote. One such example is the Sophia Heathcote case. This occurred in 1987 at a remote town in North Western New South Wales. The town did not have a resident doctor and relied on the Royal Flying Doctor Service (RFDS) for medical support. Sophie, the registered nurse at the time, sought advice about treatment of an Aboriginal patient via the HF radio to the RFDS doctor several hundred kilometres away. This conversation with the doctor showed that Sophie had summarised the patient's condition well and relayed this to the RFDS doctor, despite experiencing difficulties in hearing due to radio interference. An examination of the transcript of the conversation also showed the doctor to be fairly casual and relaxed about the assessment of the patient's condition and supportive of Sophie's management of it.

It was also clear that he had made a number of incorrect assumptions about the condition of the patient and the assessment made by the nurse. Despite this, in subsequent court actions the RFDS doctor received no censure for his actions. The doctor later admitted he would have done things differently and stated he interrupted Sophie when she was trying to relate information about the

patient to him over the radio (NSW 1988). Sophie had made checks and observations of this patient and discussed his management by phone with the hospital Director of Nursing and the RFDS doctor. Concluding he was not seriously ill, she allowed him to be returned to the care of the local police who had brought him to the hospital.

It was later determined that he had been experiencing alcohol withdrawal. The next morning the man was found hanged in his police cell. In a landmark case for all nurses, the NSW Nurses Board de-registered Sophie, claiming she was negligent and had failed to properly assess and manage the man who committed suicide in the police cells. In 1991 this judgement was overturned in an appeal four years after the original de-registration and Sophie was allowed to re-register as a nurse (Staunton 1991). It is interesting to note that of the seven individuals or organisations, including the RFDS doctor, who could have been held responsible in full or part for this tragedy, Sophie, the nurse, was the only one who suffered at the hands of the law.

This is a good example of where the professional communication between nurses and doctors is critical to safe outcomes of care. The relationship between the nurse and doctor in this particular case was a difficult one. It was conducted over distance and the nurse had only been working for eight months in the hospital and had no previous experience in rural or remote nursing practice. This is hardly a good foundation on which to build a working rapport with distant RFDS doctors. These examples of communication breakdowns and poor collaboration demonstrate that the cost to the community and society generally of ineffective professional relationships between rural doctors and nurses is very high.

1.4.8 The changing face of rural nursing

Other factors have also influenced the development and maintenance of professional working relations between nurses and doctors in rural settings. One of these is the acknowledged extended role rural nurses have been practising for some time.

Some clarification about extended and expanded roles is warranted to fully appreciate the impact this has on the rural nurse – doctor relationship. An *extended role* is generally one that involves extensions of a practitioner's traditional role for which they may not have had additional training or educational preparation. An example is a registered nurse who is not a qualified midwife caring for a pregnant woman but not delivering her baby, unless it is an emergency delivery and there are no other qualified personnel. An *expanded role* is generally one that follows specialist education, training or clinical skill acquisition. An example may be completion of a specialist program in operating room, accident and emergency or stomal therapy nursing.

Conflict in roles between medicine and nursing most frequently occurs when nurses undertake what has traditionally been seen as 'medical' work. This may include such procedures as making a diagnosis to initiate treatment, intravenous cannulation, wound suturing, prescribing certain drugs, initiating pathology specimens, taking X-rays and referring patients to other health professionals. Nurses currently lack the necessary legislative and professional systems of cover to protect them when undertaking these types of extended practice procedures, although several Australian States are introducing nurse practitioner legislation to provide a mandate for these practices (SADHS 1999). Rural and remote area nurses have for many years conducted these procedures with little or no professional or legislative sanction (Cramer 1989; Hegney 1997; (Buckley 1991; Hegney 1998).

In other words, rural nurses perform these procedures on a regular basis but have no legal or professional standing supporting this common practice. In general, this does not cause problems, but the Sophie Heathcote case shows the nurse is often the first to be criticised for practising in an extended or expanded role when something goes wrong and someone is seeking to attach blame.

Implementing effective nurse-doctor working relationships and providing clarity for both nurses and doctors can substantially reduce the overall cost of health care to rural communities. It can also provide a foundation on which the relationship can grow in a climate of mutual understanding about medical and nursing work and where the skills and knowledge of each complements the other. Moving towards this goal is an often discussed and reasonable objective but collaboration remains elusive.

1.4.9 Collaboration between nurses and doctors

This study reviewed a large body of Australian and international literature[1] on doctor-nurse relationships and collaborative models of practice. Two facts emerge. The first is that nurses have written the majority of the literature and published it in nursing journals. The second is that collaborative models of practice between doctors and nurses have been tried and few have been successful. Weiss (1985) is blunter when she comments on failures of collaboration between nurses and doctors:

---

[1] International literature was confined primarily to Western developed countries and countries where the cultural work practices between nurses and doctors are similar to those in Australia. It is acknowledged that some cultures in Asia, India and the Middle East have significant cultural differences between male and female co-workers in the health professions.

> The decline in nurses' use of collaboration implies that nurses did not find negotiation and involvement of others in mutual problem solving either an effective or possible behavioural strategy...Collaborating with individuals who are not collaborative is a difficult task. (Weiss 1985)

Failure of collaborative models. Generally failure of the collaborative nursing-medical models occurred when individual doctors or their medical unions withdrew support because they believed the outcomes might lead to encroachment by nurses on the practice of medicine. Or, in the opinion of medical organisations like the Australian Medical Association (AMA), nurses working in the delivery of primary health care services represent a potential threat to GPs in terms of competition for finances. Whether that threat is real or perceived is not the question. Nurses do not actively seek to set themselves up in competition with GPs; nor do they seek to practice medicine. They prefer to provide high quality nursing care.

Nevertheless, nurses do prefer collaborative models of practice. This is due in part to the way in which nurses work and the wide range of health professionals with whom they must interact in the organisation of care for patients. Medical political organisations like the AMA, on the other hand, actively work to destabilise collaborative models of practice, especially those in which nurses exercise a high degree of autonomy. Examples of this can be found in North American experiences where most collaborative model projects involving doctors and nurses collapsed after the introduction of independent nurse practitioners in the 1980s (Fagin 1992; Khanna 1992; Harvey 1985). There has been a similar reaction in Australia, where it has taken a decade just for the states to introduce the required legislation to allow nurse practitioners to take up these positions and practise. Over this time implementation of nurse practitioners has endured constant opposition from medico-political organisations (Coxhead 1993). This is despite the collaborative basis for practice of nurse practitioners.

The sheer volume of nurse-generated literature and research around collaborative practice and the relative paucity of medical opinion on the relationship between the two disciplines is perhaps indicative of the problem. As Ornstein (1990) remarked:

> ...before collaborative practice can begin, improvement in nurse-physician relationships must occur. (Ornstein 1990)

It may be the case that nurses need to have a collaborative working relationship with doctors, but that doctors see no need to reciprocate. It may also be that the core elements and benefits of a collaborative relationship have not been sufficiently understood by either group, so that nurses

fail to try new strategies and doctors fail to respond appropriately to any strategy. This is certainly the view of Mechanic and Aiken (1982) who concluded that the most important factor affecting the nurse-doctor relationship was the lack of understanding between the two groups and the particular problems each faced in their daily practice (Mechanic 1982).

Reasons for collaboration. In attempting to understand the essence of effective professional working relationships, consideration of some general principles around the reasons for collaboration is helpful. Casto (1994) in a book chapter about education for inter-professional practice listed several conditions necessary for collaborative programs to work effectively. These are outlined below.

- There needs to be a neutral base of operation to overcome professional 'turf protection'.
- Administrative support is required for the scheduling of meetings and observing team processes.
- There needs to be a shared interest and commitment, a real sense of the value of collaboration.
- Credit should be shared and all individuals' input recognised.
- Resources should be used for the benefit of the whole team
- A partnership needs to be developed with the community, as collaboration involving only the professionals will fail to meet the real needs of community.
- Collaborative practice does not come naturally; it must be taught and experienced.
- The challenge is to build horizontal connections between vertical structures; build bridges between the professions.
- Individuals and institutions need to be rewarded for collaborative endeavours. This may include links to promotion, salary and organisation funding.

(adapted from Casto 1994)

Casto concludes with a paradox of collaboration. This is particularly applicable to the relationship of nurses and doctors where there is an acknowledged power imbalance:

> The less power we have and the more power we give up, the more powerful our collaborative position will become. The more we give others credit for our work, the more credit our work will deserve. (Casto 1994)

1.4.10 The need for greater understanding

If we are to understand the complex relationship that exists between nurses and doctors, more work to establish how the relationship works and why it does not must be done. It is with these thoughts in mind that I, as a nurse, make yet another contribution to the existing knowledge base of the nurse-doctor professional working relationships and collaborative working models.

In conducting this study new information and perspectives can be added to the debate and previous studies of the doctor-nurse professional relationship. Of particular interest will be the unique professional partnership between rural doctors and rural nurses where there has been no Australian research and little descriptive narrative. On the surface it would seem rural nurses and doctors have more in common with each other than separates them. There seems to be evidence to support this view, at least in terms of the context in which they both practice.

It would be wrong to suggest that there are no functional collaborative models or effective working relationships between doctors and nurses operating in the Australian rural health care scene, but few of these have been documented. Equally, there is evidence pointing to dysfunctional relationships, which are hierarchical in nature and are more about power, control and self-interest than they are about the provision of quality nursing and medical care.

Before effective and productive partnerships between rural nurses and doctors can be achieved an appreciation of what makes collaborative models of practice work needs to occur. An even more basic step is for rural nurses and doctors to learn more about each other, not only in terms of professional skills and abilities, but also about the issues preventing effective working relationships. Only when this is achieved can true collaborative partnerships be formed where one professional does not control the other and where their practice is mutually complementary.

In this respect rural nurses and doctors have at least a common starting point. They both suffer from professional, educational and sometimes social isolation. They are expected to be expert generalists. They must work effectively together in an atmosphere of mutual respect and collegial trust and they must have a clear appreciation of each other's role and function whilst maintaining a degree of flexibility and autonomy that is the hallmark of rural practice.

If we accept that it is important for rural nurses and doctors to appreciate each other's practice and perspective, both groups need to understand the lessons of history. For in the case of medico-nursing relationships unless we are both prepared to learn from the past we have no future. Historical perspectives can be an accurate and impartial review of the facts or a jaundiced and distorted account of the reality. A search of both in the medical and nursing literature does,

however; enable an assessment to be made of the key historical perspectives. Some of these help and guide our perspective by a clear analysis of research on the topic, while others only serve to hinder by presentation of emotional rhetoric based more on the entrenched views of the ruling elites. One milestone in understanding how the relationship between nurses and doctors works and what behaviour it manifests is the often-quoted work undertaken by Stein in 1967.

1.4.11 The doctor – nurse 'game'

An objective overview of the literature reveals a rather unhappy picture that shows medicine and nursing in open conflict on many issues. The debate in the 1960s might be considered somewhat subdued by today's standards. Stein in 1967 described the so called 'doctor-nurse game' which defined the relationship between the two groups as being clearly hierarchical with doctors being the nurses' superior (Stein 1967). Nurses had to perform a delicately balanced act or behave as custom prescribed. They were expected to be bold, show initiative and take responsibility for making important recommendations to the doctor, but they could not make this look as though they were making the decisions about patient care. This was the domain of the doctor, and nurses learned to make suggestions in a somewhat submissive manner so that it appeared that the doctor initiated recommendations about treatment and management. The most important rule of the 'game' was: never challenge the doctor and avoid conflict at all costs. Elements of the 'doctor-nurse game' still exist and it is not uncommon to hear nurses return to it:

> Oh, by the way, Doctor, I notice Mrs. Smith has been febrile over the past 24 hours and her wound site and exudate show signs of possible infection. Would you like me to arrange for a wound swab to be taken for C&S? I have a form here. If you could sign it I will get on to it straight away. (I. Blue Personal comm.)

Of course all those who have played this game, or continue to, know that its origins came from an era when nurses were taught in very rigid and disciplined schools of nursing where subservience and 'knowing one's place' were high order behaviours. It was well understood that if a nurse made direct suggestions about clinical treatment of patients this was likely to be taken as an insult to the doctor's medical knowledge and competence. On the other hand, Stein points out that nurses were expected to communicate important knowledge to the doctor but they must learn to do it in an indirect rather that direct manner. Hence they use the 'doctor-nurse game' strategy which avoids the slippery path of conflict.

As the decades have passed, the seeds of discontent in the relationship between doctors and nurses have continued to spring up. They have been assisted in more recent times by the changing face of society and in particular the emergence of women from the status of an oppressed and disadvantaged group to a more assertive, confident and better educated workforce. Mechanic and Aiken reported the dissatisfaction of nurses in the relationships they had with doctors and doctors raised questions about the appropriate roles of nurses (Mechanic 1982, p.747). They pointed to the debate at that time being focused on 'the diverging interests and competitive strain between nursing and medicine' and concluded this caused both groups to be diverted from the core business of achieving optimum health care by working together effectively.

In a later review of the history of doctor-nurse relationships since the 1960s Stein et al. commented that while there had been significant social changes in the past 30 years the 'doctor-nurse game' was, like an old black and white movie, still being played out in many places (Stein 1990). Nevertheless, Stein and his two co-authors did acknowledge some significant historical changes that had impacted on the way nurses and doctors now interact with each other. These included the changes outlined below.

For doctors

- The public images and esteem of doctors had deteriorated.
- The commercialisation of medical care has reduced public confidence in doctors.
- Doctors are no longer seen as all important and are fallible.
- In a climate of specialised knowledge and expertise no one can know everything.
- There has been an increase (over 50% in some cases) of women in medicine. They have still been trained to play the game; but the elements of male domination and female passivity are generally missing.
- There is an oversupply of doctors and in some areas a nursing shortage.

For nurses

- A nursing shortage focused attention on the value of nursing in health care.
- There has been an emphasis on the relatively poor working conditions of nurses – low wages, limited clinical autonomy, and exclusion from health service management decision making.

- The image of nurses as handmaidens to doctors has changed to one of speciality-trained and certified advanced practitioners with consequently more independence and responsibility to patients.
- There is a greater dependence by doctors on nurses and their expertise.
- Nurses involvement in review and quality assurance has threatened doctors' authority in clinical decision making.
- The public perception of nurses has been enhanced by recent television dramas – All Saints (Seven Network), China Beach (Network Ten), E.R. (Nine Network) where nurses are portrayed in powerful roles often at the expense of the doctor. (There has been disagreement about the stereotypical roles of nurses and doctors in Australian television dramas by nursing professional groups, for example, Country Practice (Seven Network), The Flying Doctors (Nine Network) and G.P. (ABC TV).
- Nurses' involvement in review and quality assurance has threatened doctor's authority in clinical decision making.
- Nurses have embraced collaborative and multidisciplinary practice models more readily than doctors have. Such models have proved to be highly successful in certain practice areas (aged care, paediatrics, psychiatry and palliative care).

Stein et al. reflect on the extent of the historical change and the effect it is now having on the relationship between doctors and nurses and the hitherto 'doctor-nurse game':

> ...what is happening now is that one of the players (the nurse) has unilaterally decided to stop playing that game and instead is consciously and actively attempting to change both nursing and how nurses relate to other professionals. (Stein 1990, p.119)

While it may be true that nurses have stopped playing the game, structural processes and instrumentalities remain as impediments to nurses who wish to be treated as equal health care partners with doctors. The question also is: have doctors stopped playing the game? Do they still see nurses as a work group they control and who carry out their instructions without question? There is evidence that doctors still seek to actively control and limit the practice of nurses. For example, the majority of Australian state nurse registering authorities still have doctor representatives on their registration boards. The converse is not the case for nurses serving as members on medical boards. Medicine simply does not accept the view that nurses could make any contribution to the regulation, control and standards of their practice. And yet they have long sought to do just this to nurses.

The merits of whether or not there should be medical representation on nurses registering authorities cannot be addressed here. However, in terms of working towards improving the relationship and developing collaborative partnership it would seem a very important starting place to resolve this imbalance and the associated legislative controls on nursing which stem from it. Since the relationship between nurses and doctors is a critical one to the outcomes of good care, is it feasible and or likely that nurses will serve on clinical privilege committees when doctors are applying to gain admitting rights to a hospital? If this should become accepted practice it would be reasonable for doctors to sit on similar committees for nurses who are applying for the right to admit patients to a hospital as nurse practitioners.

1.4.12 Nurses seek a new dimension to the professional relationship

Despite these controls on the practice of nursing, in the recent decade nurses have worked towards a better future, whilst not forgetting the lessons of the past. Adamson & Kenny (1993) remind us of the period of rapid worldwide change nursing has experienced at a time when broader social changes have also occurred (Adamson 1993). Women's liberation and the women's health movement are but two examples. Adamson & Kenny also point to the advances made by Australian nurses in the areas of pay, working conditions and career structures over the last ten years of the twentieth century. In addition to change on the industrial front, nurses have become more articulate about what they want and have learned a new assertiveness that has challenged the traditional relationship between doctors and nurses and resulted in behaviour change by both groups.

In a study by Magee (1989) on nurse compliance to doctors' orders, it was found nurses are no longer willing to follow medical instructions without question. It was suggested the change could be attributed to the increasing self-esteem among nurses (Magee 1989). These more recent changes in the direction of nursing are an indication of a more confident, self-assured profession emerging from a history of constraint and limitation on practice. Nurses need to take responsibility for the direction in which the profession now goes and not be sidetracked by the legacy of old foes. These foes, real or imagined, may well come from nurses themselves who are still affected by being an oppressed group and behave accordingly. Opposition can also be expected from some quarters of medicine where there is a sense of loss in the relationship. In other words, sensing they have lost control over nurses' work and some might begin to regard nurses in the same hostile way they do chiropractors, homeopaths and many other alternative health professionals.

The need of medicine to exert control over nursing appeared in a campaign conducted by the American Medical Association (AMA) in 1993. The campaign tried to discredit the expanded role of nurses proposed under President Clinton's reforms of the American health care system. Johnson (1993) writes of the 290,000 members of the AMA issuing a 30 page, detailed report strongly criticising arguments that supported nurses moving into an expanded role. The AMA criticism is levelled at the education of nurses not being designed for the provision of medical care to a broad spectrum of patient needs and that nurses would not know when to refer a patient. The AMA claimed most patients are reluctant to receive basic care from a nurse, although Johnson asserts this contradicts Gallup polls which reveal 86% of consumers surveyed would visit an advanced practice nurse for primary health care needs (Johnson 1994).

In Australia many rural and remote nurses have worked in extended primary health care roles for decades, with no direct challenge from medical associations. It has only been when these nurses sought to have their practice roles formalised in the late 1990s that the attention of the medico-political organisations was aroused. The Australian Medical Association President Kerryn Phelps, in a newspaper article about the introduction of rural nurse practitioners, called for a 'balance between the skills of nurses and a community's need for doctors' and that doctor shortages would not be solved by using nurses (Stock 2000). Dr Phelps went on to outline the official and long held policy of the AMA in relation to nurses working outside the traditional roles medicine is comfortable with and what the AMAs meaning of 'balance' is:.

> Nurses are not trained in diagnosis or rational prescribing, and it is the medical profession's view that they should not be permitted to work without the supervision and collaboration of a qualified medical practitioner. (Phelps quoted by Stock 2000)

What these examples demonstrate is that the professional working relationship between nurses and doctors is a fragile one that is finely balanced and easily upset. While nurses work in the way doctors wish them to and both nurses and doctors accept that, there will be little progress in advancing the relationship to a more equal footing. In Australian rural practice it is likely the number of nurses moving towards the advanced nurse practitioner role will initially be small. This is because of the resistance they face from rural GPs and from conservative rural communities who continue to hold traditional views about medical and nursing roles. Understanding more about the professional working relationship of nurses and doctors in rural practice will go a long way towards building trust and goodwill from which new dimensions of practice can develop. The aims of this research are directed to this end.

1.5 Aims of the research

The study has as its focus the professional working relationship between rural registered nurses (RNs) and rural general practitioners (GPs). The need for the research is based on the premise that a greater knowledge and understanding of the professional relationship between these two groups of health professionals will lead to:

- improved outcomes of health care for rural people
- increased professional interaction, respect and support between rural nurses and doctors
- reduced interdisciplinary role conflict
- the identification of strategies which build on the strengths and reduce the limitations of the professional relationship between rural nurses and doctors
- clearer definition of the role and function for nursing and medical practice in rural areas
- development of collaborative practice strategies, particularly as it applies to rural health care practice
- creation of health service practice models which encourage good professional relationships between rural nurses and doctors.

1.5.1 Specific aims

1. to describe and understand the professional working relationship between rural nurses and doctors across four different rural case study sites
2. to analyse this relationship using a discursive approach, in order to understand the perspectives, characteristics, features and interrelationships between rural nurses and doctors
3. to analyse this data to construct models of practice operating between the two professional groups in the context of the four case study sites and their respective cultures.

The overall intent of the research is to describe and analyse the way in which nurses and doctors in four rural health settings work together. The internal and external factors that influence the development of the relationship and how individual nurses and doctors perceive the relationship and its various dynamics are also of central importance.

1.6 Summary

The genesis of this study is twofold. First there is my own history, interest and experience of rural life and, second, the paucity of research examining the professional working relationship of nurses and doctors in the rural practice context. The examination of literature on the subject of nurse-doctor relationships paints a picture which is pessimistic and from a nursing perspective distressing due to the absence of any real engagement or discourse from the medical professional.

Nurses should not be surprised by the general lack of interest by doctors in changing the relationship they have with nurses. After all, the relationship has been a long standing one born out of the necessity for medicine to have a group of willing workers to undertake the 24 hour care of patients who have undergone or are about to undergo medical procedures. Nurses have conformed to this role and developed their own culture around it, but this has been at a cost. The relationship has always been one where medicine has exercised control over nurses' work in various guises, some more subtle than others. This has resulted in the relationship being one of convenience for doctors and limitation for nurses.

Nurses have sought to change the status quo in the latter part of the twentieth century and in doing so have challenged societal values about the place of women in the workforce, the domination of one professional group over another and the traditional roles of nursing and nursing work. As nurses have moved to establish themselves as a profession in their own right, rather than an adjunct to medicine, the professional dynamics have been slowly altered. Nursing and medical commentators have described these changes from various philosophical and pragmatic perspectives. This research adds another voice to these discourses and will bring forward new understandings of the way nurses and doctors work together in the rural practice context. In Chapter 2 I focus attention on the rural nursing and medical workforces in South Australia, and the context of their practice domain. This assists in the understanding of the context in which the two professionals work and the influencing factors that shape and determine how their relationship operates.

Chapter 2

The nursing and medical workforce in rural South Australia

2.1 Introduction

Fundamental to this examination of the professional working relationship among RNs and GPs in the four rural case study sites is the context in which they live and work – rural South Australia. The environment where work takes place influences all working relationships and here I discuss some important aspects of rural life and health care professional practice. These include an examination of rural South Australia, defining rural, the nursing and medical workforce in the state and other workforce, education and professional factors pertinent to the focus of the study. An in-depth analysis of the nature of rurality, its lifestyle and the impact of economic and social change on the lives of rural people is beyond the scope of this thesis, however there are some important areas that explain the background in which the working relationship between nurses and doctors has been shaped and developed.

2.2 Rural South Australia

South Australia is largely an agricultural, urban centric state with large rural and remote expanses to its north and west. The capital of the state, Adelaide, was built and prospered on the gains of early pioneers who tapped the agriculturally rich rural areas outside Adelaide and generated wealth from primary industries in wool growing, cereals, mining, fishing and livestock production. The state's population at the last census in 1996 was 1,427,936, of which 978,100 (86.1%) resided in the major urban areas of Adelaide and 449,836 in other parts of the state. In June 1999 the total population of the state had only grown to 1,493,100, a growth rate of 0.4% and the lowest of all mainland Australian states (ABS 1999).

There are only two rurally located towns outside Adelaide with populations of more than 20,000 people. These are Whyalla with 23,382 in the northwest and Mount Gambier in the southeast with 22,037 (ABS 1999). Aside from these larger rural, regional towns, only a further six are in the population range 10,000-15,000. The remaining 143 towns in rural, regional and remote areas range in size from 200 to 8000 people and 90 of these are below 1000 residents. In population terms alone South Australia is described as a 'city-state' in which 70% of the population resides in the capital city, and the remaining 30% of the populous reside in the rural, regional and remote areas to the north, south and west of Adelaide. This distribution of the population has resulted in an urban-rural divide in geopolitical and economic terms.

The rural areas outside the capital city, Adelaide, have contributed significantly to the economic well being of the state since settlement by British pioneer immigrants in 1836. This legacy has been eroded by the impact of the global economy on the prices received by primary producers, changes in technology, and economic rationalist approaches to service delivery. These factors have changed the face of rural South Australia. Costs have increased in rural industries; family and business debt has risen rapidly, particularly among those who had borrowed heavily from banks. Rural businesses dependent on farming and mining for their incomes felt the squeeze as more primary producers were forced out. Unemployment levels in many rural areas rose sharply during the 1980s and 1990s and banks, businesses and eventually government services were withdrawn from many rural and regional areas across the state. Once thriving rural communities started to decline as populations moved away.

The 'Dying Town Syndrome' was a phrase coined by a person interviewed in a South Australian rural town and captured by the Australian Commissioner for Human Rights, when he released his investigative report *Bush Talks* (1999). This report described in graphic detail the parlous state of rural and remote Australia and was built from submissions and listening to rural and remote people talk about their lives and the devastation caused by rural decline (Sidoti 1999). My own early life and work experiences in a small South Australian rural community showed that these communities are self reliant, socially cohesive and stoic about their future. Much has changed since that time in the late 1960s when rural South Australia was a different place socially and economically. My Aunt, who lived with her family in a small rural town during this period, wrote about the changes that have occurred before, during and after this era. It is a revealing and powerful historical account and describes better than I can what changes have taken place in her life and her community and how they have impacted on her and her family. I have given the town a pseudonym of Mytown.

How far have we progressed?

In the 1940s, 50s and 60s there were two general stores in Mytown with fresh fruit and vegetables arriving twice weekly on the rail car – on Tuesdays and Fridays.

Bill Williams' store where Hilda Kelly now lives had a very good supply of quality tools, also manchester, shoes, some drapery, gifts and groceries. Bill had a small room at the front of the store for his barber room and most of the local men and boys had their hair cut regularly by Bill. His wife Pat also occasionally cut ladies hair. Bill had an agency for Elder Smith stock firm and also a Caltex fuel agency.

> On the other corner of the town, where Bunny and Ettie Tidswell lived until recently, Mr Dave Sampson ran the other store. He had a bank agency where transactions could be made. The Wudinna Bakery also delivered bread. Bread also came up from Port Lincoln. Pies and pasties, cakes and buns etc. could also be purchased.
>
> Pictures were held every Saturday in the hall and when a special film was available it was shown on two nights, Friday and Saturday. On many occasions stools were brought down from the Sunday school room in the Uniting Church for children to sit on in front of the hall and extra seating was brought in, as there was not enough for the number of patrons. The cinema is now held once a month and it is the only film evening held on a regular basis in the region. It is run entirely on a volunteer basis.
>
> Many years ago the doctor visited Mytown once a week and consulted in the hall. He brought his own receptionist and a small supply of drugs, bandages and ointments. The doctor has not consulted locally for over 30 years.
>
> The Post Office was open five and a half days a week and stamps could be purchased and parcels posted Saturday mornings. The Post Office is now a tiny building which is open for two hours from 9am until 11am Monday to Friday.
>
> Over 100 children attended the school with a staff of 7. The present total is 22 children with a staff of 3.
>
> Looking on the positive side, though, in 1959, which was four years after we were married, we delivered 100 bags of grain. Admittedly it was a rather severe drought but in 1997-1998 we delivered over 40,000 bags with the same number in manpower – two men and one 'dogsbody' – me!
>
> During this whole time span, fuel, fertilizer and farm implements have in some cases increased ten fold in price, whereas wool prices now compare with those gained in 1958. Grain prices are extremely low.
>
> (Murphy 1999)

On a recent visit to the town mentioned in this short story, it was all but a ghost town with the previous general stores boarded up and looking very neglected. Only a handful of residents now live in the town. Apart from the school and the local football clubrooms, the town is a shadow of its former self. Despite the difficulties faced by rural communities throughout the state, life goes on, as this quote from the 1996 *South Australian Regional Health Statistics Chartbook* illustrates:

> On an 'average' day in country South Australia, 12 babies will be born, 230 people will be admitted to country hospitals and 95 country residents will be admitted to metropolitan public and private hospitals. Country hospitals will have 850 acute inpatients, and will serve a nursing-home function for 400 long-stay patients. (Nguyen 1996)

2.3 Defining what is rural

Definitions are generally intended to assist understanding, give clarity or place in context a particular phenomenon. In Australia defining rural has been problematic because it carries with it a complex mix of social and geographical meanings. In purely literal terms it means a characteristic of the country as distinct from urban cities, but is often used synonymously with other descriptive terms (Delbridge 1995). These include terms that depict rural life – country life, country living, country people, rusticity – and terms that characterise rural work and social activities – rural economy, agriculture and bush dance.

For governments it is necessary to define what is and is not rural in order that allocation of resources and services can proceed in an equitable way. It is easy to see the contentiousness of this. The longest serving rural classification system has been the Rural and Remote Areas Classification (RARA) and the most recent, the Accessibility/Remoteness Index of Australia (ARIA). Appendix A provides an explanation of both and also highlights some of the other classifications systems and their main determinants. It shows the complexity of the various systems and exposes some of their vulnerabilities. Each of these classification systems has its own set of limitations in arriving at a suitable definition of rural. This is acknowledged by most, as did Strong et al. (1998) in comments about the RRMA classification:

> It is important to note that this method of allocating a SLA (*Statistical Local Areas)* to a rural or remote zone is not perfect. Both the size of SLAs and the distribution of the population within SLAs vary enormously. This can mean, for example, that within a remote SLA there can be pockets that are rural rather than remote, and vice versa. (Strong 1998)

In South Australia for health service administration purposes, country or rural areas are classified as including all local government areas (LGAs) and unincorporated areas north of Gawler, south of Willunga and east of Stirling (Nguyen 1996). These three towns are all within a 50 km radius of the centre of Adelaide. Other authors have described rural in varying terms:

> ...non metropolitan regions of Australia. (Blue 1995)
>
> ...rural Australia is seen by most Australians as 'the bush'. (Hegney 1996)
>
> ...It is classified as 'rural' for a number of reasons, for example farming is the primary industry, the populations of the towns are relatively small compared to the capital cities and the distance from Sydney is well over five hundred kilometers. (FitzGerald 1996)
>
> ...Rural Australia also includes large regional centres, as well as declining service towns, monofunctional mining towns and dispersed farming families. (Humphreys 1993)

While there may be difficulties defining rural in geographic and population terms, descriptions of rural people are more common. Humphreys et al. (1996) provided their own perspective of the characteristics of rural people:

> In general, rural people tend to hold more traditional religious beliefs, be more prejudiced, work-oriented, puritanical, ethnocentric, and tend to be more conservative on issues such as sexual relations, marriage, divorce, and abortion. (Humphreys 1996)

Rural may be described and made distinct from terms like remote, regional or country but in the end those people who live their lives there are not overly concerned by descriptions of where they live. They are more concerned if it means services like schools, hospitals, banks and businesses are lost because of a classification system which attempts to objectify the community by a measure they have had no say in forming or see as relevant. Indeed, none of the classification systems designed to classify rural have at their core the characteristics of rural people. The quintessential nature of people who choose to spend their lives living and working in rural areas is perhaps the real essence of rural and around which classifications systems and definitions should be formed.

Most Australians readily identify with the words and images used to describe rural dwellers – 'bushies' and 'country folk'. This is explained partly because many Australians have connections to rural areas, either through relatives who live in the country or having experienced part of their lives in a rural area. It is also because as a nation we are proud of our pioneering traditions and rugged landscape beauty, commonly portrayed in popular verse and films about Australian rural life.

The difficulties presented to early settlers in rural Australia were either overcome, became an accepted part of daily life or overtook them. Thus the legendary tales of our forebears describe characteristics of resilience, innovation, stoicism and plain hard work. One of Australia's revered poet sons, Henry Lawson, in a poem written in 1892 points to the sharp contrast in romantic views of the 'bush' held by city people and the stark reality of hard work and difficult living conditions. Ironically, the grasp of banks on the lives of rural people, evident in the last sentence of a verse in Lawson's poem, *The City Bushman*, has not changed in the last 110 years:

Though the bush has been romantic and it's nice to sing about,
There's a lot of patriotism that the land could do without –
Sort of British Workman nonsense that shall perish in the scorn
Of the drover who is driven and the shearer who is shorn,
Of the struggling western farmers who have little time for rest,
And are ruined on selections in the sheep-infested West;
Droving songs are very pretty, but they merit little thanks
From the people of a country in possession of the Banks. (Cronin 1984)

The reality as we enter the 21st century is that 72% of Australia's near 20 million inhabitants live in heavily populated coastal areas and cities and the remaining 28% are located in rural and remote areas characterised by sparse population density and small rural towns. Humphreys (1996) described the hallmarks of rural Australia as being large distances between settlements, inaccessibility to facilities and low population thresholds (Humphreys 1996). All of these factors have shaped the characteristics of rural people and in turn the practice of health professionals who go to live and work among them.

The romantic notions about rural life and rural work still persist and are in part responsible for the failure of governments to understand and remedy the disparity between the health of urban and rural living Australians. Changes implemented during the 1990s to rural health care service delivery and in particular to the professional groups, who provide it, have been led by rural health care workers. They have formed their own professional associations and alliances and through consensus have convinced governments to alter their policies and provide funds to improve the health status of Australians living outside capital cities.

In this process, the character of the health professional workforce has been changed. It has changed in a way that has allowed the rural health voice to be heard and to be valued. In the early part of the 1990s there were few recognised groups representing the interests of health professionals. It was a case of the most vocal, organised and resourced groups gaining the ear of government. Politically motivated rural general practitioners played a significant role in shaping the characteristics of what is now recognised as an accepted branch of medical practice. This was demonstrated with the establishment of Australia's first college of rural and remote medicine in 1997. The Australian College of Rural and Remote Medicine (ACRRM) claims it is the peak national body responsible for setting and accrediting professional standards for rural and remote medical practice but there is still some contestation about this from older more established

medical colleges like the Royal Australian College of General Practitioners. The important point is that ACRRM is making a claim for the right to determine rural and remote practice standards. Australian rural nurses have also formed a national association, the Association for Australian Rural Nurses (AARN) in 1991. While ARRN has not achieved the same attention or funding as rural doctor organisations it has highlighted issues of professional significance for rural nurses.

In summary, defining rural is a fruitless exercise given the wide diversity of places and people that make up country or rural Australia. Classification systems that determine what is and is not rural are flawed but will continue to be used in the absence of any other method of allocating resources to rural communities in an equitable way. The characteristics and profile of the people who live and work in rural Australia should play a more prominent role in determining rurality. If rural people call themselves such, they must have a reason for doing so. Whether this is because of a need for identity, a sense of belonging, financial advantage or a determinant of health status seems of more significance than a precise and elusive definition of who and what is rural. For the purpose of this study, rural is taken to mean those areas outside a 50 km radius from the capital city centre and to include diverse small towns and larger population centres with agriculture or primary production underpinning them. Residents in these areas are of mixed age, occupation and ethnicity. Chapters 4, 5, 6, and 7 detail the four case study sites used to examine the working relationship of nurses and doctors. They contain a more detailed analysis of rurality at a local level.

2.4 Characterising rural nursing and medical workforces in South Australia

Detailed information about rural nursing and medical workforces in South Australia is not easily accessible. While it is relatively easy to establish the numbers of nurses and doctors because both groups operate under an act of Parliament and have a registering authority, no comprehensive profiling has been completed of the rural workforce in the state. Rather, it is more common to find oblique references to them in various national reports and obscure databases.

It is, however, possible to build a socio-demographic picture of rural nurses and doctors across rural and remote areas of the state, although there is a paucity of information and analysis around professional issues such as job vacancies, skill levels, education and training needs, distribution according to community health needs and factors that attract and retain rural health professionals. There has been a concentrated effort to address the gaps in knowledge around many of these issues in recent times, particularly for the rural medical workforce. Much of the detail presented

here about nursing and medical workforces has only become available within the last five years. To gain a perspective of the numbers and location of nurses and doctors in South Australia, Figure 2.1 provides a comparison of rural and urban RN and GP workforces.

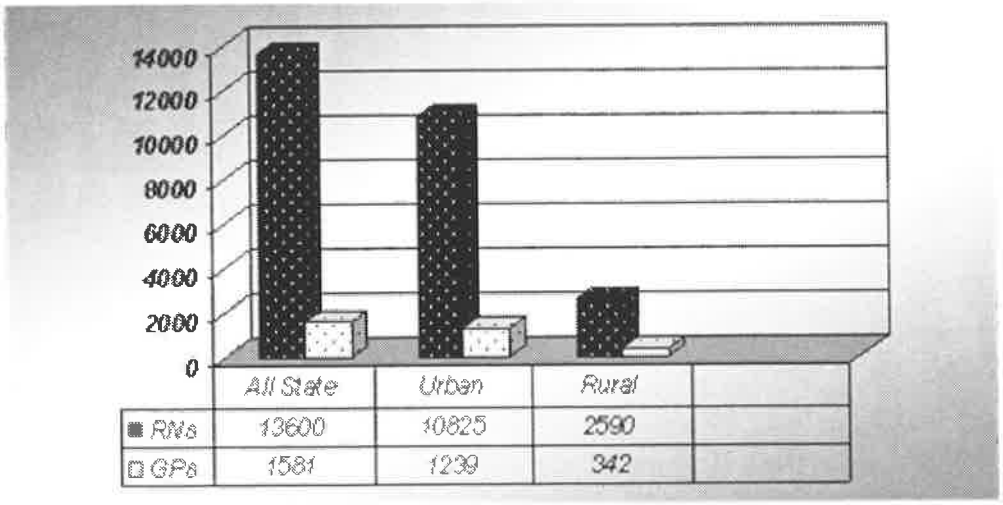


Figure 2.1 Location of employed RN-GP workforce in South Australia, 1996 (Australian Institute of Health and Welfare 1997)

Like all Australian states and territories, South Australia has the majority of its health workforce located in its capital city. The numbers of health professionals and their distribution drops progressively and dramatically as the distance from the capital city increases. The consequence of this is higher ratios of population per health professional. In South Australia the numbers of GPs per head of population in metropolitan Adelaide is around 1:582, whereas in rural South Australia it ranges from 1:1060 (outer Adelaide) to 1:1468 (Murray Lands) (Wilkinson 2000).

Of the estimated 2590 registered nurses employed in rural South Australia in 1996, approximately 1,700 or 65% worked in public hospitals and community health centres, and the remaining 890 in private hospitals, Aboriginal health services, private businesses, such as GP consulting rooms, and other non-government services (DHSSA, 1998). This represents only 16.4 % of the state's total RN population (15,814) working in rural areas and serving a population of approximately 449,000 people. Therefore, the estimate of nurse per head of population across rural areas of the state is 1:173. This compares with the Adelaide metropolitan area that has a ratio of 1:75 nurses per head of population.

Comparisons between RN and GP ratios in rural South Australia show that there are numerically more nurses than doctors and they are distributed more evenly. GPs are fewer in number, are concentrated in larger rural regional centres and serve a higher population per head of GP. The number of GPs per head of population drops as the size of the rural town decreases. In some cases this leaves rural communities with one GP to service approximately 1,500 people.

2.4.1 Registered Nurses (RNs) in rural South Australia

The terms 'registered' and 'nurse' are defined under the *South Australian Nurses Act* (1999) as being recognised terms, and can only be used by persons who are eligible for registration if the conditions outlined below are met.

- The person has qualifications approved or recognised by the Board to be necessary for the purposes of registration under this Act.
- The person has met the requirements determined by the Board to be necessary for the purposes of registration under this Act.
- The person is a fit a proper person to be a registered nurse (NBSA 1999).

Nurses who meet these criteria are eligible to call themselves registered nurses or RNs and, providing they have paid the prescribed fee to the Nurses Board of South Australia and have a current practising certificate, can be employed to practice as an RN. RNs working in rural South Australia fall into one of three levels of clinical nursing. Level 1 is the beginning RN level and the majority of nurses are in this category. Level 2 is a Clinical Nurse category reserved for nurses who have been promoted due to their seniority, experience or additional qualifications. Level 3 is the most senior clinical category for nurses who have a clinical management role and usually carries the title Clinical Nurse Consultant, or Nurse Unit Manager if the role is a management one. Other more senior classifications apply for management and administration nursing roles. From the Australian Institute of Health and Welfare (AIHW) 1996 collection of data the following statistical profile can be drawn about rural nurses in South Australia. The 'typical' rural RN profile is as follows.

Typical registered nurse profile in rural South Australia

female of Australian birth
average age of 39.6 years within a mean ranging from 36.7 – 41.9 years
classified at RN level 1
work an average of 29.5 hours per week
estimated average FTE income $45-50 thousand p.a.
prepared for registration in a hospital apprenticeship system
no university or postgraduate qualification. (AIHW 1999; Blue 1993)

More recent surveys and statistical collections have provided additional information that allows further analysis of rural nurses in the state. A majority of nurses who work in rural areas of the state are located in the larger regional centres and are employed in the public hospital system.

Since there are only two regional centres with populations over 20,000, most nurses are concentrated in regional health services in the cities of Mount Gambier in the southeast of the state and Whyalla in the northwest. Outside of these two larger centres approximately 2000 RNs are distributed across 54 small rural hospitals and health services (DHSSA,1998).

In 1998 the South Australian Department of Human Services Nurse Labourforce Bulletin reported the number of full-time-equivalents (FTEs) nursing positions had declined in rural hospitals of the state while at the same time metropolitan nursing numbers had increased. The report also noted a larger number of rural nurses working part-time when compared with metropolitan nurses. The number of RNs as a percentage of all nurses was considerably lower in rural areas (65%) than in metropolitan (82%) (Whitford, 1998). This reflects the higher proportion of enrolled nurses working in rural health services. A 1998 national survey of rural nurses by Stephenson, Blue, et al. (1999) showed a number of features characteristic of rural nurses.

- Rural nurses work where they live.
- They tend to remain in the same location for long periods.
- The number holding dual certificate qualifications, such as midwifery, was high.
- Very small proportions hold mental health qualifications.
- About 55% of the sample (n=1390) was engaged in some form of postgraduate study or upgrade of their initial nursing qualification (Stephenson, Blue, Petkov 1999).

The same study also revealed the main reasons given for working in rural areas were the healthy environment, lifestyle or being born and raised in a rural area. The main types of nursing work undertaken by nurses in the Stephenson, Blue & Petkov study reflect the diversity of rural nursing practice and included aged care, general medical and surgical, palliative care and accident and emergency. The study pointed to an increasing number of rural nurses adopting management and administration roles and the most number of nurses in the study nominated management as their choice of additional qualification, followed by accident and emergency and palliative care.

Many of the findings from this national study can be extrapolated to nurses working in rural South Australia. It shows a workforce dominated by women in their late 30s, educated in the hospital apprenticeship style of education, working part-time and with 5-10 years of nursing

experience. Few hold university qualifications, but many have post-registration certificates in midwifery and specialist areas of nursing practice. They are a stable workforce and have chosen to live and work in rural areas for family and lifestyle reasons.

The health service and social climate in which they work has changed dramatically over the past decade with reduced resources, social problems and consequent ill health brought on by rural decline. Shortages of skilled nurses in rural areas have started to emerge as a major workforce problem, particularly in the areas of midwifery, mental health and general nursing. Some rural health services are continually experiencing problems recruiting staff as present staff leave or retire, and in providing sufficient inducement to retain those they have. There is a heavy reliance of many rural health services on agency nursing staff to act as short to medium term replacements for rural nursing staff and this is a very costly option.

Limited, and some would argue belated, government action to overcome shortages of nurses in rural areas has been taken. One example is the introduction of the South Australian Department of Human Services Rural Education Scholarships in 1996. These scholarships offer $5000 per year to selected medical, nursing and allied health students who live in a rural area and undertake an undergraduate health science degree in one of the states three universities. On completion they are required to work for a defined period of time in a rural area. An analysis of the effectiveness of these scholarships in meeting shortages for nurses in rural areas has not yet been undertaken.

2.4.2 General practitioners (GPs) in rural South Australia

The term 'general practitioner' requires some clarification, as numerous definitions exist to describe the role and function. The Royal Australian College of General Practitioners defines a general practitioner as:

> ...a doctor who provides primary, continuing, comprehensive whole-person care to individuals, families and the community. (Bridges-Webb 1996)

Other definitions state that to be eligible to claim Medicare scheduled fees, a GP is:

> ...a medical practitioner who is vocationally registered or holds a Fellowship of the Royal Australian College of General Practitioners and meets the requirements of the College's Quality Assurance and Continuing Medical Education Program, or is undertaking approved training for the Fellowship or equivalent College-approved training. (Bridges-Webb 1996)

All doctors, including GPs, are registered under an act of Parliament in the same way as nurses. The *South Australian Medical Practitioners Act* (1983) governs the practice of medical practitioners. The majority of GPs working in rural South Australia are engaged in business entities that are either independently or group owned by GPs.

Compared to nurses, the information on rural GPs is more detailed and recent. As medical shortages in rural Australia became apparent during the early 1990s and were made a political issue by rural medical lobby groups, the research and collection of workforce data about rural GPs increased. Assisted by considerable Commonwealth government funding, an extensive number of reports, studies and profiles have been completed over the ten-year period 1990-2000. One of these by the Australian Institute of Health & Welfare stated there were 434 'rural primary care practitioners' (GPs) in rural South Australia in 1995. Of these, 335 were male and 99 female (AIHW 1997).

More recent figures from the South Australian Rural & Remote Medical Workforce Support Agency (SARRMSA) indicate a loss of 102 rural GPs in the five years, 1995-2000. SARRMSA estimated the number stood at 332 in 2000; 73 of these were female (Thompson 2000). Wilkinson (2000) reported the percentage of females in the national general practitioner workforce was 32% and South Australia at 31% has the lowest proportion of female GPs in all Australian states and territories (Wilkinson 2000). Using the SARRMSA estimates, South Australian female GPs represent 22% of the total GP population. From available data collections and reports the following profile of a 'typical' GP working in rural South Australia can be constructed.

Typical general practitioner profile in rural South Australia

male of Australian birth

45% aged 45+ years and 133 (40%) in the 45-64 age bracket

average number of people sharing a GP = 1262

work an average of 51 hours per week, plus on-call work

average consultation per patient = 5.6

96% of work time spent in private consulting rooms with the remaining time in hospital and home visits

estimated average FTE income $177,591 p.a.

The Australian Medical Workforce Advisory Committee (AMWAC) report in 1996 made the following observations about the differences between rural and urban GPs:

> ...rural GPs see more patients but see them less often, charged a higher co-payment, and worked significantly longer hours. (AMWAC 1996)

A later report published in 1998 on general practice in Australia found the following characteristics of rural GPs.

- Relative to population distribution, there are fewer rural GPs.
- They have a heavier workload, provide a wider range of services, and when on call they are more likely to be called out.
- Like urban GPs, rural GPs feel isolated, but unlike their city cousins isolated by distance and the impact of this on them and the communities they serve.
- The need for enhanced skills in accident and emergency, major surgery, anaesthesia and obstetrics is higher because of the lack of these specialties in rural areas.
- Rural GPs have a closer relationship with their community. This means greater expectations around issues such as confidentiality and privacy.
- Social, personal and family lifestyle factors are high priority issues when attracting and keeping rural GPs.
- Female GPs working in rural areas encounter additional problems related to security, role conflict and lack of social support, in particular childcare.
- GPs in small rural communities find working with a limited range of other health care professionals, like nurses, can sometimes lead to tension.

Positive aspects of work as a rural GP were also reported, including those noted below.

- Rural GPs experienced high levels of satisfaction because they worked as 'true' GPs.
- once settled into rural GP practice, improvement in personal and professional development is likely.
- They enjoy working with other health professionals in a team environment and gain valuable insights into their local community.
- Rural GPs also reported feeling proud about their status in their community and their role as leaders and as persons who can be trusted in difficult times (McLoughlin 1998).

These positive aspects of rural practice have generally failed to encourage graduates from Australian medical schools to live and work in rural areas. The use of temporary resident doctors (TRDs) and overseas-trained doctors (OTDs) to fill the many gaps in rural South Australian practices has been a common feature during the five year period 1995-2000. There are critics of the long-term use of TRDs and OTDs to resolve the shortage of medical practitioners in rural areas and they point to this being a short-term solution (McLoughlin 1998; Wilkinson 2000).

Of the approximately 330 GP workforce in rural South Australia, 88 or 26.7% were born outside Australia and in the period 1981-1995 only 18 doctors arrived from overseas countries to work in rural South Australia. Although figures are not available to confirm it, anecdotal evidence points to a dramatic increase in this number, particularly from South Africa in the period 1996 to 2000. This has been as a direct result of overseas recruitment by agencies such as the South Australian Rural & Remote Medical Support Agency (SARRMSA) and the South Australian Centre for Rural & Remote Health (SACRRH).

2.4.3 Educational preparation for rural nursing and medical practice

Nurses and doctors are prepared in four separate university undergraduate programs in South Australia's three universities. There are two medical programs. One is the Adelaide University Bachelor of Medicine (BM) and Bachelor of Surgery (BS) and is a six-year program. The other is the Flinders University of South Australia Graduate Medical Entry Program which is a four year program culminating also in a BM, BS qualification. The University of South Australia and the Flinders University of South Australia offer a Bachelor of Nursing degree, which is three years in duration. Upon completion of both undergraduate medical and nursing education, graduates are eligible to register with the medical and nursing registration boards in South Australia.

There is no educational intermixing of either medical or nursing students for combined learning and both curricula contain no obvious attempt at interdisciplinary knowledge and understanding. Nursing and medical students may find themselves working alongside each other while undertaking their respective clinical experiences as undergraduates but there is very limited opportunity which allows the two disciplines to share curriculum content or learn more about how they will be expected to work together after graduation. The Flinders University program does, however, require its medical students to undertake a four day nursing attachment prior to the commencement of the third year of the course. During this attachment students are expected to undertake basic nursing tasks. This experience assists them more with patient handling skills than in understanding the role and function of nurses or encouraging team building. If this does

occur it is a peripheral benefit and for this reason the current attachment is to be encouraged. Adelaide University medical students have a similar exposure to nursing activities designed more to provide students with some of the basic skills of nursing care rather than awareness of nursing and the role of the nurse.

Medical school intakes analysed by the AMWAC report in 1996 were found to have a significant maldistribution in the origin of students entering medical programs, with rural and remote students under-represented. AMWAC reported that in 1995 there were 688 more medical students than six years earlier in 1989, but of this number only 12.8% of students were from rural and remote areas. By 1995 the overall proportion of rural and remote students in medical school intakes was 7.9%, up only by .4% on the 1989 figures (AMWAC 1996).

Participation by rural students in nursing degrees at Flinders University and University of South Australia are far in excess of those for medicine. There are several reasons for this. Firstly the University of South Australia conducts the only rural, regional nursing program in South Australia at its Whyalla campus and 95% of the students enrolling in this program come from rural areas in the State. This program has been conducted since 1990 and has graduated 280 students over the nine year period, 1992-2000. Secondly, in 1997 a program commenced at Whyalla Campus offering the full three year degree by external or flexible delivery across all rural and remote areas in South Australia. This external or flexible delivery program has been very popular with rural students who can study the degree and undertake clinical experience in local health services. The University of South Australia School of Nursing and Midwifery in Adelaide commenced the same external program in 1998 with all three years of the program now available to rural students. Thirdly, nursing education was transferred to the university sector progressively during the 1980s and completed in 1993. This meant all rural hospital schools of nurse education progressively closed and rural students had no option other than to enrol in either of the two universities in Adelaide or the University of South Australia Whyalla campus.

Through the 1990s a number of national and local reports have called for greater curriculum content about rural health issues and increased exposure to rural clinical practice experience by health professional students in nursing and medicine. These reports coincided with the general movement by rural health practitioners to have their practice acknowledged and with research highlighting the different nature and context of rural health professional practice. One such report, *General Practice in Australia: 1996*, recommended medical schools be funded to bring about change in nine target areas relating to improving rural clinical practice and student experience of it.

These areas included:

- increased recruitment of rural students into medical courses
- development of curriculum suitable for future rural doctors
- a minimum of eight weeks of structured rural clinical placement, half of which should be in general practice and the other in rural hospitals
- improved educational support for rural clinical teachers
- increased rural presence of academic staff and appointment of rural based staff
- credible assessment of matters relating to rural health that involves rural practitioners
- support systems for rural students, including rural student clubs
- support for academic departments of general practice within medical schools
- cooperation with state-based agencies and rural GPs to improve the coordination of rural student clinical placements (Bridges-Webb 1996).

A South Australian report (Bridgewater 1998) examined the undergraduate rural and remote education and experience of health disciplines in the state's three universities and found the following.

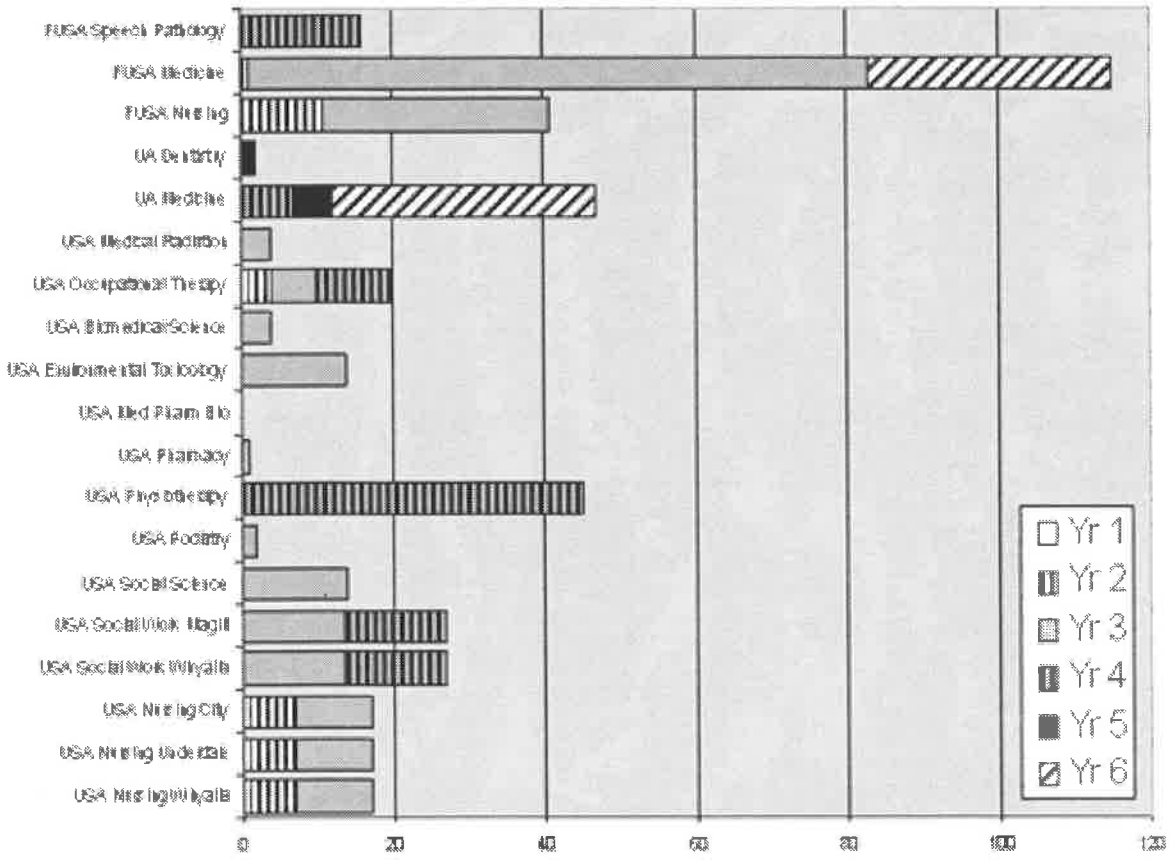
- There was low rural health and practice issue content in health science curricula.
- A wide variance of rural clinical placement weeks existed across disciplines, from two weeks to 12 months and these were not compulsory.
- Of 15 health science programs, only two (Occupational Therapy and Nursing) undertook rural placements across all years.
- Medical and nursing students had the highest attendance and allied health students the lowest in rural clinical placements.
- Reward and support for rural clinical supervisors were inconsistent and poorly coordinated.
- Databases that assist placement coordination needed improvement, as did the overall planning and coordination of students undertaking rural practice experience.
- Student preparation and orientation for rural clinical practice was ad hoc and ranged from a minimum of one hour to a full day seminar.
- Financial barriers such as travel and accommodation were major disincentives for students to undertake rural clinical placements.
- Multidisciplinary student placements were valued highly by students but were impeded by being additional to the normal clinical placement, timetable constraints and the need to retain the discipline specific elements of the placement (Bridgewater 1998).

The report made 12 recommendations designed to remedy the identified problems and encourage health science schools, students, supervisors and health agencies to adopt change. Medical schools have responded to these calls in various ways, aimed at increasing the number of rural students entering medical school, raising the profile of rural practice through undergraduate rural student clubs and supporting more students into rural clinical placements. It is important to note that medical schools have been supported in these endeavours by considerable Commonwealth government funding.

The Commonwealth Government's 2000 Budget committed $117.6 million to establish nine medical clinical schools in rural and regional locations throughout Australia. This has provided a major stimulus to increase not only the educational preparation of future medical graduates in rural health care practice, but also a long term strategy to address the chronic shortages of medical personnel in rural and regional areas. In announcing the schools the Federal Minister of Health said they would 'enable about 25% of medical students to receive at least 50% of their training in rural and remote areas' (Hailstone 2001). The extent to which these initiatives will increase actual placements in rural areas, change the attitudes of students to regard rural practice favourably and eventually work there, is yet to be seen. There is an acceptance, encouraged by large funding grants, for the two medical schools in South Australia to introduce rural clinical placements with each school adopting a different approach. Figure 2.2, based on the Bridgewater (1998) report, shows Flinders University having a greater number of rural placement weeks than Adelaide University, particularly in the third year of their four year graduate medical entry program where a one year placement in a rural area can be taken.

Figure 2.2 also shows rural placements for nurses in their third and final year at both Flinders University and University of South Australia of up to 10 weeks duration. While the opportunity for students to undertake a rural clinical placement has been available, it has not be promoted as a valued placement nor is it considered by many health science schools as something which should be compulsory. Bridgewater noted in her report:

> ...encouragement of rural placements ranged from active to less than neutral.
> (Bridgewater 1998)



Legend: Medical Pharmacy Bioscience = Medical and Pharmaceutical Biotechnology

Figure 2.2 Weeks incorporating rural placements, 1998
(from Bridgewater 1998, Figure 1.1, page 7)

Aside from encouraging the placement of students in rural areas there is the issue of rural content in the medical and nursing curricula. Several reports have noted this is minimal and is restricted to the final years (Bridges-Webb 1996; Bridgewater 1998). For medical curricula this is changing rapidly. The advent of Commonwealth funding initiatives to increase rural practice experience in the undergraduate program will continue to have a high priority, with the establishment of national rural clinical schools where the focus will be directly on preparing medical graduates to work in rural practice.

Formal teaching in medical and nursing curricula about rural communities, their health status, rural practice and working with other health professionals, particularly nurses, has been inadequate. Adelaide University medical school reported it allocated 'two workshops' in sixth year, duration unknown, in 1995 to formal teaching about rural communities and the Flinders University medical school a more substantial 12 week research elective (Bridges-Webb 1996). Adelaide University fourth year medical students were also required to complete a research project over a six-week period.

In 1997, six students received support from the Rural Undergraduate Medical Placement program (RUMP) to study in a rural community (Bridgewater 1998). However, this represents a fraction of the total student cohort. Exposure to rural health concepts, rural practice and rural nursing experience in nursing at either the University of South Australia or Flinders University is inconsistent. There are no identified subjects or courses within the undergraduate degree in rural health or rural nursing practice. Since 1997 there has been a slow introduction of some of these concepts, first with Aboriginal health and then with introductory content for rural health and rural nursing when the first year of the Bachelor of Nursing was offered by flexible (external) delivery in 1997-1998 (Bridgewater 1998). An elective course in rural and remote nursing has been written at the Whyalla Campus of the University of South Australia and will be offered in 2001 to third year students.

In summary, educational preparation for rural medical and nursing practice and developing professional relationships is underdeveloped in South Australia. Each curriculum has as its main focus mainstream health and professional aspects of acute care in the metropolitan context. There is no evidence of interdisciplinary mixing of medical and nursing students in the academic or clinical environments save a few days where medical students undertake nursing work in an acute hospital setting. Long term funding commitments have been made by the Commonwealth government to ensure a substantial proportion of medical students receive a more thorough preparation for and understanding of rural clinical practice. The same cannot be said of nursing where there has been no cohesive and consistent approach between the two universities preparing registered nurses about rural health content in the curriculum and where there are limited opportunities and encouragement for high quality rural clinical placements.

Since 1998, however, there have been encouraging signs of change in the educational preparation of medical and nursing students in South Australia. The medical changes have occurred largely as a result of Federal government funding in response to the rural medico-political lobby groups and the need to reverse the crisis in medical shortage in rural and remote regions of the country. The nursing changes have mostly been at the margins and driven by a few nursing academics who appreciate the value of including rural health in the curriculum and exposing their students to rural clinical practice. There is inadequate internal university funding allocated to supporting rural clinical student placements and certainly nowhere near the expenditure received by medical schools to develop the rural curriculum and allow more students to undertake rural clinical experience.

2.4.4 Rural and urban practice differences

To understand where rural practice sits in relation to urban practice some understanding of how specialisation influences the debate needs to occur.

The place a health professional occupies in the overall health care system defines them and their practice. Health professionals work in teams, as individuals and in partnership with patients or clients. In nursing and medicine there has been a great deal of specialisation that brings with it advantages and disadvantages. With specialisation comes prestige, power and market control. In Evan Willis's book, *Medical Dominance* (1989) he describes Peterson's (1978) view of the origins of medical specialisation:

> Medical specialisms, she argues, cannot be explained by the technical innovation or the desire for research. Rather they were more related to survival and ambition as a form of entrepreneurial behaviour as medicine became transformed into a business activity. The career benefits from this form of medical individualism were not so much related to income only but also reputation building in terms of connections and visibility. (Willis 1989)

Specialisation allows membership of an elite group and a great deal of energy and time goes into protecting it from others. The establishment of specialist colleges, such as the Royal Australian College of Surgeons, protects the interests of their members and controls entry through a rigorous process of qualification and assessment by peers. The place general practice occupies in academic institutions is very small in comparison to other specialties of medicine. The *General Practice in Australia: 1996* report noted undergraduate general practice units in medical schools were very much the 'poor cousin' when it came to funding, staff and research activity. Appointments of Chairs of General Practice only began in 1975 and in 1991 there were only 30 academic GPs in the 10 medical schools in Australia (Bridges-Webb 1996). Kamien and MacAdam (1991) acknowledged the difficult task ahead to get general practice recognised as a vital academic contributor to the future generations of GPs:

> ...there will be further development of academic general practice. There is equally no doubt that the task will be difficult, the problems great, and the rewards fickle. (Kamien 1991)

If academic general practice is in such a weak state in comparison with other branches of medicine it is hardly surprising that rural GPs have faced considerable difficulty getting the context of their practice recognised as being different from their urban counterparts. The evidence

that the style and type of practice undertaken by rural GPs is different from urban GPs has emerged over a ten year period 1990-2000. In a 1991 study of 231 GPs, 177 of which were rural, across three Australian states designed to make comparisons between characteristics of practitioners – morbidity managed, treatments provided and availability of support services – a number of distinctive features about rural GP practice were noted. These included: a considerable variance in the characteristics of the practice according to the size and remoteness of the population, a higher workload, more salaried or sessional work, a tendency to be older and working in a solo practice, more procedural and emergency medicine, fewer home visits, more hospital visits and the management of similar problems to urban GPs – respiratory system, skin, cardiovascular and musculoskeletal conditions (Britt 1993).

