# Discourses within the roles of Remote Area Nurses in Northern Territory (Australia) Government-run Health Clinics

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# DISCOURSES WITHIN THE ROLES OF REMOTE AREA NURSES IN NORTHERN TERRITORY (AUSTRALIA) GOVERNMENT-RUN HEALTH CLINICS

**Abstract**

The Northern Territory (NT) government operates remote clinics which are primarily staffed by Aboriginal Health Practitioners and Remote Area Nurses (RANs). RAN practice has been described as particularly complex due to high health needs, workforce shortages and high levels of turnover in remote Aboriginal communities. While individual incentives are offered, there has been little examination of the role and why the work takes such a toll on RANs. This paper aims to identify dominant discourses underpinning RAN practice and how these discourses reflect tensions and reinforce power relations that impact on the RAN role. Discourses were identified from a Foucauldian-inspired discourse analysis of 29 interviews with RANs in six remote NT communities. Five dominant discourses were identified, namely that permanent RANs are preferred to agency RANs, RANs portray themselves as experienced and certain, RANs use autonomous clinical judgement, Aboriginal staff are important, and RAN's belief in making a difference. However, the experience of RANs suggested that there are many types of employment, that learning from was also important, RANs often struggled to work with Aboriginal staff and they were unsure if they were making a difference. Further, these discourses created tensions between RANs who were permanent-agency, older-younger, experienced-newer, and certain-reflexive. Deconstructing these

rigid discourses could allow the RAN role to be reconstructed in ways that lead to better retention, job satisfaction and health outcomes.

**Key words:** Remote Area Nurses, Aboriginal and Torres Strait Islander Health, Remote Health, Remote Practice, Discourse, Retention, Remote Health Clinics

**What is known on this topic:**

1. There is a shortage of RANs in remote communities in Australia
2. RANs suffer high rates of stress, burnout and fatigue
3. To increase recruitment and retention, individual **incentives** have been offered

**What this paper adds:**

1. There are discourses that create tensions between RANs in the same clinic
2. Dominant discourses undermine reflexive, relational and team practice
3. Discourses underpinning RAN practice may detract from retention, job satisfaction and effectiveness



## Introduction

In the Northern Territory (NT), the NT Government operates over 50 health clinics in remote communities which provide primary health care, referral to specialist care and emergency evacuation. These clinics are primarily staffed by Aboriginal Health Practitioners (AHPs) and Remote Area Nurses (RANs) along with support staff (receptionist, drivers and cleaners) and visiting GPs, nurse specialists, allied health practitioners and medical specialists (D'Aprano, Silburn, Johnston, Oberklaid, & Tayler, 2015). RANs are "specialist advanced-practice nurses who provide and coordinate a diverse range of healthcare services for remote communities, which are predominantly Aboriginal" (Weymouth et al., 2007, p. 2). Some RANs live and work in these remote communities while others spend weeks or months on short-term contracts to make up the workforce where there is a shortage. The manager of these services is usually a senior RAN and there are also 'trainee' RAN positions.

Working in a Western health clinic in remote Aboriginal and Torres Strait Islander communities with high levels of sickness (AIHW, 2018) is challenging work. Aboriginal and Torres Strait Islander people have the poorest health outcomes in Australia with high rates of chronic illness and associated risk factors (AIHW, 2018; Carson, Dunbar, Chenhall, & Bailie, 2007). Coupled with workforce shortages and high workforce turnover (Russell et al., 2017), this leads to high levels of stress, burnout and turnover among RANs (Lenthall et al., 2009, 2015; Opie et al., 2010; Russell et al., 2017; Weymouth et al., 2007). To address these challenges, there have been incentives to increase the number and retention of RANs (Coyle, Al-Motlaq, Mills, Francis, & Birks, 2010). However, these individual incentives give little attention to the role and systems surrounding RAN practice. Given high levels of turnover, burnout and the expanded scope of practice, it is surprising that there has been little examination of the RAN role and why the work takes such a toll on these nurses.

