

Historical imagination and issues in rural and remote area nursing

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ABSTRACT

Objective

Using issues in rural and remote area nursing as the example, this paper explores how nurses can use their historical imagination in considering professional issues today.

Setting

Rural and remote area nursing.

Primary argument

Historical imagination is the creative capacity to imagine possibilities of engaging with the past. Historical imagination in nursing has the potential to help nurses address current professional issues. Points of familiarity with the past can show nurses which issues are enduring and which are transient. A sense of familiarity can bring strength, encouragement and comfort. Points of difference can show nurses that problems are not necessarily permanent or can be dealt with differently. This paper uses aspects of the history of bush nursing in Australia to illustrate how nurses in rural and remote area nursing today could use their historical imagination in addressing current issues. It explores points of familiarity and difference between issues faced by bush nurses in the past and current issues in the international literature. Ways of using historical imagination in rural and remote area nursing recruitment are considered to illustrate the process.

Conclusions

As the example of engaging with the history of bush nursing in Australia attempts to demonstrate, nurses can use their historical imagination to identify points of familiarity and difference with the past to prompt a shift in thinking and strengthen creativity in addressing current issues.

INTRODUCTION

A number of schemes arose in different countries in the early twentieth century to provide nursing services to people living in isolated, remote regions where medical aid was scarce. Research into their history shows that nurses faced strikingly similar issues to those encountered by nurses in rural and remote area nursing today. Nurses could find that viewing issues through the lens of the past offers a new perspective – historical imagination can bring fresh insights to current professional issues. This paper explores how this might be done.

Historical imagination in nursing

The imagination nurses display in their nursing practice, especially in empathising with patients, can be extended to an imaginative use of history. The author defines historical imagination as the creative capacity to envisage possibilities of engaging with the past. Historical imagination in nursing includes envisaging the ways that history might offer insight into current professional concerns. Nurses often claim that it is necessary to know about the past in order to understand the present and plan for the future (Black 1997/98). Some nurse historians have briefly mentioned the idea that nursing history can have application in the present (Mitchell 2002; Rafferty 1997/98; Lusk 1997; Cushing 1995; Hezel and Linebach 1991; Sarnecky 1990). No explanation has been offered, however, for *how* nurses can use history in addressing present professional interests.

As the historian Tosh (2006) has pointed out, a sense of familiarity when reacting to the past can allow us to distinguish between what is enduring and what is transient. He regards this ability as vital to any realistic social program in the present. In contrast, a sense of difference reminds us that there is more than one way to interpret or respond to a situation. A sense of familiarity with the past does not mean that history is repeating itself. While the issue might be the same, the details will be different as these are always determined by the context – the specific circumstances of time and place.

Nurses can use their historical imagination by engaging with an account of nursing in the past to shift their frame of reference on a current issue. Engaging with history can inspire a fresh outlook.

History of Australian rural and remote area nursing

Historical research on aspects of rural and remote area nursing in Australia between 1911 and 1930 forms the basis in this paper for exploring historical imagination in nursing. Historical sources included accounts from bush nurses published in nursing journals, early histories of bush nursing and archival records of the New South Wales Bush Nursing Association (NSWBNA) as an example of a particular service. Bush nursing services remain in different forms today (Greene and Burley 2006). Only brief summaries of this historical research are possible in this paper.

Lady Dudley, wife of the Governor-General of Australia, proposed a scheme for people in the Australian outback based on the service she had previously established in the remote west of Ireland. Proclaiming her idea on travels around Australia in 1910, she miscalculated both the nature of the system needed (state rather than federal) and Australian settlers' likely reaction to what some perceived as interference from the old country (Andersen 1951; ANJ 1911c). However, Amy Hughes, Superintendent of the Queen Victoria Jubilee Institute that provided a rural service in Britain, followed in her wake and her adept intervention saved the situation. Separate bush nursing associations were established in individual states (ANJ 1911a; 1911b; 1910b; 1910c; 1910d). The first bush nurses in Victoria and New South Wales (NSW) were appointed in 1911.

The nurse's role often combined nursing and emergency care, midwifery and public health. Their work demanded creativity, resilience, determination and courage, as well as political astuteness to deal with the often conflicting demands of policy and pragmatic necessity.