Later studies, including a national one of 1373 GPs by Strasser, Hays and Kamien in 1997 showed rural GPs as working harder, requiring a broader range of skills, working in a different socioeconomic environment and having more difficulty accessing continuing professional education opportunities (Strasser 2000).

Descriptions of the distinction in practice between rural and urban nursing are not well defined in Australia. There have been numerous studies examining the role and function of rural nurses but none that have made direct comparisons between similar types of nursing work in metropolitan and rural areas. Questions have been raised as to whether or not rural nursing is a specialty or if it is the same as urban nursing except the context in which it is conducted alters the way in which nursing is practised. There are some parallels in this regard between nurses and GPs where neither has been prepared specifically for rural practice per se. In a national two-phase study, 72 rural nurses were interviewed in 1994 and in the second phase in 1996 a randomly selected number of rural health services (129) was chosen to undertake an observation of nurses at work over one full day shift. Nurses in the study described their practice as:

- different from urban nursing because we do not 'see the patient through' if they are sent off to another referral centre (if acutely ill)
- having less facilities at their disposal and have to adjust
- often in isolation from peers and other levels of support and have to take the initiative
- working more closely and collaboratively with doctors
- being required to know individuals in their community very well
- needing to practise effectively across a wide range of skill levels necessary to manage complex issues (Hegney 1997).

When comparing the characteristics of practice for any health professional group with say an urban setting the rural context changes the way things are done. There are also characteristics shared by the various groups. These include changes to role, function, status and remuneration and a broader, more diverse range of practice in a climate where expectations are often higher because of the high visibility of health professionals in the rural community (Blue, 2002).

2.5 Summary

This chapter has contextualised the study of rural nurses and doctors by providing a background of the rural areas of the state and the respective profiles of nursing and medical workforces. These workforces are concentrated mostly in the larger regional towns where they work in conventional nurse-doctor roles in acute hospital settings. With one exception there is no rural hospital or health service outside the metropolitan area of Adelaide where there are resident medical staff available for nursing staff to call. The nursing workforce is almost entirely employed within the public hospital sector and the medical or GP workforce consists mainly of private medical practitioners.

Outside the larger regional hospitals, dozens of smaller rural hospitals and health services serve population centres ranging in size between several hundred to several thousand people. The health of these populations was not discussed but in general is worse than those who live in the urban areas of the state. The distance between these rural towns increases the further north one travels in the state and in some cases can be hundreds of kilometres. Distance is a factor in determining whether or not a town is classified rural and also effects the type and range of services provided, together with factors such as community demand, available resources (including nursing and medical personnel) and geographic location from larger service centres. Defining rural is problematic and the classification models currently used do not take account of rural people. The significance rural people's characteristics have in shaping the lifestyle of rural communities was also discussed, particularly how it might influence the working relationship between nurses and doctors.

Nurses and doctors working in rural areas serve about 30% of the state's population living in either large regional centres or more commonly, dozens of smaller rural towns. The two workforces face some similar and different problems. Nurses, with approximately 2600 individuals employed, form the largest group of health professionals working in rural South Australia and GPs one of the smallest with around 340 doctors working in rural areas. Nurses are likely to be older than GPs and to have spent more time working in rural areas but like GPs, are

not specifically prepared for rural clinical practice. Most nurses working in rural areas have graduated from hospital apprenticeship style training while the GPs have undergone 2-4 years of postgraduate training, but not necessarily in rural practice, before moving to a rural area. There are problems in the recruitment and retention of nursing and medical staff in the state's rural health services with some areas suffering chronic shortages only relieved by recruitment of overseas trained or temporary resident doctors or, in the case of nursing, with agency relief staff.

The preparation of nursing and medical students for rural practice is unsatisfactory in the undergraduate curricula of both disciplines. There is no intermixing of students in their undergraduate years and therefore no opportunity to experience what it is to work together and develop professional relationships. Recent attempts, particularly for medicine, have increased the long term exposure of students to rural clinical practice experience and this is likely to overcome some of the problems associated with maldistribution of the medical workforce. It is not likely to address issues pertaining to working with community and with other health professionals, especially nurses.

Finally, the chapter concludes with a discussion on the differences in practice between rural and urban contexts. The relatively new emergence of rural general practice as a specialty and similar directions likewise for rural nursing through research has helped focus on the issues each professional group faces on a daily basis. This study is designed to examine these issues in much more detail, particularly as they relate to development of a professional working relationship between rural nurses and GPs in similar but contextually different locations. Chapter 3 outlines the study design to achieve this end and provides a detailed explanation of how the professional working relationship of nurses and doctors in four rural locations will be examined and interpreted.

Chapter 3

Study Design

3.1 Introduction

> Dance is an interpretive art form, and I see qualitative research design as interpretive as well. (Janesick 1994)

Once professional dancer, now academic, Valerie Janesick uses a metaphor to describe the questions researchers need to consider when planning a research design. She poses the question: 'What do I want to say in this dance?' and links the reason dancers ask this question with the same question researchers should ask: 'What do I want to know in this study?' She reinforces the point that construction and framing of the question are crucial to the selection of the most appropriate method of inquiry (Janesick 1994).

This seemingly simple logic is complicated by the vast methodological discourses, each espousing one particular method or methodology as being able to effectively answer any given research question. Staying with Janesick's dance analogy, there is a large array of dance styles but in the end they all contain the essential ingredients of rhythm, choreography, and movement, usually accompanied with music. Some order must follow for the dance to make sense to the dancer and for the viewer to interpret and understand the performance. Janesick describes the stages of preparation for dance – warming up, exercises and design decisions, cooling down, interpretation, evaluation and critique. There is order in this sequence and the end result is more pleasurable to dancer and viewer alike because of it. These basic steps can be transposed into good research design. Denzin and Lincoln (1994) in their introductory preamble to a chapter on Strategies of Inquiry in their *Handbook of Qualitative Research* (Denzin 1994) list four questions that structure study design.

1. How will empirical material be informed by and interact with the paradigm in question?
2. Who or what will be studied?
3. What strategies of inquiry will be used?
4. What methods or research tools will be used for collecting and analysing empirical materials? (Denzin 1994)

The answers to these questions should bring order and structure to research design but there are some other important factors to consider. The design of a research study should reflect two things. Firstly it should sit comfortably with the researcher's own philosophy or view of the world, and secondly it should be capable of getting at the foundation of the issue. Time spent in thinking about the most appropriate method or methodology likely to answer a fundamental question or give rise to new knowledge and understanding is generally rewarded. The question to be answered or the type of research to be undertaken can sometimes determine the method; in other words, selecting the right tool for the job at hand.

The primary objective in this study is to come to a better understanding of how rural nurses and doctors work together and develop a professional working relationship. Although much has been written on the subject of nursing and medical relations, there is no specific research that develops theories or hypotheses about the relationship in a rural setting against which any collected data could be compared and tested. Therefore, a study building on ideas regarding the relationship from an inductive perspective seemed appropriate and useful.

Inductive studies work towards a general theory or set of conclusions based upon specific empirical data (Nieswiadomy 1993, p.96). They aim to collect data from life situations and researchers attempt to arrive at an explanation or series of explanations about the behaviour or subject being studied. A second objective was to describe the working relationship in the context in which it takes place, that is, rural practice. A further reason was because others have described the relationship between nurses and doctors in detailed studies (Wicks 1999; Weiss 1985; Jones 1991; Porter 1991). All of these have been situated in large urban acute care hospital settings and I found no Australian studies which examined the relationship in the rural context.

Pearson's 1981 account of nursing practice in a small, nine bed community hospital located in rural England makes some oblique references to nurse-doctor relationships. The main focus of this study, however, is directed to the norms of nursing practice during a period of major change in the way nursing care was being delivered rather than on the relationship between nurses and doctors (Pearson 1989). By observing everyday interactions between nurses and doctors in a rural context I set out to discover more about how they build and maintain a professional working relationship. An important objective was to avoid the development of themes and concentrate more on norms and rules which are in operation in the culture and how these affect the working relationship.

The design of the study therefore needed to include methods that allowed the key participants in the study to be observed in their workplace and to elicit their views on the functioning of the relationship. It also needed to manage data collection from the four case study sites in a timely and convenient manner for the researcher, participants and the rural health services involved. Finally, there was the reality that the study design and method must fit comfortably with my own philosophy and attitudes. For me, a design that was uncomplicated, effective and incorporated a range of appropriate data collection methods, while being practical and likely to provide the intended outcomes, was attractive.

3.2 Study design

When examining the working relationship between rural nurses and doctors several factors needed to be considered. These included the amount of previous research done on professional working relationships, the context of these studies, the type of methods used to gather the data and any particular barriers which might prevent examination of the relationship 'up close'. The choice of sites and the methods of gathering information during fieldwork reflected these factors.

Opinions, research in the literature and plain common sense point to the need for improved working relationships between doctors and nurses. Therefore I decided it was appropriate to undertake a study that could provide new knowledge about the relationship in the rural context in the hope that an improved understanding might inform practitioners in rural areas of Australia. This is justified especially due to the lack of any published study of rural nurse-doctor work relationships in Australia.

The overall study was designed to include a close examination of the working relationship of rural nurses and doctors from three perspectives. These were:

- the daily interactions between rural nurses (RNs) and doctors (GPs)
- what selected nurses and doctors say about the relationship and these interactions
- what the contemporary literature reports about medical-nursing relationships, particularly those in rural health care practice.

Finally, opportunities to express my own interpretation of these perspectives were accommodated in the study design. This was managed through a discursive approach to the gathered data. In general, discursive studies deal with a wide range of issues or themes through discussion of each and the reaching of conclusions or premises.

3.2.1 Overview of study design plan

The study design included three main phases: Phase 1 consisted of literature review and analysis. Phase 2 encompassed the case studies; and Phase 3 consisted of the discursive exploration.

Phase 1: Literature review and analysis. As in all research the literature review and analysis was an integral part of the study. The literature examined in Phase 1 is presented in this report of the study in order to create a background to the study and place in context the historical perspectives of nursing and medicine. In Phase 3, the literature is used again to assist the discursive exploration of issues and themes raised by the observation and case studies and to provide additional contemporary input to the outcomes of the study.

Prior to the commencement of the fieldwork an extensive collection of literature was examined. This collection was added to over the life of the study and, importantly, material relating to the contemporary relationship between nursing and medicine was also added. These additions include articles from the popular press, which often describe the effects of breakdown of the professional working relationship between nurses and doctors, and the often-tragic consequences for patients and the health professionals.

Much of the literature collected and analysed reported on collaborative practise between nursing and medicine at individual and collective levels. This related primarily to published work and theses on the subject of nurse-doctor relationships. There is no shortage of material written by both nurses and doctors about the tension between the two professional groups, and the problems are well defined over a long period of time. Stein, for example, first described the so-called 'doctor-nurse game' in 1967.

The relevance of the literature to the study design is in its ability to ground the themes that emerge as a result of the case studies and to allow discursive exploration of these as they relate to the rural nurse-doctor interactions described in this study. The more recent commentary about nurse-doctor relationships is useful in helping explain what has remained constant since Florence Nightingale first tested medical authority and accepted practices in the 1850s and early 1900s in the Crimea and later in England and India (Miller 1978). With her considerable skills in organisation, sanitation, and nutrition and as a recognised statistician, she not only laid the foundations for so called modern professional nursing but also arguably sowed the first seeds of professional relationship disharmony between medical and nursing practice.

More recently, the literature demonstrates how close to the surface that disharmony is and how fragile the relationship between nursing and medicine can be. For example, moves by the Australian nursing profession to introduce nurse practitioners, particularly in rural and remote health care practice, have resulted in open and public criticism of nurses and nursing by medical-political organisations. The relevance of this study is in helping understand the professional working relationship in the rural context and in taking steps towards reducing the potential for conflict between two professional groups with similar professed aims.

Phase 2: Case studies. Four rural health workplaces in South Australia were selected as case study sites. Each one was selected purposefully to display the range of rural practice settings in which rural nurses and doctors worked together. The four case studies included a small rural hospital, a community health centre, a rural hospital with multi-purpose services and a large regional rural hospital. Each one of the case studies is essentially a descriptive narrative of the town in which the health service is located, the health service and a profile of the nurses and doctors who work in it. Included in each narrative case study are the day-to-day interactions between rural nurses and doctors.

Data was obtained by using a combination of non-participant observation and in-depth interviews with selected nurses and doctors. These ethnographic methods for data collection were chosen to capture the essence of the relationship and what factors influenced it. Additional background material on the role and function of the health service was also gathered to build a picture of the four different case study sites. A further set of data that helped understand the context of each of the case study sites was also collected. This data related to the socio-economic and health service usage profiles of the residents of the town in which the health service was located. Collecting information of this kind assists understanding of the health and social issues which nurses and doctors, who are also residents of the town, experience in their daily working relationship.

Phase 3: Discursive exploration. In the final phase the information gathered from the four case studies was compared and analysed. It was during Phase 3 that discursive meaning was sought among the patterns and features that were common or different for each case study. The meanings were developed and have been presented through descriptive statements in a series of themes and sub themes designed to compare and contrast the four rural case study sites, their main features and the practices and interactions of the nurses and doctors in each.

A series of statements arising from the nurses and doctors or the setting is used to focus attention on the similarities and differences of the professional working relationship. Exploration of the relationship insofar as the situations, phenomena and influencing internal and external factors are the central focus of this phase to bring forth the defining qualities and features of the relationship as it is for individual nurses and doctors and the context of the case study sites in which they work. During Phase 3 there was also detailed exploration of the issues and features arising out of the data collected in Phase 2 of the research. This exploration included reference to other literature, collected in Phase 1, particularly where there were similarities to broader issues and the discursive exploration. This was designed not only to underpin and acknowledge present understandings about nurse-doctor relationships, but also to explore new directions in the context of rural practice and the way professional relationships are affected.

Themes and sub-themes that were identified in the previous two phases were explored and contrasted against the data gathered from the case studies and the general literature surrounding rural health care delivery and practice. The knowledge and understandings generated by this approach therefore emerged inductively. In other words, the data arising from the case study sites, observation and in-depth interviews was a discourse that was analysed and understood in the overall context of other discourses surrounding the subject, namely those which come from published literature and contemporary comment in the press. This has allowed minority views to be taken into account and provided for a thorough examination of the power dimensions and real or perceived barriers in the working relationships of rural nurses and doctors.

Table 3.1 summarises the three main phases of the study and explains the interconnection between each objective and strategy designed to achieve it.

Table 3.1 Study design main phases

phase	objective	strategies employed
Phase 1 Literature review and analysis	1. provide background to study 2. provide perspective to nurse-doctor relationship 3. assist discursive exploration of themes	▪ literature collection over life of thesis ▪ examine all sources of literature – including press ▪ draw out themes from literature and compare with data gathered in study
Phase 2: Case studies – observation and in-depth interviews	1. examine nurse-doctor work relationships in different contexts 2. describe the working relationship 3. determine significant factors which affect the relationship	▪ select four rural case study sites where nurses and doctors work ▪ case study site descriptions, observation and in-depth interviews ▪ analyse data for emerging themes and sub-themes & compare and contrast this across case studies and with literature
Phase 3: Discursive exploration	1. describe the features of the relationship and interpret them 2. develop major themes and sub-themes pertaining to the working relationship 3. explore the direction of rural nurse –doctor relationships	▪ search for meaning in patterns and features of the relationship from case studies, observation and in-depth interviews ▪ develop a relative whole from the discursive exploration by using main themes and sub-themes to clarify aspects of relationship

3.3 The rationale for a case study approach

As explained, the case studies were undertaken in four different settings in rural South Australia. These were selected to reflect the dimensions of the clinical practice situations within which rural nurses and doctors work. Data were collected in all of the case studies using a combination of participant observation, interview and field note analysis.

Using a case study approach in order to research a particular subject involves dealing with each individual case as a separate and discrete entity. The rationale for this form of research is that it is a type of field research that focuses on a single individual or small social system.

Case studies have been stereotyped, however, as a:

> ...'weak sibling' among social science methods of research. (Yin 1989, p.10)

Their potential to gather reliable data has been questioned by those who demand precision, objectivity and rigor (Yin 1989, p.10). Yin also acknowledges, however, that case studies are the preferred strategy when 'how' or 'why' questions are being posed, when the investigator has little control over events and when the focus of the study is on a contemporary phenomenon within a real life context (Yin 1989, p.13).

The case study method was, therefore, well suited to an investigation involving the small rural social and health care settings in which rural nurses and doctors work. Additional rigor was added to data gathered in each case study through participant observation and in-depth interviews with nurses and doctors.

Researchers carrying out case studies use a number of theoretical approaches to the collection and analysis of data. Among the most commonly used are phenomenology and symbolic interactionism, the pre-cursor to grounded theory (Stevens 1993, p.79). In this study I chose to make direct observations of nurses and doctors at work and explore with them through in-depth interviews some of the issues arising out of those observations. To these observations a further dimension was added: the case study sites. These were similar in that they were all located in a rural context, but different in terms of the way nurses and doctors interacted because of the type of health care service they provided in the case study site.

Perhaps the question should be: Could the professional working relationship be studied without the use of case studies? The answer to this question is of course 'yes' but it would not provide the comparison and contrast that is available through the use of four different case studies. Nor would it enable the effects of the similarities and differences in the working relationship in the four case studies to emerge as effectively and undergo scrutiny. This study focuses on the phenomenon of rural nurse and doctor working relationships over a period of time in different rural locations. Observation and in-depth interviewing helped describe the aspects that influenced, developed and maintained the relationship. The use of case studies allowed a broader perspective of the features of the relationship than might have been possible in one case study or a focus on one particular group of nurses and doctors. Due to the separateness and uniqueness of each of the case study sites a multi case study presents opportunities to explore common themes.

Lo Biondo-Wood et al. underscore the case study method as one which:

> focuses on a selected contemporary phenomenon over time to provide an in-depth description of its essential dimensions and processes. (Lo Biondo-Wood et al. 1994, p.274)

Burns and Grove (1993) also acknowledge that although the number of subjects in case studies tends to be small, the number of variables involved is usually large (Burns 1993, p.300). Looked at in this light, the numerous themes and sub-themes that arose out of the four case study sites through observation and interview had the potential to complement understanding of the diversity of practice of rural nurses and doctors. The use of case studies also helped in the identification and appreciation of the complexities of professional work relations, and how they are formed and maintained. This was a further reason to employ a discursive exploration of the data collected and to 'unearth' variables, features and aspects of the professional relationship and discuss these in more depth.

Burns and Grove point to the usefulness of case study methodology as a good source of descriptive information, useful when gathering evidence for theory building. In case studies which look back on the history of a particular 'case' and describe the characteristics or behaviour of those involved in the situation there is detailed exploration of what took place and why. The notion here is somewhat a retrospective examination for the purposes of learning to improve future case management or to search for particular phenomena. Polit & Hungler (1993) take this notion a step further, suggesting the case study researcher can be a passive observer, gathering information about the subject's behaviours, symptoms and characteristics as they naturally occur (Polit 1993, p.150). This particular notion appealed to me when considering how best I might understand how the relationship between nurses and doctors operated in the various case environments being studied. One main focus in case studies is finding out why the participants think, behave or develop in a particular way, rather than examining what their status, progress, actions or thoughts are (Polit 1995, p.200).

In summary, the study design revolved around four case studies. Each has been described in detail in order to understand the context in which the particular health service operated and, by association, the effect this might have had on the nurses and doctors and the way in which they related to each other. Interpretation of the professional working relationship between nurses and doctors has been undertaken for each and a comparison between the case study sites has also

been made. This was conducted within a framework of the current reality that includes policy, regulations and professional and personal constraints. Just how this worked in practice is described in later chapters. The overall intent was to appreciate the unique and individual characteristics of the four case study sites, and to bring this information together with the distinctive aspects of the working relationship of participant nurses and doctors in a more general theorizing of its structure and its reality for them.

3.3.1 Selection of case study sites

The overriding factor in the selection of the four case study sites was not the sites themselves but what was taking place within them between nurses and doctors. The study was not designed to focus exclusively on the similarities and differences of the four rural health services, although these are important factors that help us understand why the relationship between nurses and doctors might operate differently. In other words, the health services were a vehicle by which the relationship between rural nurses and GPs could be studied in varied rural work contexts.

Stake (1994) acknowledges that many case studies are selected 'intrinsically'. Put simply, the case is selected because of the very nature of the work in which the researcher is engaged. Most nurses and doctors can relate easily to this as they are used to treating or caring for 'cases' that they are allocated. In the event it was necessary to choose a case study to include in a research project the choice is already made because it is unusual or typical or as Stake puts it:

> The cases are of prominent interest before the formal study begins. (Stake 1994)

Factors influencing choice of case study sites. In selecting the four case study sites there were several factors which determined the final choices. These were that they:

- be located in a rural area
- match one of the category types of rural health services (See Table 3.3.)
- have nurses and doctors working together
- agree to be involved in the research
- were convenient for the researcher to access.

In selecting the case study sites it was important to recognise that the potential existed for the working relationship between nurses and doctors to be different according to the size, location and type of rural health service in which they worked. The maxim, 'one size fits all', does not

apply to rural health services and there is often considerable diversity in the types of services offered and the mix of staff skills and experience. The total number of private health services located in rural South Australia is very low at eight. The majority of these are within a 100km radius of the Adelaide CBD and so the selection was confined to public health organisations only. After considering these factors I decided that four categories of rural health service should be included for case study site selection. These are represented in Table 3.2 and demonstrate the diversity of rural health service delivery. The four categories included a small rural hospital, community health centre with no resident doctor, multipurpose centre and a large regional rural hospital. Table 3.2 also indicates the period over which the fieldwork was to be conducted, once the four sites had been selected.

Table 3.2 Case study fieldwork plan

Month	Case Study No.	Description of case study site
1	One	Small rural hospital in a town with 2 GPs, <20 RNs and a hospital of <30 acute & nursing home beds.
2	Two	Small rural community health centre with no resident GP & <5 RNs
3	Three	Regional rural hospital <90 beds with 10+ on-call GPs and < 100 RNs
4	Four	Small rural hospital using multi-purpose services, with 2 GPs, <25 RNs & <20 acute & nursing home beds.

The range and number of rural health services in which rural nurses and GPs work together in non-metropolitan South Australia allowed ample choice of four case study sites with the necessary characteristics. In 1996 a report by Glover listed a total of 72 hospitals located in rural and remote South Australia. The size and type of these varied considerably and included regional, sub-regional, community, remote and private hospitals. These are displayed in Table 3.3 (Glover 1996).

Table 3.3 South Australian rural & remote health service profiles

Type of health service	Approximate bed numbers	Number n=72
Regional hospitals	80-90	4
Sub-regional hospitals	50	10
Community Health Services*		34
Community hospitals	30	44
Remote hospitals	2-15	6
Private hospitals	30-40	8

*It should be noted that community health centres are commonly incorporated into one of the types of health service outlined in Table 3.3. Generally speaking the larger the rural town size the more likely it is for the community health service to be co-located on the hospital grounds or at a site elsewhere in the town (DHSSA, 1998). One of the selected case study categories to conduct the research with rural nurses and GPs was a small rural hospital offering multi-purpose services.

Multipurpose services (MPSs). In the 1992-1993 Commonwealth government budget, funding was provided to establish a number of MPSs across Australia. They were designed as a Commonwealth-state initiative with shared funding. Communities suitable for MPSs generally were those with reduced populations and inappropriate levels of health service infrastructure to meet community health care need. In many cases there were competing services and therefore cost and service efficiencies were not possible. Most MPSs provide a wide range of umbrella services that may include hospital, aged care, community health, public health, mental health and home help. By 1996 there were 24 approved MPSs in the seven state and territory health jurisdictions (NRHA 1995). South Australia had three MPSs at the time the fieldwork for this study was conducted in 1998. Two of these were located in remote Aboriginal communities in South Australia and one in a rural region. The rural MPS is a regional one based around three small rural towns and therefore presented logistical difficulties for fieldwork to be undertaken. Despite this, two of the three rural towns in this MPS met the selection criterion; that is, they had nurses and GPs working together in the town hospitals and so they were included in the list to seek permission for the fieldwork.

Selection of the four case study sites. Following approval of the research proposal by the university's Human Research Ethics Committee, a letter requesting permission to undertake the research in the health service was sent to those health services which had been identified as likely to meet the case study site descriptions outlined in Table 3.2. A plain statement Information Sheet explaining the nature of the research (Appendix B) accompanied this. Health services that were located in the mid northern, northern, and western areas of the state were deliberately chosen because they were easier to access for the fieldwork

Final selection. Several small rural hospitals declined to participate in the study. No reason was given for this. The only accredited rural MPS in the state did not respond to the request letter or to follow up telephone calls to the Chief Executive Officer. No assumptions can therefore be made as to why there was no interest or willingness to participate in the research.

This meant another rural hospital with MPS like characteristics had to be found to match the four case study categories. One that matched the criteria was found to substitute for the MPS. Acceptances for the research to proceed came relatively quickly from the smaller health service units who seemed genuinely interested and willing to take part in the research. This included both the nursing and medical personnel of those organisations.

There was a protracted delay in gaining permission from the large regional hospital included in the study. Contact with the Director of Nursing of this hospital indicated the nursing division of the hospital understood the request and the nature of the research and supported it. However, there was resistance from the medical director and some of the hospital GPs. I was requested to speak about the research proposal at the hospital's Medical Staff Society meeting and, in particular, to explain what form the research would take. During and following the meeting I sensed there was a less than enthusiastic reception by some of the GPs present to the idea of a researcher observing their interactions with nursing staff. On balance there were other GPs at this meeting who confided privately with me that they thought the research would be valuable and they would be pleased to participate. Finally, after more delay, the medical director and the hospital board granted permission for the research to proceed. It is of interest to note that although I observed many interactions between nurses and doctors in this hospital during the subsequent field research, I was only able to conduct one in-depth interview with a GP in that hospital, despite the fact that relative to other case study sites it had the largest numbers of GPs.

In summary, the selection of case study sites allowed examination of the relationship between nurses and doctors in different rural health care settings. While the case study site was important, it was secondary to the research objective of studying the relationship 'up close'. The choice of cases study sites was relatively large but due to time and access constraints approaches were made to health services that were located close to the researcher. Permission to conduct the research came more rapidly and was more enthusiastic from small rural health services than from the larger regional health service. Nursing staff from all the selected case study sites readily gave their approval to conduct the research and in many cases were enthusiastic about it. The GPs in the smaller rural sites were also supportive and willing to participate. As a whole the GPs in the larger regional hospital case study site were disinterested in participating in the study and gaining permission to conduct the research took much longer and required several layers of authorisation before being obtained.

Following the selection of the four case study sites arrangements were made to visit each one for a period of three or four days. There were varying periods of time in between each field visit to reflect on information gathered and prepare for the next visit. A total of 19 weeks elapsed between the commencement of the first case study visit and the completion of the fourth.

3.4 Methods, strategies and techniques

3.4.1 Ethnographic techniques

The study design is not a strict ethnographic one. The focus is instead on using case studies to examine the professional working relationship between nurses and doctors in a rural context. In gaining insight into that relationship the techniques that are commonly associated with ethnography seemed appropriate and likely to yield good qualitative data on which accurate conclusions could be drawn. Explanations about ethnography are plentiful because it has become accepted as a method to conduct qualitative research. de Laine (1997) provides some reasons for this:

> Ethnography is one of the major and most established approaches to qualitative research in the social sciences, and knowledge of the advantages of the approach have extended beyond the original disciplines of anthropology and sociology. (de Laine 1997)

Embodied in this explanation are the historical roots of ethnography and its popularity with researchers as a method of inquiry. Most commonly associated with ethnographic studies are the fieldwork techniques of in-depth and informal interviews, different forms of observation and focus groups. A further advantage of using ethnographic techniques in the study reported here was the potential for understanding the social and cultural aspects of the relationship between rural nurses and doctors. This understanding is not apparent when quantitative measures are used. Again de Laine underscores the usefulness of ethnography in understanding social phenomena:

> Qualitative researchers recognise the value of ethnography for the understanding of social phenomena grounded in the cultural perspective. (de Laine 1997)

In each of the case studies of this study I expected to observe a unique social and professional culture and choosing the correct techniques to bring it forth was important. The strategies chosen were non-participant observation and in-depth interviews of key informants. In practice, what I hoped to be able to achieve was to observe nurses and doctors interacting with each other and then conduct in-depth interviews with them to enquire about things I had observed.

Interviews would also provide an opportunity for the participants to describe aspects of the professional working relationship they considered significant. Other authors who write about ethnography and the use of its techniques hold that it is a pure form of enquiry and those using it should remain true to its philosophical paradigm. Others like Atkinson and Hammersley (1994) suggest it is yet another method available for researchers to use when appropriate (Atkinson 1994). I chose the latter view. I decided to use ethnographic techniques to collect information about the relationship between nurses and doctors in the field and from inside four case study sites. The two main techniques used were non-participant observation and in-depth interviews within each case study site. Some explanation about how this worked in practice is required.

Non-participant observation. Non-participant observation is a technique that arises out of the ethnographic approach to data collection. Gold & Junker some 40 years ago described a 'fourfold typology':

- complete observer
- observer as participant
- participant as observer
- complete participant (Atkinson 1994).

This was clearly an attempt to clarify the concern some expressed about the impact of the different types of observation and the effect the chosen method might have on results. Non-participant observation perhaps fits best with the 'complete observer' typology, but there are some other factors to consider. Atkinson and Hammersley argue that all social research is a form of participant observation. Hence the selection and use of a particular type is somewhat unimportant if we accept the reality that the researcher is part of the world and that includes being immersed in the culture or social circumstance they are studying (Atkinson 1994). In deciding what type of observation was best suited to the study of the professional working relationship of nurses and doctors across the four case study sites, the different variations influencing the most suitable method were considered. Four factors are outlined by Atkinson and Hammersley (1994).

- whether the researcher is known as such to those being studied
- how much is known about the research being conducted and by whom
- what activities the researcher engages in while in the field and how these are perceived by the various groups of participants
- how completely the researcher consciously adopts the role of insider or outsider (Atkinson 1994, p.249).

In locating myself in relation to each of these points I decided that I had a better chance of observing the interaction between nurses and doctors at a distance and not as a complete participant. I rejected this form of observation because I would have taken the role of nurse, since that is my professional training. It was critical to the study that I discover how existing rural nurses experienced their working relationship with doctors and vice versa. It was important to be removed as far as is possible in a small case study setting from the personal experience as a complete participant. Instead, observing the behaviour of nurses and doctors who already had established some form of relationship was more likely to reveal the essential features and subtle nuances I was searching for.

If I had taken the role of complete participant observer I would have experienced considerable difficulty. This is because of the small size of the case study sites and the fact that most interactions are between one nurse and one doctor in any given circumstance. All of the participants in each of the case study sites knew of the purpose of the research and what form it would take. Information sheets about the study had been previously circulated and for all nurses and doctors observed I gave a brief explanation of me and what I was there to achieve. Some of the smaller case study sites also carried a message about my presence in their communication book, which all staff read when they come on duty. My observations in the case study sites depended mostly on wherever the nurse and doctor interactions were occurring. Most often I located myself in the area where the nurses based themselves and from where they conducted their routine duties. It is for this reason that the majority of primary observations surrounded what work the particular nurse or nurses were undertaking at the time. For example, if a nurse telephoned a doctor I listened to the conversation. If a doctor came to the nurse station to speak with the nurse or they went together to undertake patient care, I followed and observed their interactions.

I did not sit in with the doctor during consultation with patients in their consulting room. The main reason for this is explained by my particular location in each of the cases study sites. In some it was an open office or reception area, in others a small office or nurses' station. The doctors observed in all case study sites only came to the area in which the nurses worked when they had a reason to do so. An example might be to meet the nurse to undertake a ward round of the patients or to review their progress. In all of the smaller case study sites nurses and doctors interacted with each other often in a staff tearoom area. In the large regional hospital case study site this type of social interaction between nurses and doctors only occurred in the accident and emergency department.

I used a portable laptop computer on which I made descriptive notes about all of these interactions between the nurses and doctors following my observations of their behaviour. I frequently followed nurses and doctors when they went to visit patients, attend meetings together or discuss treatment regimes. I also 'eavesdropped' on conversations between nurses and doctors when they were made in the area in which I conducted my observations or on the telephone. In fact, any and all interactions I could observe in the time available I tried to witness and make notes about. I felt comfortable in this adopted role of non-participant as it allowed me to step back and take in what was happening. Not having any obligation to say or do anything other than observe and record the actions and behaviours of the nurses and doctors allowed me to describe what I was seeing and hearing. I wore casual clothes and could not be confused with nurses who in all case study sites wore uniforms. In all three of the small case study sites it was clear I was an 'outsider' and perhaps to some staff it was an unusual occurrence to have someone in the workplace who appeared to be doing nothing constructive. In the larger case study site I wore security identification. Due to the larger numbers of staff, patients and other hospital workers this did not prevent interruptions by someone asking me if I needed assistance. In other words, who was I and what was I doing there? Generally by the second day at each the case study sites I was able to move freely around and observe interactions between nurses and doctors in whatever circumstances they were engaged.

There were two exceptions to this when it was clear my presence, as an observer may have been an intrusion. The first of these was when I observed a conversation between a nurse and doctor, which subsequently turned out to be a private conversation between a nurse and her own GP. The second occurred when observing a nurse and doctor talking with a patient who had terminal cancer when she asked the doctor to be relieved from her suffering. In both these examples it was my own sense of discomfort as a non-participant observer that led to my feeling the need to withdraw, despite the importance of the interaction and the richness of the data that might flow from it. These were private moments and, while an important part of the interaction between nurses and doctors, had the potential to be disrupted by my presence. Therein lies a quandary for researchers using ethnographic techniques. This division is sharpened for us by de Laine who points to the range of options researchers have between the two positions of participation and non-participation as observers:

> Between the two positions the researcher has other options, 'partial' observation and participation. (de Laine 1997, p.143)

In fact as I gained more experience in the case study sites I was able to move between the chosen path of non-participant observer to participant without compromising the research objective when the circumstance required it.

Case study field notations. Most of us understand the concept of note taking. As students we learn to take notes in a variety of settings and each person develops or is taught the skills of note taking. Chief among these skills is the ability to synthesize the words or actions of others into brief written notes. These should be able to be interpreted at the very least by the person who writes them. In the research context field notes take on a more significant purpose and, depending on the type of research strategy, may be central to the gathering of data. It would be uncommon to find a research strategy that does not include the use of note taking at some stage of the process. Some research strategies rely more heavily on field notes than others. These include ethnography, ethno methodology, phenomenology. Behavioural research also relies heavily on participant observation and qualitative ethology (Morse 1994).

The use of field notes in this study. Most note taking fits into one of several categories which de Laine (1997), citing Richardson (1994), lists as being:

- observational notes
- methodological notes
- theoretical notes
- personal notes (de Laine 1997, p.268).

de Laine describes the types or forms these categories of notes may be described as, particularly by ethnographers. She cites Bernard's (1994) list that includes the diary, the log, methodological notes, descriptive notes and analytic notes (de Laine 1997, p.268).

In locating my field notes in accord with both these descriptions I would place them in the observational /personal notes category as described by Richardson cited in de Laine. I did not keep a diary or a log but I did make descriptive notes that had some analytical tone to them. An example of my field notes illustrates the type of notes I used. Note the term 'interaction' is one I coined to describe nurse-doctor work interactions:

Interaction No. 1 @ 3pm

A young girl presents to the A&E department. She has banged her finger hard on a cupboard. The patient is seen by one of the RNs and assessed. The injury has left a swollen joint and severe swelling and the affected finger is mal-aligned.

The RN telephones the on-call doctor with this information. He advises her per phone to strap the finger, give oral analgesia and ask the patient to return to the A&E department later in the evening for a 'clinic'.

In the above example of a field note I provide a description of an event in which a new term – 'clinic' is mentioned. I explore the meaning of this term as it relates to a subsequent interaction with a doctor.

Clinic

The RN I ask to explain what the clinic means says she calls them 'collections'.

Why collections?

It works like this. The RNs see presenting patients to the A&E, take a history of why they have come, assess them and, if appropriate, give treatment. The patient is then given a choice. They can accept the assurance of the RN that the treatment given is all that is necessary or they can come back to see the doctor at a pre-determined time. As the shift goes on there may be several patients who are seen by RNs and then asked to return later. Hence the 'clinic' or the 'collection'.

(Extract from Bridge Town case study field notes)

The example shows how I used brief descriptions of the interactions between nurses and doctors and then followed this with a focus on one particular issue deemed important to illustrate the nature of the work relationship in reality for that particular circumstance and case study setting. Another way I used these field note descriptions in interactions was to pose questions to follow up in the in-depth interviews of nurses and doctors following observation. An example of this follows:

Interaction No. 2 @ 5.30pm, Face to face discussion (RN & GP)

The nurse and doctor stood in the hospital corridor. At first it seemed the conversation was about the need of the doctor to inform the nurse that a patient needed some more blood tests. I soon realised that this was a discussion between doctor and the nurse as a patient herself and attempted to distance myself to give them privacy. The nurse was unconcerned and asked me to continue my observation. The doctor proceeded to discuss with the nurse, now in a patient role, the tests she thought needed to be done, after which the nurse was asked to make another appointment with the doctor. The doctor then made a 'hat changing' gesture indicating she had finished the corridor consultation and was now in her other role as hospital doctor.

(Extract from Sea Town case study field notes)

The following example indicates a separate type of note where I have posed some questions for later analysis and exploration. There may be the genesis of a theme emerging and it serves as a reminder to follow it through. It contains some reflection on what effects may be apparent in the working relationship between the nurse and GP.

Interaction No. 3 – 5.30pm, Face to face discussion (RN & Doctor) continued

This brief interaction lasted no more than five minutes but it demonstrates the common reality of practice in rural areas. The nurse in this context was in fact the doctor's patient. Neither the nurse nor doctor appeared uneasy about this reality. I wondered about the potential for conflict for both professionals and the lack of anonymity that staff working in small rural hospitals has when they seek medical services. What conflicts could arise when the treating doctor knows the nurse has a medical condition, which could affect clinical judgement or place the nurse in a compromising position professionally? Does it alter the working relationship, or are they able to separate the private and professional roles?

(Extract from Sea Town case study field notes)

In this example I make personal notes about the interaction and pose some questions that relate to it. These were then explored in more detail with the nurse and doctor during interviews with them. Some of the personal notes served as reminders and others were comments or questions that I regarded as central to the working relationship of the nurses and doctors.

All field notes were made using a portable laptop computer, which allowed both flexibility and easy access and storage of field notes in each of the four case study sites. This method of storage proved invaluable when making comparisons between the four case study sites and when searching for common themes or notations which illustrated a particular point. Obviously the computer could not be carried into every situation where observation was required. I resolved this by making the necessary observations and entering them at the first available opportunity. This seemed more natural than taking the computer, note pad or small tape recorder, which may have added to the intrusion of my presence.

In summary, the primary source of field notes was observation and in-depth interviews with participant nurses and doctors. They were descriptive in nature and focussed on interactions between nurses and doctors in the various daily work activities in which they engaged. Additional notations were included as either comments about what I had witnessed and noted or questions which arose from the interaction requiring further exploration during subsequent in-depth interviews or themes emerging about the relationship. Reference is made by some authors about the use of methodological notes to assist with direction and focus in the field. I did maintain a separate notebook throughout the study that contained personal thoughts and notes about research methods and strategies and suggested readings by my supervisor or colleagues. This was not used in the same active way of the field notes when I was conducting the study but more as an open file into which I entered items of information about the whole study and not just the field work component.

3.4.2 Selection of key informants – participants

This study has as its focus the professional working relationship of nurses and doctors in four different case study sites all located in a rural context. The working relationship is central to the study and hence the design and strategies employed to examine it were directed towards discovering how nurses and doctors relate to each other in daily work situations.

For a deeper understanding and meaning about the relationship to emerge it was appropriate to provide an opportunity for nurses and doctors to talk about the critical aspects of the relationship from their own perspective. It was equally appropriate for me as a researcher to explore issues and aspects I had observed in their interactions.

I could not, however, assume that because I had observed a nurse or a doctor that they would willingly participate in any in-depth interview that might follow such observations. In this study there is an important distinction between 'subject' and participant. To gain understanding of how the relationship was in reality for nurses and doctors I needed to invite their participation and involvement rather than study it from a distance as the term 'subject' implies. Here the words of Kincheloe and McLaren (1994) remind us of the debate in some circles about the implied meaning of terms used to describe 'subjects' in ethnographic research:

> How does the knowing subject come to know the Other? How can researchers respect the perspective of the Other and invite the Other to speak? (Kincheloe 1994)

Kincheloe and McLaren are calling for a more reflective approach to ethnographic writing and in this rhetorical question seek to highlight the more recent attempts in ethnography to move away from the historical Western anthropological ways which characterises the often described 'knowing subject' to the more acceptable 'informant'; in other words, the characterisation of the subjects of the research in a way that values their status and their perspective on events. The willingness or otherwise of the subjects of research to provide information and perspective seems to imply participation rather than informant, which can have other meanings. For the purpose of this study participant seems a better descriptor than informant because nurses and doctors willingly and in an informed way participated in both the observational and in-depth interview data gathering components of the research.

Before moving on to describe how participants were selected, it is worth making a distinction between the smaller case study sites and the larger in terms of participation. In the smaller sites the numbers of staff were small and everyone including, it seemed, the kitchen and cleaning staff

were aware of the study and what it was about whereas in the large case study site there was less overall awareness. This is understandable given the larger numbers of staff in this case study site and the low impact nature of the research methods on all but two nurses and one doctor. These three participants provided in-depth interviews and were the subject of more direct observation than other staff at this site.

Participant selection. Participant selection took place at two levels. The first I have briefly described in the section dealing with choosing case study sites; and the second was through what I describe as 'convenience selection'. Each selection level requires some explanation.

The process followed in selection of the **case study sites** determined which nurses and doctors were included in the study. Health services that responded to my invitation to be involved in the research and were subsequently the case study sites which I visited, gave permission for their nursing and medical staffs to participate. As I had written to these sites and invited their participation there was an element of convenience sampling. At the second level, nursing and medical staff of the selected case study sites were given the opportunity to participate in the research either through my direct request to observe them or to participate in in-depth interviews. I could not select every nurse in every case study site for in-depth interviews due to their larger numbers compared with GPs. Again I used a convenience selection of nursing and medical staff who were available at the time I was in a particular case study site.

In relation to **selection of participants** one further exemption criterion was applied, that was to exclude any nurse or doctor from the study who had less than three months experience in rural practice. I concluded that analysing existing and relatively mature professional working relationships were preferable but new or developing ones would still be of interest. In two of the small case study sites (Valley Town and Sea Town) the GPs had their practice located within the same building as the hospital and as such were relatively accessible during consulting times. The GPs in the larger case study site operated a roster system similar to the nurses, except that it was an on-call system. They worked from their practices and visited the hospital only when called by the nurses (if they were on-call) or to visit patients they had admitted to the hospital. Selection of the GPs overall was based on their availability either outside working hours or in between seeing patients. Therefore a convenience and availability sample of nurses and doctors took place when I arrived to commence the study in each site.

This was repeated in all case study sites and followed a pattern. I would arrive at the agreed time in the case study site, which was for the first day always at the commencement of a new shift for the nursing staff. That way I could introduce myself to the nurses who were leaving one shift and those commencing the next. This provided opportunities to explain the research briefly and ensure information sheets and consent forms were signed by participants. In the smaller cases study sites the selection was limited to one or two RNs as that is the maximum number that worked on each duty shift. In the larger case study site, because there were more RNs I only approached those I knew would be interacting with GPs. In some cases this was self-evident. For example, in the large case study site (Bridge Town) there were two RNs on duty during the first shift I commenced my observation in the A&E department. I asked if they would like to participate in the study. They agreed and so I explained the research in more detail and gained their consent. In other cases it might be the more senior nurse who would interact with the doctors while the other provided direct patient care services. In the second area in which I conducted observations in the Bridge Town site, a general medical surgical area, I selected only one nurse to follow and observe and made general observations of the others. This was primarily because of the larger numbers of staff and numerous doctors who visited that area but only for short periods of time.

The selection of doctors proved more difficult in the large case study site, Bridge Town. As explained, these GPs were working to an on-call roster system and/or visiting in-patients as required. I had to establish when they would be at the health service and find an opportune time when I could approach them and ask to conduct an in-depth interview. The GPs visiting the medical surgical ward in this site made fleeting visits. They appeared to be in a hurry and for this reason I was unable to approach any of them despite spending two days in that area. The GP who I did observe and who eventually provided an in-depth interview was working in the A&E department and because he remained for longer periods of time I was able to speak with him and negotiate some time to conduct the interview.

In the smaller case study sites the process of selecting the GPs was easier because they were more accessible due in part to co-location of their consulting rooms within the health care complex. At Silo Town there was no selection choice of GP as the community health centre only conducted twice weekly medical clinics shared between two GPs who came from different towns. The days I visited this site determined the GP who was consulting at the time and fortunately she was a willing participant.

Distinctive characteristics of participants. A total of 16 nurses and doctors were selected to participate in in-depth interviews across the four case study sites. Ten of these were nurses (RNs) and six doctors (GPs). The distribution of these in-depth interviews across the four case study sites is represented in Figure 3.1. In each of three case study sites two RNs participated in in-depth interviews. These were Valley Town, Bridge Town and Silo Town. In the case of Sea Town four RNs were interviewed. In Sea Town and Valley Town two GPs participated in in-depth interviews. In both Bridge Town and Silo Town only one GP participated in an in-depth interview.

The difference in participation numbers across each of the sites has been explained already, but in essence was either a deliberate choice because they were the ones primarily observed or there were only small numbers from which to choose for observation and in-depth interviews.

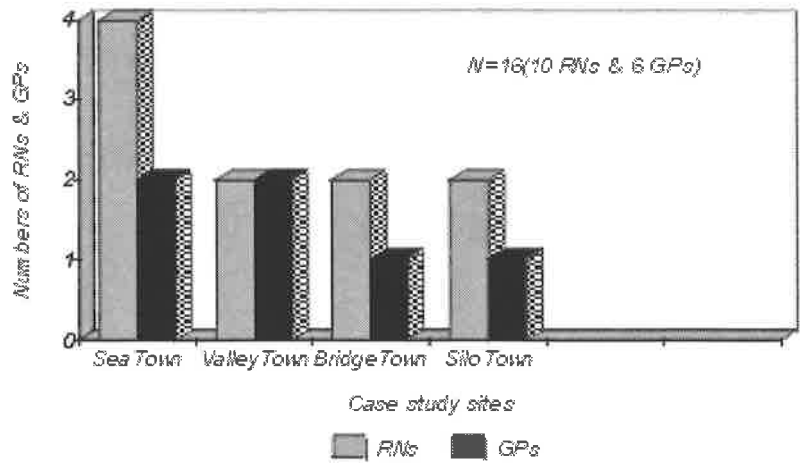


Figure 3.1 RN and GP participants in the study

The gender balance of the GP participants was equal with three males and three females. For the ten RNs, nine were female and one was male. The average age of the GPs and RNs is displayed in Figure 3.2. It shows the average age of the female RNs to be 44.8 years and the one male RN at 30 years. The average age of female GPs was older at 38.6 years when compared to the male GPs average at 34.3 years. There was a six year average age difference between the RNs and GPs with the nurses being older in some individual cases by between 10-12 years. It is clear from Figure 3.2 that the RNs are in the 40-60 years of age group while the GPs are in the 30-45 years of age group. The youngest RN was 30 years and the oldest 57 years. This contrasts sharply with the youngest GP at 30 years and oldest at 45 years.

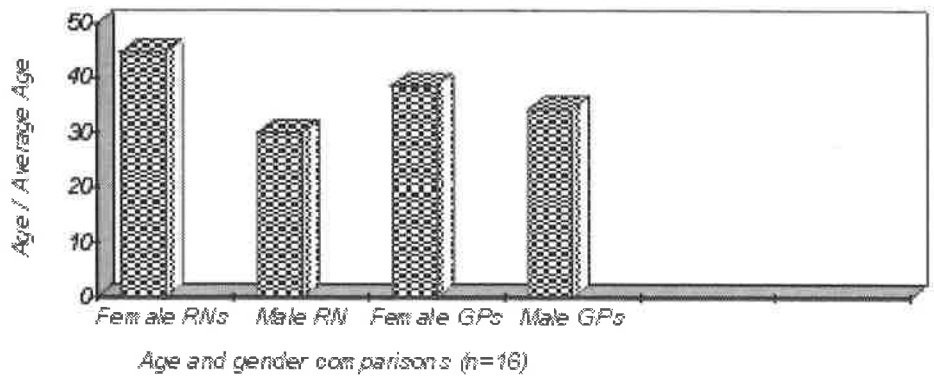


Figure 3.2 Ages of RNs and GPs

Other characteristics of the participants are described in the case studies in Chapters 4-7 of this study. Comparisons are made there in the number of years from initial graduation as a nurse or doctor, number of years experience in nursing or medicine and number of years working in rural practice. The number of years at the particular case study location is also detailed. Overall the RNs had worked longer in nursing than the GPs in medicine and also had more experience in rural practice.

3.4.3 In-depth interview technique

In planning the study design and thinking through what it was I most wanted to find out, I was conscious of the central phenomenon under study: the professional working relationship of nurses and doctors in various rural clinical settings. I also wanted to ensure all sources of data complemented each other and strengthened the overall understanding and appreciation of the relationship and how it worked in the 'real world' of rural practice. Already described are the other forms of data collection, case study data and non-participant observation via field notes. The next logical step was to obtain a deeper and direct understanding of how the relationship was perceived by nurses and doctors.

I had originally planned to conduct a series of in-depth interviews with key nurse and doctor participants whose interactions I had observed. I planned to observe their interactions and behaviour towards each other and then follow up at a later stage with in-depth interviews. These would be designed to explore not only the central question about the relationship but also deeper questions about incidents and events I had observed and made notes to follow up on. In the majority of case study sites it was possible to achieve this plan with the only exception being the larger regional hospital where I encountered a more difficulty accessing doctors than in the other three smaller sites.

Overall both nurses and doctors across all case study sites were very accommodating in giving of their time for interviews. All but a few interviews were conducted with participants after they had completed their work for the day and were no doubt looking forward to going home. Instead they responded to my needs and in doing so allowed an outsider to their group learn more about them as people and professionals. Many researchers have talked about the privilege of being granted access to knowledge of a particular group or social system through the interview process and warn of the need to not take this for granted.

Fontana and Frey (1994) underscore the importance of this relationship between researcher and interviewer and of the way questions are asked. They caution researchers to think well on the questions we ask, the way we ask them and the circumstances prevailing at the time, as they surely will yield answers commensurate with these factors. They provide a wonderful example, which supports this advice and highlights the need to ask questions person-to-person if a full and frank answer is expected:

> We are no different from Gertrude Stein, who, on her deathbed, asked her lifelong companion, Alice B. Toklas, 'What is the answer?' And when Alice could not bring herself to speak, Gertrude asked, 'Then what is the question?'(Fontana 1994)

Reasons for selecting in-depth interviewing for this study. I have discussed the need to complement the other data collection methods with follow up interviews with key nurses and doctors I had observed interacting together. In addition to this I found myself attracted to the type of interview philosophy espoused by the British sociologist Ann Oakley (1981). Oakley drew stark comparisons between the traditional scientific and positivist research perspective on interviewing and that which she described as being open, and forming a trusting, emotional engagement between interviewer and participant (Denzin 1994). While I accepted the need to be objective and detached – the hallmarks of scientific and positivist research – I also needed to lessen the differentiation between those interviewed and myself. This was so they would feel at ease and be able to talk freely about their experiences as nurses and doctors and their individual experiences with each other.

Style and rationale of interviewing used. The most common forms of interviewing are described as structured, unstructured and open-ended (Denzin 1994). Each type comes with its own established method and purpose, which the researcher must consider depending on what information is being sought and the paradigm in which the research is located. For the purpose of

this study I chose to use a largely unstructured and open style of interview to put those being interviewed at ease and allow them to talk freely about aspects of the professional working relationship they perceived as being important. According to Fontana & Frey (1994) the main objective of unstructured interviewing is to gain 'understanding' and for the researcher to empathise with the person being interviewed by placing themselves in the 'same shoes' as the person being interviewed (Fontana 1994, p.367). It was important therefore to ensure those participants in the study who were to be interviewed received prior information about the study and what effect on them it would have if they participated.

An Information Sheet (Appendix B) provided plain statements about the research and its purpose and also included information about interviewing. The extract from this Information Sheet makes clear that I intended to interview some nurses and doctors, gave a time estimate for this and indicated the interview would be tape recorded:

> ...I would also seek to interview some of the nurses and doctors whom I have observed in the case study. This would take place at a convenient time and place and take no more than one hour of your time. These interviews would be tape-recorded and you will have access to the transcript of these interviews.
>
> (Extract Information Sheet – Appendix B)

Having made the claim that I believed the interview style was unstructured there is a qualification. Four specific questions were asked of all nurses and doctors interviewed. These are best described as background or socio-demographic questions that were designed to gain specific information relevant to the study and likely to assist in making comparisons across the four case study sites. The questions were:

1. Could you please give me an indication of your age from the following range: 20s, 30s, 40s, 50s?
2. How long have you been practising nursing/medicine?
3. Of that time how many years have been spent in rural practice?
4. How much of that time has been in this location?

The four questions preceded the asking of the main question. This was open-ended in nature and designed to encourage the nurse or doctor to explore the essence of the professional working relationship from his or her own perspective:

> From your own experience could you please describe how you see the professional working relationship between rural nurses and doctors?

In addition to these questions I asked further clarifying questions, particularly if I considered they would reveal perspectives about the working relationship not brought out in the participants response. The technique of seeking clarification from participants regarding particular practices observed by researchers is a long accepted one in ethnographic research. The asking of the four initial questions allowed those interviewed to become accustomed to the process and any hesitancy about the presence of the tape recorder. Rapport was established with all of those interviewed prior to the interview because of the period of time I had already spent in the case study site observing the nurses and doctors. The two exceptions to this were the GPs interviewed at Silo Town and Bridge Town. In both cases I had only observed the GP for a short period of time (< 1 day) before the interview took place. I have previously explained why this was so for the GP at Silo Town. For the GP at Bridge Town the short observational period is explained by the on-call nature of the GPs at that site and their infrequent visits to the hospital.

I chose to interview this GP because he had worked regularly with the nurses I had been observing at that site for several days. The conduct of the interviews was such that as particular points were made by nurses or doctors that I considered warranted further clarification or exploration, I asked additional probing questions. An example for a nurse interview demonstrates this:

Nurse interview

Researcher:	This respect that you talk of between doctors and nurses, how in your view do you get the doctor's respect and vice versa?
Victoria:	You've got to earn it.
Researcher:	How do you do that?
Victoria:	Give the job your best. Not just half hearted. I guess I'm fairly old fashioned. I think when you're a nurse in the country you're not a nurse just while you're at work. You're a nurse all the time. I think nurses and doctors have to command that respect and if you go and make a fool of yourself, you don't just make a fool of your own person, you make a fool of your position in the hospital. Also I've got a family. You know …it's all the time. Everybody knows you. They know where you belong and your place. That's the difference between living in the city and living in the country.
Researcher:	The lack of anonymity?
Victoria:	Yes. There isn't any of that. You're a nurse all the time.

And one from an interview with a doctor

Researcher: …often you are on the road, you're out and about, you're at home and there is a necessity to have a strong professional relationship with this 'interim person' – the registered nurse. How do you overcome that sort of situation? I appreciate you may feel nervous because of the legal ramifications of perhaps giving telephone instructions and the nurse acts on those instructions and they subsequently turn out to be wrong.

Heather: It's not so bad if you have given instructions and they've been followed exactly and they turn out to be wrong. Obviously the result would have been exactly the same if you had been standing right there and speaking for yourself.

Researcher: Except you would have the benefit of assessing the patient for yourself?

Heather: Yes, but you could still… Well, I suppose there are two parts to it. One is, yes you have to rely on the nurse giving you an accurate physical assessment. Accurately measuring things and accurately assessing the patient's level of severity.

Researcher: Do you trust them to do that?

Heather: Yes. I normally do.

Researcher: Do the nurses have good physical assessment skills in your view?

Heather: Yes. Normally they are. Obviously you get to know individual nurses so you get to know whether to quiz them more closely on something.

In this example a line of questioning arises out the observations I have made about nurses telephoning doctors with information about patients they have assessed when they have presented to the hospital. It allows further exploration of one of the major issues raised in other interviews and is clearly a factor that goes to the heart of the professional working relationship. de Laine (1997) acknowledges the risks associated with probing questions while agreeing that they are useful for clarifying and gaining more detail. She cites Bernard's (1994) warning that the idea is to produce more information without bringing your own views and prejudices into the interview with the resulting reflection of yourself in the data (de Laine 1997, p.174). I chose to use during

all of the interviews what Bernard, cited in de Laine, calls probing by leading or directive probes (ibid). These are leading questions based on what the person being interviewed has stated or on factors outside of the particular interview context. I regarded the observations I had made and previous interviews with nurses or doctors in this category.

In summary, 16 in-depth interviews of nurses (RNs) and doctors (GPs) were conducted over the four case study sites. The majority of interviews took place during a one to four day period of non-participant observation of the RNs and GPs who participated at each site. Interviews were unstructured and, apart from four background socio-demographic type questions, were open-ended. All participants were asked one main question, which required them to describe their perception of the professional working relationship between rural nurses and doctors. Additional clarifying questions were asked of participants to explore and obtain more information about specific issues that had arisen out of the observational part of the study or from interviews with other nurses and doctors. All interviews were tape recorded and transcribed. Participants were sent the transcripts for checking of their validity and accuracy before being used in the study.

3.4.4 Transcription of interviews and checking for validity & accuracy

From a technical point of view the tape-recording of the interviews went smoothly. I used a small hand held recorder of high quality with 60-minute recording capacity micro cassettes. The type of recorder was such that at the end of one 30-minute side it automatically started recording on the other side. This meant I did not have to break the flow of the interview by having to change tape sides. Only one of the interview recordings was of poor audio quality due to background noise caused by a GP's small child who was present at various times during the interview. The GP did not appear concerned about this at the time and her concentration and participation in the interview were maintained. This particular tape took double the time to transcribe due to this 'noise' factor and is a reminder of the failings of this form of interview recording over other forms such as field notes. All 16 tape-recorded interviews were transcribed to computer data files using a micro cassette foot control player.

The average interview time range was between 20 and 50 minutes. I transcribed all but three of the tapes and employed a professional transcriber for these. On reflection my time would have been more productive had I used this service for more of the transcribing. However, by listening to the tape recordings in the transcription process I felt 'closer' to the data and made mental notes of content and 'flavour'. A total of 150 A4 pages of transcribed interview resulted from

approximately six hours of tape-recorded interviews. The transcription of the tape recordings commenced at the earliest opportunity after I had completed the fieldwork at each case study site. As I had explained to each participant interviewed some time would elapse before they received the transcript per post for their checking and approval. On average participants received transcripts within four to six weeks after I had left the site. When completed, I forwarded each participant a copy of the transcript of his or her interview. This was accompanied with a covering letter (Appendix C). This explained the reason why I had assigned a pseudonym name for them, and asked them to check the transcript for validity and accuracy.

They were instructed to return any page/s to me under confidential fax or post with corrections marked on them or to telephone me to discuss aspects of the transcript they were uncomfortable about. There were three or four participants who forwarded individual pages and I spoke with others by phone to ensure they had received the transcript and were comfortable with it. If I received no reply from them this was taken to mean they agreed with the transcript and gave their approval to use it. This had been discussed with participants at the time I was in the field and consent forms signed to that effect. If any alterations or corrections had been made and when approval was given I forwarded final copies of the transcript for participants to keep as a record.

3.4.5 Comparisons across case study sites

Data were collected in the form of observational field notes from four case study sites and 16 in-depth interviews from ten RNs and six GPs. Each case study site is described using a similar profile template. This included:

- a description of the rural town in which the case study was undertaken
- a description of the health service where the nurses and doctors worked
- a profile of the RNs and GPs at the case study site
- descriptions from field notes of the interactions between RNs and GPs
- a summary of the case study.

There are two reasons for making comparisons across the four case study sites. First the sites were different in character. Although all were within a rural context the features of each were dissimilar. This is explained in more detail as the profile of each service is described in Chapters 4.7. In brief, the types of health service included a small rural hospital, hospital with multi purpose services, community health centre and a large regional hospital. Secondly, the nature of

the professional working relationship was also different across sites and even within sites. For example, in the large regional hospital (Bridge Town) case study site I observed nurses working in two main areas, one a busy A&E area with the GPs coming as they were called for emergency work and the other a combined medical surgical ward where the GPs only visited at specific times of the day. In another example, the case study site at Silo Town had no resident doctor and the nurses interacted almost exclusively with the two visiting GPs to the community health centre via telephone. The comparisons between the four case study sites and the contrasts in the relationship between RNs and GPs working together in them will be discussed in the discursive exploration, Chapter 8. It is hoped that the obvious and the subtle issues that make one site different from the other will emerge and also what effect this has on the working relationship of the nurses and doctors.

3.4.6 Convergence of data from observations, interviews and other sources

Some consideration needed to be given to how the various sets of data – field notes from observations, in-depth interview transcripts, historical and contemporary literature and additional documentation pertinent to the working relationship – could be converged in a meaningful way. Denzin & Lincoln (1994) uphold the use of multiple methods of data collection as likely to 'secure an in-depth understanding of the phenomena in question' but warn that objective reality can never really be captured (Denzin 1994, p.2. In other words, the use of multiple methods of data gathering and the synthesis of the results arising from them improves the breadth, depth and rigor of a study, but cannot be totally relied upon to do so.

This study was not designed as a grounded theory one where frequent returning to the source of information is required. There was no checking back with participants in the field on conclusions drawn from the observational notes and in-depth interviews. It is appropriate, however, that the various sources of information be compared and contrasted to increase the reliability and validity of the conclusions. The merging of the various data occurs at strategic points in the study and as such is reflected in this thesis. The historical and contemporary literature about nurse-doctor relationships is introduced in Chapter 1 and again in Chapter 2, where discussion about the rural nursing and medical workforces and rural practice takes place. It is also used to reinforce the descriptions of the professional working relationship phenomenon, which occurs in Chapter 8. Here there is a discursive exploration of the main themes and issues arising out of the case studies, observational field notes and in-depth interviews. There are close links between the

information arising out of the observation of nurses and doctors in the various case study work settings and the in-depth interviews. For example, information arising from probing questions in in-depth interviews was used to compare and contrast with the reality of what was observed.

3.4.7 Additional data collection sources

The primary sources of data collection for the study have been identified as being:

- literature pertaining to the nurse-doctor relationship (historical and contemporary)
- case study sites: observational field notes and in-depth interviews.

In addition to these sources of information a number of others were utilised to assist with clarification and substantiation of facts. These included a notebook into which I entered general information of a methodological kind, supervisor suggestions, ideas to follow up and procedures gleaned from other fellow researchers. I used this source of information frequently in the early stages of the study and to a lesser extent during field work. However it proved to be invaluable as a tool to map broad thoughts and canvas possible solutions to problems.