To critically explore the RAN role, this paper identifies dominant discourses embedded in the talk of RANs about their work. This paper embraces a Foucauldian-informed perspective of discourse:

> consisting of groups of related statements which cohere to produce both meanings and effects… Discourses are also productive in that they have power outcomes or effects. They define and establish what is truth at particular moments… Discourses are also fluid and opportunistic… In doing so, discourses hook into normative ideas… which convey messages [and]… have material effects (Carabine, 2001, p. 268-9).

Discourses produce power relations and meanings of practice that underpin how RANs work and how they understand their role. Discourses shape power relations dynamically among RANs, between RANs and their patients, and between RANs and other health professionals. These discourses have material effects in how a RAN understands their responsibilities, how RANs implement their practice and how they relate to patients and colleagues (see Carabine, 2001). These discursive practices are not static but re/produced and re/negotiated daily (see Foucault, 1980) among RANs in small teams in remote settings. Overlaying these power relations are complex cultural interactions between Western healthcare and remote Aboriginal communities, between Aboriginal patients and non-Aboriginal RANs, between Aboriginal staff and non-Aboriginal RANs, and between non-Aboriginal health professionals coming to and living on traditional lands.

Bradshaw (1998) notes that pluralist perspectives of power yield greater understanding within organisations than a focus on polar opposites. She suggests “that power can be more fully understood by explicitly addressing the dynamic tensions that result from simultaneously

acknowledgement of opposite ends of a variety of conceptual continua" (Bradshaw, 1998, p. 121). Consequently, dynamic tensions within and between discourses, and their impact on RAN practice, are explored here. The aim of this paper is to identify dominant discourses in RAN practice and how these discourses reflect tension and reinforce power relations that impact on the RAN role.



**Literature Review**

Most writings about RANs and their role is written from two particular perspectives. Most research focuses on the myriad of issues facing RANs while fewer authors question the clarity and understanding of the role or preparation of RANs for remote practice. Regardless, solutions to these issues have focused on attracting more RANs rather than investigating the complexity of the role**,** the discourses that shape how the RAN role is practised and why workforce shortages remain.

**Issues facing RANs — Individualised problems.** One of the major issues identified in the literature is the very high turnover of RANs (Russell et al., 2017). Due to the workforce shortage, RANs are provided with individual incentives, including subsidised or free accommodation, relocation expenses, continuing professional development, higher salaries, extra travel and leave allowances, and on-call allowances (Coyle et al., 2010; NT Government, 2018; Queensland Department of Health, 2108; RAHC, 2018). The focus on recruiting 'more' has polarised the workforce based on age and years of experience (Voit & Carson, 2012). There are also concerns about sustainability; the RAN workforce is ageing faster than recruitment of younger replacements (Coyle et al., 2010; Hegney**,** McCarthy, Rogers-Clark, & Gorman, 2002; Lenthall et al., 2011).

Research with RANs has identified a range of challenges, including the emotional demands of the work, high workloads, poor staffing, lack of equipment and infrastructure, responsibilities and expectations of the role, mandatory on-call duties, frequent overtime, social issues, poor management, isolation, safety concerns, violence, the remote context, culture shock and a lack of support (Lenthall et al., 2009, 2018; Muecke, Lenthall, & Lindeman, 2011; Opie et al., 2010). The clinical demands on RANs given their extended scope of practice, on-call and emergency care provision have been noted as making the role demanding, stressful, tiring, over-whelming and a source of constant worry (Lenthall et al., 2009, 2018). Poor management has also been cited as detrimental to the role and a cause for poor recruitment, retention, staff support, communication and service provision. Most of these practitioners live in the small, remote Aboriginal community and work long hours, making separation of work and personal life almost impossible (Lenthall et al., 2009). Thus, the wellbeing of RANs is placed at risk by the demands of the job, lack of resources,

poor communication systems, lack of preparation and the context (Lenthall et al., 2018). Altogether, these culminate in high levels of occupational stress, emotional exhaustion and burnout (Lenthall et al., 2009, 2018; Opie et al., 2010), suggesting the role itself may be problematic.