DISCUSSION

To avoid influencing the historical analysis, issues in bush nursing were identified from the historical

record before examining current international remote and rural nursing literature. Historical issues were recruitment of nurses, preparation for the role, practicalities of the work (including the difficulty in getting about, and adapting and developing practice for this new and diverse nursing role), the challenges of living and working in a community, the taxing nature of long hours of work, professional isolation and professional relationships with doctors. Literature on current rural and remote area nursing in Australia, New Zealand, Ireland, Canada and the USA identifies several issues, some of which show international trends (MacLeod et al 2004; Bushy 2002; Litchfield and Ross 2000; MacLeod et al 1998).

Points of familiarity

Recruitment of nurses

In their first 20 years, bush nursing associations could not rely on a sufficient supply of Australian nurses. Nurses were actively recruited and carefully screened in Britain by the Society for the Oversea Settlement of British Women (SOSBW), a part-voluntary part-state organisation founded in 1919 by merging influential women's emigration societies (Pickles 2002).

The NSWBNA told the SOSBW that it wanted nurses who were self-reliant, reliable, trustworthy and preferably with some knowledge of country life. Being able to ride or drive was an advantage but (surprisingly) not essential (Kirkcaldie 1923). As both the candidates and SOSBW members were usually unfamiliar with Australian outback conditions, the screening process relied heavily on assessing the nurses' upbringing and qualities against this list, judged through references and interview. The Belfast matron interviewing Nurse M. Mitchell from Londonderry in 1924, for example, reported that she appeared a tall, well-made, strong, healthy woman. Although she could not ride a horse or bicycle or drive a motor car, and had no experience outside her hospital training, she had other qualities. She understood practical housekeeping and cooking, recognised that initiative, discretion and knowledge were essential, appeared to be a woman of common sense and was quite prepared for hard work. The matron judged she would fill the position creditably (Musson 1924).

The recruitment strategy worked well. The NSWBNA told the SOSBW in 1929 that the nurses it sent were doing wonderful work and seemed to cope with the most difficult situations in a remarkable manner (Morrice 1929). At that time there were 10 overseas nurses in the service (Wing 1970).

Bush nurses required qualifications in nursing, midwifery and in some regions child welfare but in times of shortage less qualified nurses were appointed (Bardenhagen 2003; Wing 1970). In an attempt to address this, bush nursing associations sometimes offered to pay for the missing training if the nurse agreed to work for a specified period afterwards (Wing 1970).

The difficulties of recruitment remain today. Literature on rural and remote area nursing services in Australia, for example, shows falling numbers, high turnover and an ageing workforce but also the active development of recruitment and retention strategies (Hegney et al 2002a; 2002b; 2002c; Hegney and McCarthy 2000; van Haaren and Williams 2000; Witham 2000). As in the past, nurses are recruited from overseas (Francis et al 2008). Enhancing job satisfaction is central to rural nurse retention (Pan et al 1995; Stratton et al 1995).

Challenges in living and working in a rural community

The bush nurse was a significant and valued member of her community but as the only nurse she could feel a conflicting mix of both social isolation and social exposure. Personal and professional boundaries were permeable. Trying to keep a professional distance conflicted with the need to be accepted as a community member and could exacerbate her loneliness. The most successful at settling into the role were those who enjoyed rural living, were able to manage life far from their usual social and professional supports and could deal with the ambiguity of their position in the community. Political astuteness was needed for relating well to local committees, fitting into the community and effectively managing the health system. The ability to use social and professional connections was crucial in ensuring an effective bush nursing service.

Recent literature identifies fitting into a rural community, being highly visible and therefore lacking anonymity and privacy, having unclear boundaries between personal and professional life, and being socially isolated as problems in remote and rural nursing today. On the other hand, the rural lifestyle, relationships with the community and having community respect are still sources of satisfaction (Henderson-Betkus and MacLeod 2004; Bushy 2002; Hegney et al 2002a; 2002b; 2002c; Crosby et al 2000; Hegney and McCarthy 2000; MacLeod et al 1998). As earlier bush nurses found, nurses today who establish networks and personal connections with hospital staff tend to be successful when seeking advice or support and are effective resource brokers (Conger and Plager 2008; Murrell-McMillan 2006; Bushy 2002).