Another information source that I relied heavily on when constructing background information on the four case study sites were documents sourced from the health services in which the study took place. I obtained these while undertaking the field work or made specific requests for them following completion of my field work. They included annual reports, policy manuals, communication books, newspaper articles and discussion papers and proved very useful in building a picture of the organisational structure and health service functions of each case study site. Some of the documents were also instructive in coming to understand some of the dynamics of the working relationship between nurses and doctors in that particular setting.

3.5 Discursive exploration

When planning the research design for this study I have avoided rigid adherence to any one methodology. This decision was taken to ensure that the inductively derived data were not constrained by the theory of philosophical paradigms. In other words I choose to be loosely guided by a post-modern view that is inclusive and understanding of the power of discourse but not one that deconstructs to the point of impracticality. In this case the experience of nurses and doctors in four similar but different rural working contexts was sought and used as the primary data.

This position does not ignore the understandings and interpretations of certain paradigms and the seduction of their application to the essence of this study. Chief among these is the work of Michael Foucoult who drew sharp distinctions between the discursive and non-discursive in his alternative theory of discourse in which he was not interested in the truth of statements or their meaning but rather the rules of their formation and the discourse from whence they came (Torfing 1999, p90). In Foucault's later work, which shifted from an archaeological to genealogical approach he emphasized the role of power in the production of what Laclau (1993a, p436) called 'unsutured discursive identities'. Foucault's archaeology provided a disinterested and detached description of the rules around discourse while genealogy provides a way to examine closely the many power struggles that shape historical forms of discourse (Torfing 1999, p91). Put another way subjugation, domination and combat are found in all the genealogist surveys (Dreyfus and Rabinow, 1986 p108-9). Genealogy is therefore a method by which discursive practices can be diagnosed.

In a previous chapter I have already pointed to the history of conflict, domination and power imbalance which exists between nursing and medicine and while it may have been interesting to examine the discourses which influence rural nurses and doctors I was more interested in the *meaning* of the working relationship for both nurses and doctors and what factors shape and influence it. Therefore the final element of the case study design is a discursive exploration of the information gathered from the case studies by non-participant observation and in-depth interviews. This is supplemented by the literature, which details the relationship between nurses and doctors and more recent contemporary publications. A way needed to be found to bring forth the meanings of the various discourses coming from the cases study sites and the ethnographic strategies used to elucidate them. The study never intended to test any particular hypothesis or search for any particular element of the professional working relationship. What it was designed to do was to inductively allow the multiple discourses to be heard and brought out into the open so that the many aspects and complex matrices of the relationship could be given shape and form, to be identified as important, at least in the minds of the participants, and to be acknowledged by me as a supposed impartial observer.

What is discursive? How is the field of discursivity described? What is a discursive exploration? Why is a discursive approach useful in dealing with the gathered information about the professional working relationship of rural RNs and GPs? These are important questions, which require explanation. A literal definition of discursive means to move from one topic to another, or

subject-to-subject. In philosophical terms it means proceeding by reasoning or argument towards some truth, understanding or meaning. It is not intuitive, that which is known or learnt, but, rather, explorative in its thinking so as not to be exclusive of important phenomena which may be unearthed by such moving from subject to subject or from discourse to discourse. The challenge in the field of discursivity is to make a relative whole out of many subjects or discourses. Jacob Torfing (1999) provides the following definitions of the discursive and discursive formation:

> The discursive (the field of discursivity). The partial fixation of meaning within discourse produces an irreducible surplus of meaning. The field of irreducible surplus is termed the discursive (or field of discursivity). (Torfing 1999, p.300)

Torfing provides the following definition of discursive formation:

> A discursive formation is a result of the articulation of a variety of discourses into a relatively unified whole. Liberal democracy is a discursive formation as it consists of a variety of different discourses, which have been articulated, in and through hegemonic practices. (Torfing 1999, p.300)

In these definitions two things become apparent. The first is that by 'managing' or working with and in discourse, meaning will be the eventual outcome. The distillation of meaning from the discourses is claimed then to be irreducible. The second relates to discursive formations. Torfing cites Foucault (1985) who concludes he 'is not interested in either the truth of statements or their meaning, but rather the rules of formation...' (Torfing 1999, p.90). In this study the discursive exploration, which takes place in Chapter 8, explores the various subjects and topics and the way in which they were formed at the case study sites and hopes to discover and illuminate the meanings arising from them. Of course, this will be my own interpretation of what I observed and heard in the complex interactions between rural nurses and doctors and therein lies the fallibility of all research in the qualitative vein. In support of my own ability, it is possible to marshal these complex discourses and give clarity to their muffled voices in much the same way as noisy children gain the attention of their parents. The discursive or field of discursivity will be the end result of this exploration and the product will be the irreducible surplus of meaning about the nurse-doctor work relationship in the four case study sites.

3.6 Summary features of the study design

The study primarily is based on a case study approach and use of the ethnographic techniques of non-participant observation and in-depth interviews. Four case study sites provided different rural health care settings in which the relationship differed because of the context of the work undertaken by the nurses and doctors. The case studies became a useful platform from which to study the phenomena of the professional working relationship. Major features include the following.

- There is the use of inductive reasoning.
  (empirical data - generalisation - propositional statements - general explanation/theory)
- A series of four (4) case study sites was used for the collection of information about the professional working relationship. Analysed using a discursive exploration method to bring forward themes and features of the working relationship between rural nurses and doctors, the knowledge and understandings generated by this approach will emerge inductively and through the exploration of themes arising from the participants.
- Information was gathered at the case study sites using ethnographic techniques for data collection. These include observation and in-depth interviews. The information gathered was critically reviewed (discursively).
- The case study work used a combination of non-participant observation, in-depth interview and field note analysis. The four case study sites are primary in understanding how the different rural contexts affect the working relationship.

Linking information sets was achieved by the means indicated below.

- Non-participant observation and in-depth interviews were conducted with nurses and doctors.
- Substantiation and evidence to support what was said and what was observed were constantly sought.
- Supplementary open-ended questions about specifically observed behaviour of either doctors or nurses were posed by the researcher.
- There was discursive exploration of what was actually going on and interpretation of meaning.
- There was comparison across cases study sites for differences and factors which might influence the relationship in one site but not another.

3.7 Ethics and other approvals to conduct research

As the research involved human subjects, approval from a human research ethics committee was necessary. The major ethics principles of any research which may directly or indirectly involve human participation or experimentation are that no harm will come to the subjects and that they are fully informed and able to give their consent to participate in the research. While the research to be conducted could not be called invasive, it nevertheless involved making case study site visits at which non-participant observation and in-depth interviews would be conducted. Issues to do with confidentiality and privacy were immediate concerns because of the relatively small size of the case study sites and the rural communities in which they were located. It was important therefore to gain approval from the participants and the management of the health services to conduct the research and to satisfy them that all reasonable precautions would be taken to protect staff and their organisation from unethical research procedures or breaches of confidentiality. These could clearly cause repercussions for the participants or harm the organisation's reputation.

In planning for ethics approval I was conscious of the relatively small numbers of participants to be included in the research and the potential for me as a researcher entering their world to inadvertently allow information I had gained from them to reach other colleagues they worked with or the management of the health service for which they worked. Gossip and rumour spreading in small rural communities can be very harmful. I wanted to assure participants that I would protect their identities and what they said or did by following properly established and ethical procedures for the collection of the information, its interpretation in the text of the thesis and in the storage of the raw data.

3.7.1 Research proposal and human research ethics approval

The Adelaide University Committee on the Ethics of Human Experimentation requires all applications for approval to comply with the university's research ethic guidelines. These are based upon the National Health & Medical Research Council (NH&MRC) Statement of Human Experimentation Guidelines. An application and research proposal were lodged with the Ethics Committee in late 1997. Included was the information listed in Figure 3.3:

1	Project title
2	Investigator name and supervisor
3	Name of award for which the research was being conducted
4	Proposed commencement date
5	Purpose of the research
6	Aims of the research
7	Background to the research
8	Rural practice
9	Study plan and design
10	Subject selection and exclusion
11	Ethical considerations
12	Safety and ecological considerations
13	Analysis and reporting of results
14	Information Sheet for participants
15	Letter inviting selected health services to participate in the research
16	Participant consent form

Figure 3.3 List of contents of the application and research proposal lodged with the university Ethics Committee in 1997

The declared subjects for the research were rural registered nurses (RNs) and general medical practitioners (GPs) working in South Australian public health services located in rural areas with an age range of 20 to 60 years. Participants would be self-selected for the research after receiving information about the study. One exclusion criteria was noted in the application. Nurses and doctors who had less than three months experience in rural practice would not be invited to participate. Specific mention was made in the application about steps taken by the researcher to avoid compromising the participants or their organisations. These steps included:

- use of an pseudonym for all participants when transcripts of in-depth interviews were made
- not informing participants of the names of other staff who had undertaken in-depth interviews
- changing site or participant identifying information in the case study site field notes and in the transcripts of in-depth interviews
- keeping field notes and tape recordings in a secure place while in the case study sites and following completion of the research
- forwarding transcripts to in-depth interview participants under confidential cover.

All participants were given a written plain language statement, which explained the research (Appendix B). This was also discussed with nurses and doctors who participated in the in-depth interviews. A consent form (Appendix D) that authorised the researcher to conduct the research was also given to each participant. These information and consent forms made clear the choice participants had to withdraw from the research at any time. Finally, the proposal to the research ethics committee gave an assurance that the researcher would not interfere with or hinder the work of participant nurses and doctors as they delivered care to clients and patients.

3.7.2 Changes requested by the Ethics Committee

Approval to conduct the research was received from the university's Human Research Ethics Committee near the end of 1997 and allowed 12 months or until the 31st December 1998 to complete the field work research. One condition was placed on the approval and a suggestion made for consideration. The condition of approval related to observations I might make of nurses and doctors where there was a patient present and was as follows:

> ...that the patient's consent will be obtained if the observation takes place in the presence of a patient. (Mortensen 1998, Human Research Ethics Committee approval)

The imposed condition of gaining consent from patients who might be involved in the research because they were present during observations of nurses and doctors working together was managed by using a specially designed patient consent form (Appendix E). The form introduced the researcher, gave the title of the research and provided a brief overview of the research project. It made clear I would seek the patient's consent in the event I was observing a nurse-doctor interaction even though they were not necessarily the focus of such interaction.

In practice this condition proved difficult to implement for two reasons. Firstly, some of the patients were not physically or mentally able to sign or comprehend the research, and secondly, there were situations where patients presented to A&E areas of the hospital precipitately. It would have been an unwarranted intrusion on them to explain the research and gain their written consent, even if they were able to give it. I overcame this in most situations by meeting with patients prior to nurses and doctors being with them and gaining their written consent. Where this was not possible I explained the research and gained their verbal consent.

The rationale of the ethics committee in seeking consent from patients was no doubt based on their concern that patients' privacy and anonymity might be compromised by any descriptions I made about them during observations of the nurse and doctor working together. In writing the

field notes and in the transcription of in-depth interviews I was especially careful not to identify patients and to uphold their right to confidentiality. This was mostly achieved by not using their names and by making general descriptions only of the medical condition for which they were being treated. As the patient was of secondary interest to my observations, detailed description of them was not undertaken and when it was, this was because it was central to understanding the interaction between the nurse and doctor. A further safeguard against identification of patients was the use of fictitious names for the case study sites from which the source of information arose.

Access to patients in case study sites Valley Town and Sea Town was relatively straightforward and obtaining consent was also convenient. In the large regional rural hospital, Bridge Town, observation mainly took place in the accident and emergency area and a medical surgical ward. Gaining patient consent was difficult and in some cases not possible due to the transient nature of the patient or their medical condition. Likewise, in Silo Town there were no in-patients, only those visiting the community health centre to see the doctor or nurses. No observations were made of the GP and patients when they were consulting.

The ethics committee also suggested:

> ...you may wish to consider whether there is a potential for results to be biased by the willingness of subjects to participate in this study. (Mortensen 1998, Human Research Ethics Committee approval)

After considering this suggested bias I discounted it. There were several justifications for this. The selection of case study sites has been explained but, in brief, four case studies were chosen from eight invitations extended to health services meeting the selection criteria. Each site then received a package of material that included letters explaining the research process and information sheets to be directed to nursing and medical staff. These explained the research in detail and invited their participation. When I arrived at the case study site some nursing and medical staff had already indicated their willingness to be involved in the study. Others I approached on the first day of my being in the site indicated their willingness to be involved. In some instances it was not possible for them to be included either because of the numbers or the time limitation of my field visit. In short, there was a combination of self and researcher selection, which resulted in a group of subjects who had agreed to participate in the research. The question to be answered is: Because they voluntarily indicated their willingness to be involved in the research, was their opinion likely to be biased. Janesick (1994) points out that:

> There is no value-free or bias-free design. (Janesick 1994)

All researchers try to eliminate bias, some more successfully than others. In qualitative research the biases should be declared and either dealt with through use of a particular method or managed in a way that minimises the effect. I have not attempted to hide the fact that all of the participants in this study self selected themselves either before my arrival at the case study site or shortly after. They did this not because they were forced or coerced by their management or me. They did it because they felt they could contribute to the research and were interested in it.

3.7.3 Participant information

Participant information was provided primarily through the Information Sheet (Appendix B). Additional information about the research and what form the non-participation observation and in-depth interviews would take was provided to groups of nurses at the changeover of shifts and to doctors and nurses directly if they were selected to undertake in-depth interviews. The Information Sheets were designed to be easy to read and were printed on coloured paper to make them easy to identify while the fieldwork was being undertaken. In some case study sites the sheets were pinned to the notice board during the time I was there. In brief, the information offered participants is presented in Figure 3.4.

1	Research title
2	Researcher's and supervisor's name & contact details
3	An invitation to participate in the research
4	The aims and focus of the research
5	Why the research was being conducted
6	What would be required of participants if they participated
7	Explanations about confidentiality and anonymity
8	Statement that no money would be paid to participants
9	Instructions on how participants should indicate their interest in being involved in the research

Figure 3.4 List of information provided to participants

3.7.4 Participant consent

Participant consent was obtained for all 16 nurses and doctors who undertook in-depth interviews subsequent to them being observed in their day-to-day work. In some of the case study sites other nurses also signed consent forms as they were observed frequently but did not provide an in-depth interview. The procedure followed in gaining consent was to explain the research using the

Information Sheet and to answer any questions the participant might have had. Upon agreeing to be involved in the research or an in-depth interview, participants were asked to sign the consent. They were sent a copy of the signed consent form. The same process was used for patients. The researcher has stored the original consent forms from both participants and patients securely. All participants and patients approached to gain consent gave it freely with many expressing an interest in the research and its outcomes.

3.7.5 Case study site approvals

For the phenomenon of the professional working relationship between nurses and doctors to be studied in a meaningful way, I chose to investigate it in various rural health care settings. This meant I had to approach a number of health service organisations that fitted the criteria I had established. That is, a small rural hospital, large regional rural hospital, community health centre and hospital with multi-purpose services. As explained, some health service management rejected the request for the research to be undertaken despite the fact that it had been cleared by the university Human Ethics Committee. There are many reasons why approval to conduct research is not given by administrators. Morse (1994) identifies the major one as being:

> ...wary of a project that will essentially evaluate their personnel or institution, if they have no control over the research outcomes, or if they feel the results may be detrimental to the organization, even if the researcher assures them that the site will not be identified in the final report. (Morse 1994)

I had to accept that these and other explanations were part of the process. This is one of the reasons why I approached more than the four case study sites I had planned for in the study design. When there are few options to choose from, the pressure on researchers to gain approval increases. I experienced this when the only recognised multi-purpose service in rural South Australia did not respond to my requests to conduct the research. I had to find an alternative that had similar characteristics. Fortunately I was able to achieve this and Valley Town was included as a case study site.

Clearance to conduct the research from the university Human Ethic Committee obviously assisted the management of the case study sites in their deliberations to give approval and with one exception all gave it quite quickly. The large regional rural hospital took twice as long and I was required to meet with the Medical Staff Society of that hospital and satisfy them of my research intentions before final approval was given.

On reflecting through the process of gaining approval an additional factor may have influenced the decision of the organisations that approved or did not approve my request. I have worked in the region in which the four case study sites were located for many years and some of the personnel I sought approval from were known to me. Where this was apparent I was careful not to apply any direct or indirect pressure on them to alter the course of events. My request should stand on its merits.

3.7.6 Confidentiality

Confidentiality is a researcher's guide rail. It should be ever present in the mind, in actions while research fieldwork is being conducted and in the management of the information collected and presented in the final report. Researchers are entrusted with information that may be intensely private, potentially damaging to others and only shared in those rare moments of candour between researcher and participant. In a quantitative study, closely guarded secrets may be disclosed to the researcher's eyes through the rather impartial pages of a written questionnaire with all its attendant anonymity.

I recall one such survey I completed several years ago that asked questions about the amount and frequency of morphine I had administered to dying patients. Before answering the questions in a truthful way I read with caution the clauses that had been provided in the accompanying instructions that described the steps taken to protect the confidentiality of respondents. From a purely ethical perspective the need for confidentiality is obvious. The need to protect the research participant or subject from being identified by the research and thereby invading their right to privacy should be obvious. The main steps taken in this study to protect the confidentiality of participants included:

- conducting in-depth interviews with participants in a private place and not within hearing range of other staff
- ensuring my field notes were not accessible during the time i was in the field undertaking observation work
- changing the name of the person being interviewed
- altering the names of places or identifying information of other staff or patients mentioned in the in-depth interviews
- forwarding completed transcripts of in-depth interviews for checking by confidential mail
- ensuring that all participants who signed consent forms understood the statements about confidentiality
- maintaining secure research data files and computer access to same

- withdrawing from the observer role when it became obvious there was confidential material being discussed
- not discussing details of fieldwork with people who have no direct connection with the research.

Despite these good intentions the risk of breaching a participant's confidentiality was ever present. In one in-depth interview I conducted with a nurse she described her own brother's death in the rural hospital in which she worked. Included in her description were general comments about the medical treatment that her brother had received by the GP who also lived and worked in the town. These were not of a critical nature but clearly if I had not used steps to protect this confidential information, both the nurse and the GP who had treated her brother could have been compromised. Trust is placed in the hands of researchers immersed in the collection of their data by participants. They need to acknowledge the responsibility that comes with it and at the same time try to use the information to explain the phenomena being researched. There is a balance to be struck between the two competing forces.

3.7.7 Secure storage of research information

The main sources of confidential information in this study were those arising out of the case study fieldwork, namely the field notes and the in-depth interviews. The actual data stemming from these took the form of computer files, hand written notes in a field journal, tape recordings of in-depth interviews and transcripts of in-depth interviews, as well as confidential correspondence.

All of these have remained under my direct control since their inception and have either been stored on my personal research computer at home or in hard copy form with my supervisor in the Department of Clinical Nursing, Adelaide University. As explained previously, I used an external transcribing service for some of the tape-recorded in-depth interviews and I made sure this person understood the confidential nature of the recordings and transcripts. The computer discs used to transcribe the interviews were all returned to me. The original tape recordings, transcripts (in computer and hard copy form) and field notes and any other confidential correspondence have been secured in a locked area in my home office, as have the signed consent forms for all participants. Following submission of the thesis, I will comply with the procedures current at the time for long term storage of data by the Department of Clinical Nursing and The Adelaide University.

3.8 Limitations of the research

3.8.1 Case study sites

Although the four case study sites selected were a typical representation of rural and regional health services in South Australia no claim is made that the insights gained in the study of nurse-doctor relationships is applicable to other similar sites. Information obtained from the case study sites reflected the culture and sub cultures operating in these locations at the time the research was conducted. In a way it was a snapshot in time of the health service and the way in which the nurses and doctors worked together. A different picture and analysis of the professional working relationship of nurses and doctors may emerge if similar research were conducted at the same case study sites now or at some time in the future.

Case studies are just that: studies of a particular case, be it a person or a phenomenon, examined at a particular point in time; and only a new case study on the same person or phenomenon will establish a pattern or be able to define differences over time. Since the completion of the fieldwork research in mid 1998 several of the case study sites have undergone changes that have affected the way in which they deliver health care services. Nurses and doctors have also changed, with some leaving the area and state completely. The dynamics of established working behaviours and procedures observed in this study will almost certainly be different as new nursing and medical staff build their own professional working relationships.

3.8.2 Selection of key participants

The process of selecting key participants has previously been described but, in brief, it occurred by one of two methods. Participants either self-selected themselves by agreeing to participate in in-depth interviews or they were approached by me and asked if they would participate. The Human Ethics Research Committee raised the issue of possible bias because of the self-selection of participant nurses and doctors and it is debatable as to whether this is a limitation of the study or not.

I hold the view that it was not a limitation because the case study site selection process was in part of a random nature; that is, a number of potential case study sites were approached and asked to participate in the research. Some declined and four eventually gave approval. Those giving approval had presumably canvassed the views of their nursing and medical staff before agreeing to participate. Participant nurses and doctors in these sites had information about the research and, assuming they had read and understood this, were willing participants or at the very least tolerant of the research being undertaken in their workplace.

What about the views and opinions of other nurses and doctors who were present at the case study sites at the time of the fieldwork research but who did not participate in in-depth interviews? Two limiting factors as far as nurses were concerned were larger numbers of nursing staff in the case study sites when compared to medical staff and the fact that they were rostered across three work shifts over a five day working week. The fieldwork was conducted in each site over a period of three to four days and this meant that not all nurses working in that site would be rostered for shift work at the same time the observation fieldwork was being undertaken. Additionally, conducting in-depth interviews on all nursing or medical staff in every case study site was never part of the research plan.

The selection of doctors (GPs) was easier in three of the case study sites because of lower numbers, relative to nurses, and their availability. In the large regional rural hospital case study site (Bridge Town) this was not so. In this site the numbers of GPs and RNs were large, but while accessing and observing nurses at work were convenient, the same could not be said for GPs who tended to visit the hospital for short periods and then leave. GPs in the smaller case study sites were more accessible because they had their surgery located within the health care facility and during consulting hours were only a few steps away from the main nursing office.

Finally, selection of nurses and doctors in the smaller case study sites of Sea Town, Valley Town and Silo Town was limited to available core staff. I have already mentioned that the total number of staff in these health services was small and the total available number of GPs at these sites participated in the study. The highest number of RNs participating in the study at any one site was Sea Town with four. Two RNs participated in in-depth interviews in each of the other three case study sites. This is not because there was a shortage of RNs willing to participate in in-depth interviews, but reflected the limited time available to me in the field and the need to interview only those nurses whom I had observed interacting with doctors.

The reason why the number of RNs interviewed at Sea Town is higher (n=4) is explained by the fact that this was the first case study site I visited and also the one I was able to stay longest in. There was also a great deal of interest in the study at this site and many RNs talked informally to me but were not subsequently selected for interview. In the largest case study site of Bridge Town only one GP was interviewed. This is ironic, as this was the site that had the largest number of GPs at 10, but GPs at this site do not have their practices located within the hospital grounds. They only came to the hospital when they had to visit in-patients, were called there for a specific reason by RNs from the wards or A&E or they were on-call. My attempts to gain at least

one additional GP to participate in the study at this site failed because of these fleeting visits, but also because of the general lack of interest in participation which prevailed amongst the GPs at this case study site.

3.8.3 Exclusion of other than nurses (RNs) and doctors (GPs)

This study concentrated on the professional working relationship between RNs and GPs across four different case study sites. One immediate limitation of the study became obvious when observational fieldwork began at the first case study site, that was, the large number of enrolled nurses (ENs) who work in rural health services.

As a proportion of all nurses (both RNs & ENs), enrolled nurses comprise 39% of the total rural nursing workforce in South Australia, compared to 61% for RNs (Handley 1998). The number of ENs in rural South Australia differs slightly to the national population where there is almost double the number of ENs per 100,000 population in major rural areas when compared to capital cities (Bradley 2000). National workforce data collection by the Australian Institute of Health & Welfare indicates there are proportionally more ENs working in rural and remote areas than RNs (AIHW 1997).

While the number of ENs in South Australia is less than the national average, in all of the case study sites except one (Silo Town) there were ENs working the same shifts as RNs. The most common ratio in the smaller rural hospital case study sites was two RNs and two ENs per shift, although this fell to one RN and one EN on afternoon and night duty shifts.

The decision to exclude enrolled nurses from the study was made for several reasons. These included those outlined below.

- The major focus of the study was on the working relationship between RNs and GPs.
- The role of ENs is a supportive one to RNs and although there is evidence they interact with GPs in similar ways in rural practice they do not carry the same level of professional responsibility.
- The educational preparation, role and function of ENs is different from RNs and therefore the professional relationship they may have with GPs is distinctly different.
- Rural health services could not provide an adequate level of health care, particularly hospital care, without RNs and GPs working together. There are few situations in rural health care service delivery where ENs and GPs work exclusively and with no direct or indirect supervision by a RN.

While there is no attempt to include the discourse of ENs in this study, others have written about it as it applies to the rural context (Bradley 2000; Owens 1998). In undertaking observation within each of the case study sites ENs were part of the culture and landscape. They sometimes featured in interactions between RNs and GPs; and where they were central to the relationship between RNs and GPs, the activities of ENs were included in field note descriptions. RNs and GPs in their in-depth interviews also included examples where ENs had influenced their relationship in some way. There is no surprise in this as ENs form an important part of the rural health service culture. As such it is highly likely the relationship RNs develop with GPs will be influenced in some way by the reality that ENs work closely with both the RN and GP.

In each of the four case studies there were a number of other personnel who were observed interacting with RNs and GPs. These included other specialist doctors, managers, allied health staff and, of course, patients and their relatives. The general rule I have applied to these additional people is that if the description of their interaction with the RN and GP assists with understanding the relationship I have included it in the data gathering and made comment about it.

3.8.4 Sample size and generalising of results

Qualitative research cannot be generalised. It is unique to the individuals from whom the information arose and the interpretation placed upon that information by the researcher. The methodology and methods used to collect it will determine to some extent whether or not the results could be applied in other similar settings. If done well it represents a snapshot in time and space of a culture or subject. This invariably includes attendant bias, which researcher and participant bring to the research process however impartial or rigorous they try to be.

The nurses and doctors who participated in the research numbered 16 across the four case study sites. Ten of these were nurses (RNs) and six were doctors (GPs). As a representative sample size of RNs and GPs in rural South Australia the number is statistically insignificant, as has been discussed in Chapter 2. The sample size of rural nurses in this study represents approximately 0.6% of the total active RN population in rural South Australia. Therefore, no general application of the results of this study can be applied to the vast bulk of rural nurses in the state. It was never intended that it should be; otherwise a quantitative design would have been chosen and a large cohort of nurses used. The number of rural GPs in South Australia is also relatively small at less than 400. In this study six GPs participated, which amounts to approximately 1.5% of the state's rural GP population. As with the sample size of RNs, this is not of significance for results to be transferable to the wider population of rural GPs.

In summary, the nature of this study was to understand the professional working relationship of observed RNs and GPs in four different rural health care settings. It was not designed to investigate a large quantitative cohort but to focus instead on the culture operating at each case study site; and to describe the relationship as observed and related through the discourses of the individual nurses and doctors in each site. That is not to say that when these discourses are interpreted by me and read by other rural nurses and doctors who have not been part of the study, that they will see some similarities and differences in their own relationship and work setting. How strongly they concur or differ from my conclusions can only be the subject of another study.

3.8.5 Rural location of study

I have previously explained the process used to select and locate the study in four rural case study sites. Each one has a different character and offers a different type of health service. The professional working relationship between rural nurses and doctors is therefore affected by different factors in each site.

How might the study of the working relationship of RNs and GPs be any different in a rural location than any other? Is this a limitation of the study? I have sought to demonstrate throughout the thesis that there is a difference between rural and other types of nursing and medical practice; and that far from being a limitation of the study, this is in fact one of its strengths. Other studies examining the relationship between nursing and medicine have been acknowledged earlier but none have been identified which examine the relationship in a rural context and in particular an Australian rural context. This is a strong justification to conduct such a study and locate it in a rural area. In the earlier chapters of this thesis I argue strongly for a greater understanding of the professional working relationship between rural nurses and doctors. The reasons for this are self-evident. If the relationship is understood, it can be improved and developed into one that promotes mutual trust and respect. This assumes more significance in the rural practice context because there is a greater reliance on other health team members for support in decision making and implementation of health care regimes.

The Case Studies

The four case studies are presented as separate chapters before we begin the discursive exploration and look at the conclusions. The name given to each case study reflects the character of the rural town and health service as I perceived it whilst undertaking the fieldwork research. In attempting to protect the identity of the town and specific site I have chosen titles, which are general enough so as not to direct attention away from the essence of the case study and the subsequent interaction between nurses and doctors at that site. It is inevitable that in describing the features of the town that the case study site will be identified by some readers. If my portrayal does not coincide with individual or local perspectives I hope no offence will be taken.

Each of the case studies will include a general description of the town, a closer analysis of the health service in which the study took place and a direct focus of attention on the dynamics of the nurse-doctor relationship at that case study site. Finally some conclusions are drawn from each of the case study sites with a particular concentration on the defining features of the nurse-doctor relationship in that place.

Sea Town

4.1 Describing Sea Town

4.1.1 Physical characteristics

Idyllic, peaceful, neat and tidy, beautiful are some of the descriptions to draw a 'mind's eye' picture of Sea Town. As I drove into the main street it was obvious this town was bursting with civic pride. Well tended gardens, neat and clean streetscape and the evidence of yesteryear were apparent, with many buildings holding their age well and boasting fresh heritage paint colours. The prominent historic buildings in the main street were obviously respected by the current community and valued as part of the town's past history. In a way they were making a statement: we value the past; our history is important to us; and we want to preserve it for this and other generations.

Sea Town has a population of approximately 1300. This increases by several thousand during the summer months when holiday makers from Adelaide make their annual pilgrimage for swimming, boating and fishing activities in the small seaside town. The holidaymakers fill the local caravan park and the rows of holiday 'shacks' which hug the shoreline close by the town. These bustle with activity, particularly at Easter and Christmas time when the visitor numbers reach their peak. During times outside these holiday periods the town survives as a retirement settlement and service centre for the surrounding mixed farming communities and a sheltered port for a small number of commercial fishing vessels. These are outnumbered three to one by recreational fishing boats of all shapes, sizes and conditions. This little armada of boats clusters at the end of a long town jetty where there is a sheltered harbour or lie resting on trailers in the driveways of the shacks located on the beachfront, awaiting the next public holiday to head to sea.

4.1.2 Socio-economic characteristics

The population of Sea Town has remained relatively stable for many years. Like many small rural towns it has weathered the storms brought upon it by changed rural economics and different forms of transport. It has never been served by a railway link and has always relied on road or, in earlier times, sea links to bring in supplies and export produce. During the past five years, banks and other businesses have closed and this has forced the local community to travel to larger neighbouring towns for some services.

In this respect there is at least a choice. Two larger rural towns are within 50-60 kms of Sea Town. One of these is a regional centre and has a well equipped hospital where residents of Sea Town can receive health services not available in their local hospital. The 1996 ABS census figures for the District Council (DC) in which Sea Town is located were 1311. The town also has a high number of aged people, with the median age being 47 years according to the 1996 ABS census (ABS 1999). This is much higher than the median age for the state of South Australia as a whole, which was 34 years at the time of the 1996 ABS census.

The main source of income and reason for the town's existence is grain and some livestock farming in the surrounding district. There is some commercial fishing, but this is also limited to a small number of primary producers. A heavy reliance on the tourist and holiday visitor trade and the fixed income from pensioners also contributes to the local economy. Unemployment is low at around 4.8% of the total district council area, or 63 individuals out of the total district population of 1311 (ABS 1999). Of more significance is the fact that 595 individuals, 45% of the town's population, are not in the labour market. In other words, there is a high proportion of aged residents who are retired and living in the town.

The people of Sea Town, then, can be described as being primarily retired pensioners and a mix of other business and professional people. The profile of the town changes dramatically during the holiday periods when young families with children are common. Table 4.1 demonstrates that health status is low and use of the health service resources is high. This is explained in part by the number of older people living in the town as permanent residents, but also reflects higher usage of the local health service in peak holiday periods.

Table 4.1 Socio-economic cluster characteristics for the Sea Town Statistical Local Area

Socio-economic status	Medium
Heath status	Low
Health service utilisation	High
Socio-economic & health status	Medium
Median individual income per week in DC (ABS)	$193
Median age of population in DC (ABS)	47 years

(Glover 1996; ABS 1999)

4.2 The health service description

The general impression of neatness and civic pride evident in the Sea Town streetscape applies also to the hospital. A low profile, one level, relatively modern brick building situated in neat and tidy spacious grounds gives an impression that this hospital and the staff who work in it assume the same ordered and welcoming mantle. This is confirmed as I meet the hospital receptionist who greets me with friendly smile. She asks me to wait while she goes to find the Executive Officer/Director of Nursing (EO/DON)[1] of the health service.

While waiting in the reception area I notice that it has a warm, almost homely feel about it. Paintings by local artists hang on the walls and a large day care activity room to the side of the waiting area beckons with the noise of friendly chatter. I can see various elderly people at work over tables and a woman wearing a bright coloured apron who is moving from table to table, giving advice to those working. This is clearly the day care centre for elderly residents in the town. A table stands in one corner of the waiting area and is laden with crafts and produce. These are marked as products of the day care centre and are for sale to staff and visitors to the hospital. This is a theme I will encounter often in travels to rural hospitals: the selling of products, the running of raffles and the organisation of other fund raising activity. These things have become a necessary part of the way of life in rural towns. Funds raised in this way are used in some cases to provide essential equipment or to pay for refurbishing and rebuilding programs unable to be funded by a cash starved public hospital system.

The EO/DON arrives. I am made to feel welcome. She takes me to the residential wing of the hospital, which in a past life served as nurses' residential quarters. This is where I will stay during my fieldwork at the hospital. I was told these rooms were used only when nursing staff worked on late afternoon or evening shifts and did not want to drive home in darkness when they had an early morning shift the next day. I make myself comfortable and prepare for the next day when I will commence observation of the nurses and doctors working in the Sea Town Hospital.

---

[1] *Executive Officer – Director of Nursing combined roles are common in rural hospitals throughout South Australia. They are in response to the downsizing of health units and the need to rationalise staff positions. Adding the additional responsibility of Executive Officer to the Director of Nursing position combines both a management and a clinical role.*

The Sea Town Hospital employs 35 staff. There are a total of 15 registered nurses and 12 enrolled nurses on the hospital roster. The duty roster usually has one registered and one enrolled nurse per shift for three shifts over a 24 hour period. An additional nurse may be rostered for morning shifts, which are 7am to 3.30pm or when there is a busy period or a visiting specialist. There are two local doctors, both in the same practice partnership. The consulting rooms for both the doctors are within the hospital building.

In addition to the nursing and medical staff there are about 17 other staff to provide catering, cleaning and clerical services. The hospital has an annual government grant of around $1.2 million to provide health services. It provides acute care and nursing home services, with 8 beds in the former and 12 in the latter. A community health service is also run from the hospital and a day care centre for frail aged. Midwifery patients attend the hospital but only after delivery in a nearby larger birthing centre.

The bed occupancy for the hospital is around 55% with a daily bed average of 10 patients. The average length of stay is 6.5 days. The majority (80%) of patients treated at the hospital are public. Private patients are in the minority (21%) and come from private funded, veterans and compensable patient groups. There is palpable pride from all staff I meet in the hospital, pride in their health service and in the facility as a whole. The hospital philosophy reflects this in a community-centred and patient-focussed place:

> We believe that our patients are the recipients of our hospitality and should be treated as honoured guests. (Arbon, 1998)

4.3 Profile of RNs and GPs

The South Australian Department of Human Services nurse labour force statistics for June1998 show the total number of full time equivalent RN positions at 5.8 or approximately 10 RNs available for rostered shifts at Sea Town Hospital (DHSSA, 1998). Over the three day period of fieldwork research at this case study site six (6) RNs and two (2) GPs participated in the study. Of the RNs, five (5) were female and one (1) male, while the two (2) GPs were male and female.

The profile of nurses and doctors in Sea Town has common features with the other case study sites with one exception. At an average of 2.5 years, the RNs had spent less time working at the Sea Town Hospital than the GPs, who had been there for an average of seven years.

Figure 4.1 demonstrates this and compares socio-demographic information for both nurses and doctors across five areas. These comparison areas were: average age, number of years since initial graduation as an RN or doctor, number of years practising as an RN or GP, number of years experience in rural practice and length of time at this particular location.

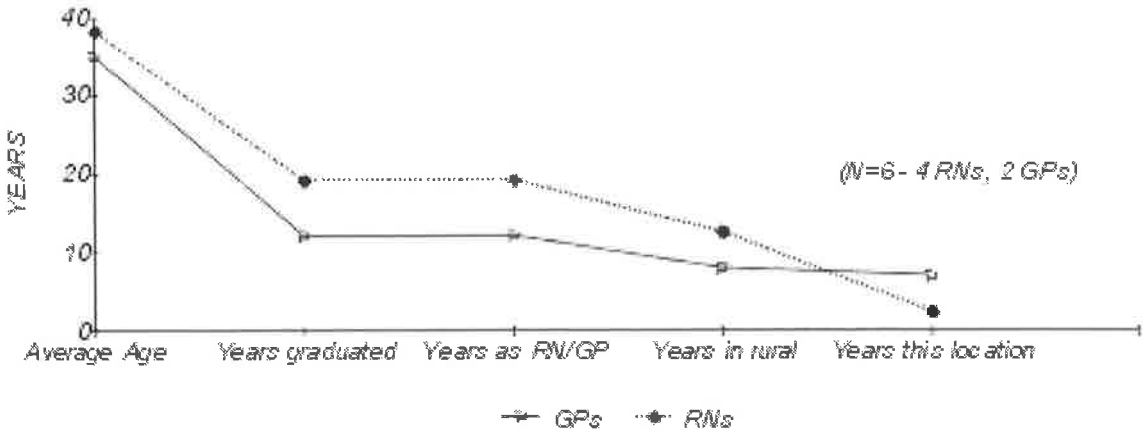


Figure 4.1 RN/GP profile in Sea Town

The ages of the nurses ranged from 30 to 55 years with the average age of the four nurses being 38.25 years. This was only 3.25 years older than the average age of the two GPs at 35. There was also a difference in the number of years practising either as a RN or GP. The nurses had been graduated from their initial preparation program on average seven years longer than the GPs. The average length of time the nurses had been working in rural practice was 19.25 years and 12.25 years for the GPs.

There was a slight difference between the nurses and doctors in the time located at this particular case study site. One of the two GPs at Sea Town had been there for 10 years, during seven of which he was the sole GP. The female GP had been working there for approximately 3.5 years. The median years spent in the one location for the two GPs was therefore 6.75 years. The time spent in this location for the nurses was less. The median years spent at this location for the four nurses who participated in in-depth interviews during the study was just over two years. The shortest duration was six weeks and the longest 3.5 years. One of the nurses was a long term resident of the town, but had worked as a nurse in other locations intra and interstate.

4.4 Nurse-doctor interactions

4.4.1 Overview

The observations and subsequent in-depth interviews of nurses and doctors at Sea Town Hospital revealed generally harmonious relations between the two groups. In observing interactions between them and during interviews it was clear neither wanted to display or say anything too critical about the other. In analysing field notes taken during the time of observation and the transcripts of interviews of the four nurses and two doctors, a picture emerges of a professional working relationship which is, at least on the surface, calm and untroubled. A more detailed examination of the data about the relationship at this case study site reveals some of the unique characteristics and attitudes of the nurses and doctors that emerged over a relatively short period of observation and from interviews with key informants. In one such example I saw a nurse and doctor conversing in the hospital corridor.

Interaction: Nurse as patient

A nurse and one of the doctors were in the corridor discussing something. At first it seemed the conversation was about the need for the doctor to inform the nurse that a patient needed more blood tests. I soon realised that this was a discussion between the doctor and the nurse as a patient herself and attempted to distance myself to give them privacy. The nurse was unconcerned and asked me to continue my observation.

The doctor discussed with the nurse, now in a 'patient role', the tests she thought needed to be done after which the nurse was asked to make another appointment with the doctor. The doctor then made a 'hat changing' gesture indicating she had finished the corridor consultation and was now in her other role as hospital doctor. (Field note ST01)

This brief interaction lasted less than a five minutes but it demonstrates the common reality of practice in rural areas. The nurse in this context was the doctor's patient. Neither the nurse nor doctor appeared uneasy about this reality. In small rural communities the reality is that both nurse and doctor live in close proximity. Their social and professional lives are intertwined and require giving and taking which is acceptable to both parties. A GP in Sea Town underscores this point when describing the balance she has to employ when treating nurses with whom she works:

> It's a tricky one when someone might approach you when they're on duty and say, 'Oh, I've got this bit of a niggle here and...' You don't want to say, 'Well, no, you should make an appointment, don't bother me with this here.' (Sea Town, female GP 2)

There is limited choice for nurses to have their own health care needs attended to in small rural towns where there may be only one or two GPs. GPs may feel obliged to help the nurses they work with and not regard them as patients, and nurses may expect the GP to provide a service at no or low cost because they have a working relationship and their choices are limited. A GP at Sea Town recognised the inherent problem in providing this kind of service in the work setting:

> ...in a way they're getting a second class service because they're not getting your full attention.
>
> Most of the staff don't have a problem with making an appointment and coming to see us. (Sea Town, female GP 2)

One concern with this informal consultation between doctor and nurse is the potential for conflict for both professionals and the lack of anonymity staff working in small rural hospitals have when seeking medical services. Conflicts might arise when the treating doctor knows the nurse has a medical condition that could effect clinical judgement or place the nurse in a compromising position professionally. Whether this alters the working relationship or is managed by nurse and doctor is of interest to this study.

Interaction: Conducting ward rounds

One morning the two doctors who work in Sea Town arrive at the nurses' station ready to undertake a round of the patients. They look for the registered nurse, who cannot be found. One of the doctors operates the paging system that all the nurses carry. A few seconds later we hear the beeping of a pager coming from a room off the corridor a few metres away from the nurses' station and the nurse arrives and greets each of the doctors.

After exchanging pleasantries the ward round commences. One of the doctors takes the patient case note trolley and pushes it to the first patient's room. The nurse gathers the bedside case records and the ward medication folder before joining the two doctors in the first patient's room. From the beginning of the round one of the two doctors takes the lead. This means he greets each patient, on most occasions initiating conversation and asks each patient: 'How are we this morning?' (Field note ST02)

The use of the word 'we', rather than 'you' in the greeting, although perhaps not intended, depersonalises the patient before the interaction commences. This is followed by further questions for the patient about their particular health problems, and, where appropriate, the doctor makes changes to the treatment orders. The nurse is sometimes consulted for her report on the progress of patients but she plays a largely passive role.

This is the pattern for the remainder of the patient rounds. This ritual of nurses accompanying doctors on patient rounds is a familiar one and has been a tradition for many years. In this rural hospital setting there are some subtle differences, one of which emerges in an in-depth interview with a GP from Sea Town:

> I guess the ward round this morning...was a little bit different to what it would normally be because 'Julie' is only fairly new on staff and she's done a lot of night duty. So it didn't flow quite as smoothly as it might otherwise have done. Which was fine, that's not a problem but I guess that reflects some of the nursing staff getting to know the doctors and vice versa. (Sea Town, female GP 2)

In this statement the doctor has pointed out that a nurse who is relatively new to the hospital and has been working mostly night duty shifts, is somewhat unfamiliar with day shift routines, in particular the ward round. The doctor states the ward rounds are usually 'smoother'. I take this to mean that the round takes less time and there are fewer explanations needed because the 'new' nurse does not yet know the doctors' routines. It is clear the two GPs on the ward round want to move through the process quickly and 'smoothly'. There are fewer than 10 patients in the hospital. The routine after the round is complete is for the doctors to commence consulting in their practice rooms. These are located within the same hospital building.

Interaction: The eye treatment

Another patient seen on the round has been taken to a treatment room in which there is an eye slit lamp. The doctor has previously requested this as he wished to examine the 93 year old man's eyes for in-turned eye lashes which are irritating the elderly man's eyes.

The man is seated in a wheelchair but this soon proves to be an impediment to positioning him close to the slit lamp device so he can place his chin and forehead onto the examination rests. The nurse attempts to push the wheelchair closer, but the doctor has by now realised the man will have to be placed in a normal chair so that he can be positioned more effectively. The doctor helps the man stand up and holds him while the nurse removes the wheelchair and places a chair behind him.

> The patient, who is unsteady on his feet, is reluctant to sit down again as he has a stiff neck and can't easily turn around to see where the chair is. He clings to the doctor like a man to a life raft. The doctor is standing up and reaching across the slit lamp, an awkward position and he has rivulets of sweat running down his face as he strains to hold the man's weight.
>
> Finally the nurse has positioned the chair and coaxes the man to sit down. For the next few minutes the doctor and nurse wrestle with a combination of the chair, the patient and the slit lamp. Finally, all is well and the doctor takes out his epilation forceps and begins the delicate task of removing the in-turned eyelashes. He complains about the inadequacies of the forceps to grasp fine hairs. He asks the nurse to hold open the man's eyelids so he can operate without the interference of blinking. The nurse continues to offer reassuring comments to the man during the procedure and on completion the nurse and doctor together help the old man to his feet and back into his wheelchair. The ward round continues. (Field note ST03)

The pattern in this small rural hospital is for procedures to be undertaken during the ward round where possible, whereas in larger hospitals treatment would be separate to the ward round, which is largely used as an assessment and review of treatment. The small size of the rural hospital allows more flexibility, including small procedures during the round. This allows additional interaction between the nurses and doctors. The nurses appreciate these opportunities and use them to build trust and confidence:

> I see it very much as an advantage for RNs and doctors to work together. I think it is important with the aspect of the teams working together for the benefit of the patient and also having confidence in one another. The doctor is also learning what abilities that person has…and what confidence they have in their working ability, their trust and also the care of their patients. (Sea Town, female nurse 4)

In interviews with nurses and doctors I asked them how trust was built between them. When nurses and doctors work together during procedures an opportunity is provided where both groups can assess the other's knowledge and skills. The ward round is mostly a passive role for nurses, taking changes in orders and providing information to the doctor, whereas the undertaking of procedures that require both to work together changes the dynamics considerably:

> Some of it's working with the doctor. Going with the doctor and working with different procedures. The doctors get to know how well the RN works, how much knowledge they have and the RN also in relation to getting to know the doctor and what their needs are. Because it's different in every hospital and knowing what to expect is important. (Sea Town, female nurse 4)

Here the nurse mentions 'knowing what to expect' as being an important factor in working with doctors. Understanding the ways doctors' work allows the nurse to anticipate their requirements. This might be regarded as a one way interaction where the nurse is the one always looking to satisfy the doctor's needs and subjugating their own. So why do nurses do it? The answer in part lies in the nurse's need to build trust and gain respect. This works both ways, for nurses and doctors:

> I look (to the doctor) for respect and the doctor vice versa. I think you get vibes as to whether the doctor accepts your knowledge and your capabilities. ...being in a relaxed atmosphere working with that doctor (helps). (Sea Town, female nurse 4)

When considering the 'relaxed atmosphere' the nurse describes as being important to allow the trust and respect to develop several factors appear to play an important part. The following example reveals the sorts of activities and conversations doctors and nurses with good rapport can share.

> Interaction: Relaxed atmosphere
>
> After the ward round and procedures are finished the two doctors and the nurse return to the nurses' station. There is a small kitchen leading off from the nurses' station and the nurse makes tea or coffee for them all. This is made easy because there is a list of staff preferences for tea and coffee located on the inside of the kitchen cupboard door. The doctors both sit down at a small table and begin to make notes from the round in the patient records as they sip their drinks. This time creates a 'relaxed atmosphere' for both the doctors and nurses as they chat between writing, and sipping their tea or coffee. I note the conversation is mostly social but includes discussion about clinical issues, either arising from the ward round or about previous patients. (Field note ST04)

The impression of a relaxed atmosphere engendered by the above field note is later reinforced by another nurse from Sea Town who describes her contribution to enhancing the relationship and actively creating a relaxing environment between herself and the local GP:

> I've had the doctor here late at night and really tired. I stood behind him and just gave him a little shoulder rub. And when we have too many peaches on our tree... I bring peaches in. And sometimes we have a chat about various things over coffee. They are very simple little things but... That probably doesn't happen so much in the city. (Sea Town, female nurse 1)

The doctors in Sea Town also understand the importance of developing harmonious relationships with the nurses, although during my observation they were not usually the initiators. One GP describes what in his view is a very harmonious relationship with nurses:

> In the country in a small setting like we have here, I think we are extremely fortunate in that our interaction with nursing staff works tremendously well. It's very close. We know the people personally and of any doctor-nurse relationship that I'm aware of...it works best here...It's a cooperative, friendly relationship. (Sea Town, male GP 1)

The same GP acknowledged, however, that it was impossible to expect harmonious relationships at all times and with all people:

> I mean I can't say that I have a really good working relationship with every registered nurse here. There is one RN here where the relationship does not work very well and the working relationship does suffer. (Sea Town, male GP 1)

When I asked why this was, he explained it was a personality clash between them and stated it was not her role as a RN that was the problem. Starting the relationship building on an open, honest basis was also important to this GP. However, he acknowledged that this is not always possible:

> The best way to achieve a useful working relationship is to have it on at least a friendly basis, hopefully with some trust, but that's not always possible with everybody, just because of personalities. (Sea Town, male GP 1)

The emphasis here is on keeping the relationship with nurses friendly but also recognising the reality that 'personalities' may prevent that from occurring.

So how do problems of this kind get resolved? If there is disagreement between the nurses and the GPs over issues at Sea Town, how do they manage the problem?

One effective strategy was to hold working luncheons. I observed one of these over soup and sandwiches with the two local doctors and the acting Clinical Nurse Consultant (CNC). These luncheon meetings are regular and both doctors and nurses are encouraged to bring issues to the meeting for discussion and resolution. Major items on the agenda during the meeting I attended are highlighted by the following example recorded in my field notes.

Interaction: Issues under consideration at a luncheon

At the luncheon the first topic of discussion was the suggestion that the local female doctor develop a sexual assault policy and also that there be training for her in the treatment of sexual assault victims brought to the hospital by police.

Following that, it was discussed whether childhood injury statistics should be kept going or not? The Acting CNC would like to continue to maintain them as he was alarmed at the number of schoolyard accidents and explained it was helpful to categorise the type of accident. One doctor reasoned that children had a higher tendency to have accidents anyway and that a schoolyard increased these incidents because children were there over a longer period. This did not stop him from acceding to the Acting CNC's wish to maintain these statistics.

Then continued a discussion about general medical/nursing issues. In the course of this discussion nursing staff expressed concern about a patient who wants to go home, against the wishes of the doctor. The doctor points to the fact that the patient is not in a physical condition to go home and be able to live independently, due to her age, frailty and that she has recently been diagnosed with terminal cancer. Nursing staff, on the other hand, respond to the patient's expressed desire to go to her own home and some even offer to call in on the patient if it will mean that her wish to be at home can be met. The medical view prevailed, not it seemed because it was the more persuasive argument, but because no coherent plan by the nursing staff to provide the home support required for the patient's needs had been presented.

The second example involved a similar case of rationale for a patient to remain in hospital. The nursing concern related to a patient with an injury to his foot and his longer than usual stay in the hospital after receiving treatment for this. This appeared to be a communication problem between the doctor and nursing staff whereby a key nursing staff member had not been informed about follow up treatment. All agreed to learn from this incident but no discussion took place about what strategies might be used to prevent future occurrences. (Field note ST05)

Overall the luncheon meeting was conducted in a light hearted, friendly and informal manner. Of the five agenda items two related to policy issues, two dealt with more effective clinical management of long term in-patients and one was a general safety consideration. The meeting seemed to be a very useful opportunity for nurses and doctors to meet and discuss issues of mutual concern. I concluded that the sharing of a meal together, albeit briefly, helped with communication and relationship building between the doctors and the nurse, and that the doctors and nurse were genuine in their attempts to listen to the other's point of view.

In a later interview with the male nurse present at this meeting, he explained why the relationship between the two doctors at Sea Town and the nursing staff was in his opinion a good one:

> If you can have a good interpersonal relationship with your doctors I think you are about 100 miles in front. If you don't, life is always going to be hard. I feel...I think the two doctors here should be commended for the way they conduct themselves because other places I have worked at, you are literally tearing your hair out to get the doctors to do something. (Sea Town, male nurse 5)

He also acknowledged the potential for great harm to the relationship when there is disagreement between the nurse and doctor, particularly over patient care issues, generally the most common ground of dispute. Increasingly nurses are prepared to dispute care treatment regimes which the doctors with whom they are working have requested or which run counter to their own care plans. Dealing with these problems in a rural work environment can compound their effect due to the lack of choice of other doctors' or nurses' opinions and access to backup services:

> On a personal level I have had to step over doctors to get appropriate treatment for patients. This places you in a terrible bind really. When that happens it means that it's impossible working with that doctor any longer. (Sea Town, male nurse 5)

When there is an identified problem between nurse and doctor, the maturity of the relationship, the standing of the nurse with the doctor and the gravity of the issue are all factors determining the outcome. One of the Sea Town GPs believes in the direct approach to resolving problems:

> If there is a problem, once again the honesty and openness is to present the problem to the source of the problem and not go sideways and go back-stabbing and talking amongst the 'tea room set' but to address the problem. To come back and say, 'I'm not sure what you mean by x, y and z. Or are you sure that's what you want to do?' (Sea Town, male GP 1)

What is being suggested here is that for the relationship to work effectively nurses and doctors must address any problems they might have with each other in a direct and open manner. To do otherwise is to risk sanction by the 'source of the problem' who will regard personal attacks on them behind their backs as damaging to the relationship. The important issue here is the power imbalance that exists between nurses and doctors. In a relationship where both partners feel equal, one might expect direct confrontation when problems exist and a willingness to accept and own problems and work towards resolving them.

As has been mentioned frequently in this work, nurses who challenge doctors do so at their peril:

> Most of the patient advocates I have seen before had 'got shot'.
> (Sea Town, male nurse 5)

They either deflect the conflict in the way described by Stein (1967) by following the rules of the doctor-nurse game, which are intended to prevent offence to the doctor; or they choose another path. One that has a greater risk for them personally and professionally. The maturity of the nurse and the relationship they have with the doctor in question will often determine which course of action they take. Even in the intimacy of a small rural hospital, where barriers might expect to be broken down, there is no guarantee 'game playing' by nurses and doctors will not happen. In fact some of the statements by the rural GP at Sea Town indicate that it does:

> It's all about appropriate questions put in an appropriate manner at an appropriate time. They're the three things I really like to talk about in any situation. An appropriate time is very important. In an appropriate way demands an appropriate answer. (Sea Town, male GP 1)

In this example the GP is making clear how he likes problems solved. The right question needs to be asked in the right manner and at the right time. Not much room for negotiation. The likely response of the nurse to this GP's stance is to revert to playing the doctor-nurse game, as this statement from a Sea Town nurse demonstrates:

> Be very certain of your observation...and hand on that observation. Don't ever say to the doctor, 'I think they (the patient) need this, that and the other'. Rather say, 'This is my observation and what would you like me to do to intervene...?
> (Sea Town, female nurse 1)

This nurse received her training some 20 years ago and the thought had not entered her mind that the doctor might welcome her clinical judgement and expertise. Not all the nurses in Sea Town held this view and it would be wrong to give the impression that the doctor-nurse game was a strategy used by all nurses and doctors in this particular setting. Like most nurses and doctors there are variations in the way each behaves when it comes to solving clinical problems. They are products of their professional training and have therefore been exposed to the stereotypical ways in which nurses and doctors interact and work together. The female GP at Sea Town acknowledges the fact that some nurses are more confident in their clinical judgements than others:

> ...there are some staff I trust what they say but obviously they don't have quite the same confidence in themselves, which is again something related to personality and experience. (Sea Town, female GP 2)

Sea Town Hospital offers outpatient services, which are provided during the day between 8.30am and 5.00pm by the two consulting GPs from their rooms in the hospital. Outside of these times nurses telephone the on-call doctor if they assess the presenting patient as needing to see a GP.

Interaction: The toenail

I observed a 70 year old man present to one of the doctor's consulting rooms. He had dropped a heavy boat trailer on his large toe one week ago. It was black and bruised with his toenail starting to lift off. The doctor asked an enrolled nurse to accompany him to the A&E room where he intended to remove the toenail.

An elderly women sitting with one leg propped up on a chair already occupied the small A& E room. The doctor explained the woman and man were husband and wife and playfully teased the woman, suggesting she had been responsible for her husband's blackened toe. An enrolled nurse from the early shift was in the process of changing a dressing on a small healing wound on the woman's lower leg. It was the shift overlap period and this meant there were two levels of staff.

Two other registered nurses entered the room. They conversed briefly to decide which of them would stay to assist the doctor with the removal of the man's toenail and which would attend to a young man who had also just presented for a scheduled ultrasound treatment. The registered nurse that stayed to assist the doctor asked him what equipment he required and while he proceeded to infiltrate the man's foot with local anaesthetic she went to a cupboard on the other side of the room and returned with a large Spencer Wells forceps. The light banter between the doctor, man and his wife continued as the doctor started to tug at the blackened toenail.

The nurse is at the foot of the patient trolley and adjusts the spotlight on the man's foot so the doctor has a clear view of the operating field. I am standing beside the man's head and he converses with me. I wonder if this is the end at which the nurse should be and at the effect my presence has had on the way the nurse and doctor are working. The doctor is asking the man if he is feeling OK. At first the offending toenail came away from the man's toe with ease but remained attached by some skin tags. The doctor asks the nurse for some scissors or a scalpel to cut these. She appears unconcerned that he had started the procedure with almost no preparation and now required her to fetch another item of equipment to complete his work.

Across the other side of the room the enrolled nurse has finished cleaning the small healing wound on the woman's lower leg and leaves the room to summon the second doctor to inspect the wound.

> The doctor arrives and after a brief inspection asks the nurse what type of dressing had been applied to the wound. She instructs the nurse to re-apply the same dressing type and asks the woman to make an appointment to see her in a week's time. Meanwhile the stubborn toenail yields to the tugs of the doctor's forceps and scalpel and parts company with its owner. The doctor asks the nurse to clean the wound and apply a dressing. He then inquires of the nurse if she is going to be on-duty in two days time, informing the patient that he should return then to have the dressing changed and checked by her. He also advises the patient that the toe will 'throb a bit' and instructs the nurse: 'He can have a couple of Panadeine'. The doctor then leaves the room.
>
> Both nurses in the room continue to finish their respective dressings and to clear away the variety of instruments, dressing packs and other disposable products used for these two patients.
>
> A registered nurse enters the room and begins to complete forms, asking the woman for her Medicare card to claim for the treatments she and her husband have just received. There is discussion by the nurse with others in the room about whether or not she should enter the local anaesthetic which the doctor had administered for the man's toenail removal into another record book kept in the A&E room. The nurses assist both elderly patients to their feet and escort them from the room. (Field note ST06)

In this A&E outpatient facility clinical interaction between the nurses and doctors indicates several factors about the working relationship.

- There appears to be an expectation by the two GPs at Sea Town that they will have access to the nursing staff to assist them in performing procedures at their convenience.
- There is no practice nurse working for the GPs. They utilise the hospital nursing staff when required.
- Nurses on duty in the hospital at the time when a GP requires assistance have learned to adapt their work practices to accommodate the doctor's needs. This may mean they have to stop their other duties to provide the necessary support.
- The nurses assisting the doctor anticipated his requirements for equipment, despite the fact that he had commenced the procedure with minimal preparation.
- The treating doctor gives discharge advice to the patient about returning to the hospital for a wound re-dressing only when he is satisfied a particular nurse will be available to do it.
- The nurses complete any paperwork associated with the treatment provided by the doctors, including that required for payment of medical treatment.

- Cost of items consumed in the treatment of patients (dressings, drugs, local anaesthetic) are borne by the hospital, not by the GP.

In this example of the way the doctors work in this small rural hospital it can be seen that they rely on being able to use the nurses to assist them in their procedural work and that there is no direct cost to them for this service. The hospital meets the cost of the nurses' time, the equipment used in the procedure and any consumable items, including medications. The GPs derive their income from the scheduled fee they charge for the procedure. The attitude of a particular doctor about charging for services provided will vary, as one of the Sea Town GPs attests:

> ...I try not to run things being financially driven. It's intriguing having worked as a locum and being salaried, where there is no incentive to do more work....And if it saves, I mean I'm a taxpayer, I don't want taxpayers' money being wasted....I would hate to think that the way I was practising medicine was driven by the way I was being paid for it. (Sea Town, female GP 2)

The GP in this case was aware of the cost of her service to the local and broader community and reflected on her motivation for rural practice being other than financial. The reality is that GPs make their income primarily by charging scheduled fees from the Medical Benefits Schedule (MBS) and the greater the savings on their overheads, the more of this income they will keep. The same doctor accepted that many of the problems patients might present with at the hospital after hours could be effectively dealt with by the nursing staff, but qualifies this by voicing her concern over the potential for small things to turn into more complicated ones:

> Dealing with that type of thing (grazes, cuts, colds) over the phone is saving the Medicare and hospital system a doctor's visit....There are a lot of things the nursing staff can deal with. I don't have a problem with that. I don't feel threatened by that. I don't think it's a problem...but if something went wrong, potentially we could be in trouble. (Sea Town, female GP 2)

Interaction: Doctors' rounds

> It is 8.45 am in the morning and I have been informed 'doctor's rounds' will be occurring. One doctor arrives at the nurses' station. She is ready to undertake a ward round and the registered nurse on duty prepares for this. The doctor already has the patient case notes trolley and is starting to push it down the corridor. The conversation between them and the first patient they greet is focussed on the large thunderstorm, which passed through the town earlier that morning. The air is still humid from the rain brought by the storm and the air conditioner in the room of the first patient they visit struggles to make the air in the room comfortable.

> The doctor and nurse move from room to room, patient to patient. The routine is clearly established for each interaction. The nurse provides the doctor with a brief update of any significant changes in the patient's condition in a low tone outside the patient's room before the doctor knocks on the door, enters and greets the patient and engages them in conversation. The nurse closes the door behind her to ensure the interaction is as private as possible. (Field note ST07)

This is a small town and it is clear additional effort is needed to keep patient information confidential, including the conversations between medical and nursing staff and patients. A nurse at Sea Town explains the reasons why this is so:

> ...I know most of the people. I know most of their history. I suppose I may have even been a little threatening to people...having known most of them. (Sea Town, female nurse 2)

At each of these doctor-patient interactions during the ward round the nurse performs one or other response. She either answers direct questions from the doctor about the patient or reinforces what the doctor has said to the patient. An example of occurred during one patient visit when there was a discussion about planning for discharge.