Job satisfaction is moderate among RANs (Lenthall et al., 2018) but has been found to correlate with supervision, opportunities for professional development, and both skill development and application of new skills (Opie et al., 2010). Improvements to RAN working conditions have been proposed to improve job satisfaction (Lenthall et al., 2009), which again appeals to individualised support. Therefore, the challenges of remote practice sit with RANs, where RANs and their managers become responsible for their own wellbeing. This calls for increasing resources and support to the few individuals working in these contexts rather than critically reframing the role and structure of RAN practice.

**Unpacking the RAN role.** RAN practice requires the skills of prevention, health promotion, understanding of the local context and empowerment along with the clinical expertise required to manage chronic and acute illness as the first point of call (Burley & Greene, 2007; Coyle et al., 2010; MacLeod, Kulig, Stewart, Pitblado, & Knock, 2004). Coyle et al. (2010, p. 240) noted that: "...health education and promotion are frequently overlooked when the medical care demands become unwieldly" (see also Burley & Greene, 2007). Roden et al. (2016) argued that nurses are confused about health promotion and health education, and how to practice these in community settings. Furthermore, Murray & Wronski (2015, p. 38) suggested that despite having an extended scope of practice, isolation and the extensive health needs in Aboriginal communities result in ambiguity about the RAN role as well as pressure on RANs to practice outside their nursing training. These writings imply that there is a lack of clarity in the RAN role, a lack of preparation in health promotion and community practice, and the need for more attention to context in the training of RANs (Burley & Greene, 2007; Coyle et al., 2010; Roden et al., 2016). Further, Lenthall et al. (2015) proposed an alternative model of consultation for RANs because usual nursing practices were found to be ineffective in remote NT communities. Lindeman, Dingwall, & Bell (2014) highlighted that the preparation of remote health practitioners is deficient, particularly in relation to orientation, cultural safety and working with AHPs. This literature questions if RANs are prepared for their practice and if the RAN role is appropriate for the context, calling for critical examination of the RAN role. As an initial step in critical analysis of the role, this paper aims to identify dominant discourses in RAN practice from the talk of RANs working in six remote NT communities, with particular attention to how these discourses reflect tensions and reinforce power relations that impact on the RAN role.

## Methods

This analysis is part of a larger study investigating workforce in remote Aboriginal communities in the NT (Wakerman et al., 2016). For the study, seven communities were selected to reflect very high turnover (2 communities), high turnover (3 communities) and medium turnover (2 communities). These included communities diverse in geographical settings, population and remoteness. Researchers designed a qualitative approach to gain the perspectives of staff working in these seven clinics, however one researcher did not visit one community. For this reason, only communities visited by all researchers have been included for this analysis, including two communities in the Central Desert region and four in the Top End of NT.

Ethics approvals were gained from the Central Australian Human Research Ethics Committee, the the NT Department of Health, Menzies School of Health, and Flinders and Melbourne universities. Following acquisition of the appropriate permits, all three researchers travelled to six remote Aboriginal communities in the NT between November 2015 and October 2016. Researchers spent 3-8 days in each community and asked all staff at the local health clinic to be interviewed. It is important to note that two of the researchers are Aboriginal women raised in the NT.

Of the 30 RANs asked to be interviewed, 29 agreed and were interviewed by the same non-Aboriginal interviewer. All interviews were conducted face-to-face and most were held in the clinic. No interviewee identified as Aboriginal or Torres Strait Islander while 25 identified as female and 4 as male. Of the 29 participants, five were RAN-5 (managers/acting managers), 20 were RAN-4s and four were RAN-3s (in training). Some were permanent staff, some were casual and some were agency staff with different lengths of contracts.