Independence and diversity of practice

The bush nurse could see several patients in one day, with a diverse range of conditions, or she could care for a sick person in their home for an extended period, depending on her other cases. Her professional isolation was amplified by the absence of doctors. Superiors sharply reminded nurses of their duty to seek and follow medical instructions yet the distance to the nearest doctor (measured in miles, hours or difficulty of intervening terrain) meant this expectation was hard to meet. Having a telephone connected to their home made it easier to seek advice. The bush nurse at Jindabyne in NSW in 1911, however, had to ask the local exchange to leave her switchboard plugs in at night as they normally disconnected subscribers from 6 p.m. to 9 a.m. (ANJ 1911d).

Nurses usually made pragmatic and skilful decisions about immediate treatment yet were relieved when these were affirmed by the doctor. Nevertheless, judging clinical situations in this context of professional isolation brought an independence of practice that they identified as one of the most satisfying features of the role. They were also keenly aware of the degree of responsibility accompanying it.

Nurses today value the diversity and independence of remote and rural practice and the absence of organisational structures (Hegney and McCarthy 2000). The complex nature of nursing practice as an expert generalist still brings a sense of carrying a major responsibility and an anxiety to maintain excellent practice (e.g. Conger and Plager 2008; Eldridge and Judkins 2003). Nurses' anxiety is exacerbated when practice interventions are vital but not necessarily legally endorsed (Witham 2000). Rural nurses in Ireland appreciate clinical supervision (Coleman and Lynch 2006) and Australian nurses the support of their managers (van Haaren and Williams 2000).

Professional relationships with doctors

Bush nurses required political acumen to manage a professional relationship with doctors who often did not relish having a nursing service diminish their income by depleting the number of patients paying fees for medical visits. Amy Hughes had alerted Australian nurses to the need to work in harmony with them (ANJ 1910c). The NSWBNA Council investigated several complaints by doctors in 1912. A medical member of the council advised one nurse to be extremely circumspect in her relation with the doctor. She was not there to take his place but to act under his direction whenever that was available (Wing 1970).

This, of course, was the nub of the problem. When a doctor could be reached, the nurse was to seek and follow his instruction. When medical advice was not available, nurses were expected to take the doctor's place proficiently and act decisively to treat the patient on their own. Apart from the necessary clinical expertise, they clearly needed political savvy to manage this conflicting situation.

As in the past, some nurses strike difficulties in their professional relationships with doctors and with doctors' views of the nurse's role (Murrell-McMillan 2006; Muus et al 1993). A positive professional relationship and nurses' sense of being valued in their role can contribute to a stable rural nursing workforce (Murrell-McMillan 2006; Litchfield and Ross 2000).

Points of difference

Accommodation and location of practice

Bush nurses had to deal with often very different living conditions than they were used to and had to rough it along with settlers. Nursing in settlers' homes was challenging when they lived in a tent, hut or basic homestead, sometimes in conditions nurses regarded as anything but clean and without separate accommodation for them. One NSW bush nurse, tending a patient in a tent, had to get what sleep she could on a chair and case, as a bed on the ground was impossible 'on account of the number of snakes' (ANJ 1913, p.94).

Getting about to patients was a major, daily issue. Reaching patients by horseback was often extremely challenging. As one example, Nurse Rowe in Victoria had to use roads that bushmen said would 'bog a duck' – they were rarely passable in summer and in winter 'worse than awful'. On one night-time journey, her horse was on its haunches, slipping and sliding. The twelve miles took three hours across paddocks, swamps, drains, marshes and streams, 'horrible enough in the daylight' but 'awful in the darkness'. The journey to the patient's cottage ended in a scramble on foot over a fallen tree across a creek (Kai Tiaki 1910, p.89). Reaching patients can still be challenging today but is infrequently mentioned as an issue in the literature (MacLeod et al 1998).

Some bush nurses had a cottage provided. Eleanor Davies in NSW in 1917 had a little two-roomed cottage for which she stencilled curtains and hangings, making it 'cosy and homelike' (ANJ 1917, p.436). Living in an adapted or purpose-built cottage with an additional room designed to accommodate a patient lessened the nurse's privacy yet presumably made it easier to care for people and meant she could enjoy her own surroundings. Some also tended patients in very small rural hospitals. In the past, breaks between cases were limited. As one bush nurse remarked: 'A nurse ought to be like a machine, ready to go day and night. Unfortunately, we are not made that way' (ANJ 1915, p.286).