> Interaction: Planning for discharge
>
> The doctor enquires of the patient: 'Who will be at home to care for you'? The patient replies that his son and his girlfriend are coming to stay with him and that they will be able to assist him. The doctor asks if the man has made an appointment with the physiotherapist. The nurse quickly intervenes at this point and indicates that she has ensured that the appointment has been made. (Field note ST08)

A Sea Town nurse explains how important she believes it is to use these opportunities to inform doctors of her knowledge and competence:

> [It's] important to show you are competent in what you are doing and not to go ahead and make a mistake and then get on the wrong side of the doctor. (Sea Town, female nurse 4)

Both nurse and doctor demonstrate their collective concern for this patient who is being discharged from hospital after a fall in his bathroom at home, lying on the floor for 15 hours unable to get up. Because the man lives alone they are attempting to ensure there is not a repeat

of this type of accident. I note there is a complementary manner in the way they discuss options for the man's safety, each contributing helpful suggestions and accepting points made by the other. A male nurse at Sea Town underscores this point:

> We all want the same thing, which is basically that the population of Sea Town should have one of the best health services around. It's a common goal. (Sea Town, male nurse 5)

The variety of work that nurses and doctors undertook at Sea Town rural hospital could be described as general nursing and medicine. This included considerable diversity and involved being prepared to alter work patterns depending on changed circumstances. The majority of patients in the hospital at the time the case study was conducted were aged and frail patients, with a few younger patients being observed for shorter periods. One of these was a woman who had delivered her baby in a neighbouring town and had returned following the birth for a few days of convalescence. Over the three days of the fieldwork in this case study site there was an average of eight in-patients being cared for in the hospital.

A larger number of outpatients (between 10 and 15) were treated at the hospital for a range of conditions during the same three day period. They had usually been referred to the hospital by the GPs who used the consulting rooms located in the hospital building. However, some patients did present at the hospital requiring emergency treatment.

The treatments and procedures for these patients were relatively minor, for example, wound dressings, removal of toenail after trauma, pathology specimen collections and some diagnostic tests such as ECGs and x-rays. Nursing staff carried out the majority of these procedures. The nurses at Sea Town explained that this is because the doctors trusted them to undertake these procedures:

> I think one of the major issues would be trust.... that the doctors actually trust you to look after their patients. I suppose that means doing as you are told. After a while you get to know what certain doctors like and the way they want things done...You realise what the doctor wants and on a continual basis you display those abilities. (Sea Town, male nurse 5)

In this description the nurse accepts that the doctors trusts him to care appropriately for patients even if that means he has to 'do as he is told' and perform things in 'the way they want things done'. Recognition of the doctor's needs is therefore paramount, as is being consistent in displaying certain abilities.

The numbers of nursing staff on duty at any given time seemed to be more than adequate to manage both the in-patients and the additional outpatients who presented either from the GPs consulting rooms or direct to the hospital as emergencies. The work pace of nurses and doctors might best be described as gentle with an occasional interruption requiring several patient procedures to be managed simultaneously.

In discussions with the RNs and GPs they indicated the workload could increase sharply, especially if the hospital in-patient numbers increased above eight or the outpatient numbers rose. The latter event was reported as a frequent occurrence during peak holiday season in Sea Town. The staffing of the hospital was adjusted according to the need but during the time of my fieldwork there were two RNs and one EN on duty most morning shifts (7am to 3.30pm) with both GPs consulting during 9am to 5pm. In the afternoon shifts (2pm to 9.30pm) it was common for one RN and one EN to be on duty with one or other of the GPs on-call. A similar staff ratio to the afternoon roster managed the night duty shift. Nurses reported that the two Sea Town GPs would come to the hospital when they were telephoned no matter what the time of day. They had a friendly, approachable manner when contacted by nurses in on-call or after hours contacts:

> Some doctors in other places might say: 'What the hell's really wrong with this patient?' I don't have that problem here because they will come. But then again...I've gone through a certain set of steps. Like with abdominal pain I've not only taken a history but I also take a urinalysis... take a central temperature...basically I would do as much of the examination as I can to ascertain what information I can get from my own observations. Then the doctor can make an informed decision (about whether or not to come). (Sea Town, male nurse 5)

The reaction of the doctors when contacted after hours was no doubt assisted by nurses who, when contacting them, were able to recite a coherent and well thought through history. The fact that nurses took the time to properly assess patients before calling the doctor, and then only if necessary, had not escaped the attention of the doctors in Sea Town. As one GP explained, this support was greatly appreciated and in his case made the difference between him staying or leaving the town:

> That makes life very much easier. I was here for seven years by myself and that filtering process of not having nursing staff ring me at home was an absolutely vital part of me being able to stay here that long. After seven years I was worn out. (Sea Town, male GP 1)

The GP in this recounting his experience shows how important the relationship with the nurses is to him. Another nurse explained the close personal relationship she felt existed between the nurses and doctors in the Sea Town Hospital:

> I feel very comfortable with the doctors here....They are really, really easy to work with. They are very understanding. I think they interact with staff more here. They interact privately with staff and they go to different (social) functions with staff. ...they're a lot more friendly but they have their professional side as well. (Sea Town, female nurse 4)

In addition to nursing and medical staff, other clerical, cleaning and kitchen staff was also on duty during the busiest parts of the day and they were reported to provide additional support outside of their roles in busy times. This was also true of ambulance crews who presented to the hospital with patients.

Nursing and medical staff used these local volunteers in busy times to assist patients, particularly in emergencies when they work together as a team. The sense of cohesion that was evident in the way the various staff and community personnel worked together is summarised by one of the Sea Town RNs:

> ...it's a very good hospital. It's got a lot going for it. This hospital is very much appreciated and supported by the town. Very supported by the doctors and they really enjoy working here and you can see that. So do the staff. The morale is very good. Sick leave rates are very low. It's a relaxed hospital. (Sea Town, female nurse 4)

4.6 Case study summary

The Sea Town community is small by rural town standards. With just over 1000 residents the town has a proud rural heritage of independence and resilience in the face of challenge and change. The evidence of that resilience and respect for their past is reflected in the way the town and its hospital are cared for. Despite the pressure on the town and its residents brought on by rural decline and the removal of services, they have managed to adapt to the changed circumstances.

These values have been incorporated into the Sea Town Hospital philosophy and set the tone of relationships between staff and between staff and members of the community receiving service from the hospital:

> It is our aim to provide, within the resources available to us, the highest possible standard of health care, pleasant surroundings and a cheerful and compassionate environment for our patients. We believe that our patients are the recipients of our hospitality and should be treated like honoured guests. (Arbon 1998)

The emphasis embedded in these vision statements is one of the highest possible health care standards within available resources, but with an important focus on the individual person and the environment in which staff and patients work. There was no single feature or characteristic that influenced the professional working interactions of nurses and doctors at Sea Town Hospital. Rather a series of factors became apparent in observing the interactions between them and in the in-depth interviews. They displayed a genuine regard and mutual respect for each other, and their lives were intertwined professionally and socially.

The 'pleasant surroundings and cheerful and compassionate environment' intrinsic to the hospital philosophy, is, in fact, a reality; at least during the time I visited the case study site. The atmosphere was relatively relaxed, and the nurses and doctors treated each other in much the same way as a large family might operate.

They often discussed patient care and other policy and management issues over tea or coffee or light luncheon. They talked about their homes and families frequently in conversation, played in local sporting teams together, ran into each other when down the street shopping and met socially in the community since the children of both nurses and doctors attended the same school. It was not uncommon for the boundary of personal and professional lives to be blurred. For example, several of the nurses were patients of the GPs. While there was evidence that some nurses and doctors formed close personal and professionals relationships, there was an acceptance that in small rural communities the expectation of everyone getting on with everyone else is not realistic, let alone achievable:

> Living in a small place you have to be mindful of other people who you are friends with. You don't have to be the best friends with everybody. Just because you work together it doesn't mean you have to be best friends, although it's a good idea. (Sea Town, female nurse 1)

There were some striking differences between the nurses and doctors at Sea Town when their experiences in nursing and medicine were compared. The RNs were older, had been graduated longer, had practised nursing for more years and lived longer periods in rural locations than the GPs. There was a significant difference in the number of years the GPs and RNs had been working in Sea Town. At an average of two years, the RNs had spent less time working at the Sea Town Hospital than the doctors, who had been there an average of seven years. The nurses at Sea Town had more experience of living and working in rural areas, but this had occurred in several different locations whereas the doctors tended to be more settled in the one location.

Overall the work environment and interaction between nurses, doctors, and patients at Sea Town appeared very harmonious. The small size of the community no doubt assisted in this with most people knowing each other. I formed the impression that they genuinely cared for each other and had implemented strategies to build and maintain a good working environment.

The relative professional and social cohesion extended beyond the hospital into the community in which they lived, and perhaps was the reason for this. Social rules and norms of behaviour are often strong in rural communities and it is reasonable to conclude that many of those same rules and norms reach into the hospital setting and are played out between nurses and doctors. If there were conflict and disharmony between the nurses and doctors at Sea Town I did not see evidence of it.

If it existed in more covert forms as an outsider and a transient visitor, they may have submerged it from my view and from my probing questions. A Sea Town nurse mentioned how she adjusted her behaviour towards doctors when she first started work at the hospital:

> ...when I came here from a big hospital to a small one...it took me a little while to get into the running of things...You have to be very tactful (about) anything that you may disagree with them about as well. But if you're up front and state your case and if it' s a strong enough one and you have evidence to back it up, then it's OK. (Sea Town, female nurse 4)

The residents of Sea Town are fortunate in many respects. They have a neat and tidy town set in an idyllic seaside location. There is a tangible community spirit that values the past, maintains the present and is working to ensure the future. The local hospital health care service environment reflects much of this sentiment and as a result the professional working relationship between nurses and doctors at Sea Town Hospital is as the nurses, doctors and community wish it to be.

Valley Town

5.1 Describing Valley Town

5.1.1 Physical characteristics

If you stand still enough in Valley Town's main street you can almost hear the clip clop of horses' feet and the rattle of buggy wheels, for Valley Town is a place where there is evidence everywhere of a bygone era. Like many small rural towns established in the late 1800s buildings are concentrated along a wide main street. Shops and civil buildings face proudly to the central thoroughfare, their wide verandahs offering shade on a hot summer's day or shelter from winter rain. Gnarled old peppercorn trees provide a green ribbon along the full length of the main street. From their age it is clear the planners of Valley Town intended them to provide welcome shade and beauty for the streetscape.

A focal point is the one remaining hotel. An imposing stone building that still wears the cloak of history well despite daubing its walls with the commercial labels of modern day beer brands. As I walk past I can hear the drone of front bar conversation, broken only by the call of horse racing blaring from a television inside the hotel. I imagine local farmers slaking their thirst after a hard day tending stock or tilling the earth and lamenting the lack of rain or the price of wheat and wool.

Further along the street, hiding behind some of the wide verandah shop windows, lie empty stores, testimony that Valley Town has also felt the brunt of rural decline. As if in defiance of this creeping reality, other businesses are trading briskly. There is a small supermarket-general store, a post office and several small convenience stores, the almost mandatory sock and station agent and agricultural supplier, and a handful of craft and antique stores, aimed more at passing than local customers. People are moving about and talking in small groups outside these various businesses. An assortment of cars, utilities and trucks, are parked diagonally down both sides of the street. The odd stock dog resting its muzzle on the side of a ute tray or perched in pride of place in the passenger seat. The vehicles all carry the trademark of rural unsealed roads – mud caked sides and dirty windscreens.

On the approach road into Valley Town and at the top of the main street is a war memorial. Akin to others in rural towns, it is a statue of a World War I soldier, rifle poised at the ready. At the statue base are fixed tablets listing those local men who lost their lives in battles far from this peaceful and tranquil place.

Many of the street names in Valley Town mirror family names listed on the war memorial. Rural communities seek to maintain and honour the past and through these monuments ensure a connection with the present and future generations.

Almost as an afterthought the last building in the main street when leaving Valley Town is the hospital. Built in the 1940s it is a substantial and solid stone building, which has suffered more recent architectural insults in the name of expansion and modernisation. Overlooking a large car park and the main road beyond, the view from the front of the hospital is uninspiring. Nevertheless, there have been brave attempts by the hospital gardener who has created an attractive rose garden buffer between car park and the hospital entrance. Behind and beyond the hospital stretch paddocks and in the distance low ranges, azure blue, complete this picture of rurality.

Valley Town has retained much of its heritage in both buildings and public infrastructure. As small rural towns go it has a well-kept and self-contained feel about it. Behind the main street facade a range of community facilities become apparent. The town oval, tennis and basketball courts attest to the importance of sporting events in rural communities. A community hall and combined public and caravan park provide further enticement to local and travelling people.

5.1.2 Socio economic characteristics

Valley Town is nestled in a long valley of good, fertile agricultural soil. Sustaining the community is an economy revolving around mixed farming – cereal growing, sheep and cattle grazing, and dairy production. A factory producing milk and ice cream products is located in Valley Town and is a major employer in the region. The population in Valley Town was 507 people on Census night 1996 (ABS 1999). The local government region in which Valley Town is located has a total population estimate of 4800 distributed across approximately 18 towns and localities (LGASA 1999). Most of these surrounding towns have populations between 100 and 1500. The largest regional town of 13,600 people and the location for the regional health service is 26 kms away by road from Valley Town. Table 5.1 shows the socio-economic characteristics of the local government area in which Valley Town is situated. It reflects the relatively high health status and prosperity of the region.

Table 5.1 Socio-economic cluster characteristics for Valley Town Statistical Local Area

Socio-economic status	Medium
Heath status	Medium-High
Health service utilisation	Low-Medium
Socio-economic & health status	Medium-High
Median individual income per week in DC (ABS)	$230
Median age of population in DC (ABS)	36 years

(Glover 1996; ABS 1999)

The low median age of 36 years may explain in part why health service utilisation is low to medium. The population in Valley Town includes a mix of retirees, business and professional people. Perhaps as many again as the town population of 500 live in the surrounding countryside and use Valley Town as their supply and social hub. As this population profile ages, increasing use of the health services can be expected.

5.2 The health service description

The Valley Town health service, like the many historical buildings in the town, has survived. It could be argued it has survived because it has been prepared to reinvent itself through the challenges imposed from outside the shelter of this tight knit rural community. There has been a hospital in Valley Town for 60 years (Crawford 1992). This community health service came close to becoming part of Valley Town's past history when the South Australian Health Commission decided it was no longer viable as an acute service hospital and attempted to close it. In 1989 the local community accepted the challenge of change and rejected the notion put to them by health bureaucrats that they should travel to neighbouring larger towns for health care services and reduce their hospital to an aged care facility. In many ways their attitude to change assisted them to think about new ways of health care service delivery as this quote from their Director of Nursing indicates:

> Change is an area which many people fear. However, change can also bring about positive results. This change has enabled the...hospital to meet the community's needs and demands in health services instead of focussing on being advocates for the sick role model. (Crawford 1992)

Instead of an ill health focus the change was embraced and remains today as a primary health care model of health service delivery. In the original planning, which involved the community, six key areas were identified. These were:

- women's health
- diabetes
- well-being education
- rural health
- outreach and home care
- asthma

A Primary Health Care Unit (PHCU) was established as an integral part of the health service and resources committed to it to implement strategies which:

> ...incorporate the philosophy of encouraging the client to be a self manager of their own health. (Crawford 1992)

In 1990 a nurse was appointed to lead the PHCU and was supported by the hospital board to undertake education and training in primary health care practice. The PHCU began offering a wide range of primary health care initiatives to the Valley Town community. Examples included: well-being clinics for diabetes patients or those at risk, pregnancy/parenting clinics, and stress awareness and management groups. Walking for pleasure groups, Tai Chi exercise classes and trim and tone sessions including aerobics, massage and relaxation were also introduced.

The initial work begun in the early 1990s at Valley Town hospital has continued and the primary health care focus has remained a dominant feature of the health service. New initiatives include farm safety, with hospital staff providing information, advice and screening at local agricultural field days, asthma prevention and management programs in schools, home based palliative care services and a Well Women's Clinic Service. In 1999 a broad range of primary health care initiatives for men was introduced, including the establishment of an Internet site to describe and report on these activities.

The change undertaken over a ten year period for the Valley Town hospital has been a remarkable one. The hospital has become widely known in rural health circles for its achievements and others have sought to emulate its success. The impact the change has had on the way the health service now operates is reflected in the words of the Executive Officer/Director of Nursing who has played a critical leadership role in bringing about the change:

> Our role change involved developing from a small country general hospital to a 16 bed (11 nursing home and 5 low dependency acute) service plus the Primary Health Care Unit (PHCU) and an accident and emergency service. (Crawford 1992)

The measure of success and the more effective use of space and resources once used for acute care services are also clear:

> Other services such as physiotherapy, podiatry, audiometry and massage also use the clinic room in our PHCU. ...length of stay for acute patients has decreased and funds are used more efficiently. (Crawford 1992)

The effect the change has had on the community has been no less striking. No longer is community focus on the hospital associated with acute illness, and a new regard for the hospital is reflected in the words of the Executive Officer/DON:

> The interesting part is how the community has reacted to the change. I felt sure we could provide a better service than we had in the past and that is just what has happened. The hospital is now seen as a place for people to come for advice in maintaining their health instead of a place to be while ill. It has become a focal point of the community that people feel comfortable with instead of a place to fear. (Crawford 1992)

The usage of the health service is a reflection of the change in focus of the hospital. The 1998 annual report states there were 336 in-patients and 1,078 nursing outpatients. The report also lists 1,097 private non-inpatients seen by the town medical staff. Of significance is the 1,973 outreach services provided by nursing staff in the aged and palliative care areas. It was also reported that nurses conducted a total of 200 primary health care issues groups with 1,606 people attending (LDHI 1998).

5.3 Profile of RNs and GPs

During the time the case study was conducted at the Valley Town health service there were two GPs, one female and one male. Two female registered nurses were included in the detailed observational component of the field visit and were participants in the in-depth interviews. Figure 5.1 shows the Valley Town profile of these four nurses and doctors. It indicates the average age of the nurses as being 48.5 years and the GPs 40 years.

The nurses had graduated from their training earlier than the doctors had from theirs. For one nurse this was some 20 years earlier. The doctors had been graduated for an average of 16 years. A significant difference between the number of years working as rural nurses or GPs was noted. For nurses the average was 21 years and for the GPs 10.5 years.

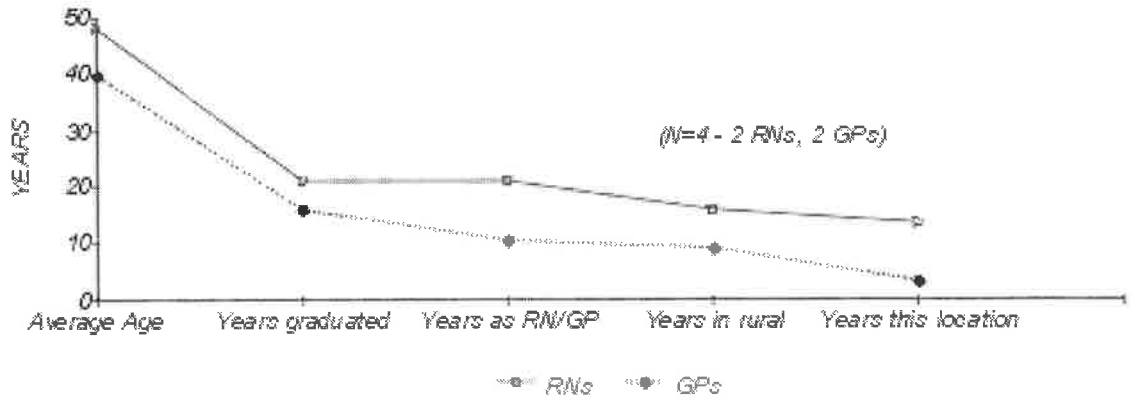


Figure 5.1 RN/GP profile for Valley Town

Nurses at Valley Town also had more years experience in rural practice – on average 21 – when compared with GPs, whose time in rural practice averaged 10.5 years. In addition, the nurses had remained in their current positions for a great deal longer at 13.5 years on average compared with the two GPs with a 3.25 year average length of stay.

Some caution needs to be exercised when making these comparisons due to the small number of nurses (n=2) and doctors (n=2) included in the profile as key informants at the case study site. Nevertheless the results are indicative of other rural nurse and doctor profiles. What can be said about the nurses who participated in this case study is that they were generally older than the GPs, had graduated from nursing longer, had more rural experience and were more stable in their chosen work site. With regards to the last point, it is pertinent to note that in the 1998 hospital annual report the Valley Town GP and his wife (also a nurse) had resigned their positions from Valley Town to move interstate (Laura and Districts Hospital 1998).

The same annual report listed 15 registered nurses and 15 enrolled nurses employed during 1998. This included one DON and one Clinical Nurse Consultant. Therefore, 30 nursing staff were listed as employed over the course of the 1998 year. However, there were five resignations (two RNs and three ENs) during the year. A more detailed analysis of the total nursing staff employed at Valley Town is contained in the Nursing in SA – Nurse Workforce tables for 1998. This shows 10.2 fte (full-time equivalent) RN and 6.8 fte EN positions (DHSSA), 1998). This approximates to a total of 24 nursing staff. These nursing staff numbers are set according to the expected roster requirements over a 24 hour / 365 days per year cycle and the type and number of patients and other services the hospital provides.

During the time of my observations at the hospital the nursing staff ratio was usually two RNs and two ENs on morning shift (4) and one RN and EN (2) on afternoon shift. During day shifts the DON and CNC were additional to other rostered staff, but did not participate in direct patient care. One of the RNs I observed and subsequently interviewed was a community palliative care nurse. Although her work was primarily outside of the hospital, she provided assistance to the doctors when they were conducting their clinic during the day. Other nurses in the hospital also provided services to the two doctors when the doctors consulted patients.

5.4 Nurse-doctor interactions

5.4.1 Overview

From my observations, the interactions between nurses and doctors at Valley Town could be categorised into three domains. The first and most common was the traditional way nurses and doctors interact. That is, the nurses provided care for the small number of in-patients in the hospital, and when either of the doctors came to the nurses' station at pre-arranged times, the nurses would accompany the doctor to see patients and take any change of treatment order the doctor might make. In these interactions the nurse role seemed passive, either taking instructions from the doctor about treatment changes or giving the doctor feedback about any significant changes.

The second interaction type was one in which the nurse provided the doctor with assistance during the conduct of GP consulting sessions. This most often involved setting up the consulting rooms prior to the session starting, taking specimens and changing dressings when necessary. During GP consulting there was a clerical staff member available to mange patient appointments and payment of accounts. If the doctor needed to undertake a minor procedure, the nurse assigned to the GP consulting room assisted. Because of the location of the GP consulting rooms in the hospital, other nurses could be utilised in necessary.

The third and quite common interaction type between nurses and doctors was around primary health care projects.

5.4.2 Examples of interactions

An example of an interaction associated with a primary health care project is recounted here from the record in my field notes.

The clinical management meeting

It is 8.30am on a cool autumn morning and as I walk through the Valley Town Hospital main entrance I feel the change in temperature is noticeably warmer. This meeting is one called to discuss patients and their case management and it is being held in the main staff room. The room is small but has a lived in feel about it. It has some comfortable chairs, a small table, television and video player. There are shelves crammed with textbooks and journals and a notice board brimming with notices. It is obvious the room is well used by staff for meal and tea breaks.

I am greeted and introduced to the two nurses and two doctors present. They are drinking tea or coffee and offer me the same. The atmosphere of the meeting seems very relaxed and before starting the business of the meeting they converse about social topics. This meeting is part of a Division of General Practice project called the Belalie project. Entitled a 'GP Meeting', it is designed to improve the case management of a particular patient group, in this case people with asthma.

One of the RNs opens the discussion about a patient who has arthritis and who is having difficulty depressing his Ventolin inhaler due to his arthritic condition. She has obtained a special tool to help him press the inhaler button but explains this device is designed for use with the Ventolin inhaler and can't be used for other medications. She continues to talk about asthma education at school and the need to use asthma medication and applicators correctly. It seems since the widespread use of asthma educators in the region has stopped due to funding constraints that the frequency of public asthma education has also dropped. The Valley Town health service has made a commitment to fund part-time asthma RN educators and the Belalie Project has allowed these same educators to take on additional activity, including closer liaison with GPs in the area of clinical management of asthma patients.

The second RN present at the meeting discusses the use of the Asthma First Aid Kit. Asthma South Australia and DECS (Dept. Education & Child Services) support and are also involved in the education of the community about asthma, and she explains this is causing confusion because of multiple players in the field and the duplication of their programs. One of the GPs expresses an opinion that the local management of asthma education seems to have got worse due to the lack of coordination between the various agencies. He claims a system that seems not to value the local asthma educators and their knowledge and experience of their community is not effective. There is further discussion about an education program using the doctors to talk with schools about asthma. The RNs suggest there is a need to include teachers and children in both Valley Town and a neighbouring town in any proposed education program about asthma management. The nurses also propose ancillary school staff need to be involved in the education sessions as they are the ones who usually assist children who are identified asthmatics in the school. (Field note VT01)

The discussion between the nurses and doctors about improving the management of asthmatic patients in this example could only have taken place if the GPs were paid for their time to attend. There is no schedule fee in the Medicare schedule that allows a doctor to have regular extended case conferences with nursing staff about patient management. The GPs at Valley Town acknowledge that clinical and primary health care meetings with nursing staff have previously taken place but they were not paid to attend them:

> ...this hospital already had these types of educational clinics before I came here...we were already holding these kinds of meetings. All that changed was that with the advent of Divisional (Divisions of General Practice) projects we started getting paid for them. (Valley Town, female GP 1)

The same GP argued that the reason why GPs do not attend more clinical case conference and primary health care planning meetings with nurses is because of the reduction in fee-for-service payments GPs get paid through the Medicare agreement by the Commonwealth government:

> The decrease in the fee-for-service that GPs receive compared to the various economic benchmarks, in real terms, has fallen by somewhere in the order of 30-50%. This means that previously GPs felt themselves well enough remunerated by the normal run of the mill work to spend a few hours per week in what amounted to unpaid time because there was enough leeway. (Valley Town, female GP 1)

One of the nurses who attended the previously described meeting on asthma management explained how valuable the meetings were to her and how in her view the meetings improved communication between herself and the doctors:

> ...when I first joined the asthma clinic there were no meetings with GPs as such. It was a matter of, catch the doctor in the corridor if you had a concern about a patient. There wasn't a great deal of communication and certainly no meetings took place between the asthma educators and GPs. (Valley Town, female nurse 2)

The nurse also acknowledged the importance of paying for the GPs' time to attend these meetings and the benefit of making the communication regular:

> We now get funded to have those hourly meetings once per month. Because there are two GPs here we chose to meet with them for an hour each month, rather than half an hour each fortnight. This is because a lot of patients here see one or other doctor. That's how we became involved with the project and subsequently these GP-nurse meetings. (Valley Town, female nurse 2)

The part communication plays between the nurses and GPs in developing and maintaining their relationship is further demonstrated in the meeting I observed. An example is the 'communication book.'

Interaction: Communication book

The nurses raise a second issue with the doctors. They ask if it would be all right to use a communication book. They explain this is to prevent the use of 'little bits of paper' scattered all over the nurses' bay station.

These are communication notes between nurses and doctors. Both nurses and doctors readily agreed that this was a good idea. It seems that the need for the communication book has arisen mainly because the doctors only come at certain times to visit patients in the health service or to undertake a consulting clinic. If the message is not urgent or does not require documenting in the patient progress notes the staff have resorted to writing a note and placing it on the nurses' bay station bench to be handed to the doctor when next they visit. (Field note VT02)

The Valley Town RN who is involved with the asthma project underscored the benefit of regular meetings with the doctors; not only to communicate and discuss ideas nurses have about improving patient management and prevent unnecessary and ineffective communication habits from forming, but also to check that patients they have referred through the asthma program are seeing the GP:

> We always had to write letters back and forth but what we weren't getting was the feedback from them for the following visit. For instance, a lot of people come to the asthma clinic, they're referred, and they come as a one off. They get some education ...and they go back to their GP two weeks later. That's where our information stops. We were not getting that feedback unless it was asked for as an informal enquiry to the GP. So what we get now is, 'OK they were supposed to come back to see you in two weeks – did they turn up?' The doctors have got their notes at the meeting and they can check to see if the patient did come. It may be that they have not turned up at all. Then we call them. So we have more continuity of knowing what actually happens to that client afterwards. Whereas, before we would not have had that. (Valley Town, female nurse 2)

The importance of continuity of care between the nurses who are working on the asthma project at Valley Town and the GPs who are treating the presenting or underlying problems is a valid reason to ensure the working relationship between the nurses and doctors is an effective one. The effective use of a recall system is an integral part of patient management, particularly in primary health care.

The recall system. At the nurse-GP meeting there was discussion as to the need to have a recall system for asthma patients. Asthma, unlike diabetes, does not necessarily have a long-term management requirement. There may be episodic incidents during which patients come in for treatment by the GP or education in better management of their asthma by the nurses.

Interaction: Recall system

The RNs are concerned about the duplication of record keeping and suggest one set of case notes for both community education consultations that the nurses undertake and one for hospital admission. I observe that they try to convince the doctors of the sense of this. The doctors acknowledge their argument but a problem in using recall systems becomes obvious. This is the potential confusion caused by common family names in this rural area. A case is discussed which illustrates this well. There are three family members with the same first and surname; all have asthma. They all live in the same small rural town. The RNs use this as an example to justify the use of common case notes to avoid confusion.

The meeting now appears to have served its purpose. One of the GPs starts to discuss the hen he has at home who has hatched chickens and the type of breed they are. The RNs join in the general discussion about poultry husbandry. It is a light-hearted exchange and demonstrates the healthy rapport that appears to exist between the two professional groups. There are two separate conversations going. The GPs are discussing another professional meeting and the nurses are discussing when next they will meet. (Field note VT03)

The overall purpose and benefit of these meetings in enhancing the relationship between the nurses and doctors is voiced by one of the nurses:

> ...opportunity for discussion is really important for us as registered nurses because we can't really work without GP support. It gives us that little bit of time to say, 'What do you think of so and so.' The GP can then say, 'Yes it's a good idea or no it's not. Ok we will go with it.' It just gives us that time that we would not have otherwise. (Valley Town, female nurse 2)

The same sentiment is reflected by one of the Valley Town GPs:

> The process is very useful because it's an opportunity to talk about different patients and different aspects of their care with regard to things that need to be done. The aspect of discussing patients is useful too because it formalises the structure and makes it happen. Otherwise it does tend to get done ad hoc and often it's very hard to get all players together at a given time. From the main aspect of that, the payment side of things it makes it easier to happen. (Valley Town, male GP 2)

One of the nurses present at the nurse-GP meeting explains she has a different means of communication with the Valley Town GP. They are married.

> From my personal perspective my lines of communication are somewhat different. I'm married to...and it's easy for me to talk to him about any sort of patient I have to deal with. He's very supportive of me and very supportive of registered nurses in the primary health care role. A lot of GPs aren't aware of what nurses do outside of the clinical setting, outside the nurses' station where they are looking after the doctors' patients. (Valley Town, female nurse 2)

The fact that the nurse and doctor have a separate relationship outside their professional one seems in this case to increase the opportunity to discuss questions about patient management from both the nurse's and the doctor's perspective. This may be beneficial and convenient but it does present some difficulties when the nurse has to take up professional issues with her husband who is the doctor, especially if other nurses have raised a particular problem:

> It's very hard for me sometimes to stay in a neutral situation. I help out as much as I can. If someone really has got an issue I'll mention it to...but I can't really be a voice for them at all. (Valley Town, female nurse 2)

This nurse admits she has limitations in bringing issues about work from other nurses to her husband who is one of the Valley Town GPs. Her work is mainly in the primary health care area and not in the clinical delivery of care in the hospital. The harmony this nurse talks of is sadly not always a guarantee for good nursing and medical practice in a rural context. In 1993 a woman patient died in a small rural hospital in South Australia from the effects of an overdose. In the subsequent inquiry it was revealed the nurse and doctor had been married but had separated and that the poor communication between them at a professional level may have been influenced by their personal relationship and contributed to the adverse outcome (Kriven 1994).

Nurse initiated patient visit by a doctor at Valley Town. The practice of nurses requesting doctors to visit patients when they deem necessary is a common occurrence. Nurses have different experiences and most will have an opinion on the relative ease or otherwise of the response they get when contacting doctors. In the Valley Town hospital I observed one of the local GPs and a nurse conduct one such patient visit. The nurse had previously telephoned the doctor who agreed to see the patient upon completion of his consulting time. The reason for seeing the patient was assessed by the nurse as being non-urgent.

Interaction: Nurse initiated patient visit

The GP comes to the nurses' station and begins a discussion with the registered nurse. There are two nursing staff on duty, one registered nurse and one enrolled nurse (EN). The RN who made the request provides a summary of the problem to the GP about a patient whom she has requested he see. The patient has some itching and discomfort associated with facial cellulitis around her nose. The RN suggests to the GP that some topical cream be applied to relieve these symptoms. He politely disagrees with her suggestion and asks to see the patient.

The nurse goes with the doctor to the patient's room. The doctor proceeds to examine the patient, an elderly woman who is sitting out of bed on a chair. Whilst this occurs the RN stands at the foot of the patient's bed with her hands behind her back. The GP explains to the patient that he does not want to put cream on her itchy skin because it is inflamed and shows signs of possible infection. He thinks oral anti-histamine would be more effective. I sense this explanation is perhaps as much for the benefit of the RN who had suggested earlier to him that a topical cream might be appropriate as for the information of the patient.

He discusses this change of order briefly with the RN and makes some notes in the patient's bedside charts. They both leave the room and return to the nurses' station. The RN returns the patient's case notes to their place and the doctor leaves the area. (Field note VT04)

In a subsequent interview with this doctor I asked him if it was his normal practice to use nurse-doctor visits to patients as a teaching opportunity:

> It probably is the way I normally do things. In fact I probably do it automatically now without thinking about it. I tend to try to explain how I do the things I do and why I do it. It is probably a better way to do it. It's the way I feel it should be done. (Valley Town, male GP 2)

The doctor is clearly happy to provide the benefit of his expertise to the nurse and use the patient visit and his assessment of the problem as a teaching opportunity. I ask him if he objects to the nurse's suggestion about the use of an ointment to resolve the patient's problem:

> I don't get offended. I don't think of everything. No one can. (Valley Town, male GP 2)

I pursue this a little further during the interview and ask the doctor if he actually seeks the view of nurses in the decision making process about appropriate treatment for patients:

> I don't formally tend to do that (ask for the nurse's opinion). If it's offered I certainly listen. There may be a situation where I will say to whomever is with me, 'What can we do with this?' It's not something I structure in a formal way. (Valley Town, male GP 2)

The doctor's response indicates he occasionally seeks the assistance of the nurse in reaching a clinical decision and also listens to suggestions, but in the end he makes the decision on which course of action to take. In situations where the nurse and doctor are unable to discuss directly the management of a patient, that is when the doctor is away from the hospital either at home or elsewhere, the nurse must contact the doctor, usually by phone. I enquire of the Valley Town doctor what his expectations of nurses are in those situations:

> I prefer them to have done some assessment. The extent to which I rely on that assessment and the depth to which I ask questions depends on the individual case. Both the staff member involved and what I know of the patient or what you could project from a patient.
>
> If you've got a little kid that may be difficult to assess anyway, then I may be a little bit more inclined to ask a series of specific questions before coming myself. I normally expect or prefer the RNs to do a bit of triage, take a history, do a set of observations. (Valley Town, male GP 2)

In a bedside visit the nurse is with the doctor, has given a report on the problem or status of the patient's condition and the doctor reviews this before making a clinical decision. The situation alters considerably when the nurse has to call the doctor and convey information over the telephone. The doctor must make a decision not only about the appropriate treatment but whether or not to come to the hospital. The Valley Town GP uses his knowledge of the nurse and the patient in deciding how he might respond. If he is confident in the nurse's ability and experience to conduct an assessment and convey pertinent information he is likely to instruct the nurse to proceed to treat the patient in the manner discussed, without actually coming to the hospital.

This procedure is varied according to the situation. His mention of the assessment of a child and the need to ask more specific questions of the nurse is an indication of the caution exercised by rural GPs when asking nurses to provide a picture of a patient's condition before they attend to the patient themselves or give instructions to the nurse to do so. The Valley Town doctor seemed to err on the conservative side:

> If they (nurses) say to me, 'I want you to come and have a look at a patient', unless I've got a good reason for not doing so, I usually do. (Valley Town, male GP 2)

Equally he acknowledges that rural nurses, at least in his experience, have more autonomy in decision making than those in larger teaching hospitals and that he would be 'quite happy for them to do things':

> I think that in the settings I have worked the rural nurses often have more autonomy and I'm quite happy for them to do things that they perhaps wouldn't be able to do if it was a large teaching hospital scenario. I'm happy, depending on the individual person, for them to do things that they are capable of doing. I don't think I could function without a good relationship with the nurses I work with. I certainly give them their sort of due for the work they do. (Valley Town, male GP 2)

What 'things' the doctor is prepared to allow nurses to do is not specified and the element of permission giving is woven through this example. Despite this there is a genuine respect for the work of rural nurses and an acceptance that expectations of them will be greater, providing they are willing and capable of accepting this added responsibility in the relationship. A nurse from Valley Town indicates the changed perceptions about nurses in terms of their willingness to make decisions and take added responsibility:

> The days of a nurse never making a decision are long gone. I think the doctors we have here at the moment, and others we have had, respect your opinion, particularly when you're working...with the people and often have to make decisions before you get to the doctor. It's no good calling a doctor every time somebody calls on us for help and asks us to do something for them. (Valley Town, female nurse 1)

The sentiments expressed by this nurse relate to her primary role as a palliative care nurse working in the rural community where it may be argued that more autonomy is allowed in what she can undertake without referring to the town doctors. The same nurse when interviewed stressed the importance of being respected by the doctors for her own unique body of knowledge:

> ...I'm older than both of them (doctors) and don't know nearly as much as they do but they respect not only me, I'm sure they respect what all the other girls (nurses) have to say. They often ask our opinion. They'll wait to hear what we've assessed before they start doing anything. (Valley Town, female nurse 1)

Respect, responsibility and relationship building. I ask this nurse how she gained the respect of the doctors. Her reply was a simple one: 'You have to earn it'. She further elaborated on how respect could be earned in her view.

> Give the job your best. Not just half-hearted. I guess I'm fairly old fashioned. I think when you're a nurse in the country you're not a nurse just while you're at work. You're a nurse all the time. I think nurses and doctors have to command that respect and if you go and make a fool of yourself, you don't just make a fool of your own person, you make a fool of your position in the hospital....Everybody knows you. They know where you belong and your place. That's the difference between living in the city and living in the country. (Valley Town, female nurse 1)

The 'every body knows you – know where you belong and your place' seems to fit the Valley Town nurse-doctor relationship. Nurses and doctors interviewed all mentioned the advantages and disadvantages of living and working in a small rural community and how that affects the relationships which develop. A Valley Town GP points to the potential tensions between social and work activities.

> ...it is a small place. That can create tensions between what's work and what's social. That (work tension) can carry over down the street. The nurses can often have problems because people on the street can go up and ask them what's going on with their treatments or assume that they might know something about what's happening with someone when they don't. This can create difficulties and reflect back on what happens here in the hospital sometimes. ...It's like living in a fish bowl in a sense. (Valley Town, male doctor 2)

When asked during an interview about the social interaction between nurses and doctors in the hospital, the wife of the doctor, also a nurse in Valley Town was more direct.

> We have no social life with the staff here. (Valley Town, female nurse 2)

The opportunity for nurses and doctors to mix socially in a small rural community might on the surface seem an obvious reality. It could also be assumed that mixing socially is likely to enhance the relationships between nurses and doctors. While this nurse states she and her doctor husband do not socialise with hospital staff she relates during an interview previous social occasions where staff mixed and acknowledges the benefits.

> When we first came here...there used to be drinks on a Friday night and (nurse's husband)...and I always went. We had a glass of wine at the end of the week and made an effort to go to those functions. When that particular staff member (who organised the functions) left, these functions discontinued and have done ever since. ...So that was something that dropped off. I don't know any particular reason why. That was a good informal sort of chat session that we used to enjoy.... (Valley Town, female nurse 2)

This nurse's husband and also one of the Valley Town GPs echoes the sentiment expressed by his partner and agrees with the value of social interaction to build relationships.

> The other thing we should do more of and was being done up until last year was having a ' booze-up'. We would frequently open a bottle of wine on a Friday afternoon and have a few nibbles. This was good because we could chat informally. Without that you can't sort of build this bridge. If you're having difficulty with someone you have more chance of doing something about it. (Valley Town, male doctor 2)

Although the prime purpose of these 'engineered' social interactions is to create an environment where nurses and doctors are more informal and relaxed, it also provides an opportunity to get to know people better and, to use the local GPs own words, 'build this bridge' between the two groups. Given the fact that nurses and doctors are prepared in separate education programs and have different disciplinary paradigms – care and cure – these sorts of social opportunities create a basis for establishing and maintaining relationships. The second Valley Town GP offers her own perspective on the relationship between nurses and doctors:

> Obviously neither doctors or nurses are better at interpersonal relationships than others. So they're either better at changing the way they approach different individuals that they work with and also the degree to which they forgive other people their little foibles and things. You see this working both ways. I mean obviously I'm aware that some nurses are much more willing to forgive you your little foibles than others. Similarly back the other way - doctors forgiving nurses. (Valley Town, female doctor 1)

In this doctor's view there is a need for nurses and doctors who work together and share responsibility to forgive certain faults of each other. How far this 'forgiveness' extends was not made explicit. Because of the obvious power difference between nurses and doctors it is more likely that faults by nurses could develop into legal issues, especially if the doctor is not prepared to accept blame for a nurse's 'foibles'. The Valley Town GP underscores this point by stating that ultimately doctors are responsible for the actions of nurses when acting on the doctor's instruction:

> One of the things which colours the working relationship (of nurses and doctors) is from a legal point of view the buck usually stops with the doctor as being the person who is seen to have made the decisions or made the diagnosis. (Valley Town, female doctor 1)

This view is held because doctors, not unreasonably, don't want to accept responsibility for the actions of other health professionals and consequently try to avoid others from intervening between themselves and the patient to minimise the risk.

In the rural practice nurses commonly carry out a doctor's orders or conduct what might be thought of as a medical procedure without the doctor present. This is because small rural hospitals like Valley Town do not have resident doctors but rely instead on a doctor to come when they are needed. I asked the Valley Town doctor to explain what happens when nurses call her at home or on the road and she has to give them instructions, knowing that the nurse's assessment of the situation is all she has to go on.

This excerpt from the transcript of the interview is helpful in understanding how the transferring of responsibility for diagnosis and treatment from doctor to nurse is a central part of the professional relationship between rural nurse and doctor:

Doctor interview (Valley Town, female doctor 1)

Doctor:	It's not so bad if you have given instructions and they've been followed exactly and they turn out to be wrong. Obviously the result would have been exactly the same if you had been standing right there and speaking for yourself.
Researcher:	Except you would have the benefit of assessing the patient yourself?
Doctor:	Yes, but you could still....Well, I suppose there are two parts to it. One is, yes you have to rely on the nurse giving you an accurate physical assessment. Accurately measuring things and accurately assessing the patient's level of severity.
Researcher:	Do you trust them to do that?
Doctor:	Yes. I normally do.
Researcher:	The nurses have good physical assessment skills in your view?
	Yes. Normally they are. Obviously you get to know individual nurses so you get to know whether to quiz them more closely on some things. The other important aspect is trusting the nurse to assess things accurately and to transfer the information. This means both the accuracy of their assessments and observations but also their quickness in transmitting information about patients that might potentially be in serious trouble. The worse thing is to be told a couple of hours later – 'Oh, Mr so and so rang and said he couldn't breathe'!

In this example it can be appreciated that rural doctors often need to rely on nurses to make accurate assessments of patients and relay information arising from these in a timely and accurate way. The doctor in this case trusts the nurses to make such assessments and believes their skill level is adequate. The important issue at the heart of this is of course the doctor's assertion: 'Obviously you get to know individual nurses so you get to know whether to quiz them more closely on some things'. The focus of this work is to try to understand what factors assist the doctor to know individual nurses and to appreciate their differing levels of skill and experience and this is the same for the nurses who try to establish professional ways of working with doctors. The different types of personality of the nurse and doctor also need to be taken into account:

> Of course people differ in their personalities. I mean there are some doctors who want to know more nitty gritty details all day long and there are some nurses who are far more anxious types and who tend to carry on with lots of little nitty gritty details all day long....The degree to which this causes problems will depend on the degree of mismatch between the doctor and the nurse. If you've got two people who agree that every minor detail needs attention of course they're not going to feel upset with each other. (Valley Town, female doctor 1)

A Valley Town nurse describes the delicate balance between a nurse who offers an opinion to the doctor and one who tells the doctor what to do:

> They may not take much notice of what we think should happen but I mean I don't really want to tell them what I think they should do. At least I don't think I do. I certainly don't try to tell them what they should be doing but I try to be my patient's advocate and say when I think something's not working or when I think they've got a problem. (Valley Town, female nurse 2)

It can be seen that the nurse is struggling with her own feelings of self worth and professional judgement. It seems inconceivable to her that a nurse could tell a doctor what to do, to give an opinion, to utter a truth, save only for one exception; that is, when the nurse deems it is in the patient's best interest to do so and even then it is to report to the doctor that 'something is not working or when I think I have a problem'. In this case the nurse does not suggest a solution to the problem and is unlikely to suggest it even if she has one. This reluctance stifles the relationship and prevents relationship growth that comes from mutual trust gained from venturing an opinion, even one that turns out to be incorrect.

The same Valley Town nurse acknowledges the place of the doctor in her mind and in so doing, her own:

> There's always got to be a chief somewhere. The only person who matters is the patient and usually they've come to the doctor anyway and it's the doctor's opinion they're going to want. They're really not going to want mine. Maybe to make them comfortable, yes. In a typical palliative care situation. With medication and that, you can't do much without the doctor. (Valley Town, female nurse 2)

The bulk of the Australian population would agree with her. You don't go to the doctor to see a nurse. But in this rural community the reverse is often the case, at least in the first instance. Nurses in the Valley Town hospital are available to the community 24 hours a day, every day of the year and the community accepts that a doctor will not always see them. To the Valley Town nurse the differences are clear. She is a nurse and does not wish to have the additional responsibility that goes with acting in the doctor's stead:

> I'm a nurse. I'm not a doctor. I was brought up in the 'old school', where the doctor was 'up there'. I think the doctors are no longer 'up there'. People still say they are but I don't think they are. I think they are respecting us more. They're still paid a lot more and they're still ultimately responsible. You're paid for responsibility I think. I'm quite happy to let them take that responsibility so long as they still listen to what I say. (Valley Town, female nurse 2)

The nurse notes the change of social status of the doctor and the higher payment of the doctor because of the added responsibility they take. She makes no mention of the fact that often this responsibility is shared and in her view this earns nurses in Valley Town respect from the doctors. It does not change the nurse's status or remuneration but in a way the nurses are not begrudging of it. They ask instead for respect and to be listened to. Sometimes they may even change roles and when doctors take a small step in that direction they receive a great deal of admiration simply because they have acted in an empathic way towards the nurse.

The following is such an example and is related by a Valley Town nurse who also has a community palliative care role:

> One night I had a lady dying at home and she was terribly, terribly sick. She was well into her 80s and dying of cancer. ...I had to call the doctor to her late at night. She came down to the house. It was a hot awful night and there was no air conditioning in the house. I was trying to sponge the woman and make her comfortable and the doctor got in a helped me.
>
> Now that's the sort of relationship that I feel I've got with the doctors. I would not hesitate to ask either of the doctors here to help me lift a patient if I were trying to do something with them at home. I think that's a measure of the type of relationship we've got. (Valley Town, female nurse 2)

The doctor's action in this case may have been an insignificant one to her and something that came naturally in the circumstance. To the nurse it conveyed a message of care and concern, not only for the dying patient but also for the nurse working in difficult circumstances. By her own admission that small action was a catalyst for building a stronger relationship with the doctors in Valley Town.

5.5 Summary

The Valley Town health service can be characterised as having undergone a transition from acute hospital care service delivery to the provision of multiple primary health care services. In essence it has become a 'hospital without walls' because it has reached into the community to provide health services rather than maintaining a 'you come to us' philosophy that most traditional acute

health services have. It still retains some basic elements of acute care with five low status acute care beds and an accident and emergency service. Within the hospital building there is a waiting area and consulting room where patients presenting to see one of the town's two GPs can go. Many of the previous acute care areas of the hospital have been converted for use in primary health care activities. The range of services offered to the community is extensive and the term multipurpose health service accurately describes the Valley Town Hospital.

The relationship between the two GPs and the nurses has developed well given the fact that the majority of nurses have been in the town for an average of 13 years and the doctors less than four years. It may also be due to the fact that the nurses have extensive knowledge of the local community and the doctors need to rely on this to practice medicine more effectively. In the observations I made of nurses and GPs working together there appeared to be a genuine respect for each other's role and an appreciation by both that by providing assistance to each other there were mutual benefits to be had. The town doctors rely on nurses to effectively manage after hours presenting patients with minor ailments without the doctor being present. However, if the nurses wanted the doctors to attend they always did.

The two doctors indicated that they had a high degree of trust and confidence in the nurses' abilities and skills and often sought their opinion when assessing and treating patients. It was common for nurses to telephone the doctors when they were not at the hospital to discuss management of patients who had presented and the nurses had assessed.

A rather uncommon but not unique relationship between one of the doctors and a nurse at Valley Town was that they were married and both working in the same health service. This intimacy made their professional working relationship as nurse and doctor very different from other nurse-doctor interactions in the health service. An added layer of complexity was introduced as they both adjusted to the external perceptions and expectations other nurses and staff had of them in their roles as nurse and doctor. This nurse did not carry a clinical role and was employed on primary health care project work. This work focussed on asthma education and patient management and as such was less likely to bring her into conflict about clinical issues with her doctor husband.

Both nurses and doctors in Valley Town are always in the 'public eye' and in the doctors' case accessible whenever they are on call, which in reality is whenever they are in town. Nurses who had lived in the town for many years had developed friends and family networks. This allowed

them to cope with their professional persona but did not prevent them being approached by members of the community after work for information about patients in the hospital. The doctors faced similar problems but as far as I could tell did not have the same network of friends and family with which to interact.

The added dimension of primary health care projects and the overall focus of multipurpose service delivery at Valley Town created more opportunities for the nurses and doctors to interact with each other in non-traditional nurse-doctor roles. This appeared to generate better understanding between them and a more harmonious and relaxing work environment.

Bridge Town

6.1 Describing Bridge Town

6.1.1 Physical characteristics

Bridge Town is a town of contrasts. A bridge spanning the narrow neck of a gulf connects two halves of the town. Beneath the bridge the sea tide ebbs and flows, and its sparkling waters on a sunny day are an inviting deep blue. A second bridge, from an earlier era, runs parallel to the newer one. It is no longer used by road traffic; but for local anglers, fishing rods poised in anticipation of a strike, it represents an ideal fishing platform. Towards the end of the bridge an old transport barge lies slowly decaying on the shore, timber ribs stabbing towards the sky like bones from an old carcass – a reminder of progress and the changes in transport methods this town has experienced. Aside from the dominance of the bridge in the town's landscape there are railway tracks criss-crossing the town like bright steel ribbons. Heavy trucks, cars and 4WDs towing caravans are a common site in Bridge Town as they journey to places further a field. The time they spend in Bridge Town is often short, stopping only for food and fuel before continuing their travels.

6.1.2 Socio economic characteristics

The local population of Bridge Town has been slowing drifting downwards, inexorably linked to the fortunes of the town's industries, which concentrate on rail and road transport and electricity generation from the coal power station on the outskirts of the town. At 14,244 (ABS 1999) the inhabitants of Bridge Town, like many other rural towns, struggle to keep services from leaving the town and search in vain for new industries to replace those, which have left. A further 'industry' on the outskirts of town is a prison, a welcome employer in difficult economic times despite the prominence of the prison and its razor wire security fences on the approach to the town. Three miniature windmills with rainbow coloured blades stand outside the prison perimeter fence on a shoulder of earth alongside the main road leading into Bridge Town. Perhaps fashioned by those inside, their blades are fixed and cannot rotate in the wind. Colourful images but frozen in time and space, perhaps like those who made them.

The main street of Bridge Town is a short but concentrated collection of shops and civic buildings. Evident are the attempts by town planners to accommodate the ubiquitous but essential car while introducing a streetscape of trees and shrubs to provide both green and shelter from the hot summer sun. The people of Bridge Town are a mix of young families, retired workers from pastoral and heavy industries in and around the town and tourists passing through to outback destinations north or to the nearby tourist attraction of the Flinders Ranges. From almost any vantage point in the town their ever-changing azure colours can be admired.

Connected in every sense of the word to the ranges and the vast outback lands stretching away from Bridge Town are the Aboriginal people living and working in the town. The 1996 ABS census stated there were 1,900 Aboriginal people or around 13% of the total population of Bridge Town (ABS 1999). This is about five times the average percentage of Aboriginal persons in the South Australian population, which is around 2.4%. As in most parts of rural Australia Aboriginal people are disproportionately represented in the ranks of the unemployed, the local prison population and in the lower socio-economic groups. Through the latter part of the 1990s the socio-economic characteristics (Aboriginal and non-Aboriginal) of Bridge Town were classed as in Table 6.1:

Table 6.1 Socio-economic cluster characteristics for Bridge Town Statistical Local Area

Socio-economic status	Low
Heath status	Low
Health service utilisation	High
Socio-economic & health status	Low
Median individual income per week	$247
Median age of population	32 years

(Glover 1996; ABS 1999)

This profile has been a source of tension in Bridge Town, which endures high crime rates and vandalism, hardly surprising given the rather bleak outlook the town has in terms of the broader determinants of health – availability of work, a stable income, satisfactory housing and opportunities for leisure and other civic activity. In the 1996 ABS census unemployment levels as a percentage of the total population were between 6% and 7% with twice as many males unemployed as females (ABS 1999).

6.2 The health service description

Like the old wooden bridge and the barge that was used in a bygone era no attempt was made by the designers of the newly constructed Bridge Town hospital to retain buildings from yesteryear. A graceful two story building with wide verandas and red brick façade built in the 1930s once stood where the new hospital now stands. I once worked in the old building several years ago and remember its grandeur from another architectural era. It was swept away to allow the new hospital to be built in 1998. The new hospital building is unremarkable in its structure but as new hospitals go it contains all of the hallmarks of late 20th century architecture – large expanses of glass, low ceilings, and one level construction.

6.2.1 Bridge Town Hospital

The hospital is classified as a regional general hospital and provides a range of acute and community health services to its local and regional communities. The nearest hospital of similar size is located 76 kms or 40 minutes away by road. Adelaide is 315 kms away by road or 50 minutes by air. Clinical, allied health and administrative services are provided by Bridge Town hospital to several remote health services located in the far north of the state. The hospital has an 82 acute care bed capacity with two on site specialist clinical facilities in renal dialysis and paediatrics. In the case of the latter there are two resident paediatricians. Visiting medical staff from Adelaide provide all other specialist medical services to the hospital. The hospital also provides a sobering up unit for alcohol affected people. This unit admitted some 2400 residents in a 12 month period during 1996 (PAHHS 1997). This represents an average of six or seven patients per day. Bridge Town's high Aboriginal population is reflected in the hospital admission figures, which were 32% for the 1996-1997 year (PAHHS 1997).

The hospital also serves as the central base for the regional health board of the Northern and Far Western regional health service area. This area covers a vast region of the state, some 86%, of the South Australian land mass, although sparsely populated. The regional health board has financial, planning and service provision responsibilities for this region, which includes many smaller rural towns with populations ranging in size from <1000-3500. These rural and remote communities rely on the hospital at Bridge Town for specialist health care services and to supplement their own services.

A large regional city of 23,400 approximately 76 kms south is also included in this health region. The Royal Flying Doctor Service (RFDS)-Central Section is also based in Bridge Town. In addition to providing outreach clinic and retrieval medical services to the remote outback areas to the north and west of the town, many patients are admitted to the hospital for medical or obstetric treatment by the two doctors attached to the RFDS in Bridge Town.

In summary, the Bridge Town hospital has similar features to a large metropolitan hospital. It contains wards and departments, offers a wide range of specialist medical and diagnostic services and has relatively large numbers of medical, nursing, allied health, administration and services staff. What distinguishes it from a metropolitan counterpart is the context in which it operates and the way it responds to the needs of a rural community. From all the available evidence, it is a hospital dealing with a greater than average level of social and health problems while overcoming the difficulties associated with provision of health services across large distances.

6.2.2 The accident and emergency area

The accident and emergency (A&E) area of Bridge Town hospital is the first of two areas where I chose to undertake observation of nurses and doctors.

Introduction to the physical setting. After walking through a large open space patient waiting area, which is carpeted and decorated with modern colours and soft furnishings, a wall of glass looms. Behind this is a counter. I have to peer through the tinted glass, as it is difficult to see the person behind it. There is a small hole cut in the glass at waist level through which items can be passed and a series of smaller 'speaking holes' at about the level of a person's face. Through this barrier I talk to the person behind the glass shield. I feel more like I am about to make a deposit or withdrawal at a bank than to state my business in a health care institution. This increased security is necessary in modern hospitals. It is the legacy of assaults on hospital staff and a cost saving measure in place of security personnel.

I speak my name through the glass shield to the nurse behind and inform her of why I have come. I assume it is a nurse as she is wearing a white gown over her uniform and peeping over the top of the white gown her collars are festooned with a fob watch, badges, pen and name identification tag. She is satisfied with my explanation for being there and opens a door into the waiting area. I am invited to come in.

In the corridor behind the door a nurse whom I recognise as a previous student of mine greets me and we talk briefly before she directs me to where I can put my case and computer. It is tiny tearoom crammed with a small sink, refrigerator, and table and chair setting. On the wall is a notice board crowded with notices and in one corner a stack of well used magazines. Two nurses occupy the table. I put my bags down before leaving the room.

Layout of the A&E department. A few steps from the tearoom are the main nurses' bay station, a low sweeping counter desk with five swivel chairs against it. This faces an open space area with five trolley beds in full view from the nurses' station. They are all empty. Curtains separate each trolley space or bay and these are pulled back. It is afternoon shift and two registered nurses staff the A&E department. I am shown around the A&E department by one of the RNs. It is newly built and much of the equipment is also new. The area is spacious and everything seems to have a place. The layout of the A&E is functional and consists essentially of two halves. One half with the emergency trolley beds for non-ambulant patients to be received assessed and treated. They arrive through a sliding external door from a covered porch where ambulances unload their human cargo.

The other half of the A&E area contains the large general waiting area through which I entered and a smaller waiting room area where ambulant patients are directed to await assessment by the nursing staff. There are two smaller consulting rooms in which the nurses can bring patients and assess them. In each there is a treatment couch, a desk and some chairs together with an array of examination equipment, rather like a GP's consulting room. The RN showing me around says she finds using these rooms very helpful as they give a sense of privacy and allow her to welcome the patient into the room and undertake her assessment of their health care needs.

6.3 Profile of nurses and GPs

The Bridge Town hospital had the largest number of both registered nurses (RNs) and general practitioners (GPs) of all the case study sites included in the study. The South Australian Department of Human Services nursing labour force figures for 1998 show the Bridge Town hospital as having a total of 86.4 full time equivalent RN positions (DHSSA, 1998). This translates to 109 RNs available for shift rosters. GP numbers at the time of the study in Bridge Town were 14 (Lian-Lloyd 1998). There are no GPs or other medical staff resident at the hospital. All medical personnel live in or close to the town. Most work in private practices and the majority has admitting privileges at the hospital.

Two of the 14 doctors work with an Aboriginal community controlled health service located in Bridge Town. These GPs also have admitting privileges at the hospital and the ability to earn additional income over their salaried positions at the Aboriginal health service. There is a 24 hour on-call roster for GPs in the A&E department. This includes the Aboriginal health service doctors. RNs requiring the services of a doctor telephone the rostered GP. Most doctors could be at the hospital within 10-15 minutes, although the nurses I interviewed indicated some doctors were reluctant to come and in a few isolated cases could not be contacted when called. Although many observations were made of nurses and doctors during the observation fieldwork period at Bridge Town hospital, two RNs and one GP provided the most detailed information from direct observation and in-depth interviews. The nurses were female and the doctor male. The profile of these nurses and one GP are displayed in Figure 6.1.

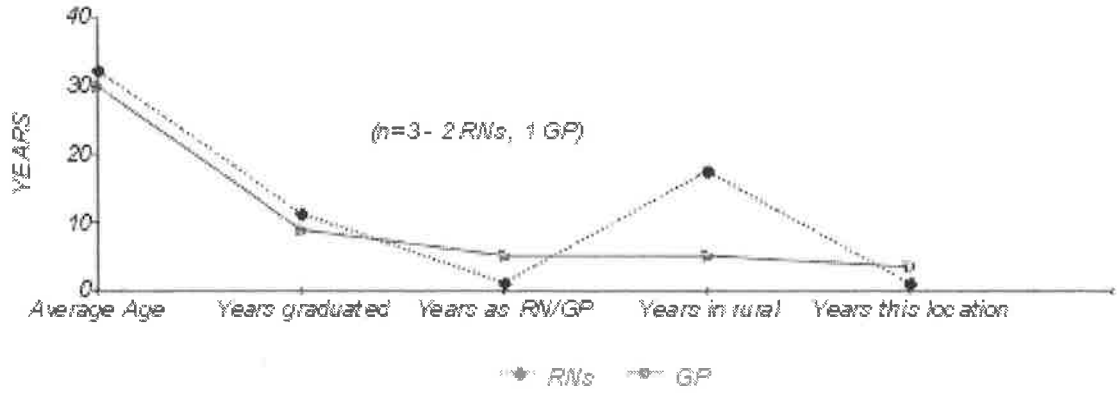


Figure 6.1 RN/GP profile for Bridge Town

The average age of the RNs was 32.5 years, which was only 2.5 years on average older than the GP at 30 years. The ages of the RNs and the GP were 10 years below the national averages of 43.5 for rural nurses and 45.5 years for rural GPs (Stephenson 1999:9) and (AMWAC 1996, p.17). The nurses had been practising nursing longer than the GP had been working as a doctor. They had been nursing for an average of 11.3 years, while the doctors had been practising medicine for two years. The two nurses included in the profile were previously Enrolled Nurses before they completed their Bachelor of Nursing (pre-registration) degrees and this explains their overall longer nursing experience. Figure 6.1 also demonstrates a difference in the number of years experience as either an RN or GP. While the nurses were new graduates with an average of 1.2 years post graduation experience, the GP had five years.

The nurses had 17.5 years more experience in rural nursing practice because of their previous experience as enrolled nurses. It is common to find RNs with previous enrolled nurse experience, especially in rural areas. Both the RNs and the GP were relative newcomers to the Bridge Town hospital with less than four years experience between them. This is explained by the fact that the nurses had completed a one year, postgraduate hospital based training program and the doctor had worked as a locum GP in rural areas. In other words both groups were in their first long-term position. The two RNs had lived and worked in rural areas for many years but had only recently commenced work at the Bridge Town hospital.

In summary, the two RNs were experienced nurses, particularly in rural areas and were recent graduates from a university nursing degree and in their first post graduation appointments as RNs. The GP had previous experience in locum work in rural areas and had only recently arrived in Bridge Town to join a local medical practice. He had just commenced on-call work at the Bridge Town hospital.

6.4 Nurse-doctor relationships at Bridge Town hospital

The observations I conducted of interactions between nurses and doctors at Bridge Town hospital took place in an A&E department and in a general medical/surgical ward. Here I report on one of these in the A&E area.