All RANs were asked a series of questions about workforce, staffing, their role, the clinic they were working in, the local community, local health needs, the rationale for their work, retention and Aboriginal Health generally. Each interviewee was asked the same questions but the order and follow-up questions differed. All interviews were audio-recorded and transcribed. Each transcription was checked with the recording. Following, each transcript was independently read and coded by the three researchers for relevant topics around workforce, fly-in/fly-out staff and the role of RANs. As these coding systems differed, all researchers engaged in multiple, lengthy discussions over several months about the inconsistencies and tensions within the transcripts about workforce, agency staff and the RAN role. Recognising language as situated and embedded with power (Foucault, 1980), the researchers engaged in critical discussions about the tensions within the RAN role that created diverse practices. Through an iterative process, the researchers agreed on five

topics that resulted in tensions between RANs, specifically agency nurses, RANs as experts, autonomous practice, Aboriginal staff and individual motivations. The researchers agreed that a Foucauldian-inspired discourse analysis would illuminate these dynamic tensions in order to present the complexity of the RAN role and deepen understanding of the power relations within RAN practice (see Bradshaw, 1998; Nielsen & Glasdam, 2013; Wetherell, Taylor, & Yates, 2001). Consequently, the transcripts were then re-coded by the first author to group the codes of all researchers around the five tensions. To ensure rigour, all researchers reviewed and agreed on the coding around the five discourses, including how they manifested material meanings and tensions between them.

## Findings

Almost all of the 29 RANs in the six communities indicated that they "loved Indigenous people," they loved the "autonomy" of the work and they enjoyed their work and lifestyle. Their talk illustrated five dominant discourses underpinning RAN practice. While a few RANs identified with each discourse and a few rejected each position, most RANs struggled with how these discourses manifested in their practice and the tensions created by them.

**Permanent RANs are preferable**

A dominant discourse was identified that inferred permanent RANs were preferred to agency nurses. 'Permanent' RANs were recruited by the NT Department of Health and allocated via contract to specific sites with the input of clinic managers. These RANs lived in the community and were provided with subsidised accommodation. 'Agency' staff were recruited by workforce agencies who credential RANs with training for remote practice. Clinic managers contacted these agencies and selected from available nurses after reviewing their qualifications, training and experience. Once selected, 'agency' nurses were provided with travel to and accommodation in the remote community and worked in the local clinic for 1-12 weeks, usually 3-5 weeks at a time.

Despite being talked about as clear categories, there were blurred boundaries between permanent and agency RANs. Some agency staff returned repeatedly to the same community to the extent that "she's really like one of the permanents." Other fly-in fly-out staff were employed by the state government as 'casual' staff. There were also 'permanent casuals' who worked on casual contracts with specific clinics, for example, six weeks on and six weeks off or three months on and one month off. Despite these multiple and mixed employment arrangements, talk dichotomised RANs as

'permanent' or 'agency'. This distinction generally separated those who lived in or returned to this community and those who came for a single, short-term contract (anywhere from one to 12 weeks), previously unknown to other clinic staff. The actual employment arrangement was less important than the time in the community.

The dominant discourse frequently espoused that "permanents were preferred" and this manifested in underlying tensions between permanent and agency nurses. This was not targeted at specific individuals and many spoke about there being "good" nurses of each type. However, permanent nurses commented on agency nurses "flying-in" for short periods, being motivated by money, not working in a place long enough to get to know the local people, and often not having the skills, experience or knowledge of the local community to be effective. Permanent staff sometimes resented "doing more" in the clinic because agency staff "don't know how things work here." Another criticism of agency nurses, mostly by managers, was that they wanted to do "emergency" care when remote clinics focused on primary care. The lack of skills in primary care, recalling patients and health promotion among agency RANs was commented on negatively. Therefore, the label of 'agency' implied a RAN role that was inferior, less dedicated, and lacking in both continuity of care and knowledge of local patients.

Agency staff spoke about "loving the work and the Indigenous people" and that they had found a lifestyle that enabled them to do the work they enjoy and control the amount of work. While agency nurses agreed that RAN practice was a "better role for the permanents" or a difficult role "when you don't know the community," in private they suggested agency nurses had skills, "fresh eyes" and different approaches to offer. They were aware that they had "to know their place," and that, as a permanent nurse suggested, "they can't come in here for two weeks and change what we do." Agency nurses also described feeling "put down" by permanent staff when they suggested new activities or potential solutions. Many agency nurses and others with shorter contracts described permanent nurses, particularly those who had worked in remote settings for a long time, as "burned out", as having "been here too long" and "plumping up retirement funds." Agency nurses indicated that staying more than two years could be damaging while permanent nurses spoke about "staying too long" as 5-7 years.