Nurses in remote rural services in different countries today deliver care in a variety of locations but do not

usually live in patients' homes to nurse them. Long hours of work, particularly in being approached for help 'after hours', is occasionally identified in the literature as an issue today (MacLeod et al 1998).

Preparation for the role was not possible for the first nurses in the bush services. The reality and requirements of the work had to be figured out on the job. As they adapted their practice, nurses tried to share their new knowledge so others could prepare for this role or enhance their existing work. Several bush nurses exchanged ideas through long letters (ANJ 1915). Specific preparation for rural and remote area nursing is now strongly advocated (Hegney 2003) and available in undergraduate and postgraduate nursing education (Conger and Plager 2008; Yonge et al 2006; Kenny et al 2004; MacLeod et al 1998).

Issues identified by nurses now but not in the past relate to technological support and dissatisfaction with lack of career pathways and access to education, excessive administration and paperwork, poor remuneration, lack of managers' support and repeated restructuring of health systems (Hegney et al 2002b; 2002c; MacPhee and Scott 2002; Crosby et al 2000; Hegney and McCarthy 2000; van Haaren and Williams 2000). These differences are largely due to the specific characteristics of the current context.

Using historical imagination to address current issues

Deciding how historical imagination might be applied in addressing current issues in remote rural services is the prerogative of nurses associated with those services. As a nurse historian, the author can only suggest some possible directions. As recruitment remains an international issue, nurses might consider using the past to promote recruitment today. Bush nurses and those in similar services in other countries nursed patients in often trying circumstances. Nurses were creative and resourceful. One bush nurse, for example, who nursed a little boy with pneumonia in a tent, quickly made an emergency steam kettle. She shaped a piece of tin into a long spout and fitted it into a hole in the lid of an old honey tin.

She published her idea so others could use it (ANJ 1910a). Nurse W. M. Thomas wrote a booklet on first aid in the bush that was also recommended for use in the New Zealand backblocks (Kai Tiaki 1911). Bush nurses were among the few nurses publishing suggestions for improving practice, a collegial effort significantly expanded today with specialist rural nursing journals. The qualities nurses displayed in the past could be celebrated as the qualities needed and shown by remote and rural nurses in any current location and used in recruiting nurses today. Nurses considering remote rural practice could identify with what Bushy (2002, p.109) has described as rural nurses' 'rich heritage of resilience, resourcefulness, adaptability and creativity'. The fact that the satisfyingly diverse and independent nature of practice is an *enduring* characteristic of remote and rural nursing could also be promoted. This does not address more fundamental issues such as isolation and remuneration but could be used as a positive aspect of recruitment strategies.

Although we need to remain aware that the specific conditions leading to issues are different in each time context, a sense of familiarity with the past can bring strength and encouragement. There might be comfort, rather than frustration, in knowing that some of the more difficult issues persist because they are determined by rural circumstances rather than any inability to resolve them. Equally, a sense of difference can show that problems are not necessarily permanent or can be interpreted or dealt with differently.

Engaging with nursing history necessarily depends on the availability of historical research relevant to different nursing interests. Care must be taken not to 'read history backwards, to see events and attitudes in the light of subsequent preoccupations and not as they occurred' (Baly 1980, p.xi). This is why in this research past issues were identified before addressing current literature. As Rafferty (1997/98) has suggested, careful historical scholarship is needed as well as scholars trained in both nursing and history. We also need to acknowledge that it is not always comfortable to engage with the past. We

can be confronted by events that are perceived very differently now. History can, however, prompt a shift in thinking and stimulate creativity.

CONCLUSION

Historical imagination in nursing has the potential to help nurses address current professional issues. As the example of engaging with the history of rural and remote area nursing has attempted to demonstrate, points of familiarity and difference with the past can show nurses today which issues are enduring and therefore not solely caused by current circumstances. Positive aspects of nursing in a particular service evident in both the past and present can be drawn on in promoting the service today. Different responses to familiar issues in the past can encourage nurses by showing there are always alternative ways of dealing with situations. New ways can be imagined. Whether generating a sense of familiarity or difference, engaging with accounts of nursing in the past can lead to a fresh reflection on issues today and open up possibilities for action.

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