6.4.1 Accident and emergency observation

Interaction: In the A&E department

(*cited previously in Chapter 3*)
It is 3pm in the afternoon and I observe a young girl's arrival to the A&E department. She has banged her finger hard on a cupboard. The patient is seen by one of the RNs and assessed. The injury has left a swollen joint and severe swelling and the affected finger is mal-aligned. The RN telephones the on-call doctor with this information. He advises her to strap the finger, give oral analgesia and ask the patient to return to the A&E department later in the evening for a 'clinic' when he will see her. (Field note BT01)

This is a common practice and the GP on-call in A&E recounts the importance nurses have in determining whether the doctor comes when called or not:

> I think as a rural GP the relationship with nursing staff has to be a very good one because of the nature of our work. You need to rely on the nursing staff to actually make their own decisions and know when to call you and know when to handle things themselves. I think communication has to be very good for that to happen. (Bridge Town, male doctor 1)

Clinics. I asked the RN to explain what the 'clinic' meant. She calls them 'collections', and explained that the RNs assess all presenting patients to the A&E, take a history of why they have come, triage them and if appropriate give treatment. The patient is then given a choice. They can accept the assurance of the RN that the treatment given is all that is necessary or they can come back to see the doctor at a pre-determined time. The RNs sometimes need the doctor to see the patient and if the matter is non-urgent, such as the girl with the injured finger, they ask the patient to return to be consulted by the doctor. As the shift goes on there may be several patients who are seen by RNs and then asked to return later. Hence the terms 'clinic' or the 'collection'.

I sensed the frustration of the RN who assessed the girl with the injured finger as to the need for the patient to return in several hours to see the doctor, and asked if it were possible for the RN to request an x-ray of the girl's hand and finger. This was not possible she said because the private radiology service which the hospital uses will not accept request forms from nursing staff under any circumstances. They will accept request forms from nursing staff only in emergency situations and when there is a doctor in the A&E department, who will when convenient, complete and sign the form.

The issue described in this example is one that repeats itself in larger rural hospitals with an A&E service. The flow of patients through the A&E area is not sufficient to justify the permanent presence of a doctor and so GPs are rostered on-call. Many of the minor ailments patients present with the nurses could treat and the patient would be free to leave. However, the system supporting the on-call doctors is a source of income generation and there is reluctance on the part of GPs to change it. The more patients a doctor consults, the more fee for service income is received. The Bridge Town GP reinforces this fact:

> In this casualty (A&E) in particular, it is a busy country casualty and the doctor's on call, generally on my roster do, say, one in ten or a one in seven. That can be very busy during the weekend. You can see 50 patients through casualty on a day sometimes and lots of trauma. (Bridge Town, male doctor 1)

The doctor explains that he may work one rostered shift every seven to ten days in the A&E department and based on his own estimates and standard AMA rates, at $30 per consultation he would earn between $1500 and $2000 gross income from consulting 50 patients. This increases as the procedures becomes more complex. The ability to manage this number of patients and to ensure they are effectively triaged rests on the nurses, a fact the doctor acknowledges:

> So, I guess what I expect from nursing staff here is good triage. And communicating that to you whether you are in the building or out of the building and giving you the right information or having it available if you ask the questions, and probably particularly for late night work or early hours of the morning phone calls. (Bridge Town, male GP 1)

6.4.2 Communication issues

I observed much of the communication between nurses and GPs is by telephone. The GP in the previous quote acknowledges the importance of the nurse giving him 'the right information or having it available if you ask the questions'. Nurses also understand their credibility with the GP is measured by how effective they are in communicating patient assessments and that in addition the doctor is aware of the nurse's capabilities to deal with the situation described. A Bridge Town RN points to how a doctor may form an opinion of her professional expertise:

> So they (the doctor) can then base their opinion on...like we do a lot of telephone assessments. I'll assess the patients and have to ring because we don't have GPs here all the time. So they very quickly get to know my capabilities and so then they can make some sort of decision as to whether... 'I believe her or not'. If I can get on the phone and give them a fairly comprehensive assessment...over time they say, 'yes, she knows what she is talking about'. And then they tend to work easier with me because they know what I'm capable of. (Bridge Town, female nurse 1)

This testing of each other's capabilities works both ways and appears to be critical in forming the relationship and generating trust in clinical judgements where the doctor is not present to make the assessment for themselves:

> ...I have the ability to know that when I am ringing such and such a doctor, he likes to know weight and urine analysis on everybody. So you get to know very quickly in a small rural setting what they want and I think they get to know very quickly what we are all capable of individually. (Bridge Town, female nurse 1)

The same nurse also indicated that the confidence she has in communicating patient assessment information per telephone to doctors comes from her long experience as a nurse and the recent added confidence gained from completing her nursing degree:

> I feel quite confident that my assessment or what I am talking about is right...especially since I've been to university and got my degree. I think it brings you to a higher level in that when they talk to you, you can understand what they are talking about. The actual ins and outs and rationale behind the practices that we do...I think that because I'm 40 plus I have been through all the 17 year old – 'Yes sir, no sir' three bags full sir', when in reality we are all here for the patient. We might be on a different level but I don't see GPs as any better than I am as a person. (Bridge Town, female nurse 1)

6.4.3 Nurse-initiated treatments

Throughout the observations I conducted in the A&E area of Bridge Town Hospital there were many situations where nurses were clearly capable of initiating treatment for a variety of patients presenting to the department. They were reluctant to do this despite having the knowledge and experience to do it. A Bridge Town GP indicated his frustration about nurse-initiated treatments:

> One of my frustrations here is that nursing staff feel they can not initiate treatment or make a decision on quite minor things that probably they would feel very confident in making as a mother or in their home setting. (Bridge Town, male GP 1)

I asked the GP to explain why he thinks this situation occurs:

> Well there is always this fear of litigation that is mentioned or that it is not a nursing role to make a diagnosis or initiate treatment…it seems a little exaggerated. (Bridge Town, male GP 1)

There is a fine line for the nurse to tread in making the decision to initiate treatment or to refer it to the doctor. Apart from the hospital policy that might prevent nurses from acting in this way or the sanctions imposed by medical staff that fear reduced patient numbers due to nurses intervening, there is the issue of adequate training and preparation for this additional responsibility undertaken by nurses and the authority to act in this way.

I observed one interaction between a nurse and a visiting orthopaedic specialist in the A&E where the nurse applied a plaster back slab to the arm of a small boy who had injured his arm in a fall.

> Interaction: The back slab
>
> The specialist had examined the boy and seen x-rays of his arm. He decided that a plaster back slab was needed to support the arm, which was not broken but strained. He discussed the type of slab he required with the RN and the degree of flexion needed on the boy's wrist. The small boy and his parents went with the RN to a room in the A&E to apply the slab. The RN asked the specialist if he wished to see the back slab after it has been applied. He declined, saying he was happy to accept the RN's work. I gain the impression he had worked with the RN before and knew her skill and capability to do this procedure. (Field note BT02)

There was pressure on nurses to undertake treatments on waiting patients in the A&E by the patients themselves and by some doctors. A Bridge Town GP describes a typical scenario where, in his view, nurse initiated treatments were appropriate.

> ...being awoken in the early hours of the morning with a paediatric patient with a mild fever and obvious upper respiratory tract symptoms and asked (by the nurse) to come in and assess the child – and I think in some situations there can be so much parental concern, a doctor may need to do that. But usually confidence and some good advice from the nursing staff would usually be able to allay parents' concern and get the child seen later in the morning. This type of thing has happened quite a few times and I would think, like very minor lacerations, certainly could be easily dealt with. (Bridge Town, male GP 1)

Of course there are many variables in this example and the trust the GP places in the nurse to make good assessments and initiate appropriate treatment is but one of them. What the GP has overlooked are the 'rules of engagement' that govern the nurse's practice. If the Bridge Town hospital has a policy that requires on-call doctors to attend to patients when called by the nursing staff, wished for changes by doctors or nurses will not alter the fact. Yes, it may be inefficient use of GP time. Yes, it may not be sensible use of skilled nursing staff and, yes, it does not always serve the best interest of the patient. Nevertheless, this paradox will continue to affect the way nurses interact with doctors, particularly in A&E departments, until the pre-dominant medical model of primary care is changed to one where the care and treatment of patients is shared more evenly.

The reality in this case study site was that nurses organised and ran the A&E department and only called in the doctors when they felt necessary. The exception to this was the practice by the nurses of 'collecting' patients for the on-call doctors to see at specific times. This is as much a convenience for the doctors as it is adherence to hospital policy.

Much of the communication between nurses in the Bridge Town A&E department and GPs was by telephone. The essence of what was communicated by the nurse to the doctor revolved around an assessment story, whether or not the nurse thinks the doctor should come and whether or not the doctor trusts the nurse's judgement or senses uncertainty in her voice. This description by a Bridge Town nurse demonstrates how these elements work in practice:

> ...we are in a rural setting and I need to rely on the doctor. In the middle of the night I might need him now, so I think when I give a phone description of the assessment I've made on a patient I think it gives the doctor a picture of what he is looking at...I think I give them a comprehensive view. I don't tend to panic a lot and the doctors realise that, so they get to know that when I am panicking, they need to come now. (Bridge Town, female nurse 1)

The same nurse commented on a young girl who had been admitted to the A&E department following an accident with a car. She had been struck by it and appeared to have had her foot run over by one of the car's wheels:

> ...like the little girl with her foot we had today. I mean my main priority was to calm the child down....she had good air entry and all the rest of it, I mean neurologically you can tell just by looking at her that she is not flat....The foot looked OK...so basically I could ring the GP and say, 'Well, she's been hit by a car, neurologically she's fine, she ran away after the incident', so then he thinks, 'Oh, it can't be that bad, its nothing major'. But if I rang and said, 'Look I've got this flat kid and she's not right and I need you to come', then he knows to come. (Bridge Town, female nurse 1)

Here the nurse communicated by telephone her initial assessment of the patient and from this the doctor can make a judgment about the potential seriousness of the problem, which influences his decision to come to the A&E or not. In this particular case the doctor did respond by attending to the patient, but as the nurse explained this had more to do with him saving time than the acuity of the patient's condition:

> I think in this instance he wanted the child to go down to the surgery....I think the reason he decided to come to the hospital was a time saver, a lot quicker to come and see her. I don't think it had anything to do with the acuity of the patient. (Bridge Town, female nurse 1)

There are two competing forces at play here. The first is the need of the nurse to have the doctor respond to her request to attend the patient she has assessed as in need of medical intervention. The second is the on-call doctor's need to weigh up the time it will take to leave his practice and make a visit to the hospital. While he is paid to make this visit, there is disruption to the patients he is consulting within his practice. This has both a financial and professional cost for him. In the end he must make a judgment based on the trust he has in the nurse's ability to undertake competent assessments and his respect for her experience. The existence or otherwise of trust and how it is established and maintained between the nurses and doctors is an important part of the relationship.

6.4.4 Building trust and respect

From the perspective of the Bridge Town GP who worked as an on-call doctor, trusting nurses to make decisions was something he did only after he got to know the nurse and was satisfied that she had confidence in her own ability and judgment:

> Trust is interesting because I do trust the nurses to make the decisions; you get to know the nurses and some are particularly good and I encourage that initiative and decision making and certainly there is junior and experienced staff here as well. Probably the trust is more of the nurses having their confidence and trust because I think the general GPs think casualty (A&E) staff are very good. (Bridge Town, male GP 1)

In this doctor's opinion trust did not happen automatically. He felt that 'some nurses are particularly good' and that there was a difference in decision making when junior as compared with more experienced nursing staff undertook it.

How then do nurses convey to doctors' that they have confidence in their own ability? How does this translate into trust between the two?

In part the answer to these questions has to do with the nurse's use of language and an ability to provide a cohesive summary of patient problems. The Bridge Town GP explained how, in his view he learned to trust nurses who telephoned him about patients:

> Well it's language firstly. If you haven't actually met them and it's over the phone stuff, often the real trust has to happen. You are not seeing the patient and so its language instinctively. You know if a nurse has it, and can sum it up well and say, 'This is what I think the problem is and this is what I'm going to do'. It's interesting that there is a spectrum of nurses who can do that and others who are probably less experienced. (Bridge Town, male GP 1)

Here it can be seen that the doctor will trust a nurse even when he has not met them, provided he hears confidence in their voice and they use language that is comprehensive and allows the doctor to appraise the situation without being there in person.

This process of nurses giving doctors information by telephone is not unique to the rural setting. The difference in the rural context is that there are no resident doctors and because of the time it might take for the doctor to visit the hospital it is more significant for nurses to convey information appropriately. It is also important that the doctors hear this information and the manner in which it is given before making a decision about treatment or attending the patient.

The doctor at Bridge Town suggested that this type of communication in the relationship leads to respect and friendship through both parties taking a risk – the nurse in conveying the correct information in a way that it is clear and the doctor in accepting the nurse's judgment:

> Yeah, you really do get a rapport or friendship with nurses, particularly casualty (A&E) ones. I guess you do spend a lot of time (with the nurses) and they do protect you at times as well. (Bridge Town, male GP 1)

The development of respect between the nurses and doctors as a result of the trust they place in each other is mutual, as a nurse from Bridge Town attested:

> For them (doctors) to gain my respect I think that, generally, I would like a little bit of respect from them as a person, not so much as a nurse necessarily. And that they are polite and that they have even just a slight understanding of what we go through everyday. I just think it is a lot of give and take and if they can do those sorts of things, then I tend to respect them more. (Bridge Town, female nurse 2)

A Bridge Town nurse recounted specific behaviours she looks for from doctors in the hospital which indicate they respect her as a person and as a professional:

> I just think that if they are cordial to me and polite and occasionally they ask your opinion, and usually I have no idea, as I'm just starting out, but then sometimes I do because I have been with the patient quite a lot. Sometimes that works out well. (Bridge Town, female nurse 2)

The nurse is not only looking for common courtesy from the doctors. Despite her relative junior status and her own self-deprecation, she wants the doctor to acknowledge the simple fact that she has spent longer in contact with the patient than he has and in fact may have a better overall view of progress than the doctor recognises. The same nurse pointed to the sharing of humour between the nurses and doctors as a way of setting the scene for more serious interactions between them:

> ...because by about 10.30pm at night or 10.45pm at handover time we are usually really tired and if he (the doctor) comes in then, there is a lot of joking and things going on. (Bridge Town, female nurse 2)

The description by the nurse underscores the importance to her of nurse and doctor sharing through humour as a means of breaking down perceived barriers. In turn this may lead to the building of trust and respect for those she works with:

> I try to adapt myself to their needs. In some ways and as much as possible, I try and have a little bit of dignity. I guess I'm not as interactive as a lot of the other nurses because I'm just not relaxed yet. I decided that I can only really be true to myself and the way I am which is to get on, do the job and have this quiet sort of respect for the other people around me. Not just the nurses, but the doctors as well. (Bridge Town, female nurse 2)

In striving to build an effective relationship with the doctors, one built on trust and respect, this nurse adapts her behaviour to suit the needs of the doctor. She hints at keeping her dignity while doing so which suggests that adapting to doctors' needs is not always a dignified process. Her

relative inexperience as a newly registered nurse means she does not have the confidence to be forthright in her opinion to doctors or other staff. For her, respect for herself comes firstly from being true to her own character and secondly from doing the job as a nurse. It seems then that only when these needs have been satisfied is she able to give equal respect to doctors and other nurses. By this nurse's own description she modifies her own behaviour in order to make the relationship work smoothly:

> I just accept what they are saying and I keep nodding and I'm just calm, speak in a low voice and I guess I'm pacifying them but I also just try and make sure that I've got this sort of quiet dignity. I do the same with patients if they get annoyed. I try not to respond, I just keep listening and just have this quiet dignity and then that seems to calm them down and they have more respect for me because they realise I didn't explode. I just find after that, even if it is a patient or a doctor, they just seem to remember you and realise that you kept control in a situation and they have more respect and from then on the relationship is better. (Bridge Town, female nurse 2)

In this statement there is a resignation by the nurse that nothing can be achieved by reacting in a way that might be perceived as negative by doctors or patients who display anger. She concludes that keeping the peace and not allowing herself to respond to direct attacks on her character takes priority over her own feelings:

> ...if you explode at them the relationship is ruined forever and it's not worth it... So, I just try and be calm, and there will be times where doctors will tell you off whether you deserve it or you don't. There's not much you can do. (Bridge Town, female nurse 2)

There is a mixture of traditional nurse-doctor relations here with that of stereotypical roles of women in our society. Being restrained, calm and being 'told off' without challenge are all hallmarks of subordination and designed to maintain the status quo. The resultant relationship, if it can be called that, is one dimensional and nurse and doctor are the poorer for it.

6.5 Summary

Bridge Town hospital is in some respects similar to a large metropolitan public hospital. The differences that set it apart are mostly contextual. It is located in a rural area. It is a long way from a tertiary referral centre. It provides health services to a population with a large number of underprivileged people and, in contrast to a metropolitan public hospital; it has no resident medical staff. These factors affect the way the relationship between nurses and doctors works in practice together.

Of the four case study sites included in this study Bridge Town is the largest in terms of the total number of doctors at approximately 15 and nurses at around 100. Observation of nurse-doctor relationships through their interactions took place over several days, mostly in the accident and emergency department of Bridge Town Hospital, but also in a general medical/surgical ward. Three key participants provided in-depth interviews, one doctor (GP) and two nurses (RNs).

The main issues emerging from the observation of nurses and doctors working together and from their interviews centred around nurse-initiated treatments of patients in the A&E department and the building of trust and respect between the two groups. The A&E nurse participant had over 20 years nursing experience, mostly as an enrolled nurse and, following completion of a Bachelor of Nursing Degree, as a RN. She was confident in her capabilities and could have assumed more responsibility in the provision of A&E services and nurse-initiated care.

She was supported in her endeavours by the GP who worked on-call in the Bridge Town A&E department and who was also a key informant in this case study site. While supportive of nurses who had gained trust and respect from the doctors and who had demonstrated their skill and capability, he acknowledged the hospital system did not allow nurses the freedom to practice in this way. He held the view that the relationship between nurses and doctors in the A&E department was a good one. This was because the nurses 'protected' the doctor from unnecessary call outs by assessing the patients and communicating the information by phone. They organised patients who needed to see the doctor to come back to the A&E at predetermined times and assisted the doctor in the clearance of those patients the nurses had already assessed in order to avoid any further delay for the patient.

The major means of communication between nurses in the A&E and the doctors was by telephone. Nurses who could convey a coherent assessment of patients they had examined over the phone to the doctor in a confident manner were respected by the doctor who in turn trusted the nurses to carry out treatments, sometimes outside the scope of practice for the nurse.

The building of trust and respect between the nurses and doctors observed in the A&E department and in the medical/surgical ward of the Bridge Town hospital developed when there was mutual regard for common courtesy, personal dignity and clinical competence. Although the GP observed in the A&E department was relatively inexperienced when compared with the two nurses, he confirmed his trust in the nurses to make informed decisions about care when he was not present.

He relied on their verbal communication by telephone to assess the condition of patients and discussed appropriate treatment without his attendance on every occasion. The nurse working in the general medical/surgical ward of Bridge Town hospital had recently graduated and was in her first year of practice. For her the development of trust and respect from doctors she encountered was based on them accepting and valuing her opinion despite her inexperience as a RN.

The observed interactions between the nurses and doctors in Bridge Town hospital were comprised in the main of short visits by the doctor to see patients or telephone discussions. This meant time spent together was limited to a quick patient visit, some notation in the patient case notes and then departure by GPs. There were no social interactions such as sharing tea or coffee together or longer discussions that were common place in the smaller rural hospitals in the study.

Silo Town

7.1 Describing Silo Town

7.1.1 Physical characteristics

Silo Town's landscape is dominated by one large feature. It can be seen easily as the town is approached from any of the four roads intersecting with the town's main street. The huge white painted concrete cells of the grain silos reach skyward , marking as they do the economic success or otherwise of the largely cereal and mixed farming agricultural community surrounding them. A collection of pigeons flap and fly around the roof of the silos – a comfortable home with shelter and good pickings when the grain filled farmers' trucks call to disgorge their golden cargo into the silos.

Atop the silos a 'pigeon eyed' view of Silo Town would clearly locate the total town perimeter and all that lies within it. The main bitumen road stretches north and south, two gravel roads entering the town from east and west. A straight ribbon of steel track is the vital railway used for grain transport to a main seaport some 140 kms to the south of Silo Town. The main road runs like an artery through the town and a row of shops, stores, offices and one lonely hotel stand in line hoping to attract not only local but passing traffic trade. The facades of these are dated and clearly intended to be functional rather than impress the passer by. The end wall of one of the main street buildings has been dedicated to a mural depicting the history of this small rural community – horse drawn implements; harvesting the crop; a travelling merchant selling everything from pots and pans to clothing; struggle with the land and elements. A common theme in the painting is celebration of the pioneering spirit needed in an earlier era to carve out a living from this marginal farming land.

Further back from the main street facade lie the civic achievements of this community: football oval and recently constructed clubrooms gleam in the morning sun; a disused tennis court with its surfaced cracked and yielding to the relentless sun and opportunistic weeds; a school and community library, neat and tidy and well protected from the harshness of the climate with shady trees and shrubs; the community health centre, one of the newer buildings in the town, low and long, facing the town football oval and clubroom complex.

This sport clubroom is frequently the focus of community activities. Like many rural communities, sport is an important social drawcard. A fire station, community hall built from local stone, a collection of agricultural machinery, a stock agent and hardware stores, mixed with two or three streets displaying an assortment of homes, complete the physical picture of Silo Town.

7.1.2 Socio-economic characteristics

Strangers or 'out-of-towners' are regarded with some suspicion and indifference in Silo Town. Given the population of the town is small, around 300, this is perhaps not surprising. With the exception of staff at the community health centre, some of which I have met on previous occasions, the reception given to me on my arrival in the town is at best cool. The front bar of the local hotel is a good example. This is where I have been advised to go for a room during the time that I will be staying in town to conduct the research at the community health centre.

Two customers are perched atop stools, leaning on the bar with beers in hand. They shoot me a glance and without acknowledgement return to their muffled conversation. The barperson, noticing me, enquires after my needs. I explain I had booked a room and ask for the keys and directions, since there are no signs indicating where the rooms are located. I soon discover why the 'rooms' are not something the hotel would want to advertise. The accommodation consists of a block of four separate motel type rooms that look tired and run down. Inside the small room the furnishings are very basic and reflect their exterior. I gain the distinct impression that paying guests are rare in the hotel. This is reinforced when I find no breakfast facilities or ingredients in the room and when enquiring about obtaining breakfast in the hotel I'm told they don't open until late morning.

I decide to purchase some basic foodstuffs at the local combined general store and supermarket. It is late in the day by now and I find it shut. I decide to shop the next day on my lunch break. On entering the store I find its shelves thinly stocked and only basic commodities available. Perhaps this is because local people shop in the larger town 140 kms to the south. Or it could reflect low local demand and tight economic times. I gather what I can and walk toward the cash register counter. There is only one attendant and she does not greet me or make eye contact despite my attempt to do both.

Suddenly another customer, sweeps into the store and interrupts our imminent transaction. It is clear from the shop attendant's reactions that this woman is a local. I am ignored completely as the attendant greets the woman and asks if she can help her. I have lived in small rural communities before and I find myself being surprised by the indifference and rudeness and wondering whether it is a symptom of a wider community attitude or just two local people with other more pressing things on their mind. The attendant serves the local customer first and then I am attended to. I bid her good day and leave quickly. Wariness of strangers and not making them feel welcome is not something normally associated with rural people and I make a mental note to follow this up in conversation with the staff at the community health centre.

The population of Silo Town has never been large. The town's infrastructure and services are testimony to that. It has been difficult to find accurate population statistics due to the low population in the town. However, estimates from the staff at the community health centre were 200 living in the town itself and another 500 in the immediate district vicinity. There is reason to accept both figures as accurate as the 1996 ABS census figures for the District Council Statistical Local Area (SLA) in which Silo Town is located were 1212 for the total DC (ABS 1999). There are only two small rural towns inside this district council area, one of which is Silo Town.

The major industry and reason for the town's existence is farming. This is mostly wheat, oats and barley with some other feed grains. The majority of farms also produce wool and meat sheep and some cattle. Due to the heavy dependence on these agricultural pursuits, the general economic malaise associated with primary production has affected the farmers in the Silo Town district and those industries that support them. Unemployment is low at around 4.5% of the total district council area or 53 out of the total district council population of 1212 (ABS 1999). This relatively low unemployment figure should be treated with caution as it reflects the tendency for farmers to remain on their farms with incomes approaching poverty levels or to leave their farms, as some have done, rather than register as unemployed.

The people of Silo Town and the district council area in which they live are a mix of young families, and a few retired workers from the farming industry in and around the town. Many retiring farmers move away from the district to neighbouring seaside towns and this explains the lower age median of 35 years indicated in Table 7.1. The table also demonstrates the resilience of the general community in terms of health status and use of health services.

It should be noted that the available options for health service in Silo Town are severely limited. There is no resident doctor, pharmacist or other health professional except the two full time registered nurse positions at the community health centre. The centre provides a wide range of primary health care services. However, it is reasonable to expect that many residents of Silo Town utilise health services outside their district area. There are no readily available statistics to gauge how many use external health services or what type of services they seek. The number of indigenous Australians in the district council in which Silo Town is located is very low at 1.2% (14) which is half the South Australian average of 2.4% (ABS 1999).

Table 7.1 Socio-economic cluster characteristics for Silo Town Statistical Local Area

Socio-economic status	Medium
Heath status	Medium
Health service utilisation	Medium
Socio-economic & health status	Medium
Median individual income per week in DC (ABS)	$242
Median age of population in DC (ABS)	35 years

(Glover 1996; ABS 1999)

7.2 The health service description

The relatively low population base of around 200 town residents and 300 in the immediate vicinity of the town has shaped the type of health services available in Silo Town. Health service planners, faced with the need to provide some basic services to a community of this size, invariably end up with a compromise. Too few services and the community is disadvantaged by having to travel great distances to access health care services. An inappropriate mix of services and the cost benefit to health outcome equation becomes obvious. In either case the health and well being of the community can suffer considerably. The health service at Silo Town is therefore a compromise. Classified as a community health and welfare centre, Table 7.2 displays the range of health services provided by local and visiting personnel or services:

Table 7.2 Range of local & visiting health services in 'Silo Town' Community Health Centre

Local Services	Visiting services
Immunization & cervical screening recall systems.	Child & youth health (Mothers & babies)
Nursing support to consulting GPs during clinic sessions.	Medical – 2 GPs. Alternate doctors on 2 days each week for 4 hour consulting time.
Public health screening at Field Days and local events.	Optician – once monthly visit.
Antenatal classes & Postnatal support group.	Dietician – cancelled due to lack of response.
Primary health care services to community as required – a wide range of outpatient treatments and procedures are undertaken by nursing staff.	Dental – once monthly visit.
First aid and emergency treatment until medical assistance arrives or the patient is transported by ambulance. Some nursing staff provide ambulance service staffing.	Physiotherapy – one clinic every two weeks.
Counselling, information and referral services.	Pharmacy – transported by bus from a neighbouring town 82 kms away.

(Silo Town Community Health & Welfare Centre Annual Report 1995/96)

While Table 7.2 represents the documented services provided by the Silo Town community health and welfare centre, it does not provide an adequate picture of the depth and complexity of services initiated or coordinated by the centre. The types of clients using this form of health service and the services they receive can vary greatly between community health services.

Glover provides us with this definition of community health and domiciliary care clients:

> Community health service clients are clients attending the health service for early intervention, prevention, treatment, health promotion/education services;

and domiciliary care service clients are:

> ...those who receive services which are either centre-based (e.g. podiatry) or are provided in the home, and without which clients are at risk of institutionalisation. (Glover 1996, p.320)

The rate of use for both community health and domiciliary care services in the total region in which Silo Town is located is significantly high, in fact 60% higher than other rural regions in South Australia (Glover 1996, p.325). This is in part explained in the case of Silo Town by the fact that the community health and welfare centre is the only health service available in the town.

In the case of the Silo Town community health service, both client groups are catered for but visiting health or welfare personnel provide large proportion of the services. This adds a layer of complexity to the administrative and financial management of the community health and welfare centre. The administration and financial structure of the community health and welfare centre is not in direct control of the local community. The senior nurse in charge of the centre reports to a Director of Nursing in a larger regional hospital located 142 kms away. The same Director of Nursing sits on the centre's seven member Advisory Committee as the Executive Officer. All financial and management services, other than day to day, are provided by the larger regional health service. The Advisory Committee's role seems to be to provide advice and recommendations on the local need, but in the end they have no formal power to control their own direction or budget.

It is not unusual for small health service units of this nature to lack autonomous decision making and to have larger regional health services act in a paternalistic way towards them. This model raises questions about whose interests are being served. Would the small rural communities health service needs be better served if the Advisory Committee were changed to a local Board of Management with the larger health service devolving a budget allocation and the Director of Nursing / Executive Officer position being changed to that of an advisory, support role?

Silo Town will never be able to justify the provision of acute care services. This means its residents must accept that if they require hospital admission they must choose one of three neighbouring towns, all of which are between 82-142 kms away from their home and support systems. In some cases they may have no choice as the type of treatment or service which they require will determine to which hospital they are admitted. If they require emergency evacuation this will be by road ambulance or Royal Flying Doctor to a larger tertiary health service. This has always been the case for residents of Silo Town and most have accepted this reality.

The fact remains, they are disadvantaged relative to other rural communities and their natural right to access health care of their choice comes at a higher cost and at greater personal risk. Some are unsympathetic to these facts and chant the mantra of: 'You chose to live in this place, you must accept the disadvantages', including the lack of access to a full range of health services. Others take the more egalitarian point of view, which holds that all Australians are equal and should have access to an acceptable level of health services. Just what is deemed to be 'acceptable' is likely to be hotly debated.

Meanwhile the residents of Silo Town go about their daily business, striving to make a living for themselves and their families and doing so in a quiet way which has long been associated deeply with the 'battling Aussie' icon of the Australian bush. One thing is abundantly clear about the health services provided in Silo Town. Were it not for the rural nurses who have provided continuous care to this community over many decades, the health and social structure of this small rural community would be far worse. This fact is of significance because of the central way it influences the working relationship between the rural nurses and visiting GPs.

7.3 Profile of RNs and GPs

At the time the case study was conducted in the Silo Town community health and welfare centre there were three registered nurses (RNs) and one visiting doctor (GP). All RNs were female and the GP was also female. Two RNs and the GP were included in the study from this case study site and their profile is displayed in Figure 7.1. It shows a significant difference between the RNs and the GP in five key areas. On average, the nurses at the case study site were 13.5 years older, at 48.5 years, than the GP at 35 years. This is partly explained by the age of one of the RNs being 57 while the others were in their mid forties; but this is generally consistent with the age profile of rural nurses nationally. A 1999 national study by Stephenson, Blue & Petkov found the average age for female rural nurses was 43.5 years (Stephenson 1999, p.9). The 1996 AMWAC medical workforce report indicates rural GPs age profiles are similar, although slightly higher than rural nurses at 45.5 years (AMWAC 1996, p.17). In this respect and one other the GP at Silo Town was somewhat unusual. Firstly she was younger than the national average for rural GPs by 10 years and secondly she was one of relatively few female GPs in rural areas. The same AMWAC report indicated there were only 12.8% of female GPs in the resident population for 'rural other' classifications (AMWAC 1996, p.16).

A second key characteristic of the RN/GP profile was that the nurses had been practising longer, with an average of 27.5 years since their initial graduation. This is 17.5 years longer on average when compared to the GP at 10 years. One of the RNs had been practising for 32 years and the other for 23 years, but the latter included a five year break for raising children.

Thirdly, Figure 7.1 shows a difference in the number of years practising between the GP and the RNs. In the GP's case this is explained by the fact that she had worked in other areas of medicine prior to becoming a GP. The past 2.5 years she had practised as a GP in rural locations, with only six months in Silo Town.

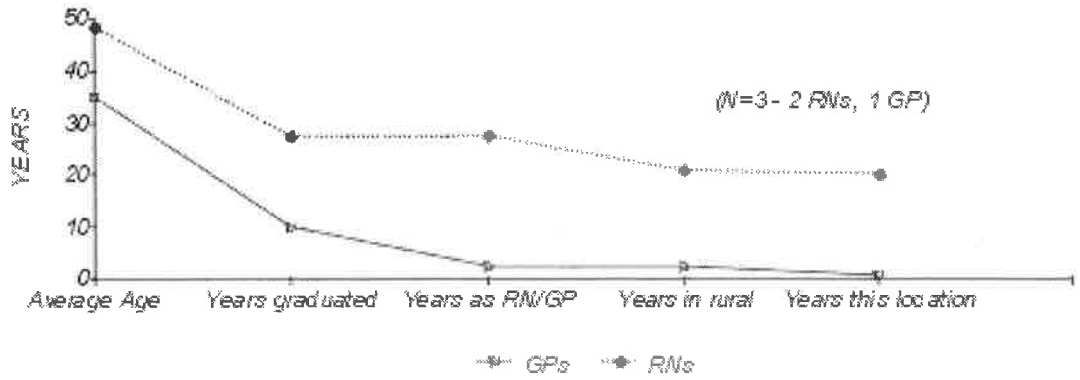


Figure 7.1 RN/GP profile for Silo Town

The fourth and fifth characteristics of note relate to the longer periods of time that the nurses had spent in rural practice when compared with the doctor. One RN had 27 years experience and the other 15 years. While the GP's length of experience at Silo Town had only been six months, both RNs had an average of 20 years experience at the location. In subsequent interviews with the RNs and the GP it was clear that the considerable experience of the RNs in terms of local knowledge about individuals and their family health and social history was of great benefit to the GP. This was particularly so when managing the health care problems of the residents of Silo Town.

A profile of the nurses and doctor would not be complete without some information about the social and professional backgrounds of the three individuals I closely observed and interviewed over the fieldwork observation period at the community health and welfare centre at Silo Town. Some of these insights are useful for understanding the nurse-doctor interaction but also in later chapters where I undertake a more discursive exploration of the features and characteristics of the rural nurse-doctor professional relationship.

From the preceding analysis it is clear the two RNs have lived and worked in Silo Town for many years and that the GP is a recent addition. The more senior RN came to the town over 30 years ago when her husband was transferred there as a policeman. She has been deeply involved in her community and especially the establishment of the community health and welfare centre. Over that long period of time she has become somewhat of a local identity and before the establishment of the current centre provided health and nursing services from her own home. She talked to me of retirement and what that might bring for her after such a long period of working in a largely autonomous role. I gained the impression she would be lost without her work because it occupies such a central place in her life.

The second RN was also a local person and she and her young family lived on a farming property not far from Silo Town. With 13 years experience at the Silo Town community health and welfare centre she has also gained a detailed history of local people and their health care needs. When talking with her I discovered that she has attended a wide variety of professional development courses over the years to keep herself up to date with current trends. She intended to make a change in nursing career soon and talked of leaving her work at the community health and welfare centre to undertake a course in child and youth development. This will take her to the large regional town 140 kms away to undertake the study component of the course and to gain clinical experience. She admitted to feeling uncertain about the impact of the change on her and the family but believed that it was necessary to move on and broaden her work options. The income she earns from her work is no doubt vital to supplement the uncertainty of farm income.

The GP is new to the area, having spent the past two and a half years in general practice in rural areas in other states. She had moved to a small seaside rural town 90 kms away from Silo Town and drives the rough gravel road once each week to conduct her consulting clinic at the Silo Town community health and welfare centre. During the time I was there she arrived with her husband, who is also her practice manager, and small toddler daughter. During the four hour clinic her husband, the nurses and occasionally the GP herself took turns to attend to the needs of her daughter, who like most children of her age is very active and seeking attention.

As the GP and her family are new to the area they have not established many social support systems, hence the reason for bringing her daughter with her when she is working. The GP indicated how important it was to her and her family to feel welcome when she visits Silo Town and for the nurses to help ensure her visits run smoothly. I sensed some restlessness in her words and behaviour. She was perhaps uncertain about what the future might hold and whether she could continue to maintain the busy schedule of a rural GP with its attendant travel and out of hours work. From the information she provided me it was clear she had moved through several positions in the past two and a half years, perhaps searching for the right place.

7.4 Nurse-doctor relationships at Silo Town health centre

Compared to the other three rural hospital case study sites Silo Town differed in one main respect. Nurses and doctors had infrequent contact because Silo Town had no resident doctor. Two different doctors from neighbouring towns provided medical services twice weekly at the Silo Town community health centre. This centre was staffed entirely by nurses who provided the small local community of several hundred residents with all their primary health care needs.

My observational visit and in-depth interviews of nurses and doctor were planned to occur when one of the visiting GPs consulted in the health centre. I was able to observe the interaction of nurses and the GP for one day but remained at the centre observing the nurses and conducting in-depth interviews for a further two days. Two RNs and one GP provided the information on which the discussion of their relationships is based.

7.4.1 Constructions of the social relationship

A constant reality for nurses at Silo Town CHC is the visiting of doctors and other specialists, since there are no other health professionals in the town. The arrival of the doctor to conduct a GP clinic provides an insight into this and how it affected both nurses and doctors.

Interaction: The visiting doctor

> The receptionist called the RN in charge of the Silo Town CHC from her office. She had seen through her window facing the street the visiting GP arrive in her car outside. Her husband and their small toddler emerged from the car laden with children's toys, bags and briefcases. The RN in charge greeted the doctor and welcomed her, asking after the well being of the doctor's child and if they had had a good journey. The RN then assisted the doctor, her husband and child to unload things from the car and to usher them into the centre. (Field note ST01)

The doctor had driven 90 kms from a neighbouring rural town to conduct a consulting clinic at the Silo Town CHC. The distance, although not great in relative terms for rural Australia, is more significant because the condition of the road surface is hazardous with only 30 kms of the total 90 kms sealed. The remaining 60 kms is rough and, when wet, slippery and dangerous. These conditions increase travel time and the risk of accident or damage to vehicle and/or occupants. The stress of the travel causes the GP to reflect on her own commitment to visiting the centre:

> There has been a lot of review and revision of current (health) services anyway and that causes stress. I had intimated that with my other commitments I might not actually continue to come out here. The exhaustion factor comes into it. (Silo Town, female GP 1)

The reception the GP received when arriving at Silo Town CHC was clearly an indicator to her of the significance of the visits and the extent to which the staff of the centre are prepared to go to make her and her family feel welcome. The GP reflected on the attitudes of the staff from previous visits and compared them to the one she experienced on this occasion:

> ...the whole thrust of today has been really good. When we first started coming here we were welcomed with open arms and people came out and helped us unpack the car, including our daughter and everything. Then things got busy and more complicated as the discussions about the inclusion of this health centre in the MPS (Multi-purpose Service) went on. As the implications of that became clear, some of those things we had had got dropped. Now we're back to pretty much where we started. (Silo Town, female GP 1)

Here the GP is revealing her perception that because of the proposed changes to include the Silo Town CHC in a regional proposal for a MPS her own services may have been affected and that this had caused the nurses at Silo Town to express some concern at her implied threat to cease providing GP services to Silo Town CHC. The removal of this proposal, for the time being, had led to a change in attitude towards the GP by the nurses and staff at the Silo Town CHC:

> They (the nurses) went out and met us and helped unpack the car. A morning tea had been arranged. Bookings had been kept to a minimum with only the odd occasional extra one snuck in. They have spent more time with my daughter. It's not their job to look after her but it just a different approach today. There has been much more clarifying of little things like, 'Do you want me to do this?' Not that they are bad normally. They're good nurses but there's been tension in the past. (Silo Town, female GP 1)

From the nurses' perspective the welcoming of all visiting medical and other staff is an important part of establishing rapport and building a relationship. A Silo Town nurse explained how she welcomed the second doctor, who provides alternate week consulting sessions at the centre, and made him feel part of the 'family':

> ... well I always make a point of making sure everything is ready when the doctor comes and I try to go outside and meet them when they pull up, introduce myself, take them in and whiz them around the building, and then just say yell out (if you need something). All the staff here is like that, introduce the staff and make sure they get a cuppa somewhere along the line and just experience a family feeling. To say, 'You are part of our family now.' (Silo Town, female nurse 1)

The female visiting GP brought her young daughter with her and her husband was the practice manger. This reflects the reality of a young practising female GP who is trying to balance home and work life. The GP acknowledged the nurses at Silo Town CHC do not have to take responsibility for her daughter. I concluded they had been given little choice and had to work around the inevitable disruptions that come with a small child. The nurses accepted it as part of the deal that comes with having a GP with a young family:

> I am concerned for the child when it gets upset. That it is affecting the mother who is trying to do her work. It doesn't seem to worry her, but it worries me. When it gets upset, Dad (GP's Practice Manager) is not always available, so I feel I need to go and check her out and look after her which makes it a bit difficult, but I think it is worth it. (Silo Town, female nurse 1)

A second Silo Town CHC nurse explained the importance to her of making the visiting GPs feel they are valued and part of the centre:

> I guess because we usually know that if our locum is coming we like to make them feel at home. That we welcome their service, they are valued. We can't operate without them. We give that message by being friendly and welcoming, showing them what's here. Say to them, 'If we can be of any assistance, just ask.' 'If you need to query how things are done here, just ask.' (Silo Town, female nurse 2)

It was apparent the nurses make the visiting doctors welcome and part of their 'family' and the doctors expect to be treated this way because they experience some level of inconvenience when travelling long distances to undertake consulting sessions. That said, one of the Silo Town nurses described the rationale for acting the way they do towards the doctors as simply:

> But that's human nature. (Silo Town, female nurse 2)

In other words, this was the way they treated all visitors in the country with whom they wanted to build a successful relationship.

7.4.2 Nurse-doctor roles in a visiting GP consulting session

I observed over a four-hour period during which time the female GP consulted with approximately 20 patients. Each consultation lasted on average 12 minutes.

The two nurses in the CHC had arranged the patient records in readiness for the clinic and there were a number of occasions when the nurse was required to perform a function at the request or on behalf of the doctor. The following briefly describe these occasions:

Interaction: Working with the doctor

1. Doctor requests the RN to do a urinalysis for a female patient who is pregnant. The test is normal and the RN records this in the patient's notes and verbally advises the doctor of the test result.
2. Doctor requests an appointment for a bone density check be made for a female patient. The RN telephones the Royal Adelaide Hospital to establish if there is a Mobile Bone Density Clinic to visit this rural region and makes an appointment for the patient.

3. At a female patient's request doctor requests RN to give massage for back pain. The RN makes a time for this patient to return to the CHC at a later time for the massage.

4. Writing up patient medication orders for the pharmacist in neighbouring town. The patient hands a script from the doctor to the RN and asks her to order it. As there is no pharmacist in Silo Town, the RN writes the order form out and faxes this to pharmacist. The patient will be able to collect the script and pay for it the next day. There is a courier who collects all the ordered medications from the pharmacist and delivers to the CHC on a daily basis.

5. RN assessed man with rust stain on cornea and contacted other visiting doctor by telephone to discuss treatment and management. This was done because the patient was travelling to the town where the doctor was and it was deemed appropriate the RN contact the doctor in that town rather than the one consulting in the CHC.

6. Doctor requests RN to supply patient with a medication from the CHC's pharmacy impress. The RN reports that this is a frequent occurrence and is seen as a benefit to the patient for two reasons. Firstly the patient can take their prescribed medication with them and secondly they do not have to wait 24 hours to obtain the medication from the neighbouring town pharmacy. The RN uses an authorised schedule of pharmaceutical benefits publication to check the prescribed drug to ensure the correct dose is ordered to replace the one going out from the Silo Town CHC's pharmacy impress and to determine the correct charge to make to the patient.

   The RN takes the prescribed medication from the CHC impress and places the amount and dose of the medication into a container. She then labels this with the doctor's instruction for taking the medication. There are times when the doctor may have to alter a prescription dosage to reflect the availability of what is in the CHC impress. The RN brings this to the doctor's attention if this is the case. When the patient collects the prepared medication the RN checks to determine if the patient understands how to take the medication. She gives him advice on when and how to take the medication. The doctor, passing by this conversation, provides additional information on taking the medication to the patient. The providing of advice and treatment by nurses to patients is a common feature at the Silo Town CHC. This is mainly because the town has no resident doctor and the nurses are often required to take the initiative in the treatment of patients who present at the CHC. (Field note ST 02)

In response to this situation a myriad of guidelines and policies have been developed for the nurses to follow.

7.4.3 Policies influencing nursing-medical relationships at Silo Town CHC

The Silo Town CHC has a policy manual. The policies contained within the manual include the following:

- Accepted nursing abbreviations for documentation
- Annual Practising Certificate for nurses– renewal of same
- Taking of blood alcohol after breath analysis – Role of RN
- Informed consent to medical & dental procedures
- Documentation
- Dress code in the hospital/community setting
- Escort of patients using transport
- Use of glucometer – Competency Assessment of Registered and Enrolled Nurses
- Higher duty allowance for acting or relieving positions
- Incidents and reporting of
- Disclosure of information
- Intravenous Infusions – Role of Registered and Enrolled Nurse
- Pharmacy prescription service
- Snake bite envenomation detection kit
- Last will and testament

Of these policies, surprisingly only four specify interactions that must occur between nurse and doctor. These are:

1. Informed consent
2. Incidents and reporting of
3. Intravenous infusions
4. Snake bite envenomation detection kit.

The common denominator in all is the need of the RN to advise the doctor of an anomaly or to ensure a written medical order is obtained before nursing intervention takes place. There is no policy that provides direction to nurses about medication management in the absence of the doctors from the Silo Town CHC.

For example, medication scripts for regular patients presenting to the CHC are kept on file and are accessed by the nursing staff when required by the patient. A check is kept on the need to order repeat scripts and the nursing staff brings this to the attention of the GPs when they visit. The Silo Town CHC has a policy in relation to providing a pharmacy prescription service to patients, but this does not give clear instruction to either nurse or doctor about their role:

> The 'Silo Town' CHC Advisory Committee has resolved that this Centre will continue to assist patients by facilitating the transfer of prescriptions to the pharmacies at (name of town) or (name of town) as in the past. The Committee wishes to re-enforce that it does not accept responsibility for this process but it is prepared to act as a facilitator on behalf of patients who will always be personally responsible for arranging dispensing of their prescriptions. The Centre is able to transfer prescriptions by facsimile/post to other pharmacies at the request of the patient. In these cases a charge of $2.00 per page will be imposed to cover facsimile and postage costs. In all cases where a prescription is forwarded to a pharmacy by facsimile the Centre will ensure that the original is also forwarded to that pharmacy in a secure manner. On no account will the original be returned to the patient. (Silo Town – *Policy Manual* – Pharmacy Prescription Service)

This policy is clearly designed to assist patients who, after consulting with the doctor, need a prescription filled. There is no pharmacy in Silo Town so the nurses fax the prescription to a neighbouring town that has a pharmacist. The medication then returns by road transport the next day for the patient to collect.

The problem for nurses and the patients they serve at Silo Town in relation to prescribing and dispensing of medications in the absence of medical staff is a significant one. The following example illustrates this:

Nurse:	The other thing that comes into this is pharmacy and that has to be all reorganised here.
Researcher:	In what way? What's the problem with pharmacy?
Nurse:	With pharmacy? Nurses can't dispense. Here we can't dispense pharmaceutical items.
Researcher:	But you do?
Nurse:	At the moment there is a cupboard at the Centre owned by the pharmacist and he takes responsibility for all the medications that are in that and that is a huge responsibility.

Researcher: I observed that there is a fairly high occurrence for this impress stock of pharmacy items to be used to give patients their drugs then and there rather than for them to have to come back. The pharmacist from the neighbouring town replaces them at the earliest opportunity. So in fact nurses are dispensing?

Nurse: Yes. If we have any queries we do ask him.

Researcher: You do have some policies that allow you to dispense? Unless the one I read yesterday was out of date.

Nurse: Oh really? Perhaps I need to read that one.

Researcher: Unless this is outdated what it says is you have the ability to obtain and dispense medication when there's clearly a disadvantage for the patient.

Nurse: Yes. That's basically what would happen. A lot of the non-essential, well all of the non-essential things come through the pharmacy. We fax the scripts to...for antibiotics. But I think all of that is going to be reviewed very shortly because of accreditation.

Researcher: What are your feelings about all of that? It seems an awful imposition on you not to have access to drugs immediately on a premise like this?

Nurse: I suppose as a consumer as well as being a nurse in this Centre, it's very difficult to tell a mother who lives 50 kms out of town with a child who is ill with bad tonsillitis that 'Sorry I haven't got any antibiotics here. You will have to come back and collect them tomorrow'.

Researcher: Do the doctors talk to you about this? How do they feel about it do you think? What would they like to see happen?

Nurse: I think they would like us to be able to give the antibiotics and that medications should be available. It makes sense for treatment to start straight away.

Researcher: So if that's the situation you did have. I understand you did have at one time quite a stock of medications and that's been slowly eroded. Where is the pressure coming from to change that? The doctors, the hierarchy or the pharmacists?

Nurse: The hierarchy and the push for accreditation are where the pressure is coming from for the change. And if the CARPA (Central Australian Remote Practitioners Association) manual is instituted, well then the present system will have to be looked at and something put in place so it can all follow.

Researcher: So in effect you would have access to a limited pharmacopoeia from which you could draw according to what is listed in the CARPA manual?

Nurse: Yes. (Silo Town, female nurse 2)

The restrictions placed on the nurses with regard to the dispensing of medications in this context do not have the patient as the primary focus. The external 'hierarchy' for the nurses is a nursing administration over 140 kms away from Silo Town and they are obliged to adhere to policies and regulations imposed on them from afar. This is done in the name of health service accreditation. Or in other words another way of imposing control in the guise of best practice and quality care. It does not take account of the local needs of patients, nurses or doctors. Despite this, the nurses at Silo Town are supported by the visiting GP. She understands their restrictions and acknowledges the difficult choices faced through being the community's main source of primary health care:

> I think they're under a bit of pressure from their hierarchy in terms of who's accredited and what they are and aren't allowed to do.... All of which put pressure on them to cross their Ts and dot their Is. Not very useful for us but probably I guess the best under the circumstances for them. I suspect there are certain things that they have always done which now they have found out from (name of regional hospital which administers Silo Town CHC) they must be accredited for a whole range of things, which some nurses have been doing quite capably for 10 to 20 years. (Silo Town, female GP 1)

In her own assessment of the degree of autonomy the nurses at Silo Town had, the visiting GP rated it as being limited and below that expected in similar work settings where she has worked with nurses of similar experience and responsibility:

> I think that for the isolation we have here the amount of independence and autonomy the nurses exercise is pretty limited. I think that's the best way of describing it. Other areas that I have worked in where nurses have been relatively isolated and had to function, such as a nursing post or medical centre, their autonomy is a lot greater. (Silo Town, female GP 1)

7.4.4 Nursing autonomy and its effect on the relationship with GPs at Silo Town

The nature of practice for nurses at the Silo Town CHC might be described as semi-autonomous. If by full autonomy we mean self-governing, subject to own laws and independence, then the nursing role at Silo Town does not fully meet this definition. However, there are many times when the nurses do practice in an autonomous way but are governed by policies and unwritten protocols from either the visiting doctors, the distant nursing administration or the self imposed limitation of their own fear of something going wrong. One example illustrates this point and highlights the trepidation experienced by the nurse who describes administering an intravenous drug to a patient on instruction from a doctor who was at a distance:

> Well, a woman came in with a migraine quite bad and I rang doctor up and it was a stress-related thing and I didn't know the lady very well. However, I certainly found out a lot about her afterwards. Anyway, I rang doctor and the orders were to give her two ampoules of Maxalon, which is 20 milligrams. Twenty minutes later give her two Disprin dissolved in water and just observe her. He said 'I would like you to give it intravenous, are you happy with that?' I said 'if you are happy to ask me I am happy with it.'
>
> Now that's the pits. We shouldn't have done it. However, I went into the woman, slipped it in easy, got it in, but terrified the whole time, confident that I could do it but afraid something was going to go wrong. I had the oxygen there, and everything all ready, but I was thinking to myself, well what could go wrong? I looked up what the effects of Maxalon were, whether you could give it intravenously, whether it had to be given slowly. Because doctor said, 'Oh no don't worry about that, and don't follow it through with normal saline'. So I looked it up and the MIMS actually said do it slowly, so I did. The Doctor knew what he was doing, but I just wanted reassurance for myself. So I did that. Anyway the patient was fine. She didn't vomit or anything and later on we gave her the Disprin and water and left her quietly in a dark room to sleep and did regular obs. Within a few minutes I heard her moving around and she said 'I feel a lot better, thank you very much' and off she toddled. Then I came to check the Maxalon and there was an ampoule missing. I just about had a cardiac arrest because I could not have drawn up three; surely, this is how it had got me. I knew I had put them out on a tray, so I knew I only had two, but what had happened, someone had not documented down the track so I thought I was missing one. I worried about it all night, and even when that woman went home happy, I had to ring her the next morning and say 'how did you go?' and that gives me the pip. It shouldn't have to be, because in the 20 years I have been here, I have been very confident, done things, and it's only in recent years that I have started to feel uncomfortable, (and asked) have I missed something? (Silo Town, female nurse 1)

The apprehension expressed by this nurse at having to administer an IV medication on instruction from a far distant GP and her own self doubt about possible harm to her patient from an incorrect dosage provides a useful insight into the importance of nurses trusting their own skills and judgement and the advice from a GP who has not had the benefit of examining the patient themselves. The GP visiting Silo Town CHC expressed her own view on what nurses should contact her about and what they should not:

> When I'm away from here I expect them to contact me when they have a patient who is actually ill and they want advice on. They need to have done a thorough assessment and they need to give me a real idea so I can make a diagnosis and give advice over the phone.
>
> It's not really that much of a problem when there is a sick patient; they're very good at that. If someone comes in with a bee sting they know what's to be done but there's a stream of other calls that need not even be made. For example on Thursday I took a call from a nurse who had a patient with an ear infection again and she asked if it was all right to send off a specimen? It's just this sort of thing that eats into your day and I think the nurses should not call for that minor sort of thing. (Silo Town, female GP 1)

In this statement the GP admits to a sense of annoyance that nurses at Silo Town CHC telephone her with questions about the management of certain minor problems she believes they are quite capable of dealing with. At the same time she acknowledges that the nurses are 'very good' at managing sick patients. The GP does expect the nurses to call her when they have a patient who is assessed as being acutely ill to discuss appropriate treatment. So why is there a discrepancy between the doctor and nurses expectations of each other?

One reason is the conundrum faced by many rural nurses. They know they are capable of undertaking procedures not normally considered common nursing practice but in the absence of any alternative, they perform these:

> ...one part of me says I really shouldn't be doing this and the other part says that you are quite capable. It feels like two people having a fight and it's not very nice. (Silo Town, female nurse 1)

Another reason is the absence of accepted guidelines for nurses to use for assessment and treatment of certain common conditions and which have the approval of the doctor:

> The thing we have suggested for use is the *Central Australian Remote Practitioners Association (CARPA) Manual*. That would be perfect. Certainly in other places where I have worked it has been used and it works well. In the West (Western Australia) I used it and so did the nurses. I mean I don't see all that much of a difference between there and here. The nurses are actually quite happy to use it and undertake procedures very well. I would rather they use it. It's no skin off my nose. (Silo Town, female GP 1)

In giving her support for the use of protocols and practice guidelines by nurses, the doctor accepts the limitations placed on nurses who may use them:

> What I worry about is that they'll just follow this blindly and they will miss out on something. Whenever you use guidelines there is the potential to miss out on something and it's harder. (Silo Town, female GP 1)

The nurses understand their limitations. Their frequent contacting by telephone of the two GPs who provide visiting services to Silo Town is as much to protect the nurse's own practice as it is to discuss appropriate treatment of the patient:

Researcher:	GPs sometimes say that nurses ring them with trivial things. What is your view about that?
Nurse:	At times, yes perhaps we do but if it's a non-urgent thing I don't expect them to ring back straight away. I would like them to ring back but usually I'll tell the doctor's receptionist that this is not urgent and ask if it is possible for the doctor to ring me back a bit later.
	I guess the reason we ring, it's a fact, is that we are taking legal cover of the treatment which is happening.
Nurse:	Is that a requirement of this health centre or is it imposed from other places?
Researcher:	I guess because in recent times it's just been emphasised that the legalities of nursing practice and accountability. So we tend to relate the situation to the doctor and they're taking the responsibility for the treatment. (Silo Town, female nurse 2)

The nurse in this statement refers directly to issues of accountability and legal responsibility. She chooses to 'cover' her independent actions by notifying the doctor of them. In her belief the imperative to do this stems from the increased pressure on nurses to ensure their practice remains within defined limits. In this case study site there is a sharing of responsibility for the management of patients between nurses and visiting GPs. However, it is difficult to accept that by telephoning the GP and advising them of action contemplated or taken that nurses are absolved completely for their actions.

7.4.5 Building trust and rapport between visiting GPs and nurses

In the other three study sites the nurses and doctors worked together on a daily basis, lived in the same town in which the health service was located and generally interacted socially and professionally. This did not occur at Silo Town because the two GPs who provided visiting services only came twice each week for approximately four hours. The nurses therefore needed to

establish trust and build relationships and rapport with these visiting GPs over longer periods of time due to the visiting nature of the relationship. When there were changes in GPs from time to time, the nurses had to repeat this process. The nurses spoke of their need to build trust with visiting GPs quickly:

> I think that there is actually a lot of trust in the working relationship. Because the doctors are visiting and it takes time to build a relationship....the relationship is built up fairly quickly because of the honesty and openness between both parties. This is because of the necessity of phone conversations and because the nurses realise the practice area at Silo Town doesn't function without the GPs. We need their support to make this particular practice work. (Silo Town, female nurse 2)

The Silo Town nurse described one of the ways the establishment of trust occurs. It took the form of nursing actions that were sanctioned by the GP following telephone discussions about the management of patient problems. In essence the nurses acted as the eyes and ears of the GP, reporting their assessment and participating in mutual shared decision making:

> You work out I guess that they start to trust us when they can see what we've observed and told them about. When they see it, their thinking is along the same lines as ours is. Often we have to do observations and then ring doctors for treatments or a decision may have to be made as to whether a patient or client is sent on to further treatment.
>
> I guess they soon learn that if what we say is correct when they see them then that trust is built up. Or if we are unsure we will say – this is what the patient says but I feel that there is a hidden agenda. The trust is built up by having the honesty to say, 'I'm unsure about that', and then they will often take that up and make a decision on that basis.
>
> So, it's the openness and honesty that becomes very much part of the relationship. (Silo Town, female nurse 2)

The GP learns to trust the nurses' assessment and the communication of it via telephone. The nurse has their assessment and suggested treatment plan confirmed by the GP and together they decide what is the best course of action for the patient or client at the time. In subsequent visits to the Silo Town CHC the GP has the opportunity to check those patients and satisfy themselves that the nurses' assessments and follow up treatment have been effective.

In other words the GP learns to trust the nurses' assessment, diagnostic, treatment and experience skills. The Silo Town visiting GP explained the way she managed telephone communication about patient problems and that she trusted certain nurses implicitly to provide the most appropriate care:

Researcher: So how do you get to trust that nurse? You just get to know them and know they are a good assessor and believe them when they tell you things?

Nurse: Either that or you just have to grill them like you would an intern. Ask them if they have looked at this, or do you think it could be that? Or you say 'Look, I'm not really sure, I can't tell over the phone.' You're going to have to tell them they need to see the doctor.

There are some nurses that will ring you up and say XYZ and you know they will have done it better than you would have anyway. So they haven't missed the point at all. (Silo Town, female GP 1)

Here we have an example where the GP accepts the information given by the nurse and supports the nurse's action arising from it. Not all nurses at Silo Town have a clear appreciation of how trust and rapport is built between themselves and the visiting GPs. This example from a Silo Town nurse with 20 years experience working in the CHC shows the subtle nature of trust and relationship building:

Nurse: I think the doctor has to trust you and that needs to be shown fairly quickly.

Researcher: How does the trust happen?

Nurse: I don't know, Ian.

Researcher: How do you know when they trust you and how do you know when you trust them?

Nurse: It's an old gut feeling.

Researcher: ...are there other ways that they demonstrate their trust? Do they say things to you?

Nurse: Not really. I was only saying this morning that of all the years the doctors have worked with us, I have never heard a doctor say, 'You did a good job with that.' Occasionally you will get a thanks, which you know is a very meaningful one. Not said very often but if it is done, you know. You don't have to have the flowers and the cards

Researcher: Are you looking for those thanks?

Nurse: Not really, but it would be nice to know you are on the right track.

Researcher: Otherwise you are left to guess whether you are doing the right or wrong thing.

Nurse: I would wonder whether something would happen if something went wrong drastically. But because you don't get any input you just take it for granted everything is going all right. Which is hard when you think about it.

Researcher: So it is a lot of guesswork. You are trying to guess what is going on in the doctors' minds?

Nurse: I don't know what it is. It's back to the gut feeling, and they respect that feeling. (Silo Town, female nurse 1)

In building a trust relationship the nurse in this example does not actively seek acknowledgement of her worth as a nurse but when the doctor does give recognition it affirms her skill and professional standing. The same Silo Town nurse recounted one example of good rapport between a rural nurse and a locum doctor during a telephone conversation about a baby who had an infected umbilical cord:

> Now you ask how do we trust one another. I haven't even met this guy, wouldn't know him from a bar of soap. Spoken to him several times, great rapport. I rang him one day and said, 'Look we have got a baby here and her mother says that the 'umbi' smells like maggoty meat', and it did. He said, 'Did you find any maggots?' I said 'No'. I told him I cleaned it up and trimmed off the black stump and he said there was not much else you could do and he was happy. (Silo Town, female nurse 1)

This short but rather humorous exchange illustrates the absurdity of the nurse having to 'check in' with the doctor with what had been an entirely appropriate action on her behalf. The reason why the nurse made the call in the first place had to do with rapport and trust building as well as the conveying of a clinical action.

It is reasonable to assume that both nurses and doctors want to have a working relationship based on trust and respect. How they go about achieving this end will differ according to the personalities involved and the work setting. The visiting Silo Town GP provided a candid appraisal of her own ability for establishing good working relationships with rural nurses:

> I don't know how you do it. I know what they should be but I don't know how you do them.
>
> You need to be a human and be a friend but you also need to take the line. That's where I screw up all the time. The line gets moved. You are nice and you make friends with the nurses and whether that sounds a charitable thing or an arrogant thing or not, I don't know. Those lines come that way and favours get drawn in and you loose your respect and your perspective about what you will and won't do. Things are expected of you because you are a 'good fellow', not because the doctor should do it and that gets lost.

> You need somehow to achieve those strict guidelines but remain friends with them. You've got to in a town like this. You've got to be able to do things for each other and work together and socialise together if you can. But you've still got to have the lines. (Silo Town, female GP 1)

The 'lines' to which the doctor refers are of course the accepted ones that have always been the demarcation between nursing and medical work. The power the doctor exercises in the relationship with nurses is not an equal one and in a rural setting like Silo Town there is a blurring of the power boundaries. On one hand, the Silo Town GP wants to be friends with the nurses and to mix with them socially and create an equal relationship. At the same time she expects them to follow her medical orders and 'tow the line' in the work setting. She accepts this reality but also acknowledges the need to work together with the nurses and build friendships at the same time.

7.5 Summary

When compared with the other three case study sites, the relationship between nurses and GPs at Silo Town CHC is atypical. In all other case study sites the nurses generally had unrestricted access to doctors who lived and worked in the same town. In Silo Town there are no resident doctors. Nurses have to build a working relationship with visiting GPs who spend only a few hours consulting time each week at the Silo Town CHC. This means that nurses are frequently required to assess and manage patients on their own and in the absence of a doctor. They use the telephone extensively to discuss the more difficult cases with the two GPs who provide visiting services to the CHC.

It is primarily in these numerous telephone conversations and the short visits that the relationship is established and either develops into an effective one or becomes a source of irritation for the GP and a legal risk for the nurses. As a direct consequence of there being no resident medical presence in the town the nurses carry a heavy professional and personal burden. They are expected to asses and manage all presenting patients to the CHC, including those requiring urgent medical attention. They have a long history of achieving this with apparently few mishaps.