While there was acceptance that *permanent RANs are preferred*, this discourse created a hierarchy where "fresh" perspectives were ignored. Underpinning the permanent-agency tension were issues of money, motivation, control and commitment. Further, while this discourse dichotomised permanent and agency RANs, more than half of the interviewees held employment contracts that were not easily categorised as "permanent" or "agency."

**RANs have to be experienced and certain**

Experience and certainty were clearly important to how RANs perceived each other. The clinics expected RANs to independently manage any presenting health condition. Without being asked, most described their training, skills and years of experience as a RAN, knowledge of health conditions specific to remote practice (e.g., scabies) and relayed clinical situations they had experienced. Many older nurses highlighted the need for advanced clinical skills and the need for RANs to have "life experience" or "remote experience." Permanent RANs talked about nurses who "come out here" and "are not prepared" or are "not up to it" and how it "makes it harder for all of us." Many older RANs felt younger nurses were not "ready" for RAN practice. Managers talked about "sending agency nurses home… when they don't know what they are doing." At times younger RANs were critical of older, senior and/or permanent RANs for being unsupportive, not working as a team or not open to alternative practices.

RANs assured researchers they were competent, skilled and experienced. To be perceived as competent, many older RANs presented themselves as certain in any clinical situation. Despite reinforcing certainty, RANs simultaneously talked about learning from Aboriginal staff, learning new practices, learning local culture, "asking" or "checking" with others as part of "good teamwork" or stating "I'm always learning." Learning was spoken about more by trainee, younger, newer and agency RANs, highlighting the role of age, life experience and training in being perceived as experienced and certain. There was clearly a tension between "I know" (being seen to be sure of what to do in any clinical situation) and "I am learning" (I will seek help or "I don't mind having to ask"). While some RANs positioned themselves as the 'experienced' or the 'learner,' many oscillated between them (see MacLeod, 1996). Despite varied individual positions, knowledge, experience and certainty seemed more valued among RANs than inquiry, learning or reflexivity (see Rix, Barclay, & Wilson, 2014). The result was a hierarchy where those portraying certainty attained leadership roles in the clinic and judged those asking questions negatively, particularly agency nurses. However, Aboriginal writers have suggested that effective cross-cultural practice requires listening, learning, reflexivity and collaboration (see Coffin, 2007; Fredericks, 2010; Rix et al., 2014). This unspoken tension reflects a power struggle between RAN expertise in a Western model of health care and cultural reflexivity required in Aboriginal practice, that each RAN silently negotiated.

**RANs use autonomous clinical judgement**

RANs talked about having an expanded scope of practice and being trained to work autonomously to deal with critical situations. RAN-4 and 5s talked with more certainty about having the clinical skills,

experience and judgement to work with medical emergencies. This emerged repeatedly in discussion of after-hours call-outs. Each clinic had a different approach to "on-call." The role of being on-call involved a telephone triage to determine if the health condition was serious enough to be "called out" and then a possible visit to the clinic to treat the patient. Most RANs agreed "you can't go to every call out" and so a triage process decided if the health condition is an "emergency" or "serious enough." Most said they only respond to call-outs that "need urgent attention" or "have to be looked at in person." Despite this general consensus, there were clear differences in how clinics responded to "call-outs." In some clinics, the expected approach was that an after-hours call had to be "life threatening" for the RAN to see the patient after-hours for fear that "we get called [out] for everything." In these clinics, permanent staff often stated, "it has to be life or death for me to get out of bed." Managers in these clinics were often critical of agency RANs who "take every call out 'cos it puts more money in their pocket." Challenging such a response to "call-outs" had repercussions for RANs, including being reprimanded, given the "silent treatment" and not being respected in future clinical judgements. However, in other clinics, the approach was less rigid, including "we always respond if it's a child," or "I always see the patient if I'm unsure" and "what may not seem an emergency for me, may be an emergency for a community member." Some managers suggested they have "to trust the decision of the person who took the call" or "I encourage staff to call for support when they are uncertain." For an agency nurse, who often did "on-call" in their first few days of arriving, it could be difficult to understand the dominant discourse surrounding after-hours care in their new clinic. While RANs talked about triaging as a clinical skill, each clinic had particular expectations of response to call-outs.