In recent times, however, they have come under increasing pressure to practise with constraint and to refer on patients they would have previously attended to. They attribute this change to increased accountability required by a distant nursing administration, which is focussed more on the management of risk and potential legal problems than it is on constructing sound practice guidelines and supportive frameworks for the nurses to practise effectively.

The two nurses in the Silo Town CHC have considerable experience and skill levels, one with over 20 years experience in the town and the other, 15 years. Despite this high level of experience and their low adverse patient incident rate, they now have more controls on their practice than in the past. The nurses indicated it had always been their practice to consult closely with the visiting GPs about treatments, usually by phone. However, the additional imposed controls on their practice have resulted in a sharp increase in the number of calls to the GPs to discuss cases they had assessed and treated, however minor. One of the visiting GPs complained about the high number of calls, especially for minor issues she felt the nurses were more than capable of managing. The reason given by the nurses for referring to the GPs was to protect themselves from any adverse outcomes of the care they provided and to comply with instructions by their nursing administrator.

It is patently obvious that the Silo Town CHC service would collapse were it not for the service the nurses provide to the several hundred residents in the town and surrounding area. The relationship they have with the visiting GPs is critical to the overall outcomes of care for those residents. That they have been languishing in a relative vacuum, devoid of accepted practice guidelines and protocols and have not received the appropriate legislative and professional accreditation to do their job effectively and safely is a matter of grave concern. It is clear they have the respect of the visiting GPs who support them as much as they can and as far as possible allow them a great deal of freedom to act on their own initiative.

It might be argued they have little choice in this because of the distance the GPs live away from Silo Town. Given these circumstances it is remarkable the nurses and visiting GPs have been able to build an effective working relationship, a relationship that has resulted in a diverse range of primary health care services being delivered in a small rural community with limited resources. It is perhaps the common experiences of professional isolation, distance from tertiary centres and diversity of practice shared by the GPs and the nurses that binds them together and creates a mutual understanding of each other. The Silo Town visiting GP put it more eloquently:

> We've got common bitches. We've got common bitches and common glories and we've got common things that we feel good about. (Silo Town, female GP 1)

Chapter 8

Discursive exploration

> ...the field of discursivity is precisely what makes possible the articulation of a multiplicity of competing discourses. (Torfing 1999)

8.1 Introduction

While this chapter acknowledges the numerous 'competing discourses' to which Torfing refers it is not a Foucauldian analysis of the professional working relationships of rural nurses and doctors. No attempt is made to examine the rules of discourse around the nurse-doctor relationship; rather the emphasis is on those aspects of the relationships that are not entirely fixed in the historical perspectives of the relationship between nurses and doctors. The chapter does address what Laclau and Mouffe (1985) call the 'terrain of unfixity' (Torfing 1999); in other words, the excluded meanings (or the field of the discursive) which have arisen from what the literature says about nurse-doctor relationships, what was observed in the four case studies and what participant nurses and doctors in the study said about the ways in which they worked and related to each other. The chapter draws together these various meanings. Meanings that have their foundation in the original purpose of undertaking the research and help clarify the relationships as a whole.

This includes an examination and description of the working relationship of rural nurses and doctors from three perspectives – firstly the daily interactions between rural nurses and doctors (GPs), secondly what selected nurses and doctors say about the relationship; and thirdly how this affects the relationship in the context of rural health care practice. Here I will discuss characteristics of the relationship, fundamental differences between rural nurse-doctor relationships in each of the four case study sites, whose voices are speaking about the relationship and what they are saying, rural RN and GP interactions and how they develop and maintain the relationship.

The chapter is developed around a rubric that explains how the relationship is and what factors influence and shape it. This contrasts with the infinite process of signification attached to discourse analysis and assists us to move closer to what Torfing terms 'a field of irreducible surplus' or the discursive (or field of discursivity) (Torfing 1999). The many parts of the working relationship and their attached perspectives are opened to scrutiny and when combined the sum of

these parts portrays the relationship as it is for rural nurses and doctors at one point in time across a range of rural contexts. This perspective is not developed from a multiplicity of discourses, rather the participants themselves, my interpretation and perspectives from the literature.

Finally, having explored the numerous parts of the professional working relationship as it is for rural nurses and doctors, the chapter will distil out the meanings of the relationship, its interconnecting aspects, strengths and limitations and uniqueness due to the influences of the rural practice setting.

8.2 Perspectives of the relationship across rural case study sites

While all four case study sites share a common characteristic, that of being located in a rural area, certain distinguishing elements set them apart. Sea Town, Valley Town, Bridge Town and Silo Town each possess their own unique history, character and population profile influencing the type of health service they provide and the style of practice undertaken by nurses and doctors who live and work in these communities. The range of work performed by RNs and GPs across the four sites is best described as diverse; however, the smaller the health service, the broader the range of skills and practices in which the staff engaged. For example, nurses at Silo Town performed a range of functions including social welfare tasks for patients in addition to high-level procedural skills in the absence of medical staff. At the other extreme, nurses at Bridge Town working in a regional accident and emergency department were constrained in what they could and could not do because of the risk of encroaching on 'doctors' work'.

GPs in this larger site had less direct contact with the nurses, were more likely to refer patients on to available specialists than treat themselves and were sometimes reluctant to come to the hospital when contacted by nurses. This would seem to be because they assumed there were other medical personnel available to attend to a patient if their condition worsened. In the smaller rural hospitals no GPs refused a nurse's direct request to attend the hospital to see a patient or to discuss appropriate treatment over the phone. There was evidence, however, that some GPs were irritated by what they regarded as trivial phone calls by nurses for minor matters. Indeed, the GPs in the smaller sites reported that they were comfortable with nurses performing appropriate treatments and in many cases encouraged nurses to make assessments, diagnosis and treatment before informing the GP. This practice occurred often in the absence of agreed or written protocols.

8.2.1 Similarities and site-specific features in the relationship

Apart from the geographical, socio-economic and population health service profile differences between the four case study sites, there were some similarities between each site. There were also some noticeable differences in the way nurses and doctors worked together. Table 8.1 compares the similarities and differences across the four case study sites and highlights some of the unique features of each.

Table 8.1 Comparison of the RN-GP relationship across case study sites.

Case study site	RN – GP Relationships	
	Similarities	**Specific features**
Sea Town Hospital <30 beds RN staff = 10 GPs = 22 Population = 1300	RNs older than GPs. RNs have more experience in rural practice than GPs. GPs have been longer in town. Frequent contact between RNs and GPs due to on-site practice and GPs living in town. High access of GPs to RNs and hospital resources. Frequent use of telephone by RNs to contact GP.	Harmonious relationship. Established patterns and routines – Ward rounds. Small, friendly family type team. Close social & professional lives. High trust, respect & confidence of RNs by GPs. RNs are GPs' patients. RNs work hard to establish and maintain relationship. RNs often initiate treatment & inform GP afterwards.
Valley Town Hospital/MPS <20 beds RNs staff = 25 GPs = 2 Population = 500	RNs older than GPs. RNs have twice years experience in rural practice than GPs. RNs have worked longer in town. Frequent contact between RNs and GPs due to on-site practice and GPs living in town. High access of GPs to RNs and hospital resources.	Interaction between RNs and GPs high in Primary Health Care projects (asthma, diabetes). Traditional nurse-doctor patterns and routines – Ward rounds. Limited social mixing of RNs & GPs. Use of RNs by GP consulting rooms. Valuing, respect & confidence of RNs by GPs. Frequent use of telephone by RNs to contact GP.

Case study site	RN – GP Relationships	
	Similarities	**Specific features**
Bridge Town Hospital <90 beds RNs staff = 100 GPs = 14 Population = 14,000	RNs older than GP. RNs have more years experience in rural practice than GPs. GP has worked longer in town than RNs. Infrequent contact between RNs and GPs at the hospital.	RNs 'collect' patients for GPs to see in A&E department. High use of telephone to communicate with GPs. No social contact between RNs and GPs outside work. RNs reluctant to initiate any action without GP approval.
Silo Town Community health centre – no beds RN staff = 5 GPs = two (visiting) Population = 200+	RNs older than GPs. RNs have 3 x years experience in rural than GP. RNs have worked in same health service for up to 20 years. GPs are not resident in town (provide a visiting service). Only twice weekly contact between RNs and GPs. Moderate social contact between RNs and GPs at times outside visiting clinics.	GPs turnover is high - RNs have to re-establish relationship. High use of telephone by RNs to discuss patient treatment with GPs. RNs act independently due to no GP in the town but have imposed restrictions. Low use by RNs of established protocols due to differences between GPs. RNs accept meeting GP family needs (childcare) is part of relationship.

This comparison demonstrates that nurses and doctors across the four sites have to contend with a number of different factors that shape and influence how their working relationship is constructed. In the majority of relationships the RNs were older, had more experience in rural practice and had worked in the same health service for longer than the GPs. Aside from these similarities the most obvious differences are those relating to the way RNs work with GPs. In very small sites, such as Silo Town, the nurses worked mainly on their own with GP visits twice weekly. The GPs were not resident in the town and could not attend easily when requested, if at all. In larger sites like Bridge Town the RNs also worked without GPs being present except when they came to conduct a clinic in the A&E department or to visit a patient in hospital. The major difference at Bridge Town is that when RNs need a doctor to attend a patient, they can get one in less than 15 minutes because of the close proximity and larger numbers of GPs and specialist doctors available.

In the two other case study sites of Valley Town and Sea Town, the GPs had their practices located in the same building as the hospital and hence access and interaction for both RNs and GPs were high. When the GPs had left the hospital they could return if requested in less than 10 minutes because all lived in the town.

In all case study sites RN-GP telephone communication was a primary source of information exchange and giving and receiving of patient management instructions. Use of the telephone to convey information to GPs by RNs was highest in the smallest site, Silo Town. This is explained by no GPs being resident in that town. In Valley Town, Sea Town and Bridge Town nurses used the telephone extensively to communicate with GPs but this was generally after hours when the GPs were on-call at home. Based on the way information was conveyed and the GP's confidence in the RN caller, the GP would decide whether it was necessary to come to the hospital or ask the nurse to undertake the necessary patient treatment.

In the majority of cases GPs would come if the RN directly requested them to do so. The one exception to this was in Bridge Town where nurses reported some reluctance by doctors to attend or that they encouraged the nurses to ask the patient to return at a specified time for a consult with the GP. In all the sites the overall relationship observed between RNs and GPs was harmonious, friendly and cooperative. However, when specific aspects of the RN-GP interaction are examined more closely certain themes emerge which allow a deeper appreciation of the basis of the relationship and how it was built and developed.

8.3 The rural nurse-doctor relationship rubric

8.3.1 Introduction

Here the essential themes that emerged out of the 16 in-depth interviews and the observation of nurses and doctors working together in the four rural case study sites are assembled. These themes stem from particular issues or interactions observed or statements attributed to rural RNs and GPs. They are developed and expanded upon to give meaning to and interpretation of what is happening and why it is of significance for the professional working relationship. Three important objectives will be achieved here. The first is a description of the key features of the relationship and an interpretation of their meaning. The second is the development of major and sub-themes that pertain to the working relationship, and the third explores forces and factors that shape and direct the rural nurse-doctor relationship in the four case study sites.

Given the complexity inherent in these objectives, a rubric has been developed to make visual note of the important parts of the relationship and external influencing factors. Figure 8.1 provides a diagrammatic representation of the component parts of the relationship as revealed in each case study site, through observation of nurses and doctors working together and from what they said in in-depth interviews.

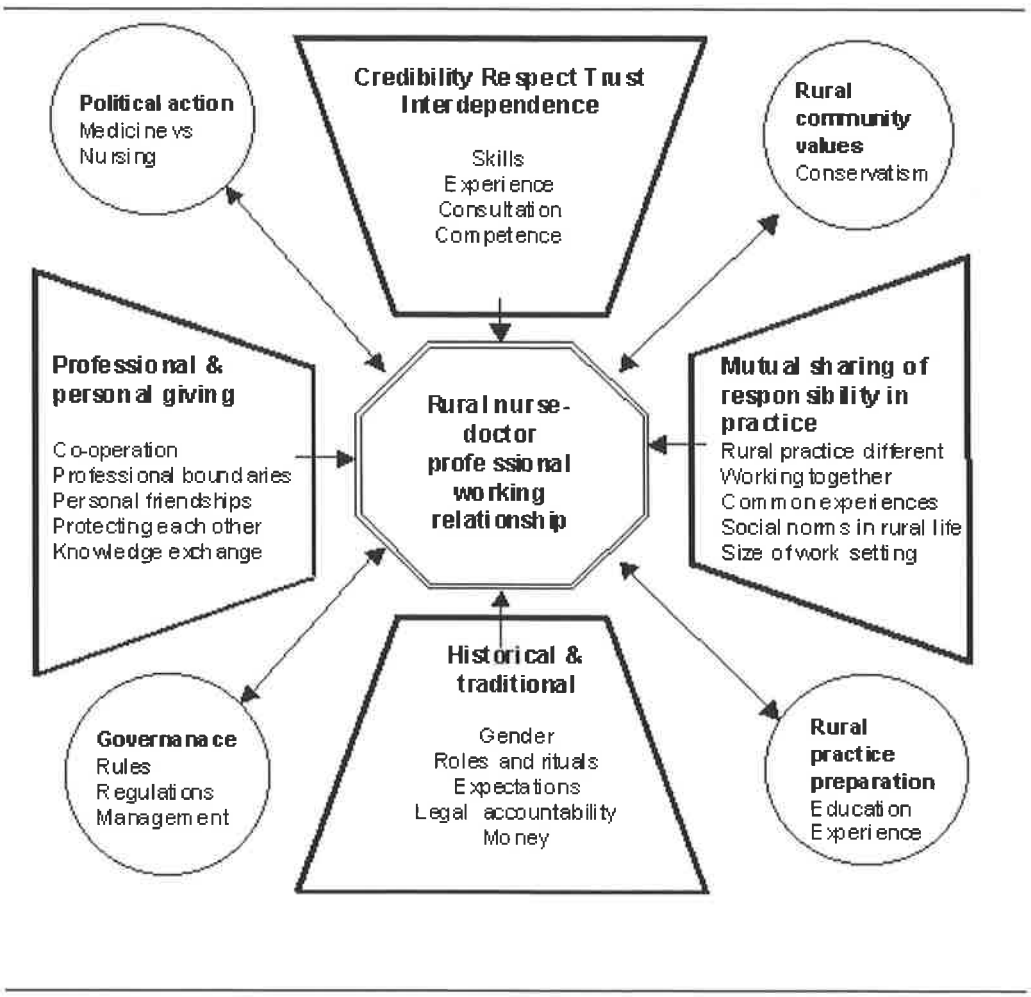


Figure 8.1 Rural nurse-doctor relationship rubric

8.3.2 Explanation of the rural nurse-doctor relationship rubric

The shape of the rubric is analogous because it helps explain how the relationship functions at the individual and case study site levels. Overall the shape is like a Maltese cross with four equal arms that expand outwards from the central core. Each arm represents one major characteristic:

- Credibility, Respect, Trust and Interdependence
- Professional and Personal Giving
- Mutual Sharing of Responsibility in Practice
- Historical and Traditional.

For each of these major characteristics there are sub-themes from which the characteristics are formed. For example the characteristic of Credibility, Respect, Trust and Interdependence is shaped or formed by nurses and doctors demonstrating their skills, experience, consultative ability, competence and initiative. Similarly for Professional and Personal Giving, where co-dependence, professional boundaries, personal friendships, protecting each other and knowledge exchange are the shaping factors. The centre core of the four-armed cross is the working relationship itself. It is represented as an octagonal with a non-solid line indicating its permeability not only to the factors contained in the arms of the cross but importantly to four external influencing factors. These are:

1. Political Action
2. Rural Community Values
3. Governance
4. Rural Practice Preparation

One of the four external influencing factors is Political Action. This represents the ongoing political debate around nursing and medical work and who exercises control. Importantly the arrows connecting the four external influencing factors are two-directional. That is, they influence and in turn can be influenced by the professional working relationship between rural nurses and doctors. This study showed external forces influenced the relationship. It lacked the maturity to change these factors but has the potential to do so if both parties want.

The stability of the four armed cross (or its analogy – the relationship) relies on balance in each of its four arms and on managing the tensions introduced by the four external influencing factors. Hypothetically, if one or more of the arms was 'out of balance' the relationship might never be established or where it exists, be damaged. If a major characteristic were absent, immature or deficient, the relationship core would be affected. In other words the relationship as it is demonstrated in each of the four case study sites can be more or less functional according to the presence or absence of main characteristics or the degree of control over external factors.

Before leaving this analogy it is important to return to the previously mentioned Laclau and Mouffe (1985) term, 'terrain of unfixity' as a reminder that the characteristics and factors referred to in this explanation remain in a state of perpetual motion. They can be expected to change with the ebb and flow of relationship building, but also in response to existing and yet to be defined external influencing factors.

The relationship core is therefore never entirely static. It is easily influenced by changes in major facets characterising the essential parts of it, by changes in individual nurses and doctors and the volatility of external influencing factors.

The challenge therefore is to improve or make stronger the professional working relationship between rural nurses and doctors. For this to be achieved the gap which currently prevents the relationship from realising its full potential must be eliminated; or, metaphorically speaking, bringing together the arms of the cross so they connect with the central core. The effect will be a more cohesive, collaborative and effective relationship that is certain about the characteristics needed to establish and maintain it and to make it less vulnerable to external influencing factors likely to play a spoiling role. To connect this abstract rubric to the reality of nurse-doctor relationships in the study I will present examples arising out of the study under two main headings. These are major characteristics shaping the relationship and attendant sub-themes and external influencing factors on the relationship.

8.4 Major characteristics shaping the relationship

8.4.1 Credibility, Respect, Trust and Interdependence



Skills. The Silo Town GP explains how important it is for her to have nurses to use their patient assessment skills before deciding whether or not to call the doctor to the hospital:

> So instead of the nurses assessing the patient and saying, 'Look I think you've got x,y and z but I think that's fine. You can see the doctor in the morning, I don't think it is an emergency.' They say, 'I think you should stay here and I'll ring the doctor and she'll come now to see you.' If you say no I won't, in a town of 750 people, some of which you play sport with and with whom you socialise, it's impossible.
> (Silo Town, female GP 1)

Here the frustration of a rural GP who is tired of being called out to attend to trivial or minor ailments by nurses shows. In her view nurses have not used their skills and initiative in making decisions that do not require the intervention of the town GP. She was also critical of nurses who

lack the skills to determine what is severe and what is not, when the doctor should be called and when they should not:

> People, including nurses, don't realise that in order for you to come out fresh (make an on-call visit to the hospital) when their Grandma has got chest pain, you need not to be called about their child's immunisation record. (Silo Town, female GP 1)

Here the GP expresses concerns about her credibility and standing in the community and the disruption from repeated call outs, but it has to be remembered that the nurses in this situation may not have a choice to use their own initiative. The comment shows the GP does not fully appreciate this fact.

Experience. The nurses in the study had more years of experience than the GPs both in terms of working in the same site and in rural nursing practice. The study revealed that trust and interdependence are built through experience, not only over time but also by deeds. This is demonstrated in the words and actions of the RNs and GPs in the study:

> I think it (trust) definitely does take time and I think it comes from respect as well. (Sea Town, female nurse 1)
>
> Trust is very important I find. Also we have to depend on each other. There's just no way around that. You have to depend on them and they have to depend on us to make decisions….(Sea Town, female nurse 2)

and from a GP perspective:

> …there are some staff that I trust what they say but (they) obviously don't have quite the same confidence in themselves, which is again something related to personality and experience. (Sea Town, female GP 2)

In these perspectives it can be seen that the building of trust between RNs and GPs occurs over time. Respect is necessary for the trust to build to a point where each can depend on the other. In addition, some GPs in the study linked ability to perform skills to confidence displayed by the nurses. One GP stated in her experience the gaining of her trust was related directly to the nurse's personality and level of experience. In other words, as nurses become more experienced and gain confidence, doctors trust and depend on them. A rural GP confirmed his reliance on the nurses in his rural town:

> I don't think I could function without a good relationship with the nurses I work with. I would certainly give them their due for the work they do.

> They provide services I can't effectively do because I don't have the time to do or sometimes I don't have the training to do. Or they are complementary rather than doing what I'm doing. (Valley Town, male GP 2)

Consultation. One important way respect, trust and interdependence can be established is for nurses and doctors to consult with each other about clinical matters. A nurse at Sea Town explained how her own confidence in her relationship with a GP increased dramatically following confirmation by the doctor of her assessment and diagnosis of a very distended bladder:

> ...had a guy with a very great difficulty in trying to pass urine and with a much distended bladder. When I phoned doctor, I guess he was very tired, and I told him and he said to me in a gruff voice, 'How do you know'? I said I'm not an absolute expert in palpating but it certainly feels like a distended bladder to me. So he came to the hospital, had a feel and catheterised the guy. He was saying to the man, 'Oh there's no doubt about these midwives; they know how to feel things'. (Sea Town, female nurse 1)

Had the GP believed in this nurse's skill and experience and consulted with her about her findings, he may well have saved himself the inconvenience of attending to a patient needing catheterisation, assuming, of course, that the nurse was competent to perform this skill. GPs in the study also sought to consult with nurses, particularly when the nurse was contacting them by phone:

> I guess what I find most off putting is when someone rings and says, ' Oh, hello it's so and so – I've got so and so with such and such and such and such' and then a pause... I want to know – Do you want me to come? Do you want some advice? Are you not sure of what you want? (Sea Town, female GP 2)

The GP here was not requiring the nurses to conduct and in-depth consultation, rather to convey information about the patient and then to discuss options for treatment. The level of consultation between nurses and doctors in the study varied from minor telephone discussions about the patient's condition through to more detailed consultations about an appropriate course of treatment. Two GP perspectives underscore this point:

> There are a lot of things the nursing staff can deal with. I don't have a problem with that. I don't feel threatened by that. (Sea Town, female GP 2)

> The process (consulting nurses about patients) is very useful because it's an opportunity to talk about different patients and different aspects of their care with regard things that need to be done. ...it formalises the structure and makes it happen.
> (Valley Town, male GP 2)

In summary, for the nurses and doctors alike consultation is important. The circumstance should determine what type of consultation is appropriate. If nurses undertake a thorough assessment and communicate this well to the doctor, agreement on a path of action can be swift. Doctors also appreciate the expertise nurses can bring when the consultation involves aspects of patient care.

Competence. In all four case study sites nurses frequently contacted GPs by telephone, as there were no resident medical staff in these small or larger regional rural hospitals. Normal communication by telephone requires good verbal expression skills but a higher level of competence is required when conveying complex patient assessment information. The 'sending' nurse is required to communicate an accurate clinical scenario to the 'receiving' doctor, who in turn must interpret the information and build a picture of what the nurse may be dealing with.

The doctor must decide if the situation presented by the nurse warrants attendance or whether instructions over the telephone for a course of action will suffice. During the fieldwork I frequently observed nurses talking with doctors over the telephone. Some of these calls were brief and to the point, while others were much longer and consisted of more complex interactions involving the relaying of information. The importance of what is said, how it is said, and by whom should not be underestimated. This type of communication between rural nurses and doctors is critical to the outcome of care as well as the professional working relationship. A Sea Town GP illustrated his expectations of nurses when they called him after hours and stressed the importance of orientation to time, place and speaker before giving information.

> What I like the staff to do for me is to first of all say what day it is, what time it is, and who is speaking. That gives me 30 seconds to get out of a deep sleep and allows me time to collect my thoughts, instead of launching into, 'I've got a problem here…' So its 'Jenny from the hospital here, its Friday morning and its 4am. I've got a patient here I would like to discuss with you'. That's just a preamble of politeness.
> (Sea Town, male GP 1)

Nurses in the four rural sites were very competent at making these calls because they repeated the routine frequently. Most had marshalled their thoughts before making the call and knew what they wanted to say. They would also make notes of the conversation and any instructions given:

> But if I'm going to ring him up I want it to be clear and concise about what I want. That way he is left with no misunderstanding. He doesn't have to guess what I want. He knows. I suppose that's trust because he's got to trust my opinion.
> (Sea Town, male nurse 4)

While the rural nurses and doctors I observed and interviewed gave no specific examples of where a breakdown in communication over the telephone led to an adverse outcome, there are several cases in Australia where it has. Two prominent examples both ended in tragedy.

The 1987 Sophie Heathcote nurse de-registration case involved the death of an Aboriginal man who was brought by police to the Wilcannia hospital with what was later found to be alcohol withdrawal (Staunton 1991). Following an assessment of the patient, the nurse discussed his symptoms by radio with a doctor at the Broken Hill Royal Flying Doctor Service (RFDS) base about treatment for the man. In a later coroners' inquest a recording of the conversation between the nurse and the RFDS doctor was produced in evidence. The coroner concluded that the doctor and nurse had made assumptions in their radio conversation about the patient and what might be wrong with him. The doctor was criticised because he failed to ask the nurse for the vital signs of the patient. He assumed that the nurse would have told him if they were abnormal. On the other hand the nurse wrongly assumed that if the information she had given the RFDS doctor over the radio were insufficient he would have said so, asked additional questions or provided more instruction (NSW 1988).

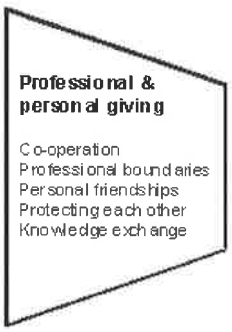
In a more recent case in rural South Australia a patient died as a result of an overdose and the coroner investigating the 1993 death pointed to poor communication between the nurse and doctor as a contributing factor. In this case the nurse had telephoned the doctor twice during the early hours of the morning with concerns about the patient. She was told on the first occasion to 'watch' the patient and on the second to administer anti-emetic drugs to prevent the patient vomiting. The doctor had come to the hospital after being called by the nurse at 4am and treated the patient, who was severely dehydrated, but she died of a cardiac arrest shortly after he had left again at 6.45am to go home (Kriven 1994).

The competence of the nurses in these cases was called into question but subsequent court cases found they acted appropriately given their rural and remote circumstances. The effective use of the telephone to relay critical information was also an important factor.

In summary, competence in the use of the telephone by nurses and doctors in rural practice settings is clearly a major factor in the day-to-day working relationship. Nurses must appreciate the ramifications of communicating patient information poorly to doctors over the phone. Rural GPs must understand that if they expect nurses to act as their eyes and ears, they must accept the associated risks of misdiagnosis and put in place appropriate risk management strategies.

There will be less risk of harm to all concerned if rural nurses and doctors agree on what information is appropriate to be conveyed over the telephone and what actions nurses can or can't implement in the absence of the doctor. An agreed protocol when using the telephone and competence in its use is critical to effective professional relationships.

8.4.2 Professional and Personal Giving



Cooperative behaviours.

> In the country in a small setting like we have here, I think we are extremely fortunate in that our interaction with nursing staff works tremendously well. It's very close. We know the people personally and of any doctor-nurse relationship that I'm aware of...it works best here...It's a cooperative friendly relationship. (Sea Town, male GP1)

The description given by this doctor shows he clearly thinks the relationship he has with nurses is one that works well and is close and cooperative. Factors that increase cooperative behaviours include the size of the setting, close interaction and a friendly relationship. Nurses in the study repeatedly mentioned how important it was to them to have GPs working in their town's health service and that they could not do their work effectively without them. The GPs in the study wanted nurses to take on more responsibility but did not provide clear guidelines about how this should occur.

Certainly the doctors could not work as they do without the nurses and it suited them to have the nurses take additional responsibility. However, a significant part of nurses' work was largely dependent on doctor initiated activities. This tension between dependence and independence will not change because in large part neither the nurses nor the doctors really want it too. They are comfortable with the roles they have and their traditional history reinforces this way of working. If nurses or doctors became totally dependent on each other that would be seen as undesirable because that reduces the ability to respond to the needs of rural work. Rural health service work

demands diversity, flexibility and responsiveness of practitioners. Professional relationships devoid of these characteristics are unlikely to be able to respond effectively to these demands.

Professional and personal role conflicts. One standout factor in the relationship between RNs and GPs in the study was the close personal interactions between them and the intermixing of personal and professional confines. An example from the study illustrates the intermixing of personal and professional confines.

Example

It was a private conversation between a nurse and a GP in a hospital corridor in one rural case study site. At first I thought the conversation was about a patient as they were discussing the results of some diagnostic tests. It soon became apparent that the nurse was in fact having a conversation with her own personal GP. Because they worked together the opportunity presented for the GP to pass on the test results and discuss what she intended to do about them with the nurse or in this case, her patient.

Field note ST03

In discussion with nurses and doctors in the study I found this was a common occurrence in small rural communities where nurses were not only in a working relationship with the doctor but in many cases the doctor was their personal GP. The important issue for the relationship is that the GP can differentiate between the nurse in the work setting and the nurse in the patient role as a Silo Town nurse explained:

> I was working here seven years ago and was pregnant but I saw the GP that was here throughout my pregnancy. That worked successfully for me because, and this is important, they are able to differentiate between the working relationship and the patient relationship. Once you are in the room as a client, they treat you as a client and they don't bring work into it and it does not go out of that room. (Silo Town, female RN 1)

A second example illustrates the close personal and professional boundaries common in the rural context. A nurse from Sea Town described the difficulties she experienced when her brother was admitted to the local hospital and she had to care for him and also worked with the GPs providing her brother's treatment. He subsequently died, not from any fault of the GP:

> My brother was a patient in here as well when I came back. He's since passed away and that was very hard working here. Yes, it was stressful for me, especially. I think that may have strained the relationship between the doctors and me because I was finding it so stressful. (Sea Town, female RN 2)

These two examples demonstrate the way the personal and professional boundaries of nurses and doctors intertwine. In small rural towns there is a high probability that sick relatives will be treated in the local hospital and that nurses will provide care for them. They will also be working closely with doctors who make decisions about the treatment for their relative. This could be a source of conflict.

In addition, there is the necessity for nurses to visit GPs with whom they work as patients because they have no other choice unless they wish to travel to a neighbouring town. The same dilemma is presented for rural GPs who may have no option for their own health care needs but to see another GP in the town and with whom they might be in partnership.

There are a number of issues raised by the close personal and professional working relationships described here. One is the lack of anonymity or privacy nurses and doctors have in rural settings. Another is the difficult circumstance presented to a GP who has as a patient a nurse with whom they have an established working relationship. If the nurse has a drug or alcohol or mental health condition, the GP may be compromised when making allowances for this nurse in the course of his or her daily work. Similarly nurses might also be aware rural GPs have a medical or other condition which affects their work relationship. It is very difficult for nurses to report incidents involving doctors in the best of circumstances. In a small rural town it assumes much more significance because of what is at stake – the possible loss of the only doctor from the town.

Professional roles are defined early in the education and training of nurses and doctors and are shaped by experiences as students and upon graduation. Nurses and doctors are prepared in separate 'education silos'. Apart from exposure to each other while undertaking clinical experience, they have little opportunity to understand each other's perspectives. At the end of their respective training periods they are thrown together in often high stress, high workload situations and are expected to get on with each other and work as a team. It is not surprising that they often fail and have conflicts over 'territory' and the boundaries around it. In a review of doctor-nurse relationships by Ryan, one researcher, Webster (1995), found that after four years of medical school students' perception of the doctor's role regarding responsibility for the patient and the health care team became more specific, but their perception of the nurse's role became vague and diffuse (Ryan 1996). The development of the general understanding that nurses care and doctors cure comes in large part from observing the practice of peers in given clinical settings

and in particular how they relate to other disciplines. In rural practice the traditional roles of nursing care and medical cure blur and merge and at times are imperceptible.

Their social and professional lives are intertwined and require giving and taking which is acceptable to both parties. A GP in Sea Town underscored this point when describing the balance she has to employ when treating nurses with whom she works:

> It's a tricky one when someone might approach you when they're on duty and say, 'Oh, I've got this bit of a niggle here and…' You don't want to say, 'Well, no you should make an appointment, don't bother me with this here.' (Sea Town, female GP 2)

The options are limited for nurses to have their own health care needs attended to in small rural towns where there may be one or two GPs. GPs may feel obliged to treat the nurses they work for and not regard them as patients. On the other hand, nurses may expect the GP to provide a service at no or low cost because of a working relationship and since their choices are restricted. A GP at Sea Town recognised an inherent problem in giving this kind of medical service:

> …in a way they're getting a second class service because they're not getting your full attention. (Sea Town, female GP 2)

In summary, professional boundaries between nurses and doctors in this study were often intermixed with nurses using GPs with whom they worked as their personal family doctor due to restricted choice. Nurses and doctors in this situation said it did not alter the work relationship but the fact that it occurs places both in a precarious position should conflict arise between them or should the treating GP have information about a nurse-patient that could affect the working relationship. For example, mental illness, substance abuse or some other illness that might cause the GP to respond to the nurse differently in the work setting.

Personal friendships. In all four case study sites nurses and doctors identified friendships that continued outside the work environment. Nurses and doctors recognised the benefits and the problems associated with this. One GP emphasises being friendly towards nurses' was helpful in building relationships in the work place but accepted that 'personalities' might prevent that occurring:

> The best way to achieve a useful working relationship is to have it on at least a friendly basis, hopefully with some trust but that's not always possible with everybody, just because of personalities. (Sea Town, male GP1)

The reference to personalities is a reminder of the fact that some individuals 'get on' with each other readily and others do not. Whether this has to do with the person themselves having particular personality traits not conducive to ready acceptance by others or whether it has to do with the work circumstances altering peoples perceptions is not something I can elaborate on here.

Wherever people work together, whatever the context, they are likely to find one another physically and emotionally attractive. Nurse-doctor romantic relationships have been fertile ground for authors, film and television scriptwriters for a very long time. Much of this material is fictitious, salacious and stereotypical in its portrayal of the way nurses and doctors relate to each other. This example of fiction from a 1961 series of romantic novels on nurses – *Student Nurse*, *Chief Nurse*, *Boarding School* Nurse – reinforces the stereotypic romantic image of a rural nurse and doctor and the expectation that nurses should play a compliant role:

> Dr Miller and Cherry stood for a minute in the shade of the courthouse trees. He mopped his forehead with his handkerchief. 'Had a busy afternoon, Doctor?' Cherry asked, with a hint of a smile. He grinned back at her. 'You look a little warm and dusty yourself. Say, would you mind coming back upstairs for a quick conference? I know it's late, I know we aren't supposed to work as a regular thing on Saturdays, but the work does pile up.'
>
> 'Of course I don't mind', Cherry said. Sick people and prevention of sickness could not wait. *Cherry Ames – Rural Nurse* (1961) (Wells 1961)

While stories of fiction are embellished to hold the readers' attention, they have some basis in truth. Of the 16 nurses and doctors who participated in the in-depth interviews of this study, three indicated they had formed romantic relationships with either a nurse or doctor. A nurse and doctor were married and one nurse talked of an affair she had with a doctor several years ago. Like most work settings, opportunity is the main reason for these relationships developing:

> ...there can be a lot of humour and fun in caring. Certainly there is the opportunity for good relationships. (Bridge Town, male GP 1)

A Bridge Town nurse also highlighted the close physical nature of the work nurses and doctors engage in and the extent of time they spend together:

> I think it can happen especially in a rural setting when you are working quite closely in an accident and emergency department with these GPs all the time. You spend a lot of time together. You get to know each other both personally and professionally. (Bridge Town, female nurse 1)

The same nurse believed that having a romantic relationship with a doctor she worked with did not affect the way she did her job, but that it was stressful, particularly when she had to call the doctor at his home:

> I don't think it made any difference whatsoever to me or to him in a professional sense. What does make a difference is when the rest of your colleagues get to know about it and that's when I found it very difficult to liaise with him if you like. Not so much the hands on stuff. When stuff had to be done it didn't matter what they thought but the decision making thing, again in a rural setting, they are not there all the time, so you are having to ring, having to ring the home is very off putting....
> (Bridge Town, female nurse 1)

This example from a Valley Town GP married to a nurse with whom he works shows the potential difficulties in personal and professional communication:

> ...because my wife is a nurse who works here in various jobs, that blurs to some extent the lines of communication. Some people assume that my wife knows everything about what goes on here – that I've told her about everyone. Other people expect either me to give messages to her or her to give messages to me, which is not really an appropriate way for things to go. It's not really an appropriate way or should not be a formal means of communication. (Valley Town, male GP 1)

His wife, also a nurse at Valley Town, accepted that she has a different line of communication with her husband. In her opinion, it is a more convenient and supportive one:

> From my personal perspective my lines of communication are different. I'm married to (name of doctor) and it's very easy for me to talk with him about any sort of patient I have to do with. Also about what happens at the hospital and other projects I'm involved with. He's very supportive of me and very supportive of registered nurses in the primary health care role. (Valley Town, female nurse 2)

These examples of the views of rural nurses and doctors help us to understand the dynamics when individuals who work together have to manage two relationships, one personal and one professional. The potential for the professional relationship to be influenced by a poor personal relationship is high and vice versa.

When personal relationships have become damaged there is increased risk of serious consequences. A case reported by the South Australian coroner of the death of a woman patient in a small rural hospital is one example. In this case the nurse and doctor were married but had separated and it was shown subsequently that the breakdown in communication between them had led in part to the tragic outcome (Kriven 1994). While men and women continue to work

together in nursing and medicine, romantic interactions will certainly continue. How this impacts on the individuals concerned and on the services they individually and collectively provide is open to conjecture. Suffice to say in this study there was no evidence to say having a personal relationship caused either the nurse of doctor to become dysfunctional.

Protecting each other. Australia continues to experience a shortage of Australian graduate doctors willing to practice as GPs in rural areas. Much has been documented of the high workload and consequent burn out rates of rural GPs and the difficulty in obtaining replacements (Strasser 1997; Kamien 1987; Wilkinson 1999). There are increasing concerns for the rural nursing workforce in terms of their age and skill levels and many areas are experiencing acute shortages of skilled and experienced nurses. The average age of RNs in this study was 44.8 years and for the GPs 35 years. The nurses had spent more years in rural nursing than the GPs and also had longer periods of time in all but one of the four case study sites. The longest serving nurse was in Silo Town with some 27 years and the longest serving GP with 10 years in Sea Town. The extent to which the state of the working relationship between rural RNs and GPs influences each group to remain in rural practice and reduces or stops high workloads and stress is not a focus of this study. This study demonstrates the importance of good working relationships between nurses and doctors as a factor that prevents doctors and nurses from leaving, as this GP from Sea Town attested:

> ...when there is someone on (duty) that you know and have developed over time with, you know what they can do and what they're up to doing and if they say something, you know what it means. That makes life very much easier. I was here for seven years by myself (single GP practice) and that filtering process of not having the staff ringing me at home was an absolutely vital part of me being able to stay here that long. After seven years, I was worn out. (Sea Town, male GP 1)

There are two significant points to be made about what this GP says about nurses. The first is that the support and protection he received from nurses prevented him from enduring unreasonable workloads and burnout. Secondly, his relationship and knowledge of nurses' capabilities has allowed what he terms a 'filtering process' to occur. Put another way, this meant nurses only called the doctor at home when they felt it was absolutely necessary. They assessed patients according to the need to see a doctor and where appropriate provided treatment the GP would normally undertake:

> ...if a tetanus injection is indicated and the registered nurse has asked them if they are allergic to it – they give a tetanus injection. I think it's more up to an individual's common sense and comfort zones, so long as they're competent of course in what they do....we have some children coming in and the girls (nurses) strip them up (apply Steri-strip wound closures) and send them away and ask them to come and see the doctor the next day. If the staff member is comfortable doing that, fine. But they must be reviewed the next day of course because there's a chance of a tendon or some other thing, which may have been missed. (Sea Town, male GP 1)

The practice of nurses undertaking procedures that normally are considered the domain of medical staff is common in all four rural case study sites. The nurses gave two reasons for this. Firstly, they wanted to respond to the patients' immediate need and, secondly, they wanted to protect their local GP from unnecessary after hours on-call work. A nurse from Silo Town explained how she was able to sense when doctors were tired and what she did to recognise and assist or protect them:

> I can tell when the doctors are tired. I guess you tune in...you tune into people because they are such a relevant part of us. I often say to one of the doctors, 'You've had a hard day', or 'Did you have a good afternoon off?' You get an answer back and I'm a great one for telling jokes and trying to jolly up their day. You just hope this helps. (Silo Town, female nurse 2)

Here the nurse is making an effort to be sensitive to the doctors' feelings and to make an appropriate response by asking about their physical state. She uses humour to ease any perceived tiredness in the GP. The same nurse reflected on her surprise when confronted with a doctor who was upset and crying:

> ...we actually had a doctor that arrived one day and was really upset and finished up crying. I thought, wow this is different. I mean you always look at the doctor as fixing you up when you are crying and it was a big lesson for me....(Silo Town, female nurse 2)

This example demonstrates the human frailty that is part of us all, even in professional work relations. The reaction of the nurse seeing a doctor in a distressed condition was one of surprise because of her perception that doctors are always in control and able to hide their true feelings. Whether intended or otherwise, a display of underlying emotion by the doctor to a trusted work colleague made it possible for the nurse to relate more to them and develop a closer rapport. It also brings respect for the worth of rural nurses by doctors as a Silo Town GP stated:

> By far and away the most memorable good nurses I've worked with have all been – whether that is in hospital or general practice – have been rural nurses really.

And

> There are a handful of staff here who are really deserving of help and I will walk over coals for....(Silo Town, female GP 1)

As a general rule rural nurses and doctors in this study were protective of each other and this had a beneficial effect on the relationship both in terms of the patterns of work and in promoting self worth. In the case of a GP in the A&E department in Bridge Town nurses 'protected' doctors:

GP:	...they (nurses) do protect you at times.
Researcher:	What do you mean by protective?
GP:	... arrange to see patients and cohorts in clinics and they tend to try to keep to that and they are quite mindful of how long the hours are we work. (Bridge Town, male GP 1)

At the end of the day the question of protective behaviour by nurses and doctors and vice versa is one of balance. A Silo Town GP explained the difficulty in getting the balance right:

> It's almost a sort of boundary thing and it makes it really hard. It could lead to one or two things that tend to happen in these places. One, the nurses become too protective of you in the screening of patients and the patients can't get at you... Or they think that you're so approachable, that they don't worry about ringing you at all. I don't know how you get to the middle ground. It's always a se saw thing and you go so far then you have to pull back and say, no, I'm not going to play this game. It's pissing me off. (Silo Town, female GP 1)

In summary all of the case study sites showed more evidence of nurses being protective of doctors than the other way around. Nurses frequently took action to protect doctors from overwork, even if this meant their own workloads and stressors increased. The doctors recognised the protective behaviour of nurses and some said they would defend the nurses if the need arose but only if the balance were right, meaning only if the nurses were not overly protective to the point where they assumed too much responsibility and encroached on the GP's workload.

Knowledge exchange. Several nurses in this study said that doctors did not value their opinion whereas all of the GPs in the study agreed they would listen if a nurse offered an opinion on the clinical management of patients. The extent to which nurses and doctors actively sought each other's knowledge and opinion is another question. If the relationship is not well developed the GP is less likely to admit to a nurse they do not have the knowledge or experience in any given circumstance. The following examples demonstrate this:

> ...one of them was using dry ice. I'm not saying that she didn't know but she obviously really didn't. So I just got it all ready for her and said, 'How much acetone would you like me to mix in it?' and she just watched me while I dropped it in and she said, 'Yes, well, I'll have that.' So I've got a feeling that perhaps she wasn't quite sure, because they (the doctor's practice in another town) have a machine. (Silo Town, female nurse 1)

> ...one was the emptying of chemicals in the x-ray unit. We always change them every six weeks – the developer. The Clinical Nurse Consultant went away and the doctor said, 'I don't want that changed.' We said, 'OK, we won't change it for you' but when the x-rays came back they were not as good as if the developer had been changed, so therefore we had the evidence. So we laughed about it and he said, 'I still don't like it going down the sink though.' (Sea Town, female nurse 2)

In these two examples the doctor was not prepared to admit their knowledge in a particular area was less than that of the nurse. They could not bring themselves to defer to the nurses' greater knowledge and experience as if doing so would weaken their professional status. From the GP perspective, asking for a nurse's opinion does not come easily as this exchange with a GP in Valley Town shows. After observing an interaction between a GP and a nurse in which she offered an opinion on a clinical treatment, I asked the GP if he felt offended by nurses suggesting patient treatments to him:

GP:	I don't get offended. I don't think of everything. No one can.
Researcher:	Do you look for it though?
GP:	Probably not as much as I should.
Researcher:	What do you mean by that?
GP:	I don't formally tend to do that. If it's offered, I certainly listen. There may be a situation where I will say to whoever is with me, 'What can we do with this?' It's probably not something I structure in a formal way. (Valley Town, male GP 2)

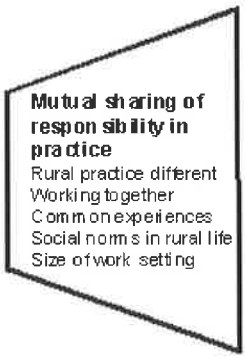
In considering these examples it would seem logical for rural nurses and doctors to ask each other's opinions on the diagnosis and treatment of patients. They both have compelling reasons to do this. Professional isolation, dealing with a very diverse range of presenting illnesses, lack of other medical backup facilities, and shared responsibility for the quality of health care service delivered to the local community of which they are a part.

Why nurses feel uncomfortable about putting forward their opinion and why doctors don't routinely ask for it can partly be explained by the separate preparation of the two professions and the historic division of labour between the two groups. The irony of this is embedded in this statement by a rural GP who admitted to embarrassment in asking nurses how to do things as a medical student but who now realises the benefits of having a more equal relationship with nurses:

> ...as a medical student I was always intimidated by the nursing staff and that was probably because I felt uncomfortable asking them. Here it can be much more an equal partnership in looking after someone and there can be a lot of satisfaction from that. (Bridge Town, male GP 1)

In summary, nurses in this study did not actively seek an equal partnership with rural GPs in terms of diagnosis and treatment but felt valued when their opinion was sought. They were comfortable to leave the full responsibility for assessment and diagnosis to the GP in the majority of cases and only assumed this responsibility when they had little other choice. Typically this was after hours when the doctor was not present in the hospital. In all observed nurse interactions with GPs the response from nurses was highest when being acknowledged and sharing in the decision making process around the care of patients. Where this was evident, the nurse-doctor relationship was positive and productive and although not measured in this study, the patient outcomes appeared better. GPs who recognised the nurse had considerable expertise and experience and asked for it said they enjoyed a much more equal partnership with those nurses. This suggests the relationship is strengthened considerably by collaborative decision-making.

8.4.3 Mutual Sharing of Responsibility in Practice



Rural practice difference. A groundswell of rural medical, nursing and allied health disciplines claims that things are done differently in rural areas. National peak bodies such as the Association for Australian Rural Nurses (AARN), the Australian College of Rural & Remote Medicine (ACRRM) and the Services for Australian Rural and Remote Allied Health (SARRAH) highlight the differences between urban and rural practice. In the case of ACRRM, educational and professional criteria against which their members can be measured and recognised as Fellows in that college have been developed. This is held up as a national standard for what is considered good rural or remote practice for GPs and other medical specialists. In this study several examples of the difference were found:

> I mean, I just got off the phone about a patient and the nurse told me about what medication he had been taking, where he lived, how long he had been in hospital....in a city centre I would be lucky to have that sort of information so readily to hand. (Silo Town, female GP 1)

This example recognises the critical role the rural nurse has in knowing the health and social status of the community very well. This study has shown that many nurses have lived and worked in rural settings for longer than doctors. Because of this they have built up a detailed knowledge of the individuals, their family structure and the supports and resources to which they have access. This background information is invaluable to the doctor when planning appropriate investigation or treatment. It also means rural nurses take on roles of other health professionals because they have to:

> In a little place like this we haven't got a social worker so we've gone into that too. You can get them. They'll come for a 'one off' and sort out the money or something and then they're gone again. (Valley Town, female nurse 1)

If there are visiting services into the rural community it is often the nurse who has to undertake the ongoing management of the patients' treatment. This happens because the present Medical Benefits Schedule (MBS) does not allow such services to be provided by the GP. The rural nurse often provides or coordinates these services. This presents nurses, doctors and patients in rural locations with a dilemma. Some patients are reluctant to accept advice or treatment from nurses and despite the often heavy workload of rural GPs, insist on receiving a GP service no matter what time of the day or night. A female GP from Valley Town related an incident when the nurse at the small rural hospital tried to give advice to a woman visiting from the city who was concerned about her husband's well being:

> Her husband had been drunk the night before and had been falling about the place. I spent half the night stitching, patching him, assessing him, and trying to work out whether there was some other reason why he was falling about the place besides drunkenness.
>
> Then his wife wanted me back there at 9 o'clock next morning when I'd had about three hours sleep. She would not take the RN's information that doctor was now trying to sleep, having been the only doctor here and that perhaps the husband, who was now sitting up having breakfast, could have this discussion later in the morning. In other words, completely uncaring about who it was who was giving the service and completely uncaring about the fact that it was obvious to anybody that the husband did not require any immediate attention because he was sitting up eating his breakfast. (Valley Town, female GP 1)

Rural people do not necessarily have any greater appreciation of nurse and doctor roles and workloads than do urban people. Nevertheless those who come from an urban-based health care system where 24 hour medical, pharmacy and hospital services are readily available may expect a level of service that is simply not available in rural areas. They may also be unaware of the way in which nurses and doctors work together. The differences between the urban and rural levels of care relate more to the context in which the care is delivered and by whom. Rural doctors in this study consistently stated their willingness to allow nurses to choose which clinical circumstances they dealt with themselves and which they did not. In my view doctors in the study encouraged nurses to take more responsibility than some nurses were prepared to accept. The following example demonstrates the range of options nurses might have when confronted with a relatively minor ailment when they don't want to bring the doctor from home to the hospital to provide a treatment they know they are competent to provide:

> So there are various things the nurses do. Again it's a matter of important things and trivial things. The patients may well come to the hospital just for reassurance. They may bring a child who turns out to be screaming it's lungs out, have a runny nose and is obviously not particularly sick and yes it's got a fever but nobody has given it any Panadol yet. So the nurses may well give the child Panadol, take all its observations and know from their own experience as nurses and as a mother, that the child just has a cold and is not short of breath, not dehydrated, not weak in any way. So just give them a dose of Panadol appropriate to their size and discharge them. But also commonly say, 'If you're still worried, or if the child's still screaming or if they haven't settled down, then bring them in at 5pm when outpatients are going to happen'.
> (Valley Town, female GP 1)

As can be seen in this example the doctor has set some clinical intervention and common sense guidelines for the nurse to follow. The problem arises, however, when there are two GPs in town with different medical opinions on treatment for the same condition, as this example about the initial treatment by nurses of patients presenting with chest pain shows.

> They both…treat them differently. Doctor A's treatment is an Anginine and an aspirin and put a trans dermal patch on, oxygen and do an ECG and, 'I'll be in there to see then shortly, as soon as I can get out of bed and in the car.' Doctor B's treatment is an Anginine, do an ECG and I'll come and see them straight away. Just knowing the little differences is important. (Sea Town, female nurse 2)

Scenarios such as these were common across the four case study sites in this study. Most were informal, such as the example above when a doctor communicates to nurses what their expectation is in cases like this. Evidence of formal written protocols and procedures was harder to find and when protocols were in place, doctors and nurses did not know about them as this response to a question about the existence of a nurse managed cardiac arrest management protocol shows:

> Researcher: Is there such a protocol in the hospital?
>
> GP: Oh, I can't be sure. (Sea Town, male GP 1)

In another case study site the area being explored with a nurse was the dispensing of medication from a pharmacy impress in the clinic. There was no resident pharmacy in the town:

Nurse: At the moment there's a cupboard at the centre owned by the pharmacist and he takes responsibility for all the medications that are in that and that is a huge responsibility.

Researcher: You do have policies, which allow you to dispense. Unless the one I read yesterday is out of date?

Nurse: Oh, really? Perhaps I need to read that one.
(Silo Town, female nurse 2)

One of the distinctions between urban and rural practice and a good example of how things are done differently in the country revolves around the whole issue of prescription, storage and dispensing of medications. In Silo Town there is no pharmacy. If doctors want a prescription filled it must be faxed to a nearby town where there is a pharmacy service. They send the medication back by bus; the nurses take delivery and after checking the medication, dispense it to the patient. This does not meet the needs of the patient who, unlike city dwellers, may have to wait up to three days before they receive their medication:

> ...as a consumer as well as being a nurse in this centre it is very difficult to tell a mother who lives 50 kms out of town with a child who is ill with bad tonsillitis that, 'Sorry I haven't got any antibiotics here; you will have to come back to collect them tomorrow.' (Silo Town, female nurse 2)

In summary, there are distinct differences in the way nurses and doctors practice in each of the case study sites. This requires adjustment in their way of working and means being more flexible, less formal and restrictive in deciding who performs which function. Professional boundaries are blurred as a result of this way of working but it is the nurse, not the GP, who has to make the most adjustment to their practice in order to maintain the relationship.

Working together. An important first step in working together is relationship building. According to one GP this is best achieved on an open, honest basis; however, he acknowledged that this is not always possible:

> ...what I try to do is approach everybody the same in a very open ended professional manner. As the interaction between you and an individual goes on you can build a relationship on that. (Sea Town, male GP1)

If problems do arise when nurses and doctors work together, a way to resolve them needs to be found. One GP suggested this strategy:

> If there is a problem, once again the honesty and openness is to present the problem to the source of the problem and not go sideways and go backstabbing and talking amongst the 'tea room set' but to address the problem. To come back and say, 'I'm not sure what you mean by x, y and z. Or are you sure that's what you want to do?' (Sea Town, male GP 1)

What is being suggested here is that for the relationship to work effectively nurses and doctors must address the problem they may have with each other in a direct and open manner. To do otherwise is to risk sanction by the 'source of the problem' who will regard personal attacks on them behind their backs as damaging to the relationship. Overriding this direct approach is the power imbalance that exists between nurses and doctors. In a balanced relationship where both partners feel equal, one might expect direct negotiation when problems exist, also a willingness to accept and own problems and work towards resolving them. As has been mentioned frequently in this work, nurses who challenge doctors do so at their peril. They may do it in the way described by Stein (1967), which is to follow the rules of the game, intended to prevent offence to the doctor by taking an outwardly passive stance, or choose another path that has a greater risk for them personally and professionally.

The maturity of the nurse and the relationship they have with the doctor in question will often determine which course of action they take. The fact that the options are few indicates the immaturity of the relationship.

In all of the case study sites and particularly the three smaller ones a common theme emerged in relation to the interdependence associated with working together. In reality the relationship could not function if nurses were not providing the GP with support and 24 hour nursing care services in the rural hospital. The doctors could not practise medicine in the way they do without the cooperation of the nurses. The relationship therefore is one of co-dependence. Similarly the nurses would be severely restricted in the type and range of procedures and treatments they could offer the rural public without the support and cooperation of the doctors. It should be noted there are many examples in rural and particularly remote communities where nurses provide the only health care service however, it is rare for doctors to work in isolation with no direct access to nursing services or support in such settings.

In examining the ways in which nurses and doctors related in the four case study sites it is clear there would be a major impact on the way doctors practised if the professional working relationship between the nurses and doctors were dysfunctional.

- GPs would not have access to a valuable resource of knowledge, skill and experience to discuss patient management in the absence of other medical colleagues.
- GPs would not be able to admit patients to the local hospital and rely on the provision of 24-hour nursing care and implementation of medical treatment and procedures.
- GP workload, stress and eventually burnout would increase if the protective behaviours and work habits used by the nurses were reduced or absent.
- Access to rural community networks, social structures and knowledge of individual's and family circumstances often comes through nurses because they have lived longer in the rural community than the doctor.
- The health care interests of rural communities would be compromised due to the lack of collaborative endeavours that would flow from a diminished relationship.

A nurse at Bridge Town summarised the inter-dependency aspect of the relationship:

> I think we need each other. I think medicine needs nursing, although I think nursing is very different to medicine. I think basically we are all there for the patient. The doctor looks after the medical part of it and the nurses look after the nursing and I think the doctors fairly well accept that. (Bridge Town, female nurse 1)

This neat categorisation of nursing and medical work responsibilities denies the complexity inherent in the relationship but accepts the division of labour between the two groups. There is 'nurses' work' and there is 'doctors' work'. However, in observing and interviewing nurses and doctors in these rural settings I found that nurses undertaking doctors' work was a far more common occurrence than doctors doing nurses' work. Nurses in the study generally did not wish to undertake 'doctors work' but did so for the sake of the patient and in the absence of the doctor. They expressed reluctance and concern, which related to sanction by either the doctor or their nursing administrators. What nurses needed to reduce these concerns was to be listened to and valued for their opinion as this example from a Bridge Town nurse shows:

> I think from my experiences the doctors are fairly open to listening to your opinion about the actual holistic care if you like, taking away the medical part. Like I don't want to be able to prescribe but I want to be able to say to the doctor, 'Well this medicine you have given them is totally unrealistic because this patient lives by themselves and they are not going to be able to keep this up after they leave.' I think most times the doctor listens. (Bridge Town, female nurse 1)

In return the GPs in the study provided numerous examples of how much they relied upon and needed nurses. This example from a Bridge Town GP demonstrates the pivotal coordination and management role of patient care services that nurses provide in rural areas:

> I think the nurses are incredible really. I think they really run the job in many ways because as you would see we are in and out and don't stay long. (Bridge Town, male GP 1)

In summary, rural nurses and doctors rely on each other and the relationship is very dependent on smooth interaction and established patterns of work. Neither group can conduct their work without the other's intervention or involvement. There is acceptance of this by both and an understanding that working in isolation is undesirable and unproductive. The smaller rural sites in which the RNs and GPs practise dictates to some extent their need for each other but I found a genuine respect for the ability and capacity of each to contribute to the development and maintenance of the relationship by word and deed.

Common experiences. Nurses and doctors share and experience many things in common when their respective practice is compared. One GP in the study described these as 'common bitches and common glories', no doubt referring to the high and lows associated with providing health care services to people. The nursing and medical dictums of care and cure ensure both professional groups share successes and failures. When there are good outcomes of care for patients, nurses and doctors are happy. Conversely when things go wrong it is not unusual for them to feel a sense of failure and perhaps seek to place blame on the other. Most relationships are tested when times are tough and if they survive are generally stronger for it. This study shows that rural nurses and doctors share common experiences by working in close association in small teams and living in small communities. The sharing of common experience gives equity to an otherwise inequitable relationship. A female GP from Silo Town observed that although nurses and doctors have different objectives when providing their services to the public, they have much in common when it comes to rural practice:

> We've got common bitches and we've got common glories and we've got common things we feel good about. (Silo Town, female GP 1)

There are times to reflect on what went wrong and times to celebrate what went right. For example, in Silo Town both nurses and doctors practise independently for most of the time. They work together for scheduled clinics twice weekly but for the remainder of the time the interaction between them is largely by telephone. That they achieve mutual successes in the management of the people they jointly care for is an achievement given the common problems they both share.

The frustration of those problems is evident in the following statement from the GP at Silo Town who lamented the high visibility and therefore accessibility that nurses and doctors alike have in the rural community:

> We can't go out without somebody showing me their rash and the nurses get that too. I mean it's not like it's just poor me. That's probably what binds us together…
> (Silo Town, female GP 1)

Wherever they go, shopping, playing sport or for a drink at the local pub, the community thinks it is reasonable to ask their professional opinion on whatever ails them. Nurses also reported expectations of rural community on their time:

> I think it's actually easier for GPs because it's such a clearly defined thing. Doctors don't usually work out of hours. It's not acceptable to ring them at home and ask them medical questions whereas it still seems that it is OK to ring nurses.
> (Silo Town, female nurse 2)

It is acknowledged that both nurses and doctors in rural communities are considered 'public property' and this often means intrusion on non-work time with requests for assistance. This practice seems more prevalent in smaller rural communities and the nurses are less able to decline these requests by telling the person to come to see them in work time, as would be expected by the GP in consulting hours. The opportunities for the rural community to access nurses and doctors are also greater than in larger communities:

> We jest here at work amongst registered nurses about being sidelined in the supermarket or somebody sidles up to you at the football and…'Oh, little Johnny has such and such, what should I do?' I guess it is a problem and we have to deal with it.
> (Silo Town – female nurse 2)

How they deal with these intrusions on their social and leisure time depends on the position of the nurse or doctor in the community, their experience and confidence to use assertive responses. They might want to say to the person; I respect you and want to help you but please approach me about this issue in my professional time. More often they find themselves giving advice and in some cases treatment because that is what the community wants and expects. The fact that it is an unreasonable expectation is glossed over as this account by a GP at Valley Town attests:

> …it's a small place. That can create tensions between what's work and what's social. That can carry over down the street. The nurses can often have problems because people in the street can go up and ask them what's going on with their relative's treatments or assume they may know something about what's happening with someone, when they don't. (Valley Town, male GP 2)

That rural nurses and doctors experience this constant focus of community attention as both a benefit and a curse. The benefit comes from their deeper understanding of the rural community dynamics and the curse because they rarely obtain anonymity within their own community. The fact that they both experience similar problems and share in the great satisfaction arising from their practice allows empathy with the other. The sharing of common experience is therefore a strong point from which a professional relationship can develop.

Social norms in rural life. Friendships between nurses and doctors through social contact are not limited to rural work settings. Many nurses and doctors have established successful personal relationships with each other after meeting in a work setting and no doubt some progress to romantic relationships. How the social norms in rural areas affect the working relationship is of interest. Before analysing this issue it is helpful to understand that in three of the case study sites, nurses and doctors lived and worked in small rural communities of <1000 and health service staff numbers were between 5 and 30. The exception to this was Bridge Town, a larger regional town with a population of several thousand and in excess of 150 staff working in the hospital. The effect of smaller rural communities on nurses and doctors alike is that they are much more likely to encounter each other in social settings outside the work environment. Some examples include the children of both nurses and doctors attending the same school:

> I have a lot of interaction with doctor's children. My child is in the same class as his child at school. So we…help each other doing things around town.
> (Sea Town, female nurse 2)

The local doctor and his family were staying with a nurse's best friend's relative in her beach house:

> …she was one of my very dear friends. It was her mother-in-law that doctor and his family stayed with in their beach house. So in the country it's a bit different than the city. Everybody knows everybody. (Sea Town, female nurse 1)

Nurses and doctors met in social settings in the community:

> …we have met with our GPs socially on occasions and we still do but we are able to shut off and become friends. I think that's important. When we are out, work is never referred to but we meet them as people and its hat changing again. (Silo Town, female RN 1)

There are additional pressures placed on nurses and doctors because of the limited social interactions with other than work colleagues, as one Valley Town GP explained:

> There are sets of people that we know and I suppose you can end up just not getting away from work. It's hard enough to get away from work as it is without going home and talking about work to someone who also works there. (Valley Town, male GP 2)

The same GP pointed to the problems associated with making social contacts in a rural town obsessed with one particular type of sport, when the enthusiasm for that sport might not be shared by the GP:

> There aren't necessarily the people with the same interests you would have in a small area. If you don't like football, you're in big trouble! (Valley Town, male GP 2)

A GP in Silo Town stated the importance of social relationships, despite the potential hazards:

> Outside of the hospital I think the social side of the relationship is important. Even though sometimes it's your downfall, it's what makes it good as well....
> (Silo Town, female GP 1)

Her expressed concern about social interaction related to the nurses getting 'too familiar' with the doctor and allowing the relationship to be impaired by judgements based on knowing the doctor as a friend or socially, rather than on a professional footing. In all four case study sites GPs did not actively seek the social company of nurses outside of the hospital environment.

The converse was also true of nurses. Social interaction between the nurses and doctors occurred primarily as a result of the small communities in which they both lived and worked. Part of that meant shopping at the same supermarket or store, playing social or competitive sport together and sending their children to the same local school.

This close social proximity does not guarantee the development of a healthy social and personal relationship but nurses and doctors accept it as a reality. Inside the rural work environment the potential for social interaction and the building of cohesive personal relationships is there but nurses and doctors have to create the opportunity for it to occur. There was evidence in several of the case study sites that this occurred to a greater or lesser extent. A Valley Town GP described how they used a social occasion at the end of each week to mix socially and build the relationship:

> We would frequently open a bottle of wine on a Friday afternoon and have a few nibbles. This was good because we could just chat informally. Without that you sort of can't build this bridge. (Valley Town, male GP 2)

In summary, the working relationship is influenced by the social interaction between nurses and doctors in and outside of the work setting. The smaller rural towns created more opportunities for social interaction to occur inside the workplace and externally in the community. There are positives and negatives to this close social interaction, but generally speaking nurses and doctors alike welcomed it as a platform from which to build a more successful relationship. Nurses and doctors alike welcomed social interaction opportunities in the workplace, believing them to be useful in building better relationships.

Size of work setting and its effect on the relationship. In Chapters 4-7 of this thesis the respective size, relative to each other, of each of the rural case study sites was explained in detail. In brief, Sea Town and Valley Town were of comparable size in terms of population numbers and staff complement in the hospital. Silo Town had a very small population of <500 and also low staff numbers, <5 in the community health centre. Bridge Town was the largest case study site in population and staff terms. The size of the town and health service in it is likely to affect the working relationship between nurses and doctors. To what extent is of interest. A nurse from Sea Town indicated that the size of the town does influence the development of a social relationship:

> Of course in very small settings when you live in the town there's also the social contact and friendship which is all part of that. (Sea Town, female nurse 1)

Another nurse commented on the small size being a factor in building trust and respect quicker but at the price of privacy:

> (a good working relationship)…one that is based on trust and respect for the person and also offers a certain degree of privacy as well for the individual, which is very hard in a small town like this….you know a lot more about the doctors in their private settings. (Sea Town, female nurse 2)

A GP from Sea Town pointed to the close personal relationship with the nursing staff because of the size of the town and the close interaction with nurses in the work place:

> In a small country setting like we have here I think we are extremely fortunate in that our interaction with the nursing staff works tremendously well. It's very close. We know the people personally....We understand each other. (Sea Town, male GP 1)

Conversely in the largest case study site a GP indicated his preference not to be involved with nurses socially:

> I have opted not to be too socially involved and this is a town where you can probably do that because it is big enough, but on the other hand they (nurses) get to know you and they get to know about you and enjoy that. (Bridge Town, male GP 1)

A commonly raised issue in relation to size of the community was the reality that staff would be treating their own relatives in the local hospital, and also the need for nurses to use the services of the local GP for their own health care:

> The nurse that's related may be to a very close relative; it may be hard for them to treat that person.....Occasionally you may get a nurse who tries to convince you that you should be doing such and such for a patient. You will know it's not necessarily in that patient's best interest and that the nurse is actually speaking because of their own fears for their relative or the pressure their family is putting on them.
> (Valley Town, female GP 1)

In summary, there are a number of factors relating to physical size that influence and shape the relationship. Smaller rural sites value the benefits that come from increased social interaction, despite the associated lack of privacy and anonymity. In larger sites with more GPs and nurses the relationships are not as familiar and work roles remain more distinct. In all four case study sites nurses and doctors were often required to treat relatives and friends from the community. This places additional strain on a relationship when there is pressure to provide information on the progress of patients to family and friends in the community. Where there is only one GP in the town, tensions may also arise over the treatment choice of a particular GP when it conflicts with nursing opinion.

8.4.4 Historical and Traditional



Gender and its influence in the relationship. The majority of nurses in Australia is female, while the majority of GPs is male. While there is increasing feminisation of the medical workforce, nursing remains solidly female in its character with only 7.4% of the national nursing

workforce male at the 1991 census (AIHW 1997). Nurses and doctors in this study reported some inconsistencies in relation to gender as a factor influencing their working relationship. The gender profile of the participants in the study was atypical for rural GPs, where women are underrepresented in the GP population. Of the six GPs in the study, however, three were women.

The profile for the nurse participants was typical for RNs, where nine were female and only one male. A nurse from Sea Town made no distinction between the male or female GPs she worked with, but did note that she talked about different things with the female GP:

> The relationship is certainly different. I mean obviously they're different personalities....I've probably had more to do with the (female) doctor than the (male). It is a different relationship, doctor—is obviously female and we talk about different things to what I would talk about with doctor—(male).
>
> They both have different interests so therefore you would talk about different things with them in general conversation. But when it comes to medical situations and actual work on the wards, it's basically the same. I would tell them exactly the same things. (Sea Town, female nurse 2)

The nurse accepts that there are differences in personality between the male and female GPs in Sea Town and because of this she relates differently on a personal level, but not when it comes to giving professional information and interacting with each GP.

A male nurse at Sea Town offered a counter view:

> Well, working as a male nurse you get treated differently....It's hard to put your finger on it. It is different. I can't describe it though. It's just different. I certainly don't get treated like one of the girls (nurses). (Sea Town, male nurse 4)

This nurse has difficulty describing what is different in his relationship with the two GPs he works with in Sea Town, but makes a distinction between himself and the female nurses. When I observed this particular nurse interacting with both the GPs he was self assured, used humour and appeared relaxed in their company. Like the female nurses, he made no separation between the two GPs because of their gender when it came to professional issues and stated he related no differently to either the male or female GP:

> Gender doesn't really effect the way that I treat them because really I'm trying to relay information to them and I and other nurses expect that they will do the appropriate thing in working out a care plan or management for these patients. (Sea Town, male nurse 4)

When I asked a female GP at Sea Town if her gender made any difference to the way she interacted with any of the male or female nursing staff she gave a qualified answer which indicated that she was not conscious of it affecting the relationship:

> I don't think so. I think...I mean it's hard to pick how other people perceive you. (Sea Town, female GP 2)

In observing her with other nurses she appeared to engage in more social talk with the female nurses and in turn them with her than the male nurse. She did explain that gender had made a difference to nurse-doctor relationships in her previous experience as a medical intern:

> I think seeing some of my intern colleagues, both male and female, not getting on with nursing staff. Some of the fellows it was because they were cracked anyway. Some of the girls it was a case of, 'Oh, I have to make my mark and be the dominant force.' I can't see that as being a good way to get on with people.
>
> I think I'm fairly relaxed and fairly easy to get on with. I don't think I've ever found it difficult or found that people find me difficult to get on with or made it more difficult to get on with being female. If anything it seems maybe I'm easier to get on with. (Sea Town, female GP 2)

This female rural GP accepts that some male and female doctors have difficulty relating to nurses because of their gender differences but in her case she has no particular problem. In fact she indicates she is easier to get along with. In observing her interactions with nurses she displayed a relaxed, friendly and cooperative manner. Most of the nurses called her by her first name and indicated that she was very approachable. Some had become friends with her outside the hospital environment:

> I was also playing netball and she came out and helped. So we play netball and you always see her around. She is very friendly with several of the nurses and considers them long-term friends. (Sea Town, female nurse 2)

The extension of the nurse-doctor relationship into the social context is not an uncommon one in this study, but of the three female GPs in the study, two played sport in the local community and had a wide circle of friends including nurses from their place of work. On the other hand, the three male GPs reported they did not play sport and did not mix socially, at least to the extent of the female GPs. Two of the male GPs were reserved about social involvement despite their relatively young age:

> I have opted not to be too socially involved....(Bridge Town, male GP 1)
>
> ...to effectively doctor someone you have to be objective. It's hard if you're very closely aligned to someone to do that effectively. So to some extent to function properly you have to have some distance to people. (Valley Town, male GP 2)

Where social or work friendships between female nurses and female doctors had formed they were strong as is evidenced by this quote from a female GP:

> There is a handful of staff here who are really deserving of help and I will walk over coals for....(Silo Town, female GP 1)

In summary, gender influences the relationship between rural nurses and doctors in subtle ways and avoiding social interaction is not a gender-specific behaviour. In this study two of the female GPs mixed with nurses during sporting activities in the community, whereas the male GPs tended to keep to themselves outside of the hospital or consulting room.

In the workplace nurses and doctors interacted at a professional level without much conscious regard for the gender of either. In social situations both inside and outside the professional work settings there was evidence that nurses and doctors formed deeper personal relationships. The effect of this I observed was a more relaxed, friendly attitude between the nurse and doctor:

Roles and rituals. There were numerous roles and rituals in which nurses and doctors in this study participated. I have described these as historical and traditional ways in which nurses and doctors perform their work. To others they are a confirmation of the division of labour between men and women. Alternatively they could be examples of nurses (and to a lesser extent I observed doctors) giving of themselves personally and professionally to enhance the working relationship:

> They (the nurses) went out and met us and helped unpack the car. A morning tea was arranged. Bookings have been kept to an absolute minimum with the odd occasional extra one snuck in. They have spent more time with my daughter. It's not their job to look after her but it's just a different approach....(Silo Town, female GP 2)

The nurses who provided for the doctor's social and professional needs in this example stated that although it was not their role to do these things it was 'just plain good country manners' and worked to their advantage by having the doctor 'in a good mood'. Providing massages and bringing food for the doctor might be construed as confirming the omnipotence of the doctor but

a Sea Town nurse described her actions as designed to enhance the relationship between herself and the local GP:

> I've had the doctor here late at night and really tired. I stood behind him and just gave him a little shoulder rub. And when we have too many peaches on our tree and they don't have a peach tree, I bring peaches in. And sometimes we have a chat about various things over coffee. They are very simple little things but...That probably doesn't happen so much in the city. (Sea Town, female nurse 1)

The significance of these seemingly minor social and clinical interactions between nurses and doctors cannot be underestimated for their ability to forge strong personal and professional relationships.

That being said, I did not observe similar reciprocal behaviour of doctors towards nurses. If there is a genuine, mutual regard for each other the relationship is more likely to grow and develop.

One role that has ritualistic trappings is the practice of ward rounds. It is a practice common in most clinical settings whether they are rural or otherwise. The routine for ward rounds I observed in the four rural case study sites was similar. When doctors initiated the visit it was usually as a routine progress check of in-patients. Nurses also initiated ward rounds of specific patients because of a change in the patient's condition and/or the need for medical attention. Nurses went with the doctor on the rounds of patients for three main reasons. Firstly, they want to hear first hand any change in the medical orders likely to alter the nursing care of the patient. Secondly, the doctor might request information from the nurse about the patient's status and condition. Thirdly, the doctor might need the nurse to assist in an examination or treatment of the patient.

The most compelling reason the ward round with the nurses occurred was because the doctor expected it too and attendance by the nurse was not optional. There was an expectation that the ward round should go according to plan. This Sea Town GP expected the ward round to go smoothly:

> ...the ward round this morning...was perhaps a little bit different to what it would normally be because 'Julie' is only fairly new on staff and she's done a lot of night duty. So it didn't flow quite as smoothly as it might otherwise have done. Which was fine, that's not a problem but I guess that reflects some of the nursing staff getting to know the doctors and vice versa. (Sea Town, female GP 2)

Here there is an acknowledgement by the GP that the new nurse is not entirely familiar with the ward round routine and that if things are to go smoothly, as the GP wants, the nurse will need to get to know what the doctor expects. It is implied that the GP wants to know what the nurse's

needs are. With respect to this, however, I saw more evidence of nurses trying to meet doctors' needs than the other way around. The nurses tended to anticipate the doctors' needs and make efforts to meet them. The reasons for this are varied. One Sea Town nurse proffered an explanation, which is common. Nurses fear the relationship they have with doctors will be damaged if they appear incompetent, unorganised or don't anticipate what the doctor will require in a given circumstance.

> I can see being afraid of doing something wrong in the presence of a doctor can really make you a less competent nurse. (Sea Town, female RN 1)

In the four rural settings observed, the practice of nurses going on ward or patient rounds had much the same objective as in other practice settings. However, there were some differences. Firstly, there is the availability and access of nurses to the doctor. Unlike in a metropolitan hospital setting where doctors are resident or in larger numbers, rural nurses have limited access to the doctor after hours. Therefore the time spent in face-to-face communication during the visit assumes more importance. Secondly, the numbers of patients in the smaller rural hospitals are relatively low and the time it takes for nurses and doctors to complete a round of them is less. The nurses' use the time spent accompanying the GPs to see patients for two main purposes –to give and receive information about the patients and also to learn new skills or observe and assist with medical procedures. The smaller numbers of patients enabled the nurses and doctors to spend more time with each other. On completion of the round, they continued to build social and professional rapport in the hospital staff room while the doctors updated the case notes.

None of the nurses mentioned they disliked the rounds or found them a burden on their time. They did not regard them as 'old fashioned' and an outdated practice and accepted the need for them to continue. A nurse in the large regional hospital site, while supportive of ward rounds, indicated she wanted the doctors to recognise that she had spent more time with the patient and this meant she was in a better overall position to monitor and report any change in the patients' condition. She expressed annoyance when doctors ignored this fact during patient rounds.

If the doctor requires the presence of the nurse, it seems reasonable the part the nurse plays is elevated from that of a note-taker to that of a professional who is invited to participate equally in the provision of the patient's care plan. However, the role of the nurses in ward rounds was largely a passive one. Rarely did the GPs use the occasion to discuss the management of the patient in more detail with the nurse.

There may be two explanations for this. Firstly, they do not value or need the nurses' opinion and, secondly, they believe the nurse is there to meet their needs and obliquely the patients'. If the first is true, rural GPs pass up an opportunity to develop a closer working relationship and get a second, albeit not a medical, opinion. If the second explanation is true, it is another example of nurses accommodating the needs of doctors rather than their own:

> I always feel a bit more comfortable when I have got something to do, rather than just standing next to the doctor. So I think nurses are constantly smoothing over to the doctors and sometimes I hate it. I feel we have been to university, why can't we...I mean it's very rare that they ever accommodate us, although we do have a few doctors here that are very good in that way. So nurses are always doing that and I hate it and find it a little bit humiliating but I do it as well. (Bridge Town, female RN 2)

Despite this nurse's objection to the expectation of doctors that nurses will accompany them when seeing patients and the absence of any collaborating interaction between them, she accepts she is unable to change what has become accepted practice in this large rural regional hospital.

In summary, historical and traditional rituals like the ward round reinforce nurse and doctor roles; however, this study shows nurses and doctors used the ward round to share information and increase interaction between the nurses and doctors during and after these ward rounds. Because they have fewer patients to see, time is used to enhance the relationship through social interaction, teaching and learning and participation in treatments.

Expectations. A recurrent feature emerging from comments by nurses and doctors in the study was the expectations they had of each other. A GP made clear his expectation with regard to how nurses should ask questions:

> It's all about appropriate questions put in an appropriate manner at an appropriate time. They're the three things I really like to talk about in any situation. An appropriate time is very important. In an appropriate way demands an appropriate answer. (Sea Town, male GP 1)

In this example the GP is making very clear how he expects nurses to phrase questions about clinical problems. The right question needs to be asked in the right manner and at the right time. Not much room for negotiation here, but on the other hand the nurses who worked with this GP understood this expectation and adapted their behaviour accordingly:

> Be very certain of your observation...and hand on that observation. Don't ever say to the doctor, 'I think they (the patient) need this, that and the other'. Rather say, 'This is my observation and what would you like me to do to intervene...? (Sea Town, female RN 1)

This is what Stein (1967) describes as the 'doctor-nurse game' where the nurse tries to avoid giving the GP her direct observation when she has every right to do so. A Sea Town GP explained his expectations of nurses when it came to resolving problems between nurses and doctors in a way that left the relationship intact:

> ...about appropriate questions put in an appropriate manner at an appropriate time.
>
> They're the three things I really like to talk about in any situation. Appropriate time is very important. In an appropriate way demands an appropriate answer.
> (Sea Town, male GP 1)

The context of what the GP describes here relates to how building the relationship with nurses is made possible, at least in his opinion. In these circumstances the nurses must demonstrate they are to be trusted when given a request to do something for the GP and it is completed successfully:

> ...if you're building a relationship and somebody says, 'Yes I'll do that' and it happens, you say, 'Well I can trust that person to make a request and it will happen'. And if I ask them about a patient or their drugs or if they can go home if everything is well, if all that sequence of events happens, well you know that's going on. And coming back the other way, if you say you are going to do something, make sure you do it.
> (Sea Town, male GP 1)

In this sequence of events the doctor asked the nurse to do something and expected they would complete the task. If they did, the expectation was that the doctor would trust them because they acted appropriately. The doctor in this case stated that he also lives by the same rule, particularly when solving problems about the relationship:

> If there's a problem – once again the honesty and openness. Present the problem to the source of the problem and not go sideways and go back stabbing and talking amongst the tea-room set, but to address the problem. To come back and say, 'I'm not sure what you meant by x, y and z, or are sure that's what you want to do?'
> (Sea Town, male GP 1)

What the GP is saying is that he wants nurses to speak about problems directly to him and not go behind his back. He also expects them to challenge him when they are unsure about any issue by asking questions but they must follow his rules – appropriate question, appropriate manner and appropriate time. We can assume therefore that if nurses follow this sequence and ask inappropriate questions in an inappropriate manner and at an inappropriate time, they will have broken the rule and the relationship, at least as far as this GP is concerned, will be harmed.

When I looked for evidence of nurses asking questions of the GPs at Sea Town, in my observations of them at work and in interviews, I found several examples. One nurse explained how she felt when a GP challenged her initial assessment of a fractured arm in a child:

> ...She had fallen off a stool at a local sports club and was holding her arm and had a real pained looked in her eyes and just where she was feeling and where I touched, was terribly sore. So I got her comfortable and phoned the doctor and said, 'I wouldn't be surprised if she's got a fracture.' When the doctor walked in he said, 'Not fractured'.... I thought she was very tender in the radius area and anyway we took an x-ray and it was fractured. I just felt like going nah, nah, but I didn't. I still got on really well with him but felt I was walking on eggshells. I don't feel that now. I haven't been 'put down'. Doctors do sometimes 'put nurses down', don't they? (Sea Town, female nurse 1)

Here the nurse respected the appropriate time, place and manner rule of this particular GP and because her initial assessment was correct, she felt vindicated and 'got on really well with him' without feeling her knowledge and skills were inferior. It did not occur to either the nurse or the doctor to consider how each would have responded if a nurse were the one contradicting the doctor. A Sea Town nurse cautioned about disagreeing with the doctor:

> Obviously I think that you have to be very tactful and anything that you may have disagreed with them about as well. But if you're up front and state your case and if it's a strong enough case and you have the evidence backing it, then its OK. (Sea Town, female nurse 2

Providing the nurse is certain of the facts and conveys these confidently it would seem less likely that the doctor would regard them as acting inappropriately. A Sea Town GP revealed her own concerns about how nurses would regard her if she acted inappropriately when contacted by phone over relatively minor issues:

> ...even if I hang up the phone and think 'that was pathetic; why on earth did they ring me about that?' I hope they haven't got that message because I would hate for someone to be in a situation that they didn't feel comfortable with, and feel, 'Oh, I can't ring her because she's going to spit at me or jump down my throat'. (Sea Town, female GP 2)

The inappropriate question, manner and time are all elements noted in this example.

In summary, the expectations of RNs and GPs of each other are around rules of appropriateness and not what is actually required in any given circumstance. Nurses and doctors should be unfettered in their responses to each other, especially when communicating vital clinical information. If they have to filter this through some complex maize of rules and appropriate

behaviour, the end result is bound to be a compromise. If the relationship is to progress GPs and nurses have to make clear what their expectations of each other are. The stakes are therefore high in terms of ensuring behaviour is appropriate by nurses and doctors. In this study nurses perceived they had more to loose if they got it wrong than the doctors.

Legal accountability. A recurrent theme in this study was the issue of legal accountability for actions taken by either nurse or doctor. A Sea Town nurse explained what was at stake when the nurse challenged a doctor over the treatment of a patient:

> On a personal level I've had to step over doctors to get appropriate treatment for patients. This places you in a terrible bind really. When that happens it means it's impossible working with that doctor any longer. (Sea Town, male nurse 4)

Nurses who challenge doctors over their management of patients do so at great risk to themselves because of the power difference between them. The consequences of such challenges to the working relationship in the rural context can present many problems for nurses and doctors as individuals. When the conflict is serious and unresolved, hospital management can face difficult dilemmas.

In one rural hospital case in South Australia, for example, the Director of Nursing and Chief Executive Officer resigned due to a conflict with a local GP with whom they had a major disagreement over alleged non-compliance with hospital policy affecting nurses. The doctor in question effectively blackmailed the local community by withdrawing his anaesthetic services, effectively paralysing the hospital's surgical procedures. The conflict split the local rural community into those who supported the doctor and those for the hospital board and nursing management (Holden 1997). This example shows the power small town rural GPs have if they choose to wield it in circumstances where they believe their cause is just. In the face of this nurses with a grievance against a doctor have little or no chance of achieving a fair and equitable outcome. I asked a Valley Town GP if there was an opportunity to have input into and receive feedback about conflicts to do with nurse-doctor relationships:

> We go to the hospital board meetings and concerns that nurses have are brought to board where we will be privy to them and are able to put our point of view.

And

> Last week I went to a staff meeting to talk about an issue with a few of the nurses. It was nothing dramatic, just a few minor points I thought might be worth changing. (Valley Town, male GP 2)

It is clear from these statements that the GP is in a position of power. Nurses do not have voting rights on hospital management boards in small rural towns in South Australia. If they attend they do so as staff members with limited power and influence despite representing the largest group of health professionals.

At best these meetings may impartially consider the facts and work towards personal and policy outcomes that satisfy both parties. At worst they are an excuse for unilateral action taken against nurses who are accused of not fitting in and having poor relationships with the doctor/s. If the hospital wishes to back the nurse and keep them employed, it is far more difficult in a small rural community to provide alternative work options for the nurse so they do not have to work with the doctor with whom they are in conflict. The evidence as reported by Holden (1997) suggests that when these conflicts are unresolved it ends with the nurse, not the doctor, leaving the town.

Several of the nurses I spoke with in the study were confident they had the right to say their piece to doctors even though they felt uncomfortable doing it. Interestingly, nurses with the longest experience in rural nursing, who had been located in the same place for many years, expressed hesitancy to challenge the doctor despite their years of confidence, experience and knowledge. This may be explained because they continue to hold traditional views about the nurse-doctor relationship that discourage any challenge of medical authority. It could also mean that they had developed other strategies to achieve their goals. Other nurses in the study used more assertive strategies when doctors tried to subjugate them. One newly graduated nurse I observed and interviewed surprised herself by her own actions when confronted with a doctor who 'started tearing strips off me':

> ...I stood up to him without meaning to, just by accident. Since then the doctor has been so respectful to me and very nice. I'm quite amazed. So the moral of the story is that it is a good thing that I stood up to him. (Bridge Town, female nurse 2)

The root cause of these conflicts in the relationship between nurses and doctors often stems from the legal twists and turns that have dogged medicine and nursing for decades. It is helpful therefore to examine the facts of the matter in relation to the fears held by nurses and the assumptions made by doctors. In this study all six GPs in the four rural case study sites expressed views on legal aspects relating to the action of nurses. Some examples included:

Oh yes, they're (nurses) worried about the legal stuff.

...I know it's been proven in specific cases, nurses do still carry their own sort of liability even when they're acting under doctors' instructions.

...in the hospital setting its usually the doctor that 'carries the can'.

...I think these people (nurses) wouldn't ring me if they didn't have pressure on them from their administration to get everything legally sorted out.

These nurses are being stopped from doing the best they can and having that ability to branch out and grow and learn. Squashed by the idea that they are going to be legally liable.

So there is obviously a difference in liability between doctors and nurses.
(Silo Town, female GP 1)

...certainly one of the things which colours doctor-nurse relationships in any setting is the fact that basically in the end, the doctor is the one who has to decide on the diagnostics and treatment course.

...from a legal point of view the buck usually stops with the doctor as being the person who is seen to have made the decision or made the diagnosis. There have certainly been court cases in Australia in recent years where even when the patient has not followed the doctor's advice and has done something different, resulting in a bad outcome. It's still been the doctor's fault.

...these sorts of things ... can make doctors feel very uneasy about anyone coming between them and the patient in quite a number of areas. (Valley Town, female GP 1)

...because we do to some extent have the ultimate responsibility for what happens and how our treatments and orders are carried out. (Valley Town, male GP 2)

Throughout these statements the central messages conveyed include:

- Nurses are very concerned about legal issues.
- Nurses must act on and follow implicitly doctors' orders and instructions.
- The doctor is ultimately responsible, even when they are not directly involved.
- Nurses are pressured by their administration to cover themselves legally.
- Nurses fear legal sanction by doing something outside their scope of practice.
- There is an implication that doctors have a higher legal liability than do nurses.
- Doctors dislike any third party interfering with the doctor-patient relationship.

While some of these beliefs can be challenged, the fact remains that rural GPs in this study believe they must shoulder the majority of legal risk when working with nurses. Notwithstanding this fact, GPs in all of the study sites actively encouraged nurses to take more responsibility in the

work place for clinical decisions and intervention where they felt comfortable. This was particularly noticeable in after hour periods when the GP was at home and on-call. A Sea Town GP explained the frustration she felt when nurses called her at home and were not sure whether they wanted her to come to see the patient at the hospital or not:

> But it frustrates me a little bit when its – here's the story but then there's no questioning, or this is the story and the ball's in your court now. Which ultimately, yes I accept the buck stops with me, but I'm quite happy for them to say, well, yes I'd like you to come and have a look at them. If they ask me to come, I'll never not come. (Sea Town, female GP 2)

The problem for both nurse and doctor here is, of course, the unwritten and unspoken word. The doctor wants the nurse to be specific and clear: Do you want me to come to see the patient? Or do you just want to discuss it over the phone? The nurse may want to transfer all responsibility for assessment and diagnosis to the doctor believing this is what the doctor gets paid for or because the policy, again sometimes unwritten and unspoken, says nurses must contact doctors for all patients presenting to the hospital. It is in these circumstances that nurses and doctors develop fractious relationships and are exposed to risk of negligence cases being brought against them when there has been an adverse outcome of care.

On the available evidence the only time when doctors are legally liable for the actions of nurses is when they employ the nurse directly. Even in these situations it is vicarious not professional liability to which the doctor would be culpable (Chiarella 1999). In her PhD law thesis work, which examined nurse legal responsibilities in working with doctors, Chiarella (2001) makes the following point:

> In truth, the reality is that the presence of a competent nurse acts as a wonderful shield for a doctor, regardless if she or he is acting on their instructions – it is in fact a means of mitigating their liability even for erroneous instructions. (Chiarella 2001)

In the four case study sites rural nurses and doctors depended greatly on each other to deliver the best quality of care each was capable of giving. A substantial part of the negotiation of care was over a telephone and after hours.

The nurses in the study were not employees of the GPs but the GPs were under a misapprehension about their legal responsibility for the action of nurses. In effect this meant the common practice of nurses contacting the doctor for every little detail, and the consequent frustration felt by the GPs, seems unwarranted given there is no strict legal reason for it. If there

is confusion in the minds of these nurses and doctors around who is legally accountable and for what, then the framework governing the way they work is flawed. This has a flow on effect on the operation and quality of their professional working relationship, manifested by the uncertainty of the nurses and the lack of policy or protocol guidelines agreed to by the GPs.

The current legal position puts nurses who convey clinical concerns to doctors, and those concerns are either ignored or minimised, in an invidious position. Chiarella (1999) holds that in situations where a nurse is concerned about a patient's condition, they have no authority to intervene if the doctor will not listen or attend the patient. The present options nurses in this position face are to seek the support of more senior nurses or to go over the doctor's head to a more senior medical officer (Chiarella 1999). This places rural nurses in an especially compromised position. They may have access to a more senior nurse but not necessarily in the hospital or the town and it is most unlikely other senior medical officers would be available in small rural towns.

In two of the case study sites there were two GPs in the town and this at least gave the nurse wishing to follow this course of action a choice. In the other site there were no GPs in the town at all and in the largest site of Bridge Town, several GPs would be available in addition to specialist doctors. All six GPs in this study indicated their willingness to come to the assistance of nurses if they were asked. By this they meant attend the hospital and assess the patient for themselves, even if they felt the nurse had not adequately assessed the patient or the patient's condition was relatively minor. The one exception to this was a nurse at Bridge Town A&E department who stated some on-call doctors had refused to attend in certain circumstances or who were notoriously difficult to contact.

In summary, there is a need for both rural nurses and doctors to work towards a clarification of their respective legal responsibilities. This is particularly important because of the diverse range of practice skills used by nurses and doctors in rural work and the unusual situations they have to manage in the absence of support from each other or other health professionals. The relationship has considerable potential for disastrous outcomes if trust cannot be built on unambiguous foundations. The legal basics must be agreed along with a method of resolving disagreements around patient treatment and management. Rural nurses and doctors would benefit from easily understandable information about their true legal and accountability responsibilities. This should be updated regularly and where possible reinforced in continuing professional education programs.

Money. In any professional relationship the status of the individuals and therefore how they regard each other is influenced by the remuneration they receive for their job. Our society has come to expect that those who have positions of power, authority and a high degree of professional responsibility get paid more. Doctors get paid more than nurses and the difference in income between the two professions has always been justified on the grounds that medicine has a longer more complex preparation period than does nursing. In addition the type of work and the degree of public accountability allows medicine to charge a higher fee for its service to the community. Nursing on the other hand, although valued highly by the community, does not enjoy anywhere near the same remuneration as medicine. The rural GPs in this study earned their income primarily from the Medicare fee-for-service scheme whereas the nurses were all paid employees of a local publicly funded rural hospital.

Depending on numbers of patients seen, hours worked and procedural status, a rural GP has a gross earning capacity commencing at $181,775 p.a. (Butler 1996) compared to a RN with five years postgraduate experience earning between $45,000 and $55,000 p.a. In addition to the base salary earned by GPs through the Medicare fee-for-service payments a number of other incentive payments from both state and Federal governments could increase the rural GPs per annum earning capacity by many thousands of dollars. Many of these incentive payments were given to encourage GPs to practise in a particular way. One example is the additional payment to GPs conducting immunisations.

To understand how income might influence the relationship I asked a Sea Town GP what would happen if a nurse discussed a patient assessment over the phone and the GP provided instruction on treatment without actually seeing the patient. Would that entitle the GP to receive a payment? The answer was no:

> Researcher: So you physically have to come here to the hospital and do the consult before you can make the claim?
>
> GP: Yes. But I try not to run things being financially driven. It's intriguing having worked as a locum and being salaried, where there is no incentive to do more work that I probably learned that way of dealing with it. And if it saves, I mean I'm a taxpayer, I don't want taxpayers money being wasted willy nilly. If I can minimise that, then to me that's a good thing....I would hate to think that the way I was practising medicine was driven by the way I was being paid for it. (Sea Town, female GP2)

In other words this GP is comfortable with the nurse undertaking assessments and after discussion over the telephone, implementing the agreed treatment. By not attending the patient herself she looses income but accepts this as a reasonable trade off to reduce her working hours. A nurse from Valley Town explained how important it is for her relationship with GPs to have time to discuss patient management issues. If this requires a different source of funding, other than Medicare, then that is what should happen in her view.

> I think there probably does need to be built in to the working week a time when the GPs are getting paid, so they're not getting cranky about that. Then some sort of structure where the nursing staff can get their issues together and meet together.
> (Valley Town, female RN 2)

At the time of my fieldwork in Valley Town the two GPs in the town were paid by the local Division of General Practitioners approximately $100 per hour to attend patient management meetings with nurses. In this case it was around the better management of patients with asthma. These meetings were held every two weeks and nurses reported how much they valued them because of the dedicated time it allowed with the GPs. A Valley Town GP pointed to the drop in Medicare fee-for-service payments overall to GPs as a reason why they were reluctant to allocate any time to activities outside seeing patients. This included professional meetings with nurses.

> The decrease in the fee-for-service that GPs receive compared to the various economic benchmarks, in real terms, has fallen by somewhere in the order of 30-50%. This means that previously GPs felt themselves well enough remunerated by the normal run of the mill work to spend a few hours per week in what amounted to unpaid time because there was enough leeway. Now, because of this effect it means the GPs are much more inclined to feel that all their efforts need to pay otherwise they just can't run the business. (Valley Town, female GP1)

The implication here is that if GPs were free of the burden of having to earn all their income from fee-for-service, they would spend more of their time working with other professionals such as nurses, undertaking public health programs in their local communities. There is of course no guarantee this would be seen as a priority for GPs and it is fanciful to suggest it. If GPs were paid to allocate more of their time to work in case management discussions with nurses, an equitable system of payment for both the RN and GP would be needed.

The notion of paying GPs to improve their professional working relationship with nurses is worthy of discussion. There have been recent attempts in this respect with the introduction of Extended Primary Care (EPC) for health assessments on 75 years + patients. Nurses are often

engaged by GPs to perform the home assessment and be involved in subsequent case conferences and planning with GPs. GPs are paid around $500 per patient for a three-stage assessment plan but there is no sustainable funding mechanism for the work nurses may do in EPC.

In the end it comes down to the different means by which nurses and GPs earn their income. Nurses are salaried employees whose income is provided by a health service that derives its income from the state government. GPs derive income from the Commonwealth government through Medicare scheduled payments. The cost of maintaining the Medicare system has been rising significantly. Over the 10 year period, 1984-1985 to 1994-1995 the expenditure on non-specialist services – mostly GP services – increased by 5.2% in real terms (Bridges-Webb 1996). In all four of the health services in this study, nurses provided a substantial after hours service and yet the GPs in these towns continued to receive on-call allowances from the same health services. One GP indicated the fee she received was $100 and she might be on-call three or four nights per week. The fee was paid whether the nurses called her at home or not.

GPs in the study expected nurses to triage and treat patients who attended the hospitals after hours. They might discuss the appropriate treatment of the patient over the telephone but only attended the patient if the nurse made a direct request or the GP was in doubt about the patient's condition. Nurses are not paid any extra to take on this role, despite the extra skill and responsibility it entails. In the largest case study site, Bridge Town, nurses in the A&E department regularly assessed and diagnosed presenting patients. Their skill level was high and they could have treated many of the patients effectively if allowed. This raises the question of using nurse practitioners in such settings as a more efficient use of health care expenditure than paying on-call GPs.

Australia is introducing nurse practitioners into all states and in particular to rural and remote areas. There has been fierce opposition to this move by medical organisations like the AMA and the Royal Australian College of General Practitioners. These organisations argue that diagnosis, prescribing, certain procedural skills and referring to other health professionals are solely the domain of medicine and that the quality of health service and patient outcomes will deteriorate if nurse practitioners are introduced. The reality is that in many rural health services such as those in this study, nurses are already performing these roles and not receiving professional or financial recognition for doing so. Whilst medico-political lobby groups point to the harm nurse practitioners might inflict on the community, the real issue doctors' fear is that their income will be reduced if nurse practitioners gain acceptance as they have elsewhere in the world.

The NSW health Minister put this more bluntly:

> So much of the doctors' resistance I see is nothing more than self-interested bunkum. (Stock 2000)

The GPs in this study were content to allow nurses to take on these expanded or extended roles and for good reasons, one being that it is impossible for one or two GPs in a small rural town to provide a 24-hour GP service without long-term consequences for the health of the GP or the quality of their decisions. The GPs deserve to earn an adequate income for their skills and high level of training, but they should not stand in the way of new models of health service delivery in which nurses who have the required experience and training can provide their community with appropriate levels of care in defined circumstances and at a lower cost. This study showed the nurses at Silo Town already operating at this level but under pressure to reduce services deemed to be medical in nature. A small number of nurses in the study were prepared to accept additional responsibility for changed roles with higher levels of training, but only if these were recognised professional positions such as a nurse practitioner. The majority of nurses in the study were happy to keep the status quo in this regard and not move outside the roles and responsibilities they currently had.

In summary, under the present system time spent on building the relationship is cost neutral for nurses earning a salaried income but not for GPs who earn income by fee-for-service. Money does influence in the relationship in several ways. If GPs allow rural nurses to manage a percentage of their after hours work, they loose income despite the attraction of reduced working hours.

The potential for the relationship to develop is greater if there are opportunities created for nurses and GPs to meet and discuss patient or project management issues. Currently that opportunity is very limited by the way GPs earn income. New strategies need to be found to allow a higher proportion of GP time to discuss the effective management of patients with nurses.

Finally, new models of health service delivery that involve the use of nurses with a higher level of experience and training, such as nurse practitioners, need to be introduced in rural areas. This will require an even greater degree of cooperation and collaboration between these types of nurses and GPs to ensure the delivery of a safe and cost effective health service in the rural context. GPs and medico-political groups must understand that these models are complementary to the GP and not a separate health service alternative.

8.5 External factors influencing the relationship

8.5.1 Political Action



Medical vs. nursing. As in most relationships there is a need to give something before receiving something back. There is also a need for equal giving and taking. When reflecting on the history of nursing and medicine it can be seen that the relationship of the two professions has not been conducive to either of these principles. It could be argued that medicine has increased in importance and stature at the expense of nursing. Medicine as a discipline does not enjoy the privileged position it has in society by being humble and by promoting the value and relevance of other disciplines. Historically it has treated aggressively any health profession, which has attempted to remove or erode what it regards as its right to earn income and perform certain procedures, consistently excluding other related professions. Nursing has struggled to find its own identity and to claim what it sees as its core business.

A recent example of the effect political action can have on the nurse-doctor relationship demonstrates how threatened medicine is when nurses begin to develop different working relationships. At the time of this study the South Australian government was undertaking a feasibility study into the introduction of nurse practitioners in the state. Preliminary work began on the project, called NUPRAC (Nurse Practitioner Project) in 1995 and the final report was delivered to the state Minister of Health in November 1999. Doctors were over represented in the working committees of the NUPRAC project as a way of defusing some of their objections, and rural doctor groups were included in the committees. During the project a large number of rural health services identified a need for a nurse practitioner position in their health services. In fact, some already had nurses working in this advanced practice role.

Since the completion of the NUPRAC project in 1999, a second phase of implementation has been introduced; but despite this no nurse practitioner positions have been established in 2000 and 2001, seven years after the proposal was first mooted.

Medical opposition to nurse practitioners has come from the Australian Medical Association and the Royal Australian College of General Practitioners. Their arguments are heavily cloaked in self-interest and do nothing to advance the cause of closer professional working relationships

between nurses and doctors. This is particularly apparent in rural areas where the need is greater for health care services and organisations like the AMA and RACGP have failed to find effective strategies to overcome the problem. In rural South Australia the problem of insufficient GPs continues and a crisis in nursing shortages has commenced. It is ironic that attempts to introduce responsible solutions like nurse practitioners have to run the gauntlet of medical opprobrium while the health and well being of rural communities suffer.

Nurses and doctors in this study revealed various perspectives on the political aspects affecting their working relationship. Several GPs expressed liberal views on nurses in rural areas being able to accept more responsibility, particularly after hours. This view is not in concert with the majority of medical organisations, which seek to reduce and control, rather than expand the work of nurses in advanced practice. GPs in the study also lamented the administrative controls nurses worked under, claiming them to be restrictive and out of step with the reality of the practice required of nurses in these rural sites. Despite these protestations there was no evidence that these GPs took these issues up politically on behalf of themselves or the nurses.

Nurses in the study were generally apolitical, at least in relation to their immediate work environment. None of the nurses had state or national profiles in rural nursing organisations; nor were any recognised as being outspoken on political matters affecting nurses. One nurse at Silo Town who had over 20 years of rural nursing experience held strong views about the advanced practice roles of nurses and had previously tried, unsuccessfully, to change rules and regulations governing her practice. She had gone about this in a quiet, persistent manner devoid of all political or Machiavellian intent. This was a characteristic common amongst nurses in her generation who avoided embarking on the path of political action because senior nurses strictly forbade them to act in this way. Fortunately for 20th century nursing, many rebelled against this hierarchy of repression.

8.5.2 Rural Community Values



Conservatism.

One of the four external influencing factors on the rural nurse-doctor professional working relationship is the prevalence of rural conservatism. Conservatism per se is not the sole domain of rural communities. Nevertheless it is a cherished value that has its origin in the way these communities have developed and weathered the adversity that has come their way. The way it manifests itself in the nurse-doctor relationship is subtle but pervasive.

When listening to or observing nurses and doctors in the four case study sites, it became obvious that they wanted to preserve existing conventions and practices. It was not that they were opposed to innovation and change but it was not at the top of the agenda insofar as their working relationships. The common 'bush' aphorism – if it isn't broken, why fix it – best describes how conservative attitudes influence the working relationship. It is useful to remember that the interest in the professional working relationship was a construction of my making, not theirs. This explains why most nurses and doctors in the study described their relationship in positive terms. Generally speaking they were happy with the way it was. Nurses and doctors in the study defined their relationships around the conservative principles that apply generally in rural communities. These included:

- Hard work does you no harm.
- There is man's work and there is women's work.
- Know your place in the community.
- Honesty is the best policy.
- Be polite and well mannered to all you meet.
- Look out for your neighbour.
- Help those in need in your community.
- Take pride in your town and what it stands for.

The values that stand behind these principles shape and direct the behaviour of nurses and doctors and the way they work with each other. Hospital boards and communities where the health services are located, even the people themselves, subscribe to these conservative values. There are no calls from any of these elements of the broader society for radical change to the ways nurses and doctors work together in the local health service.

8.5.3 Governance



Rules and regulations. Despite the presence or absence of rules or regulations about what nurses should and should not do, there are many examples in this study where rural nurses act unilaterally on a patient's behalf, without contacting the town GP. They do so at risk to themselves not because they are rule breakers or risk takers, but out of need to provide a quality nursing service. Reasons include management, described by a Silo Town nurse as the 'system, not grasping the reality of rural nursing practice and unworkable rules and regulations made to control rather than encourage professional initiative:

> But I feel sad that the system doesn't seem to be able to grasp the situation here. Unless they live in the town, they don't seem to understand.
>
> I am hopeless because I don't read policies and procedures and that's where I get myself into trouble. And when I go to court one day I am going to say, 'Well I didn't know' and they will say, 'It is in your procedure manual' and I'll say, 'Oh is it?' Hopefully I will get out of this before it ever happens. (Silo Town, female nurse 1)

This nurse placed little faith in the policies and procedures, and openly acknowledged the professional risks she was taking.

Nurses and doctors in the study were aware policies, procedures, rules and regulations existed but few found them of practical use. One exception was the *Central Australian Remote Practitioner Association* (CARPA) Manual that was in use informally by nurses at Silo Town for clinical information and treatment guidelines. Despite the CARPA manual's widespread use in rural and remote health services, it was not approved for use by nursing administration or the visiting medical staff.

In summary, there were considerable inconsistencies across the four case study sites in regard to acceptance and use of rules, regulations, policies and clinical guidelines by nurses and doctors. Nurses and doctors alike did not know of the existence of policies that had a direct bearing on the way they worked with each other. Governance is an important factor influencing the work relationships of nurses and doctors, but in this respect there is room for improvement. This means standardising regulations and guidelines across rural health services, involving staff in their development and providing ongoing education about them.

Management. Although the management of the health services where nurses and doctors worked was not a focus of the study, some mention needs to be made about the important effect it can have on the nurse-doctor work relationship. In two of the case study sites – Sea Town and Valley Town – there was evidence of direct involvement of nurses in overall decision making with medical staff. Both sites held regular formal meetings between senior nursing staff and GPs to discuss issues of mutual interest. In addition, their smaller size created opportunities for informal meetings between nurses and doctors. Nurses and doctors in both these sites appeared to take more interest in the general running of the health service and in solving problems around patient care. They reported being able to get their message to management quickly and gain a response.

In the largest site, Bridge Town, nurses and doctors expressed more frustration about management listening to their concerns. It is a fact that larger organisations have more difficulty in allowing all levels of staff to feel they are participating in overall management decisions. This does not excuse management of its responsibility to involve staff and listen to their suggestions on how things should be done. This study did not look for management indifference to the working relationship between nurses and doctors, but there is evidence from my own observations and from speaking with nurses and doctors that it is not a high priority. The attitude seems to be one of resolving problems as they arise, rather than adopting prevention is better than cure management approaches.

8.5.4 Rural Practice Preparation



Education. None of the participant nurses or doctors in the study had received any special preparation for rural clinical practice. It was also apparent none had received any educational preparation during or after their undergraduate program about professional working relationships. Given the average age of GPs in the study was 35 years; it is likely these doctors would have received their undergraduate medical education in the early 1980s. The nurses had an average age of 44 and most of these nurses would have received their training in the late 1970s. Medical and nursing curricula of these times paid scant attention to rural health, rural practice and effective professional relationship building. A doctor at Silo Town expressed very definite views on the educational preparation of nurses who come to work in rural areas:

> I mean it's just the whole thrust of nursing education today. It's much better in the rural areas because people have to throw some of that away. In the city it's impossible; you can't order a single thing without being questioned and the thing that aggravates me is you get a question and even if you give an answer – that's judged by the nurses. I don't quite understand that. It's got worse and worse I think. But out here it's not so bad. Whether that's because people realise it hasn't or because we've got predominantly hospital-trained nurses rather than university-trained nurses. (Silo Town, female GP 1)

Here the GP makes a clear distinction between urban ways of nursing practice and what happens in rural areas. She resents the structure and process she associates with nursing in the metropolitan setting and being questioned by nurses about her actions. She notes that nurses she works with are not university graduates, whom she links with a different education system, one likely to produce nurses who challenge and make judgements of doctors. While university schools of nursing would not expect, as a first priority, their graduates to sit in judgement on the actions of medical staff or directly challenge them, they would expect graduates to be able to analyse the behaviour of other health professionals and make clinical judgements based on their own assessment. Graduate nurses would not be expected by their mentor-educators to take actions they knew to be incorrect just because they had been ordered to.

In summary, the preparation of nursing and medical undergraduates for effective professional working relationships is inadequate and continues to adhere to past educational practices which prepare nursing and medical graduates in isolation. A similar deficit exists in the preparation of

nursing and medical graduates intending to work in rural practice. Students need to be educated in collaborative ways of working together where one discipline is not dominant to the other. Rural nurses and doctors in the study recognised they had not been adequately prepared for working with each other and for the type of practice in rural areas. What they had learned had been through personal experience, something they were willing to impart to students and graduates following in their footsteps.

Clinical experience. During the time of the fieldwork for this study there were no undergraduate medical or nursing students undertaking clinical experience in the four case study health service sites. Increasing numbers of medical and nursing students are undertaking clinical experience as part of their undergraduate and postgraduate training in rural South Australia. This has been as a result of university departments of rural health becoming established with funding from the Commonwealth government. Departments like the South Australian Centre for Rural and Remote Health (SACRRH), based at Whyalla in rural regional South Australia, have increased student clinical placement numbers and the duration of the students' experience in rural practice. In 2000 and 2001 nursing and medical student numbers for the Whyalla and Port Augusta region exceeded 200 students, experiencing over 1000 weeks of clinical experience (SACRRH 1999; SACRRH 2000).

The potential for undergraduate medical and nursing students to develop the essential skills for effective professional working relationships during such placements should not be underestimated. Nurses and doctors in this study had no opportunity to avail themselves of this type of clinical placement as organisations like SACRRH did not exist. What they have learned has been through their own experiences that have been shaped by two separate education programs with two different ideologies. Future nurse-doctor relationships in rural practice could be very different if an effort is made by both medical and nursing educators, assisted by university departments of rural health, to design and implement multidisciplinary clinical placements for their students based on strengthening the working relationship of medicine and nursing.

8.6 Distilled meanings of the relationship

An important feature of a discursive exploration is the ability to synthesize the different elements, or terrain of unfixity, of the topic of study into a cohesive whole, the so-called 'irreducible meaning'. Through this chapter I have provided examples arising directly from observation of the participants and from in-depth interviews. These have been arranged around themes and influencing factors to understand the context in which they took place and the foundation on which they are built. Here I distil the essence of the relationship as I have interpreted it for rural nurses and doctors in the study.

8.6.1 Meaning of the relationship for rural RNs

For nurses in this study the relationship with GPs is both central and co-dependent; central because the health service they work in is the only one available in the rural town; co-dependent because the delivery of those health care services is structured on the provision of general practitioner services through hospital or community health services that cannot operate without nurses. All 10 nurses in the study, with the exception of those at Silo Town, relied heavily on frequent interaction with GPs. Even those at Silo Town were in regular contact with GPs by telephone. In the smaller rural health units where the GPs had their consulting rooms on the hospital premises, interaction with GPs was high and nurses had relatively easy access during 9am to 5pm. After these hours access to GPs by nurses was variable and depended on the following factors:

- the doctors proximity to the hospital
- a compelling reason for the doctor to leave home and come to the hospital
- the willingness of the doctor to allow nurses to perform assessment and treatment
- the degree of trust and dependence established between the nurse and doctor
- established protocols and routines within the health service.

For the nurses in the study the meaning of the relationship centred on the above issues.

An additional factor that gave meaning to the relationship the nurses had with the GPs is their age. The older, more experienced nurses who had worked in the same location for many years demonstrated their worth and value by being confident in their actions and purposeful in their dealings with GPs. They had seen GPs come and go and as each new one arrived they established a relationship that suited their style of working and the rural health care work environment.

This group of older nurses held traditional views about doctors. These are based on giving respect because of the position doctors hold in society and the time honoured role of nurses accepting 'orders' from doctors as opposed to using initiative and taking independent action. The older nurses gave the doctors respect but expected it in return when they demonstrated their confidence, experience and skill level. The younger nurses in the study had more experience of rural practice than the doctors and developed a meaningful professional relationship based on mutual understanding and being accepted and treated like an equal.

Only two of the ten nurses had completed their initial undergraduate nursing education in the university sector. The others had received their training through the hospital apprenticeship system, prevalent in South Australia until 1990 when it was phased out. The expectation of the nurses who had obtained undergraduate university degrees was one of confidence in their rapidly growing knowledge base. They valued their university experience as it allowed them to see their role as a nurse differently and enhanced their ability to think and problem solve clinical issues in conjunction with the GPs. Both nurses with a university degree had previous experience as nurses and believed their status in the eyes of the GPs was increased. However, no distinction appeared to be made by the GPs about the differences in educational preparation of the nurses.

The overall status of the RN-GP relationship for nurses in the study was one of stability and harmony. There were no 'boat-rockers' among the nurses, no strongly held feminist views, no revolutionary urge for change, no, 'doctor-bashing' rhetoric. If there were consensual or common views it would be this: the relationship was meaningful because it existed for the benefit of the patients and the rural community in which the nurses and doctors worked. If the relationship fails, it is a collective failure and the patients and the community suffer. Nurses in the study did not see themselves as subservient, dominated or oppressed in their relationship with GPs, despite evidence in certain cases that they were. They embraced the relationship in practical terms and measured its success by the levels of harmony, good patient care outcomes and the reputation their health service as a whole had in the local community.

For nurses in the study meaning was about getting on with the job. This included a functional relationship with the GPs they worked alongside. In fact having a job in a rural community is more significant than deep analysis and reflection on their lot in life or their relationship with the local doctor. This is not to trivialise the role of nurses or the part they play in the relationship. It serves only to put into perspective the relative weight nurses give to it in relation to the other competing factors they deal with each and every day.

The majority of the nurses in the study were married women who worked to earn a second income. They had no professional voice driving them to change their working relationship with GPs. For many it was abundantly clear this was a job with an income that was important to their financial stability whether their partner was a farmer or held some other job in the town. They were not seeking other career paths and most were not engaged in postgraduate study to improve their prospects.

It might be said the work relationship with doctors was a means to an end. They had accepted long ago the way the fundamental nature of the relationship. If it was oppressive, they either accepted it or found ways to overcome the oppression. Others who enjoyed a closer, friendly relationship with doctors did so within the boundaries established by that relationship. This usually meant giving the doctor what they wanted.

8.6.2 Meaning of the relationship for rural GPs

The ability of the six GP participants in the study to practice rural medicine would have been severely disrupted were it not for the working relationship they had with the nurses. Two factors became immediately apparent when examining the meaning of the professional and personal relationship for GPs in the study. The first was that they needed the professional service nurses provided and that without it they would deliver a poorer quality medical service with increased risk of misadventure.

Some freely admitted to nurses saving them from burnout that would have encouraged them to leave the rural town in which they worked. Secondly, their personal working relationship with nurses was, in their opinion, a good one. There is evidence to support these two contentions in the observations made of their behaviour towards nurses and in what they said in interviews. In interviews with GPs and in observing their behaviour towards nurses, this study showed a high level of consideration for the nurses and praise for their work ethics. GPs were remarkably uncritical of the individual nurses with whom they worked, but more critical of external forces, including the rules and restrictions governing the practice of nurses. Criticism of the restrictions that hinder rural nurse practice related directly to the role and function of the nurses and of the perceived lack of support from some nursing administrations. Many of the GPs expressed surprise at the petty nature of some of these restrictions and argued that nurses should be able to do more and take additional responsibility, even if this meant the GP might see fewer patients.

Several of the GPs made supportive remarks about the nurses and developed friendly personal relationships with them. These friendships extended beyond the workplace and into the community through sport or other social activities. Nevertheless an ever-present invisible and unspoken barrier existed – the power differential between the doctor and the nurse. It could be said that the GPs were generally happy and had no specific issue or concerns about their working relationship with nurses. This is because they got want they wanted from it without much investment of time or change to their routines.

In other words the GP largely determined the patient's treatment and the nurse implemented it. For the GPs in the study this usually meant without question but all of them indicated their willingness to listen to the nurse's point of view, particularly in cases where the nurse's knowledge and experience was greater than the doctors.

A widely held view of GPs in the study was that they were ultimately legally responsible and accountable for the actions of the nurse. For them, allowing a nurse to be their 'eyes and ears' in assessing a patient in the absence of the doctor was a calculated risk. If the nurse conveyed information about a patient accurately, thus allowing the doctor to confirm a provisional diagnosis over the telephone and direct the nurse in appropriate treatment, the risk was deemed worth taking. On the other hand, if the doctor did not trust the clinical judgement of the nurse they were more likely to directly intervene, either by attending the patient themselves or requesting the nurses undertake a more thorough assessment and report the findings back to the doctor.

In fact, GPs are not legally accountable for the action of nurses unless they directly employ them. This is not the case, as a public health authority employs the nurses in all the rural health services in the study. The real issue is likely to be fear of litigation stemming from a GP making an incorrect diagnosis over the phone or a nurse undertaking a procedure they are not qualified to perform. The GPs readily acknowledged they depended heavily on the nurses to support and assist them in the management of in-patients and those presenting as casualty or in-patients. Some were prepared to go further and state that nurses played a significant role in organising their work routine in the hospital setting. GPs also acknowledged that nurses protected them from unnecessary out of hours work, which meant screening patients thoroughly and only calling the doctor when absolutely necessary.

In considering the meaning of the relationship to GPs a number of factors emerge as likely influences:

- GPs in the study expressed the view that nurses could take on more responsibility, particularly for the management of minor illness and injury that presents to the rural hospital, particularly outside of normal office hours.
- There was an expectation on the part of GPs that nurses would provide the necessary no cost support for them to conduct their work in a small rural hospital. This included assistance with minor procedures on outpatients, arranging and collecting pathology specimens and obtaining prescribed medications.
- The GPs participating in the study expected rural nurses to use their skills and abilities to make thorough assessments of patients and convey a comprehensive picture to the GP, including where possible their own analysis of the problem and initial steps they might take.
- The personal rapport between individual nurses and GPs determined to a large extent the quality of the relationship. Some GPs stated they did not 'get on' well with a few nurses and put this down to personality clashes.
- GPs responded differently to nurses who demonstrated their confidence and skill and were aware of what the GP expected of nurses. They admired competent, capable and organised nurses.

From the perspective of GPs in this study the relationship with nurses was not a high priority. They were busy attending to their primary function as providers of medical services in small rural towns. There was an acceptance that nurses would always be there and do what they have always done – provide a complementary service. I observed no obvious intention of the GPs in the study to take this service for granted, but at the same time there was complacency, acceptance and reliance on the nurses by the GPs.

With few exceptions, scant effort was made by GPs to fully understand the importance of the relationship and work towards strategies to make it stronger. More time spent with nurses in building the relationships through collaborative patient management inevitably meant a greater commitment in GP time, time GPs were not prepared to invest because they do not get paid to do it. This contrasts sharply with the nurses' almost constant attempts to develop and maintain an improved working relationship with the GPs.

A very considerable effort is made by rural health services to accommodate the wishes of GPs and the benefits of this to the GP in terms of income and ways of working are considerable. In the end GPs in the study had relatively comfortable lives. They earned good income, had all the facilities they needed provided for them by the rural health services in which they worked (including nursing services), lived in supportive communities where the local doctor enjoyed respect and high status and faced few challenges to their authority from management or other health staff.

In return they provided an essential service, keep unusual hours and were expected to be competent medical practitioners in the absence of other medical support alternatives. The GPs in the study were 'good people'; that is, they had pleasant personalities, a healthy work ethic and from my observation and interaction, practised effective medicine. Of the six GPs in the study only two, however, were involved in activities I would describe as likely to improve their working relationships with nurses with whom they worked. They were both female GPs. One provided a mentor role to a nurse involved in a postgraduate degree in general practice nursing and the other took a particular interest in education and training for nurses and the wider community. It might be said that actions speak louder than words when it comes to building effective work relationships.

8.7 Summary

This chapter provided a discursive exploration of the key features and characteristics of the professional working relationship for nurses and doctors in four rural work settings. It explored and interpreted the meaning of the relationships through the development of themes and influencing factors. These were represented in the rural nurse-doctor relationship rubric diagram that described how the relationship is formed and functions around four key characteristics and four external influencing factors.

Throughout this process I have sought to reinforce that discursive studies are not intuitive, that is known or learnt, but seek to be inclusive of phenomena likely to explain and give rise to understanding about how the relationship is in the rural context.

The examination of the professional working relationship between RNs and GPs across the four case study sites allowed a natural comparison. They were all rural in locations but different in the range and style of health care services delivered. This determined how the relationship worked for RNs and GPs. Each case study site had its own unique set of circumstances that affected the way nursing and medical care was delivered and the way the nurses and doctors conducted

themselves. There are a number of significant hallmarks of the relationship across all case studies. These included:

- the great diversity of practice for RNs and GPs
- the general goodwill and harmony which existed between the nurses and doctors
- the common social and professional experiences which bond them
- the considerable pressures they jointly face around role and boundary, division of labour issues and power and control issues.

The relative meanings of the relationship to nurses and doctors in the study were explored and found RNs and GPs in this study have more in common than they perhaps realised. The concerns about being competent to manage all the health care needs of their community, the need to be resourceful in a resource thin environment, the desire to work collaboratively and harmoniously, all drive and shape the relationship. The alternative is unpalatable, energy sapping and time consuming. It is easier to 'get on' with each other than to be antagonistic, particularly when expectations are high and the community need is great for quality professional services in rural communities where the burden of disease and ill health is higher than in urban areas.

None of the RNs or GPs in this study admitted to or appeared to have dysfunctional professional working relationships. There were inequities, failings, fears, and misunderstandings but also trust, respect, support, and co-dependency. Whilst there are some encouraging signs of incremental change in attitudes and value shifts in the nurses and doctors in this study, the professional relationship is not in a state of total equilibrium. As the discourses through the chapter show, nurses make the biggest investment in the relationship and this is largely due to their need to get on with the job of nursing, a job created in large measure by the work of the GP.

On the other hand GPs do not invest equal time in building the relationship. They are more likely to 'hope for the best' and work with nurses whom they trust and with whom they have an affinity. Neither group has a strategic view of the relationship and the discourses around it. There is no conscious attempt on their collective parts to change the working relationship from its current status. They are unaffected by a professional body of knowledge that describes nurse-doctor relationships and improved collaborative ways of working. Those of us outside this culture may point to the inequities, the unmet potential, the unchallenged challenges, but in the end this is our reality not theirs.

Chapter 9

Conclusions

9.1 Introduction

> Radical uncertainty prevails, for in the end what one knows and experiences is to an indeterminate extent a projection. (Tarnas 1993)

These words from Richard Tarnas in his book, *The Passion of the Western Mind: Understanding the Ideas That Have Shaped our World View*, place in perspective the search for truth and meaning in the world around us. They caution us that our own reality and view of the world shapes and interprets all that we see, hear and understand.

This study has sought to bring clarity and meaning to the professional working relationship of rural nurses and doctors, as it is for them. This work had its beginning in my own curiosity in matters rural and in particular how the historically fractious relationship between nurses and doctors revealed itself in the context of rural health care practice. The treatise preceding this conclusion provides a detailed and comprehensive analysis of the professional working relationship as it is for 16 nurses and doctors living and working in four separate health services in rural South Australia.

The study was based on four case study sites, selected to represent a range of rural health services in which nurses and doctors work. Information gathered about the working relationship through direct observation of them working together and in-depth interviews was analysed and explored discursively. Questions asked included those pertaining to features and characteristics of the relationship, fundamental differences in each of the four case study sites, the various discourses influencing the relationship, how rural RNs and GPs interact and what ideas they have about developing and maintaining the relationship.

The conclusions and meanings that arose from exploring these questions are both predictive and revealing – predictive because they reflect elements of the long history of nurse-doctor relationships and the assumptions and stereotypes that have arisen from that past, and revealing because they provide insight into the unique features and dynamics of the relationship and how it functions within the four rural contexts examined. The history on which the relationship is based, its present status and future are inexorably linked to how relevant the relationship is to the nurses and doctors in it and the health service and community they work for.

9.2 Relevance and standing of the relationship

This study shows that relationships between nurses and doctors in their professional working lives are important and relevant in the various rural contexts in which they occur. The relevance and importance relate to the overall effectiveness of individual nurses and doctors and to the rural communities for which they provide health care services. The significance of the relationship in determining outcomes of care should not be underestimated. Although not the focus of this study, a dysfunctional working relationship between nurses and doctors in any sphere of professional work is likely to bring undesirable and tragic consequences.

This study analysed the international reporting of nurse-doctor relationship research over a 30 year period – 1966 to 1999 – and showed a history of conflict, division of labour and domination and control by medicine of nursing work. It also revealed nurses want a working relationship with medicine that is professionally meaningful and equitable. Their attempts to this end have in large part been rejected by the indifferent attitude of medicine. This thesis explores the long road the two groups have moved along insofar as their professional interactions. It converges in four rural health services where nurses (RNs) and doctors (GPs) work together and describes and explores the relationships in these sites.

Nurses in the study obtained their professional standing through credibility, respect, trust and interdependence. In situations where doctors acknowledged their skills and experience in a genuine way, the standing of the nurse in the eyes of the doctor, other work colleagues and the rural community, was enhanced. Doctors in the study gained professional standing in part by their positions as GPs in rural towns. Their standing increased or decreased according to the way they integrated into the community and to a limited extent developed a working relationship with nurses. In some of the case study sites the standing of the GP was significantly enhanced by an individual GP's ability to build trust with the nurses and work collaboratively, even if this meant supporting the nurses when they were performing functions outside their normal scope of practice.

Thus, relevance and standing for nurses and doctors are achieved in different ways when working together in a rural environment. For doctors, they are defined largely by position and power and for nurses by demonstration of skill, experience, consultation and competence as judged by the doctor, patients and the rural community.