While responding to a "call-out" was said to be a clinical decision, in the private interviews most RANs talked about how hard telephone triage was where English was not the first language and/or patients/carers were clearly worried. The majority added that "nobody sleeps after a call, whether you go out or not." It was clearly stressful to make these clinical decisions. Long justifications were given as to why a particular clinical judgement was made and these decisions were clearly influenced by the power relations between RANs. Tensions existed for most RANs between the polarities of "we just can't go out to everything and I'd already been out that night" and "I don't care what others think; I was worried and wanted to see that the patient was alright." Therefore, while all talked about practicing autonomously and using their own clinical judgement, these judgements were influenced by unspoken discourses within each clinic.

**You have to have Aboriginal staff in the clinic**

When asked, all the RANs interviewed spoke about the importance of having Aboriginal staff in the clinic. Beyond the prevailing discourse that "the clinic needs to employ local Aboriginal staff", there were few examples of working with Aboriginal staff, utilising the skills of Aboriginal staff and developing relationships with Aboriginal staff. Underpinning the need to employ local staff were assessments of "work ethic", skill levels and developing relationships with Aboriginal staff. Much of the talk reflected a tokenism, it is "good if they get locals that come to work," but there was little discussion of how RANs worked with these staff. Interviewees ranged from having very low expectations of AHPs ("when they show up") or very high expectations, including for AHPs to always be available, to have strong clinical skills and to be able to forge all relationships between the clinic and the community. Talk reflected inconsistencies and tensions between the polarities of: regarding cultural brokerage as critical while regularly seeing clients without an AHP; the importance of employing Aboriginal staff yet having low expectations of their work; respecting Aboriginal knowledge but prioritising Western clinical skills; and wanting to train Aboriginal staff while being "too busy to give them time."

Despite varied descriptions of how RANs worked with Aboriginal staff, they usually placed themselves in a position of power. Fewer interviewees talked about working with Aboriginal staff, getting to know the local staff, and both teaching and learning from Aboriginal staff. There were few examples of genuine relationships or two-way learning between Aboriginal staff and RANs. Thus, the dominant discourse of the importance of the clinic employing Aboriginal staff did not translate to RANs working with, valuing and being responsible for the employment of AHPs.

**I am making a difference**

The interviewees discussed motivations for their work. While most RANs stated that they worked in remote settings to "make a difference," when asked about improvement in Aboriginal health, answers were vague and uncomfortable. Only a few were certain: "Of course, that's why I'm here, I'm helping to make a difference." For many, answers began with a pause, a nervous laugh or a shuffle in the chair. After consideration, some felt that health outcomes for Aboriginal people had improved slowly over the last three decades. Others were unsure, some were reluctant to comment and some suggested that if they were to come back in 10 years, "the health of these people wouldn't be any better." Agency nurses were more likely to question their role and whether their work "had an impact" or "really helped the local community." While embracing the discourse of "I am making a difference," few interviewees were comfortable that their experience of RAN practice achieved this. This discordance goes to the heart of the RAN role, the motivation for working as a

RAN and the impact of the work of RANs. This subtle tension reflected an unspoken power dynamic of who benefited from their work.

## Discussion

The five discourses identified make visible the discursive practices, tensions and power relations among RANs (see Clinton & Springer, 2016). Most RANs identified the dominant discourses while also re-interpreting, re-negotiating and re-positioning their own practice within these discourses. While the five discourses reflect positions of power, they are embedded with tensions and co-exist to complicate how these tensions, inconsistencies and power relations manifest (see Bradshaw, 1998). This creates a dynamic situation where such tensions and power relations, along with high staff turnover, result in diverse practices with patients and Aboriginal staff.