To fully appreciate the significance of the relationship it is necessary to understand the 'irreducible meanings' formed from essential features and characteristics inherent in the way nurses and doctors interacted with each other in their respective rural sites.

9.3 Essential features of the relationship

In this study essential features of the relationship need to be seen in the historical and contemporary context of nurse-doctor professional relationships. As has been shown, the relationship is characterised by conflict, domination, division of labour, gender stereotypes and power differentials. Given this background it is remarkable that there was no overt hostility or resentment displayed by either nurses or doctors participating in the study. On the contrary, there was a climate of harmony. This was due in part to nurses and doctors in the study having established routines around common practices such as ward rounds, on-call protocols and initiation of treatment in the absence of the doctor. Established routines bring a degree of comfort and order, which was made possible by smaller work place environments that allowed a friendly, family orientated culture to prevail. Johns (1992) points out that in nursing there is a tendency to maintain a harmonious team. All appears amicable on the surface but in reality problems exist that are never confronted and dealt with (Johns 1992). The progress of the relationship and the team are therefore stifled.

Doctors in the study placed a high degree of trust in the skills and experience of the nurses. This built respect by doctors for nurses and nurses for doctors. It also increased levels of confidence in both. This was tempered by the incorrect view of doctors that they were legally accountable for the nurses' actions. The frequency of contact and interactions between nurses and doctors was highest in the three smaller rural case study sites and slightly less in the largest site. When doctors were not available out of normal day time hours, nurses in all the sites communicated frequently with them by telephone. The use of the telephone to discuss patients and decide appropriate action was a prominent feature of the relationships in all sites.

Nurses in the study were older, had more experience in nursing and had lived and worked longer in the same rural town than the doctors. The doctors valued this depth of experience because it provided them with information about patients they were treating. This sometimes caused problems because doctors treated friends and relatives of nurses and in several cases even the nurses themselves.

One feature shared by nurses and doctors was the lack of social anonymity in the rural towns. Individual nurses and doctors in the study managed this in different ways. Some accepted the fact that people in the community would approach them at social functions and at home with health problems or general enquiries. Others felt uneasy and avoided social contact outside of the workplace. Nurses and doctors who mixed socially through sport or friendship seemed able to put this into perspective in their work relationships.

The nature of rural clinical practice requires working in partnership because of the diversity of health problems, professional isolation and limited access to resources. Nurses and doctors in the study appreciated the need to work collaboratively and to resolve conflict; however, a feature of the relationship in all case study sites was the deference of nurses to the decision of the doctor, even when they disagreed with it. Doctors in the study were mistakenly of the view they were legally responsible for the actions of nurses, despite the fact the health service and not the doctor employed the nurses.

9.4 Factors that build or weaken the relationship

The study identified four major sets of characteristics of the nurse-doctor relationships in the four study sites. These were: Credibility, Respect, Trust and Interdependence; Professional and Personal Giving; Mutual Sharing of Responsibility in Practice; and Historical and Traditional Factors. For each of these main characteristic sets further sub-themes or factors were identified as shaping the major set. If major characteristic sets or their attendant factors are absent or defective, the 'arms' of the relationship become unbalanced, affecting the inner relationship core. Nurses and doctors have the ability to influence the major characteristics, their shaping factors and any external influences – if they choose.

9.4.1 Personal factors

A consistent theme across all nurses and doctors in the study was the way in which effective work relationships were built. Not surprisingly the personality of the individual nurse or doctor is an important foundation for good relationship building. Nurses and doctors in the study referred to people they 'got on' with naturally. When observed interacting, these relationships appeared relaxed, friendly and communicative. Although liking the person is a good start to building a work relationship, this study shows more is required if it is to become an effective and durable one.

Doctors in the study wanted the nurses to be direct, open and honest in their communication, particularly when problems arose. They expected nurses to display confidence, especially when using their clinical judgement and expertise. Doctors said they appreciated and were assured by nurses who conveyed coherent and thorough assessments of patients over the phone. Nurses gained credibility, respect, trust and interdependence from doctors when they met these expectations. Some very experienced nurses were reluctant to develop this type of relationship because they discounted their skill and knowledge against that of the doctors. On the surface this would seem to be about mediocrity and maintaining the status quo because they are lower order goals requiring minimal effort to achieve. In fact, these nurses held more traditional views about medical and nursing knowledge and believed it was not their place to give direct advice to a doctor. In other words, respect for the doctors's position prevailed over their own knowledge and experience.

Nurses in the study believed building a closer working relationship with doctors meant demonstrating their capacity to be well organised, reliable and protective of the doctor's time. Nurses worked harder than the doctors at trying to build effective relationships, despite the minimal effort by doctors to reciprocate. This is not to say the doctors were unaware of the efforts by nurses, only that they did not actively seek to engage with nurses in identifying relationship strengths and limitations with the view to overall improvement. A major inhibiting factor preventing doctors from spending more time developing positive work relations with nurses was the fact that they do not receive income for it.

Factors likely to adversely affect the professional working relationship include real and perceived ones. The obvious power imbalance between the two professional groups influences the way nurses and doctors work together. Doctors occupy positions of power and authority, sometimes out of proportion to their influence over health outcomes in small rural communities. The health service size can affect the way the relationship develops and is maintained. Opportunities to build more effective relationships between nurses and doctors in the largest rural health service in the study were reduced by defined, traditional boundaries of medical and nursing work. Barriers in the smaller rural sites were lower as a result of more frequent meetings between nurses and doctors, planned social events and a more obvious team structure. In the largest case study site doctor visits were brief and allowed no time for relationship building.

Another barrier to growth and development of the relationship relates to the way in which nurses and doctors are employed. Doctors receive income from the Federal government Medical Benefits Schedule under the Medicare system of universal health cover. Nurses are employed by state funded health services.

There is a considerable difference in income levels between a rural nurse and doctor with five years postgraduate experience. While it may be argued medical responsibility deserves a greater level of remuneration, evidence in this study shows that nurses with far greater levels of rural practice experience and a high degree of responsibility in the absence of direct medical assistance, do not receive adequate financial or professional recognition. If they received appropriate recognition and greater remuneration, their status would increase and in turn the way they are regarded by medical personnel might change.

9.4.2 External factors influencing the relationship

The body of literature referred to in earlier chapters of this thesis describes a history of poor relationships between nurses and doctors. It also shows strong evidence, particularly towards the end of the twentieth century, that where nurses and doctors choose to work together optimally, relationships are positive and collaborative (Ryan 1996).

This study identified four external factors directly influencing the relationship of nurses and doctors in the rural context. First is the political action between medicine and nursing. The politicisation of the nurse practitioner debate is a further example of attempts by medicine to control the work of nurses rather than develop a positive work relationship model. The second factor is evident in the values of rural communities and in particular the part conservatism plays in determining the shape of the relationship. The third factor is the role governance has in influencing how the relationship functions through rules, regulations and overall management structures. The fourth influencing factor is rural practice preparation and the way nurses and doctors are prepared (or not) for their roles in rural health practice at undergraduate level and in their experience in working with each other in clinical practice settings.

It should be noted that these external factors have a strong influence on the relationships in this study not because the nurses and doctors are engaged with them or necessarily aware of them but because there is no current debate in South Australia among rural nurses or rural doctors about these factors or the relationship per se.

Put another way, nurses and doctors participating in this study were happy to talk about their work together and to allow me to observe them while doing so but this was at my instigation not theirs. None of the participants in this study expressed a strong desire to make changes to the professional relationship as they currently experience it. In fact, many aspects of the relationship are rooted in the past and based on a division of power and authority (Blue 2002). Nurses in the study continued to do what doctors required of them and doctors were content to maintain the relationship at a sub-optimal level, except when it suited their purposes to 'allow' nurses to take more responsibility for clinical decisions.

The fact that nurses in the study accepted a continuation of the traditional role relationship and additional responsibility brought on by the context of their practice without reciprocal change in their professional standing, role definition, authority and remuneration, points to an acceptance of their lot and an unwillingness to move toward a new order of working relationship.

Major national professional associations for nursing such as the Royal Australian College of Nursing, Australia and The Australian Nursing Federation have nothing to say specifically about nurse-doctor professional working relationships. Surprisingly neither body has policies about improving professional work relations with medical staff nor provides guidelines about how nurses could resolve difficult work relations with doctors. Even rural professional associations such as the Association for Australian Rural Nurses and the Australian College of Rural and Remote Medicine provide no specific advice to their memberships on relationship building. Given the enormous attention the literature pays to nurse-doctor relationships and the research conducted on the relationship, it is disappointing to find that professional bodies pay scant attention to this important issue.

9.5 Recommendations

The following recommendations were formed after consideration of the many issues raised during the course of the study and the exploration and analysis of them. For each issue a specific recommendation and a brief rationale are provided and grounded in the study.

Recommendation 1:
Preparing nurses and doctors educationally for the relationship

Undergraduate nursing and medical programs should include in their curricula distinctive educational content designed to prepare students for professional working relationships. To complement this, nursing and medical students should undertake planned joint rural clinical experiences. Current nursing and medical curricula provide inadequate preparation for professional working relationships. The assumption is made that both professionals can be prepared separately and then upon graduation work collaboratively. There is individual frustration and collective condemnation when they don't meet this expectation.

Nursing and medical work is inexorably linked and more effort is required to mix undergraduate nursing and medical students during their respective studies. Planned educational activities designed to give students the necessary skills and mutual understandings of their respective roles and responsibilities are needed. Students should be given the opportunity to work together, particularly in clinical settings during the final years of their program.

The relationships between nurses and doctors in all contexts, including rural, would be enhanced considerably by greater attention to inter-professional student interaction at undergraduate level. In current nursing and medical curricula there is limited mixing of the two professions. No structured, integrated attempt is made by either group to understand the philosophy underpinning the other's approach to health care or their role in its delivery in conjunction with other health professionals.

Preparation of nursing and medical students for improved professional relationships such as the multi-professional education program conducted by Linköping University in Sweden is a positive step toward changing attitudes and long held traditional values. The Linköping program includes medical, nursing, physiotherapy, occupational therapy and social welfare students in problem based learning groups for an initial 10 week period followed by scheduled seminars and a two week ward experience. Established since the mid 1980s and based on a similar model to that in place at the McMasters University in Canada, the Linköping multi-professional education model has produced many health professionals who have different attitudes to multidisciplinary ways of working and collaboration to achieve common health care goals (Wahlstrom 1997; Areskog 1994). Australian medical and nursing schools could well adopt this approach, particularly those establishing new rural clinical medical schools.

Recommendation 2:
Rural clinical practice at undergraduate level

Australian undergraduate nursing and medical programs should provide selected students with an opportunity to experience high quality rural clinical practice placements, particularly those with a multidisciplinary focus. This study has highlighted the inadequacies of tertiary education programs in nursing and medicine to provide students with sufficient exposure to rural clinical practice. Nurses and doctors in the study had no preparation or educational experiences to help them develop and maintain the working relationship. What they had learned was as a result of trial and error and reliance on traditional nurse-doctor roles.

By encouraging students of nursing and medicine to undertake joint rural clinical practice they can experience the way in which rural health care is practised and how members of the health care team work together in functional working relationships.

Rural clinical practice placement experiences for nursing and medical students cannot be expected to operate in a vacuum. They require careful planning and a spirit of cooperation between universities, students and rural health services. One major factor required to increase the quality of undergraduate rural clinical practice is the ability of health services in rural areas to provide adequate supervision or clinical teaching for students. For too long universities have relied on clinical staff to take responsibility for teaching students clinical skills without due recognition or support. This is a particular problem for rural clinical staff with high workloads.

Any solution to these problems must include payment for loss of clinical time when students are present in the workplace, regular education programs for clinical teachers to improve their teaching and learning skills and a support network between clinical teachers where resources, information sharing and experiences can be developed. Support of this kind is more important for rural clinical teachers who are often isolated from peers and access to resources is limited. Creative information technology solutions can overcome some of these difficulties but should be mixed with other strategies, including a greater 'on the ground' presence by universities. The advent of university departments of rural health during the late 1990s, located in rural regions throughout Australia is a positive step forward in this regard but only if they apply their resources wisely and maximise the clinical learning opportunities for students with emphasis on quality rather than quantity rural clinical placements.

Recommendation 3:
Strategies for making the relationship stronger

Strategies for improving nurse-doctor working relationships identified by research and in this study should be adopted by employers, governments and health services and reflected in their personnel policies. These must be supported with adequate resources to ensure they work.

The study provides an opportunity to reinforce existing strategies known to assist in the building of professional relationships and to introduce those specific to these rural settings. In this study numerous relationship-building strategies were revealed.

1. Allocating meeting time to discuss patient management in both formal and informal ways. This is a powerful strategy to develop a collaborative working relationship. In this way nurses and doctors lengthen the time they spend together, allowing trust and appreciation of each other's perspectives to develop.
2. Encouraging nurses to offer doctors the benefits of their greater rural experience and local community knowledge and the doctors to accept it. This is a strategy likely to result in protection from unnecessary call outs for the GP and increased sharing in joint clinical decision-making. Nurses also felt the GPs valued them more when they made clinical decisions in the absence of the doctor.
3. Adoption of a strategy by doctors of being confident in the abilities of nurses resulted in a less one-sided approach to the treatment and management of patients and contributed to joint decision-making. Doctors in the study respected and trusted nurses who exercised their skill and ability, used their initiative, and who had the confidence to express their point of view even when it was counter to their own.
4. The diversity of rural clinical practice brings the two professional groups together on common ground and is a strengthening experience for both. Diversity in practice requires a broader and deeper knowledge and skills base and an effective strategy used by both was teaching and learning as a relationship building opportunity. Nurses in the study mentioned numerous occasions when the GP had taken the time to explain a disease process or teach a procedural skill. Doctors also mentioned the lessons they had learned from nurses about particular individuals or family history in the local rural community and how to use this knowledge to benefit the patient or gain cooperation in a treatment regime. Doctors new to a rural town also learned much from experienced nurses about the health service, policies and procedures, and the operation of equipment and facilities.

5. Informality between nurses and doctors to establish and maintain the working relationship, while not a conscious strategy, is very effective as a workplace norm. Nurses and doctors in the study used first names, shared jokes and stories, talked openly about community events and their own families. They both seemed aware of the boundaries for the use of informality and used it appropriately in the presence of patients.

6. Working together on common public health issues or problems is a very effective strategy for relationship building. This was demonstrated in case study sites where RNs and GPs worked together on a defined project. In one example nurses and doctors formed a small team to more effectively manage asthma in their community. Funding from a Division of General Practice allowed the GPs to attend these meetings with nurses. Nurses and doctors reported a high degree of satisfaction working in this way.

In addition to these relationship-enhancing strategies arising out of the study there are other factors that help nurses and doctors develop stronger working relationships. The relatively small work settings in rural areas reduce the divide between medicine and nursing. This leads nurses and doctors to a shared commitment to and feeling for the overall well being of the community to which they provide services. Each has a different task to perform but often their professional and personal roles are blurred. Sharp distinctions and separations along medical and nursing lines were not observed in small rural health services of the kind in this study. Separate staff or tearooms are unheard of and in all but the largest case study site, nurses and doctors shared a common room for meals and refreshments. Informal and formal meetings between the two groups were common.

Evidence gathered in this study also points to a strong and effective work relationship based around the traditional roles of nursing and medicine but with unique features grafted on by the rural context in which the relationships operate. There are differences between rural nurses and doctors about what makes the relationship stronger.

When establishing the relationship nurses seek a cooperative, caring, friendly and trusting relationship with doctors. They also rank giving of their own time and energy to the relationship and receiving positive feedback when they challenge medical opinion as constructive in building a strong relationship. Important qualities expected of nurses by doctors in the study included: respect for the doctor, trustworthiness, skills, experience, interdependence and competence. Open and honest communication was also valued. Doctors also appreciated nurses who had formed their own opinions and were prepared to put them in a confident way because it helped them make better decisions.

Issues of little or no concern to nurses and doctors in building the relationship included factors such as the gender of the person, romantic attachments and, in the case of doctors only, personal caring. Both nurses and doctors valued maintaining a friendly disposition toward each other.

Nurses and doctors in the study acknowledged time is a factor in building the relationship. When nurses and doctors worked together several features contributed to strengthening the relationship. These were aspects of traditional work, such as ward rounds where nursing and medical roles are clearly delineated; common experiences in rural practice through experiencing the highs and lows of practice together; accepting the reality of living and working in a small rural community and all that entails; the high degree of telephone communication and the special skills and rapport this brings to the professional relationship; protective action by nurses to prevent overwork by doctors; and the belief by nurses and doctors that they did things differently in rural practice than elsewhere and this common bond strengthened them.

Nurses and doctors in the study agreed these things strengthened and limited the relationship. It was regarded a strength because they could not complete the task expected of them without co dependence on the other and a limitation because of the legal and professional boundaries set around their respective practices.

Recommendation 4:
Health service responsibility

Rural health services employing nurses and providing practice privileges to general practitioners must take responsibility for actively encouraging effective and equitable professional working relationships between nurses and doctors.

The rural health services in the study employed the nurses and also provided the necessary infrastructure and resources for GPs to conduct a general practice, thus there are two, competing systems of employment and remuneration in operation. Nurses essentially operate in a 'master-servant' relationship with the health service, while the doctor or GP operates as an independent small business providing a benefit to the health service. The competing forces between a GP earning income through fee-for-service and a nurse earning a static income must be managed effectively by the health service to avoid inequities. There were several examples from the study where GPs used nursing staff and health service resources in the conduct of their daily work to earn income without incurring a direct cost. Most rural health services accept this as a reasonable trade off for having a medical service in their town.

It becomes unreasonable and inequitable when the GP uses more nursing service time and health service resources to increase income. This inevitably leads to tension because nurses are being used as a ready source of labour at the expense of the professional work relationship. Nurses in the study did not complain about this and saw it as part of their job.

The resolution of workforce problems by rural health services is made more difficult for two reasons. Firstly, there is the size of the rural community where everyone knows everyone else and impartial decisions are made more difficult because of association and in some cases direct relationships. Secondly, many rural hospital boards have medical staff members but no nursing staff members with decision-making powers. Hospital boards have a responsibility to protect the rights of both medical and nursing staff members. This includes allowing equal representation in matters before the board that go to the heart of the professional working relationships of nurses and doctors. They cannot allow themselves to be swayed by a medical practitioner who is prepared to use the threat of withdrawal of services from the rural community if they deem decisions unsatisfactory and in their best interests. Anecdotal evidence suggests these threats are not isolated incidents.

Rural health services must do all they can to establish a climate in which nurse-doctor professional relationships flourish in the workplace. They should achieve this by equitable and fair management of medical and nursing issues, regular reviews, orientation of new staff, an agreed conflict resolution procedure and endorsement of clinical procedures and guidelines which help, not hinder the way rural nurses and doctors work.

Recommendation 5:
Professional organisation responsibility

Professional bodies responsible for collegial, industrial, registration, educational and professional standards should provide rural nurses and doctors with clear policy statements, practical guidelines and promote the benefits of effective working relationships.

Professional organisations representing the professional and industrial interests of nurses and doctors generally, like the Australian Medical Association, the Australian Nursing Federation, the Royal Australian College of General Practitioners and the Royal College of Nursing, Australia do not provide any specific policy or guidelines to their members about nurse-doctor professional working relationships.

Professional organisations with a special interest in rural practice such as the Association for Australian Rural Nurses (AARN) and the Australian College of Rural and Remote Medicine might be expected to place more emphasis on the working relationship in policy, guidelines and continuing professional development activities. There is a conspicuous absence of such things in the public documents of these rural professional organisations. Whether this is by intent or oversight is open for debate. The fact remains neither nursing nor medical organisations place improving the professional working relationship high on their agenda. This could be explained by their members putting a low priority on improvement of working relationships or by the professional organisations failing to attribute more serious issues they are dealing with as symptoms of poor working relationships between nurses and doctors.

The study identified four external influencing factors on the professional working relationship of nurses and doctors. These were: political action between medical and nursing organisations, conservative rural community values, the rules and regulations that govern the practice of RNs and GPs and the preparation for rural practice in undergraduate programs. Professional organisations purporting to represent the interests of their rural members could make a significant contribution in these four areas. This could be achieved by reducing political point scoring when there is disagreement between rural nurses and doctors, being more active in rural communities and supporting strategies which value both nurses and doctors, working collaboratively in the development of rules and regulations which assist nurses and doctors to work better together and actively encourage and support undergraduate nursing and medical programs which bring students into rural areas for clinical experience.

The endeavours of national organisations like the National Rural Health Alliance (NRHA) in bringing together a multitude of rural and remote professional and community interest groups to voice their collective concerns in a unified way are to be applauded; however, this very strength is also a weakness, because of the need of the Alliance to represent the whole rather than individual member groups like rural nurses and doctors. This explains why there have not been strongly worded statements of policy from the Alliance on nurse-doctor relationships and about the inequities that have existed during the decade of the Alliance's existence between rural doctors and nurses.

These criticisms aside, the publication of the Australian Journal of Rural Health (AJRH) by the National Rural Health Alliance is one example of cooperation and collaboration among rural health professionals from nursing, medicine and allied health to provide a common forum in which to discuss clinical as well as professional issues in the context of rural health practice. The history of the AJRH is a good example of what can be achieved when positive working relationships exist between nursing and medical colleagues. The journal was the initiative of rural nurses in 1992 through the AARN and soon after the Rural Doctors Association of Australia became partners and joint owners. In more recent times the journal has expanded to include allied health professionals through their professional association – Services for Australian Rural and Remote Allied Health. The journal is now managed by the NRHA.

Recommendation 6:
Changes to legislation, rules and regulations

State and Commonwealth governments, registering authorities, health services and their respective boards of management need to review legislation, rules and regulations which impact directly on the nurse-doctor relationship with a view to removing unnecessary governance or instituting more appropriate forms of control.

Nurses and doctors in this study revealed repeatedly their uncertainty about the legislation, rules and regulations governing their practice. There is an expectation of all health professionals to be completely au fait with all the rules and regulations governing their practice. The reality is that these are often forgotten with the passage of time. Unfortunately the legal records are littered with cases where ignorance or uncertainty have been the undoing of many good health professionals who have made serious unintended mistakes with tragic consequences to themselves and the patients they care for.

In all four of the case study sites in the study nurses and doctors were unsure or unaware of policies, rules and regulations that potentially affect the way they work with each other. Doctors in the study were mistaken in their belief that they were legally accountable for the action of nurses, irrespective of their direct or indirect involvement with a case. They were not aware that legal accountability for a nurse's action only occurs when the doctor works with the nurse under a contract of employment. Nurses often undertook procedures for which they had no formal training but were aware they were working outside their normal scope of practice. They did this in the absence of clear clinical guidelines or agreed protocols not because they were risk takers or cavalier in their approach to patient care but because the patient's need outweighed the risk of sanction.

In many cases I witnessed, they were encouraged by the GP to undertake these procedures, especially after hours when the doctor was reluctant to come to the hospital. One case study site had access the Central Australian Rural Practitioners Association (CARPA) manual. This is a clinical guidelines manual that provides nurses, doctors and Aboriginal health workers with assessment and treatment guidelines for a range of common conditions. Nurses in this site had tried unsuccessfully to gain approval from their nursing administration to adopt the manual despite the absence of any medical practitioner in the town. In other case study sites different protocols of clinical management existed for the same medical condition. The reason given was that the two medical practitioners in the town could not agree on standardising their treatment.

Clearly these confusions and uncertainties are disasters waiting to happen. Rural nurses and doctors don't need more legislation, rules and regulations to govern their practice but they do require some consensus and standardisation across rural health services. They also need regular updates on changes that affect they way they work with each other and education programs that clarify existing regulations governing practice, particularly those that are a source of tension in the working relationship such as the giving and taking of telephone treatment or drug orders.

Recommendation 7:
Community participation in enhancing the relationship

Rural communities have an important role and responsibility in determining the status of working relationships between nurses and doctors. They need to exercise more influence and provide more support to help establish and maintain the relationship at the community and professional levels.

Some rural communities take for granted the nursing and medical skills resident in their community and it is only when these skills are needed or lost that they are galvanised into action. The role rural communities have in helping nurses and doctors build effective relationships should not be underestimated. One way they can achieve this is to examine strategies that support their existing nurses or recruit new ones in much the same way they do when new doctors come into the town. Commonwealth and, to a lesser extent, state governments have funded a succession of strategies to attract and retain rural GPs over the decade 1990-2000. Calls from nursing and allied health staff in rural areas for similar support strategies have at best received token funding and, at worse, have been ignored.

A constant refrain from the Commonwealth government is that nursing and allied health workforce funding is the responsibility of state governments. Redressing the imbalance in how medical and nursing staff are regarded can change the culture of the work place and give nurses and doctors the clear message that they are equally valued. This is a fundamental first step in building sustainable working relationships, and rural communities that accept this equal valuing will be more successful in attracting and keeping nurses and doctors.

Recommendation 8:
Research priorities

Research priorities that assist nurses and doctors to establish, maintain and develop collaborative models of professional working should be encouraged. Research that examines structural, personal and professional barriers and identifies effective solutions should also be encouraged.

The study exposes a number of research areas to be further explored. Nurses and doctors in this study fitted a certain profile. The nurses were older than the doctors and the majority had undertaken their initial training in the hospital system of nurse education. A study that examined a sample with a similar profile to this study with one where the nurses were graduates from a university nurse education program might provide some interesting comparisons in attitudes and values to nurse-doctor relationships. A longitudinal study of medical and nursing graduates who had been exposed to a greater degree of educational content on professional working relationships and experienced joint rural clinical placements as undergraduates might reveal whether strategies of integration and inter-professional awareness influence the professional working relationship. The effectiveness of undergraduate multi-professional education in changing attitudes and perceptions about other health discipline groups, particularly the types of experiences students need to have together to change behaviour, would complement longitudinal studies.

A larger study of rural nurses and doctors using quantitative methods might confirm whether the trends shown in this study are more widespread. A focus on strategies to establish, maintain and develop professional working relationships leading to collaborative ways of working would be helpful in determining the important parts of the relationships which needed attention and remedy.

This study did not examine the impact of successful versus unsuccessful professional working relationships on the quality or outcomes of care for patients. While some international studies referred to in this work have examined this aspect of nurse-doctor relationships, the differences in rural practice have not been scrutinised.

The international research on nurse-doctor relationships has been conducted in the main in large metropolitan health services. It would be useful to compare urban and rural nurse-doctor groups with similar working characteristics; that is, a small team with one or two doctors and four to six nurses. The dynamics in both settings might be similar, but the contexts in which they take place could reveal lessons on which improved working relationships between these two professional groups could be built.

Finally, research that assists nurses and doctors in rural practice to adjust to the changes in the way both professions provide their services to the community is an important priority. There is an increasing emphasis by governments to change the way GPs practice and to encourage them to work more closely with other health professionals. The introduction of Enhanced Primary Care (EPC) is one example and requires GPs to establish professional working relationships with nurses and other health professionals in the assessment and case management of people over the age of 75 years (or 55 in the case of Aboriginal people). Many of these aspects of care lend themselves to applied research that examines nurse-doctor relationships and the impact on outcomes of care. Measuring particular relationship enhancing strategies and using the evidence to apply more generally would be a worthy research endeavour.

Whether the research priority stems from those mentioned here or elsewhere it must be informed by the results of past studies. There is an imperative to move on with the development of the relationship between nurses and doctors rather than dwell on the past. There has been a tendency for nurse-doctor relationship studies to focus on questions around power differentials and division of labour and while these are important core issues more progress would be made if research focussed on new models of professional working based on the cornerstones of good professional working relationships. This study showed these cornerstones to be: credibility, respect, trust, and interdependence; professional and personal giving; mutual sharing of responsibility in practice; and historical and traditional factors.

9.6 Critique of the body of work

At the end of any intellectual piece of work a self-reflective critique is useful as a means of review. The limitations of this study are described more fully in Chapter 3 and are more of a reflective kind here. The strengths of this work lie in a comprehensive review of the literature surrounding nurse-doctor relationships in the work place, the solid grounding of the relationship through the rich descriptions in the four rural case study sites and finally in the discursive exploration which gives rise to 'irreducible meanings' of the relationship for rural RNs and GPs in the study. The research focus arose out of the national and international literature describing

the poor relationship existing between nursing and medicine but was imposed on the participants in the study and was a lower order priority for them. A research method using participative action research may well have identified more effectively internal day-to-day problems that manifest themselves in the relationship. I could then have worked with the nurses and doctors to contrast these with their own professional ideals.

No previous studies have been conducted in Australia on the working relationships of rural nurses and doctors. The in-depth interviews coupled with observations of behaviour provide a detailed and revealing 'snapshot' in time of the culture and norms in each case study site. The data obtained by these ethnographic techniques is of course open to criticism because it relies heavily on what the participants choose to disclose to an external researcher. The validity of the conclusions drawn from it is open for all to see and interpret. My interpretation is but one perspective but I have been careful to balance both medical and nursing perspectives in weighing the evidence and reaching conclusions. Overall the work provides a timely contribution in an area where no major research effort is being made and where there is an increasing need to understand the dynamics of professional working relationships.

9.7 Future directions

Nurse-doctor workplace relationships have been the focus of attention in literature, research and professional debate for a very long time. The sum of this attention has produced no real progress. Arguments advanced in both medical and nursing debates are circuitous and feed a climate of confusion and mistrust. The nurses and doctors in this study are participants in shaping their own relationship and make it what it is, or is not. It is their reality and the fact that reality does not connect with the other discourses outside of the rural context is of no consequence to them.

It is unlikely any of the doctors and nurses in this study will be opinion leaders and visionaries championing the cause of improved nurse-doctor relationships. Most have accepted their place in life and their position relative to each other. Their future direction together will remain unchanged unless and until internal or external forces of change challenge either or both of them.

Wicks, at the close of her book, *Nurses and Doctors at Work,* came up with a radical suggestion to change the dynamics of the nurse-doctor relationship. It was that doctors be nurses (Wicks 1999). In other words the present subordinate role nurses' play in the dominant discourse advanced by doctors can only be altered if they change roles. A fanciful suggestion, but if adopted it could lead to changed perspectives as nurses and doctors 'walk in each others shoes' as a way of appreciating their respective role and function.

This too simplistic notion guarantees no empathic behaviour change will occur. Health professionals should learn to respect other health professionals not because they are artificially encouraged to do so but because they genuinely develop respect through positive professional relationship building. It is more likely this will occur when individuals make conscious decisions to work towards relationship building as opposed to accepting the class system of professional status where one profession determines it has the right to control and dominate the other. Nurses and doctors in this study showed that they had the power to change the relationship and to make it what they wanted. They chose not to exercise this power and opted instead to maintain the status quo.

The future direction of nurse-doctor relationships lies in the celebration of their individual and unique differences but more importantly a removal of the belief that any discipline is omnipotent and central to the delivery of health care. Wherever medical power is absolute, or any other power for that matter, it should be challenged. The rural GPs in this study were powerful, relative to the nurses, but they did not use this power to dominate the nurses or control their work in an oppressive way. The reason for this was the realisation that their work could not be performed effectively without a co-dependence on nurses. If they exerted more control, the balance would change and the relationships become threatened. Of course, it must be acknowledged that the pre-existing systems advantage doctors more than nurses and therefore allow doctors to behave in benevolent ways in the relationship. In other words if nurses do things in the relationship which do not challenge the status quo, doctors can expect to reward them by elevation to a favoured status where there is more independence and equality.

Epilogue

There is an inherent danger in finishing a body of work of this kind with a flourish of summary words, sentences and paragraphs. To do so, risks trivialising the important and more complex aspects of the research and my interpretations of it. However, a few highlights around what I have presented in the preceding chapters helps provide some closure.

Emerging strongly from the work are the perspectives of the participant nurses and doctors and their professional working relationships, embedded as they are in their own rural contexts. They were not influenced by other discourses and the data collected demonstrates this fact. That the study revealed a relatively harmonious relationship that the nurses worked harder to establish and maintain should not lead to the conclusion that there were no problems requiring attention. The GPs in the study presented as being a relatively happy and contented group. No pattern emerged

suggesting they wanted to change the way they relate to nurses on a professional level. Given the extent of support they received from the nurses, the position they enjoyed in the rural community and the resource infrastructure afforded them by the health services in which they worked, it is unlikely they would think otherwise.

There was genuine respect given and received by nurses and doctors in the study and in some cases a self deprecation of position by doctors who acknowledged the importance of nurses and expected more of them. The realisation of nurses seeking a more equal relationship with doctors and of doctors who are comfortable with that is still far off. In nursing contexts other than rural there is still much contesting of professional territory. Despite sophisticated attempts to change the status quo, little progress is being made in bringing closer together the two health professional groups who arguably have the most individual and collective impact on the provision of health care to humanity. And yet at the same time they remain strangers to the realisation of their true potential as professional work colleagues.

References

Australian Bureau of Statistics (ABS) (1999) *1996 Census of population & housing*, Australian Bureau of Statistics 2000.

Adamson, B. & Kenny, D. (1993) Structural and perceived medical dominance: A study of barriers to nurses' workplace satisfaction, *Australian Journal of Advanced Nursing* 10(4), pp.10-19.

Australian Institute of Heath & Welfare (AIHW) (1997) *Medical labour force 1995*, Australian Institute of Health & Welfare, Canberra, ACT, p.36.

AIHW (1997) *Nursing labour force 1993 and 1994*, Australian Institute of Health & Welfare, Canberra, ACT, p.54.

AIHW (1999) *Nursing labour force 1999,* Preliminary Report, Report No. HWL18, Australian Institute of Health & Welfare, Canberra, ACT.

Australian Medical Workforce Advisory Committee (AMWAC) (1996) *The medical workforce in rural and remote Australia*, Sydney, Australian Medical Workforce Advisory Committee, p.58.

Arbon, R. (1998) *Port Broughton District Hospital and Health Services, 1997-1998 Annual Report*, Port Broughton District Hospital and Health Services, p.51.

Areskog, N-H. (1994) Multiprofessional education at the undergraduate level – the Linköping model, *Journal of Interprofessional Care,* 8(3), pp.279-282.

Atkinson, P. & Hammersley, M. (1994) Ethnography and participant observation, *Handbook of qualitative research*, N. Denzin & Y. Lincoln (Eds.), Sage Publications, Inc., Thousand Oaks, California, pp.248-261.

Blue, I. (1993) *A critical analysis of postgraduate education opportunities for rural nurses practising in the Northern and Western regions of South Australia*, Published Masters thesis, Faculty of Education, Deakin University, Geelong, Victoria, p.50.

Blue, I. (2002) *Characteristics of Australian rural health care professional practice,* Chapter 11, The New Rural Health. Wilkinson, D., Blue, I. (Eds.), Oxford University Press, Melbourne, Australia.

Blue, I. & FitzGerald, M. (2002) Intra-professional relations: Case studies of working relationships between registered nurses and general practitioners in rural Australia, *Journal of Clinical Nursing* (accepted for publication 8/2001), In press, Vol. 11, May 2002.

Blue, J. (1995) *Adjustment experiences of rural human service providers*, School of Social Work and Social Policy, Faculty of Humanities & Social Science, University of South Australia, Whyalla, South Australia, p.7.

Bradley, C. (2000) *Research into recruitment, retention and role of rural enrolled nurses in South Australia*, Centre for Research into Nursing & Healthcare, University of South Australia, Adelaide, South Australia, p.38.

Bridges-Webb, C., Butler, J., Calcino, G., Colmer, P., Del Mar, C. et al. (1996) *General practice in Australia: 1996*, General Practice Branch, Commonwealth Department of Health & Family Services, Canberra, ACT, p.347.

Bridgewater, K. (1998) *Survey of South Australian undergraduate rural and remote education and experience: Health disciplines*, South Australian Centre for Rural & Remote Health, Whyalla, South Australia, pp.11-26.

Britt, H., Miles, D., Bridges-Webb, C., Neary, S., Charles, J., & Traynor, V. (1993) A comparison of country and metropolitan general practice, *The Medical Journal of Australia* 159(Supplement), pp.9-64.

Buckley, P. & Gray, G. (1991) *What can be done to assist registered nurses working in rural and remote South Australia: Across the spinifex*, School of Nursing, Flinders University of South Australia, Adelaide, South Australia, p.16.

Burns, N. & Grove, S. (1993) *The practice of nursing research: Conduct, critique and utilisation,* Philadelphia, WB Saunders, p.84.

Butler, J. (1996) The financing of general practice, *General Practice in Australia: 1996,* Commonwealth Department of Health & Family Services, GP Branch, Canberra, ACT, p.161.

Casto, M. (1994) Education for inter-professional practice, *Interprofessional Care and Collaborative Practice,* C. Verduin (Ed.), Brooks/Cole Publishing Company, California, USA, pp.95-109.

Chiarella, M. (1999) The status of the registered nurse in law, society and scholarship, PhD thesis, Faculty of Law, University of New South Wales, Sydney.

Chiarella, M. (2001) Personal communication, 15/5/2001.

Coxhead, J. (1993) United we stand – divided we fall, *Australian Journal of Rural Health* 1(2), pp.13-18.

Cramer, J. (1989) Remote area nurses in Australia: A mantel of safety? *Australian Journal of Advanced Nursing* 7(1), pp.23-30.

Crawford, J. (1992) *Hospital accepts challenge of change*, Laura & Districts Hospital Inc., Internal report, Laura, South Australia, p.2.

Cronin, L. (1984) *A camp-fire yarn: Henry Lawson complete works 1885-1900*, Lansdowne, Sydney, pp.234-236.

Crouch, B. (1996) *The $200,000 job nobody wants*, Sunday Mail, Adelaide, South Australia, p.18.

Coroner's Office, NSW (1988) *Inquest into the death of Mark Anthony Quayle*, Coroner's Court, Wilcannia, NSW, pp.730-789.

Dayton, N. (1992) *Nurses and physicians: Attitudinal and demographic correlates of communicative style,* Memphis State University, Memphis, USA.

de Laine, M. (1997) *Ethnography –- Theory and applications in health research*, Maclennan & Pretty, Sydney, Australia, p.xxi.

Delbridge, A., Bernard, J., et al., (Eds.) (1995) *The Macquarie encyclopaedic dictionary*, Macquarie Library Ltd, Macquarie University, Castle Hill, NSW.

Department of Community Services and Health (DCS&H) (1991) *Rural/remote areas classification,* Statistical Services Division, DCS&H, Canberra, ACT, pp.3-6.

Department of Human Services (South Australia) (DHSSA) (1998) Nursing in South Australia, *Nurse Workforce, June 1998,* www.health.sa.gov.au/nurselabour/nurseworkforce98.

Department of Human Services (South Australia) (DHSSA) (1999) *South Australian (NUPRAC) nurse practitioner report*, Statewide Services Division, Strategy and Operational Services – Nursing, DHSSA, Adelaide, pp.1-65.

Denzin, N. & Lincoln, Y. (Eds.) (1994) *Handbook of qualitative research*, Sage Publications Inc., Thousand Oaks, California.

Dreyfus, H.L. and Rabinow, P. (1986) *Michael Foucault: beyond structuralism and hermeneutics.* Brighton: Harvester, p. 108-9.

Dunne, L. (1999) *Accessibility/remoteness index of Australia* (ARIA), Information & Research Branch, Department of Aged Care, Canberra, ACT and The National Key Centre for Social Applications of Geographical Information Systems (GISCA), University of Adelaide, p.30.

Evans, F. (1994) The role of the registered nurse in the rural, but not remote, setting, *The Australian Journal of Rural Health* 2(2), pp.15-18.

Fagin, C. (1992) Collaboration between nurses and physicians – no longer a choice, *Nursing and Health Care* 13(7), pp.354-363.

FitzGerald, M. (1994) Chronic illness in a rural area, *Nursing*, University of New England, Armidale, NSW, p.24.

Foucault, M. (1980) Truth and power, *Power/knowledge: Selected interviews and other writings 1972-1977*, C. Gordon (Ed.), Harvester Press, London, pp.109-133.

Fontana, A. & Frey, J. (1994) Interviewing: The art of science, *Handbook of qualitative research,* N. Denzin & Y. Lincoln (Eds.), Sage Publications Inc., Thousand Oaks, California, p.374.

Glover, J., Shand, M., Forster, C., & Woolacott, T. (1996) *A social health atlas of South Australia*, Policy & Budget Division, South Australian Health Commission, Adelaide, South Australia, p.44.

Griffith, D. (1994) *A Northern Territory approach to quantifying Access Disadvantage to educational services in remote and rural Australia*, Northern Territory Department of Education – Planning & Review, Darwin, Northern Territory, p.11.

Hailstone, B. (2001) Medical students to taste country lifestyle, *The Advertiser*, Adelaide, South Australia, p.22.

Handley, A. & Blue, I. (1998) Education, training and support for Australian rural nurses, *The Association for Australian Rural Nurses,* Vol. 8, Whyalla, South Australia, p.78.

Harvey, J. (1985) Nurses and physicians: Prospects for collaboration, *Annals of Internal Medicine* 103(1), p.134.

Hegney, D., Pearson, A. & McCarthy, A. (1997) *The role and function of the rural nurse in Australia*, Royal College of Nursing, Australia, Canberra, ACT, p.316.

Hegney, D. (1996) *The windmill of rural health: A Foucauldian analysis of the discourses of rural nursing in Australia, 1991-1994*, Faculty of Health Sciences, Centre for Nursing, Southern Cross University, Woolongong, NSW, p.364.

Hegney, D. & Hobbs, L. (1998) Policy, politics and legal issues: Education, training and support for Australian rural nurses, H. Hamilton & A. Handley (Eds.), *The Association for Australian Rural Nurses* (AARN) 2, Canberra, ACT, p.1-33.

Hofling, C., Brotzman, E., Dalrymple, S., Graves, N. & Pierce, C. (1966) An experimental study in nurse-physician relations, *The Journal of Nervous and Mental Diseases* 143(2), pp.171-180.

Holub, L. & Williams, B. (1996) The general practice rural incentives program, development and implementation: Progress to date, *Australian Journal of Rural Health* 4(2), pp.117-127.

Holden, R. (1997) Hospital drama widens, *The Advertiser* 20/9/1997, Adelaide, South Australia, p. 8.

Humphreys, J., Mathews-Cowey, S., & Rolly, F. (1996) *Health service frameworks for small rural and remote communities: Issues and options*, University of New England, Armidale, NSW.

Humphreys, J., Rolley, F. & Weinand, H. (1992) How healthy is life in the bush? Problems associated with the assessment of health status in rural Australia, *The Australian Journal of Rural Health* 1(1), pp.17-27.

Humphreys, J. & Rolley, F. (1993) *Health care behaviour and service provision in rural Australia,* Department of Geography and Planning, University of New England, Armidale, NSW.

Janesick, V. (1994) The dance of qualitative research design, *Handbook of qualitative research,* N. Denzin & Y. Lincoln (Eds.), Sage Publications, Thousand Oaks, California, p.21.

Johnson, J. (1994) Nurses vs doctors: The battle between the caregivers in health care reform, *Nursing Connections* 7(2), pp.1-3.

Johns, C. (1992) Ownership and the harmonious team: Barriers to developing the therapeutic nursing team in primary nursing, *Journal of Clinical Nursing* 1(2), pp.89-94.

Jones, R. (1991) Nurse-physician collaboration and outcomes of care, PhD thesis, School of Nursing, Indiana University, Bloomington, Indiana, USA..

Jones, R.A.P. (1994) Conceptual development of nurse-physician collaboration, *Holistic Nurse Practice* 8(3), pp.1-11.

Kamien, M. (1987) *Report of the ministerial inquiry into the recruitment and retention of country doctors in Western Australia,* Department Community GP Practice, University of Western Australia, Perth, WA.

Kamien, M. & MacAdam, D. (1991) Academic general practice in Australian medical schools, *Medical Journal of Australia* 154, pp.395-400.

Keddy, B., Gillis, M.J., Jacobs, P., et al. (1986) The doctor-nurse relationship: An historical perspective, *Journal of Advanced Nursing* 11(6), pp.745-753.

Keyzer, D. (1997) Working together: The advanced rural nurse practitioner and the rural doctor, *Australian Journal of Rural Health* 5(4), pp.184-189.

Khanna, P. (1992) While physician extenders proliferate, doctors worry about competition, care, *Wall Street Journal* 78(208), pp.B1, B6.

Kincheloe, J. & McLaren, P. (1994) Rethinking critical theory and qualitative research, *Handbook of qualitative research,* N. Denzin & Y. Lincoln (Eds.), Sage Publication Inc., Thousand Oaks, California, p.152.

Kriven, S. (1994) Death brings call for aid to rural doctors, *The Advertiser,* Adelaide, South Australia, p.4.

Laclau, E. (1993a) Discourse. In Gooding and Pettit (Eds.), The Blackwell Companion to Contemporary Political Philosophy. Oxford: Blackwell, p.436

Laura and Districts Hospital Inc. (LDHI) (1998) *Laura and Districts Hospital Annual Report 1998,* Laura, South Australia, p.5.

LeDuc, S. (1979) Sound off! We've been put down long enough, *RN* 42, pp.67-70.

Lian-Lloyd, N. (1998) Port Augusta Hospital & Regional Health Services, Internal GP list, Port Augusta Hospital, Port Augusta, South Australia.

Lo Biondo-Wood, G. & Haber, J. (1994) *Nursing research: Methods, critical appraisal and utilisation,* Mosby, New York.

Local Government Association of South Australia (LGASA) (1999) *Council – Northern Areas* (DC), http://www.lga.sa.gov.au/public/councils/northern.htm, accessed 4th December 2000.

Magee, M. (1989) Don't treat nurses as if they were invisible, *Physician Nurse Relationships* 85(1), pp.67-68.

McLoughlin, V. (1998) *General practice: Changing the future through partnerships,* General Practice Branch – Commonwealth Department Health & Family Services, Canberra, ACT, p.362.

Mechanic, D. & Aiken, L. (1982) A cooperative agenda for medicine and nursing, *New England Journal of Medicine* 307(12), pp.747-750.

Miller, B. & Keane, C. (Eds.) (1978) *Encyclopaedia and dictionary of medicine, nursing & allied health*, W.B. Saunders Company, Philadelphia, USA.

Morse, J. (1994) Designing funded qualitative research, *Handbook of qualitative research*, N. Denzin & Y. Lincoln (Eds.) Sage Publications Inc., Thousand Oaks, California, pp.220-235.

Mortensen, C. (1997) Adelaide University Human Research Ethics Committee. Letter of approval – H37/97, 4/11/1997.

Murphy, B. (1999) How far have we progressed? Personal communication, Letter 11/8/1999.

Nurses Board of South Australia (NBSA) (1999) *Nurses Act 1999*, The Nurses Board of South Australia. http://203.17.199.126/ISYSquery/IRL5c6E.tmp/18/doc 19/4/2000.

Nguyen, A-M., Roder, D., McCaul, K., Priest, K., Carman, J. & Luke, C. (1996) *South Australian regional health statistics chartbook 1996: A working document,* South Australian Health Commission, Epidemiology Branch, Public and Environmental Health Service, Adelaide, South Australia, p.21.

Nieswiadomy, R. (1993) *Foundations of nursing research*, Appleton & Lange, Norwalk, Connecticut.

Norington, M. (1996) Medical student vacation scholarships, *John Flynn Scholarships, Guidelines*, General Practice Branch, Commonwealth Department of Health & Family Services, Canberra, ACT, p.7.

National Rural Health Alliance (NRHA) (1995) *Local government and multi-purpose services in non-metropolitan areas,* National Rural Health Alliance, Canberra, p.14.

Ornstein, H. (1990) Collaborative practice between Ontario nurses and physicians: Is it possible? *Canadian Journal of Nursing Administration* (November/December 1990), pp.10-14.

Owens, J. & Macarty, M. (1998) Enrolled nurse practice in rural Australia, *The Association for Australian Rural Nurses,* Vol. 5, Whyalla, South Australia, p.36.

Pearson, A. (1989) *The social reality of clinical nursing in a rural hospital*, Deakin University Press, Geelong, Victoria.

Polit, D. & Hungler, B. (1993) *Essentials of nursing research: Methods, appraisal and utilization*, J.B. Lippincott Co, New York, p.150.

Polit, D. & Hungler, B. (1995) *Nursing research: Principles and method,* J.B. Lippincott Co, New York.

Port Augusta Hospital and Regional Health Services Inc. (1997) *Annual report 1996-1997,* Pt. Augusta Hospital & Regional Health Services, Port Augusta, p.20.

Porter, S. (1991) A participant observation study of power relations between nurses and doctors in a general hospital, *Journal of Advanced Nursing* 16, pp.728-735.

Prescott, P. & Bowen, S. (1985) Physician-nurse relationships, *Annals of Internal Medicine* 103(1), pp.127-133.

Ryan, A. (1996) Doctor-nurse relations: A review of the literature, *Social Sciences in Health* 2(2) pp.93-106.

South Australian Centre for Rural and Remote Health (SACRRH) (1999) *Annual report,* Whyalla South Australia, p.8.

South Australian Centre for Rural and Remote Health (SACRRH) (2000) *Annual report,* Whyalla, South Australia, p.12.

Sidoti, C. (1999) *Bush talks*, Office of the Commissioner for Human Rights, Canberra, ACT.

Stake, R. (1994) Case studies, *Handbook of qualitative research,* N. Denzin & Y. Lincoln (Eds.), SAGE Publications, Inc., Thousand Oaks, California, p.243.

Staunton, P. (1991) Sophia Heathcote vindicated, *The Australian Nurses Journal* 21(1), pp.10-15.

Stein, L., Watts, D. & Howell, T. (1990) The doctor-nurse game revisited, *Nursing Outlook* 38(6), pp.265-268.

Stein, L. (1967) The doctor-nurse game, *Archives of General Psychiatry* 16(June), pp.699-703.

Stephenson, J., Blue, I. & Petkov, J. (1999) *A national survey of Australian rural nurses*, The Association for Australian Rural Nurses Inc., Whyalla, South Australia, p.130.

Stevens, P., Schade, A., Chalk, B. & Slevin, O. (1993) *Understanding research: A scientific approach for health care professional,* Campion Integrated Studies Series, Campion Press, Edinburgh, UK.

Stock, S. (2000) Wider role for nurses opposed, *The Weekend Australian,* Sydney, p.7.

Strasser, R., Hays, R., Kamien, M. & Carson, D. (2000) Is Australian rural practice changing? Findings from the national rural general practice study, *Australian Journal of Rural Health* 8(4), pp.222-226.

Strasser, R., Kamien, M. & Hays, R. (1997) *National rural general practice study*, Monash University, Centre for Rural Health, Traralgon, Victoria, p.2.

Strong, K., Trickett, P., Titulaer, I. & Bhatia, K. (1998) *Health in rural and remote Australia*, Australian Institute of Health and Welfare, Canberra, ACT, p.136.

Svensson, R. (1996) The interplay between doctors and nurses – a negotiated order perspective, *Sociology of Health & Illness* 18(3), pp.379-398.

Tarnas, R. (1991) *The passion of the Western mind: Understanding the ideas that have shaped our world view,* Ballantine Books, New York, pp. 418-419.

Thompson, D. (2000) *GP numbers in Rural South Australia*, South Australian Rural Remote Medical Workforce Agency (SARRMSA), Adelaide, South Australia.

Torfing, J. (1999) *New theories of discourse – Laclau, Mouffe and Zizek,* Blackwell Publisher, Oxford, UK pgs.90, 91, 300.

Turnbull, E. (1992) Student-patient perceptions of communication with the physician or nurse practitioners in a university health service setting: Implications for patienthood, *Nursing*, University of Massachusetts, Massachusetts, USA.

Wahlstrom, O., Sanden, I. & Hammar, M. (1997) Multiprofessional education in the medical curriculum, *Medical Education* 31, pp.425-429.

Warelow, P. (1996) Nurse-doctor relationships in multidisciplinary teams: Ideal or real? *International Journal of Nursing Practice* 2, pp.33-39.

Weiss, S. (1983) Role differentiation between nurse and physician: Implications for nursing, *Nursing Research* 32(3), pp.133-139.

Weiss, S. (1985) The influence of discourse on collaboration among nurses, physicians and consumers, *Research in Nursing and Health* 8, pp.49-59.

Weiss, S. & Remen, N. (1983) Self limiting patterns of nursing behaviour within a tripartite context involving consumers and physicians, *Western Journal of Nursing Research* 5(1), pp.77-89.

Wells, H. (1961) *Cherry Ames – rural nurse*, World Distributors (Manchester) Ltd., London, England.

Whitford, R. (1998) *Nurse labour force*, Health Information Centre, Department of Human Services (SA), 1999.

Wicks, D. (1999) *Nurses and doctors at work: Rethinking professional boundaries*, Allen & Unwin, Sydney, Australia.

Wilkinson, D. (1999) *Rural and urban general practitioner workforce characteristics: How does South Australia compare?* South Australian Centre for Rural and Remote Health, Whyalla, South Australia, p.2.

Wilkinson, D. (2000) Inequitable distribution of general practitioners in Australia: Analysis by state and territory using census data, *Australian Journal of Rural Health* 8(2), pp.87-93.

Wilkinson, D. (2000) Selected demographics, social and work characteristics of the Australian general medical practitioner workforce: Comparing capital cities with regional areas, *Australian Journal of Rural Health* 8(6), pp.327-334.

Willis, E. (1989) *Medical dominance: The division of labour in Australian health care,* Allen & Unwin, St. Leonards, New South Wales.

Yin, R. (1989) *Case study research*, Sage Publications, USA.

Young-Hee Kim, E. (1989) Interpersonal relations between the nurses and the doctors and their professional performance and quality of patient care, *Philippine Nurses Association* 59(3, July-September 1989), pp.26-34.

Appendices

Appendix A	Rural and remote area classification systems
Appendix B	Plain statement – Information sheet for participants
Appendix C	Letter to in-depth interview participants requesting validation of transcript.
Appendix D	Participant consent form
Appendix E	Patient information and consent form

Appendix A Rural and remote area classification systems

Classification system	*Description*
Rural & Remote Areas (RARA) Classification	Developed by Commonwealth Department of Community Services and Health in 1989 and updated around census data. Based on Local Government Areas (LGAs), Statistical Local Areas (SLAs), population statistics and distance/time travel factors gathered from these areas by the Australian Bureau of Statistics. It has seven (7) classifications:- 1. Capital City, 2. Other Major Urban, 3. Rural Major, 4. Rural Other, 5. Remote Major, 6. Remote Other, 7. Other Offshore Areas.
Rural, Remote and Metropolitan Areas (RRMA) Classification	A later version of the RaRA Classification involving the use of the Australian Standard Geographical Classification (ASGC) which focuses on descriptions of rural in geographic terms. Defines any area not urban as rural. Urban centres are considered as having populations in excess of 1000 and rural below this.
Accessibility/Remoteness Index of Australia (ARIA)	Developed in 1996-97 by the National Key Centre for Social Applications of Geographical Information Systems (GISCA) to obtain a national standard classification and index of remoteness. A geographical approach to defining remoteness that excludes socio-economic, urban/rural and population size factors. ARIA scores allocated according to road accessibility to 201 service centres (distances are converted to ratios of the mean, a threshold of 3.0 is applied and then they are summed). These values are interpolated to a1km grid on a map and range from 0 (high accessibility) to 12 (high remoteness). The values are grouped in 5 categories. 1. Highly accessible, 2. Accessible, 3. Moderately accessible, 4. Remote, 5, Very Remote.
Griffith Service Access Frame	Developed by Dennis Griffith in 1992 in the Northern Territory to measure access to resources by isolated Schools. Uses population size to indicate the range of available services, a time-cost-distance factor that allows relative time, cost and distance of a population centre from a service centre to be calculated. Also uses the economic resources available to the community as a measure to differentiate between wealthy mining towns and remote and isolated communities with no main industry to support them. The GSAF classifies rural communities according to the population size of locality, characteristics of the SLA where the town is located and the distance of the town (population >200) from a hospital.

(Dunne 1999; Health 1991; DPIE 1994; Hegney 1996; Griffith 1994)

Appendix B Plain statement – Information sheet for participants

THE UNIVERSITY OF ADELAIDE
Department of Clinical Nursing
Faculty of Medicine

INFORMATION SHEET FOR PARTICIPANTS

The University of Adelaide Human Ethics Committee requires an Information Sheet to be given to all potential research participants to assist you in your decision about involvement in the proposed research. In addition to the Information Sheet you will also be asked to complete a Consent Form if you decide to participate in the research.

Project Title: ***The rural nurse - rural doctor professional working relationship***

Researcher: Ian Blue
Phone (08) 8647 6062 or 0419 816798 (mobile)

Supervisor: Dr. Mary Fitzgerald - Senior Lecturer
Department of Clinical Nursing
Phone (08) 8303 3637

Dear rural nurse – rural doctor,

I am inviting you to participate in the above research study being undertaken by me as part of my PhD in the Department of Clinical Nursing. To assist you to make a decision about your participation in the study I have outlined some questions and answers to issues I think you may need further information about.

What is the focus of the research?
The study has as its focus the professional working relationship between registered nurses (RNs) and doctors (GPs) practicing in different rural settings in South Australia. The main aims of the research are to: -

1. Describe and understand the professional working relationship between rural nurses and doctors.
2. Analyse this relationship using a discursive method to formulate major and minor aspects of the relationship in order to understand the different perspectives and inter-relationships between rural nurses and doctors.
3. Construct this information in a form, which will have meaning to rural nurses and doctors and the professional and public institutions that prepare these health professionals for practice.

Why conduct the research?
The need for the research is based on the premise that a greater knowledge and understanding of the interaction between rural nurses and doctors will lead to: -

- improved outcomes of health care for rural people;
- increased professional interaction, respect and support between rural nurses & doctors;
- reduced interdisciplinary role conflict;
- identification of strategies which build on strengths and reduce limitations of the relationship;
- a clearer defining of the role and function for nursing and medical practice in rural areas;
- development of collaborative practice strategies and;
- application of health service practice models which encourage good professional working relationships between doctors and nurses.

If you participate, what will this involve?
The method I have chosen to collect the data for this research is to undertake four case studies in different rural practice locations throughout South Australia.

I will spend 3-4 days in each of the chosen venues observing the professional working relationship that exists between rural nurse/s and doctor/s. This is called participant observation and the intention is for me to become part of the work environment to enable me to observe the interactions and behaviours of the nurses and doctors.

What about your confidentiality?
I appreciate that many of the rural settings in which this research will be conducted are small and participants will know each other professionally and socially. There are several steps that I will put in place to ensure your participation in the study does not cause you any embarrassment and ensures your privacy. These include: -

- All participants being observed and interviewed will sign a Consent Form, which assures confidentiality.
- Participants can withdraw from the study at any time, without any pressure or consequence.
- No names will be used in the write up of any results or any subsequent publications and the names and locations of the venues used for case studies will be disguised to prevent obvious connections.
- All field notes taken during participant observation, tapes of interviews and transcripts arising from these will remain strictly confidential. The researcher, and supervisor will be the only external persons who will have access to them. Computer records of transcripts and field notes will be securely stored at the University of Adelaide Department of Clinical Nursing for 7 years. Tape recordings will be erased following transcripts being made.

Will participants receive any payment for taking part in this research?
No form of payment is offered to participants of the study.

How do participants give their approval to take part in the research?
This will occur in two ways. First a letter will be sent to a number of rural health services asking their permission to undertake the research. If this is given, notices will be sent to all RNs and GPs working in that service, requesting their participation. Second, those rural nurses and doctors willing to participate will be sent a Consent Form, which they must sign after reading this, attached Information Sheet.

Thank you for taking the time to read this Information Sheet. If you have any questions or need clarification, please contact me at the telephone numbers shown on this sheet.

Ian Blue

Appendix C Letter to in-depth interview participants requesting validation of transcript

Dear <name>,

RE: The rural nurse - rural doctor professional working relationship

Please find enclosed the transcript of interview I recorded with you on the <date> at <place name>. Also enclosed is the original Consent Form, which gives your permission to be included in the research. Please keep both the original transcript and the Consent Form for your records.

As you will appreciate taking verbal recordings and translating them to the written word is problematic because sometimes what is said does not have a clear written meaning. Due to this fact I have had to make some small changes from what the recording of our conversation said and what you see in the enclosed transcript.
If however, you feel I have not interpreted your meaning in any answer you gave to my questions or if there are any inaccuracies which need correction please bring these to my attention. The easiest way this can be done is if you write the changes/corrections on your transcript and fax them direct to me on <phone>. This is a secure fax and will get direct to me. If you prefer they can be posted to my home address, which is <address>

You will note that I have given you a pseudonym that conceals your identity and also removed any reference you may have made in your transcript to identifying people, towns or events. Apart from the first letter of your name being used if you dislike my choice of pseudonym for you I would be very pleased to have your suggested alternative! You will understand I am required under ethics provisions to ensure your anonymity is protected as much as is possible.
If I do not hear from you I will assume that the transcript meets with your approval and I will then be able to incorporate it into my work.

Your assistance in this part of the research is greatly appreciated, as is your openness about the topic. In all I had <number> interviews from medical and nursing staff at <place name> and I have found this data to be very powerful in understanding the relationship between nurses and doctors in your particular setting.

You may remember I have four case studies to conduct at various sites in rural areas. I will be undertaking the second of these next week and the final two in early May. This will conclude this part of the research and then I will commence the discursive analysis.

Once again, thank you for your cooperation and support so far.

My best wishes,

Ian Blue

Appendix D Participant consent form

THE UNIVERSITY OF ADELAIDE
Department of Clinical Nursing
Faculty of Medicine

CONSENT FORM

See also Information Sheet attached

1. I _____ (please print) herby consent to take part in the research project entitled: *The rural nurse – rural doctor professional working relationship.*
2. I acknowledge that I have read the Information Sheet entitled: The University of Adelaide – Department of Clinical Nursing, faculty of Medicine – Information Sheet.
3. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker. My consent is given freely.
4. Although I understand that the purposes of this research project are to improve the quality of medical care, it has also been explained that my involvement may not be of any benefit to me.
5. I have been given the opportunity to have a member of my family or a friend present while the project is explained to me.
6. I have been informed that, while information gained during the study may be published, I will not be identified and my personal results will not be divulged.
7. I understand that I am free to withdraw from the project at any time and that this will not affect medical advice in the management of my health, now or in the future.
8. I am aware that I should retain a copy of this Consent Form, when completed, and the relevant Information Sheet.

Signed _____ **Date** _____

Name of witness _____ **Signed** _____
(Please print)

Date _____

I, Ian Blue have described to _____

the nature of the proceedings to be carried out. In my opinion she/he understood the explanation.

Status in Project: Chief Investigator

Appendix E Patient information & consent form

The Rural Nurse – Rural Doctor Professional Working Relationship

Dear Patient,

My name is Ian Blue and I am currently undertaking a research study with the above title in this hospital / health centre. This study is part of the requirements for my PhD.

The main focus of my research is to examine and understand the professional working relationship between rural nurses and doctors. While I am observing this relationship you as the patient receiving care from the nurse and doctors may become part of the interaction between these two health professionals. Under the rules of proper research I need your permission to continue to my observation of them in your presence.

What does it mean if you give your consent?

- I will not be using your name or any specific details about your personal or medical condition.
- If I observe a nurse-doctor interaction with you I will ask you to sign this form, which gives you confidentiality.
- You can withdraw your permission for me to observe at any time.
- Any notes or documentation I make will remain strictly confidential to the researcher and the university, which has given permission for this research.
- There will be no payment made for participation in this research.

If you require more explanation about this, please ask me.

CONSENT

My name is:

I have read the above Patient Information Sheet and understand what is involved. I give my permission to the researcher, Ian Blue to conduct his observation of the nurses and doctors who are providing my care.

Signed Date