Identification of these discourses highlights a clear hierarchy between agency and permanent RANs, where permanent staff reproduced specific team cultures and ways of practising. Overlaying this were age, experience and certainty. For RANs who were training, young and/or inexperienced, their place in the team was clearly directed by RANs who were senior, older, certain and/or permanent. Agency and trainee RANs entering a rigid team culture were more likely to feel unwelcome and intimidated, which discourages recruitment of younger nurses. Further, a dominant discourse that expects RANs to portray certainty restricts a team culture of inquiry (see White, Fook, & Gardner, 2006). It also places RANs in a position as 'experts' which undermines the cultural knowledge of Aboriginal staff and patients on their traditional lands (see Coffin, 2007; Pease, 2002). In addition, privileging the knowledge of permanent RANs reinforces situated knowledge that must be adhered to rather than welcoming "fresh eyes," learners and other contributions (see Hamilton & Manias, 2009; Lindeman et al., 2014). There was, however, resistance to these discourses with some RANs challenging "staying too long", some identifying as "the learner," and many failing to identify the impact of their work. Such tensions within the RAN role take an emotional toll on these RANs, destabilise teamwork and are likely to result in mixed messages to local Aboriginal residents (see Ward & Gorman, 2010).

Highlighting these discourses, and the tensions within and between them, identifies that there are understandings within the RAN role that undermine its effectiveness and sustainability. The discourses re/produced in remote clinics can create a rigid model of care that challenges a dynamic team culture, relational knowledge exchange and the wellbeing of RANs. These discursive practices prevent RANs from learning, growing, changing and creating innovative healthcare to address local

needs. In a stressed and under-resourced health system, dominant discourses are more easily re-produced than challenged. The stress, pressure, lack of staff and significant health needs have created a system calling for more nurses to provide more clinical consultations rather than examining the RAN role and constraints to its effectiveness. That is, while the "immediate" struggles of stress, workforce and resources are easily identified, the "chief enemy" is a system of power that reproduces a culture of remote practice founded on doing, certainty and Western expertise (see Foucault, 1982, p. 780). In this sense, the role of the RAN is 'stuck' until the NT health system can deconstruct these discourses and make clear the RAN role, purpose and potential.

This paper is based on interviews with 29 RANs from only six of 53 government-run remote clinics in the NT at one point in time. While only a small number of clinics and RANs, this analysis highlighted some understandings of RANs and tensions embedded in RAN practice across the six clinics. Collecting data in the remote clinics enabled RANs to draw on clinical situations and team interactions from earlier in the day or week. These conversations highlighted the commitment of RANs, their potential to contribute to Aboriginal health and wellbeing as well as limitations due to clinic culture, expectations of colleagues and tensions between staff. Further, this discursive analysis enables examination beyond the immediate and the individual by presenting challenges embedded in the RAN role.

RANs work hard to address the overwhelming health burden in remote communities (Lenthall et al., 2011, 2018) but are restricted by discourses that prevent new initiatives, re-thinking of the role, and addressing mechanisms of power that re/produce current approaches. Enabling a health system to reproduce empathy, reflexivity and patient centred care (see Fredericks, 2010; Rix et al., 2014) in these clinics could assist in a more relational, rather than colonising, approach to practice that works with the local Aboriginal staff/community in culturally specific, place-based ways (see Carter & Hollinsworth, 2009; Pease, 2002; Rix et al., 2014). Focusing on the voice of the patient may give RANs a more satisfying role (see Fredericks, 2010; Pease, 2002). Deconstructing and reframing the RAN role to work with Aboriginal and Torres Strait Islander staff, communities and cultural protocols could enhance the ways RANs work with, engage and learn from the community whose land they work on (see Bourque Bearskin, 2011; Lindeman et al., 2014). This requires a systematic change in the RAN role that may lead to more effective practice, increased job satisfaction and easier recruitment and retention.

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