

*Editorial***IS RURAL NURSING A SPECIALTY?**

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Like many other nurses who work in rural and remote areas, I never considered myself a specialist. That is until several years ago when I started to teach an undergraduate course in rural nursing. As I immersed myself in the little bit of rural literature that was available at the time, I recognized that I was becoming increasingly convinced that indeed rural nursing is a specialty. I remember feeling really pleased that finally someone somewhere understood that nursing in rural sites was not merely the poor relation of urban nursing, but something that required special knowledge and skill. From that time to the present, I have proudly pointed out this fact to students. In Canada, however, rural nursing is still struggling to become recognized as a distinct entity. This caused me to consider the obstacles that we still face on the road to specialty status.

Historically, rural nurses believed they were not doing anything particularly important. McKinnon (1997) suggests that because these early nurses believed they were “just doing what is necessary” (p. 799) for their rural communities, they failed to analyze or write about their practice. This may be one of the primary reasons that rural nursing has failed to establish itself as a distinct entity. It is also possible that the reasons are more insidious. Nursing has historically been considered an extension of the work that women do (Crowe, 2000). Therefore, its contribution to health care has been undervalued. Further, rural nursing has always been considered to be just like any other type of nursing practice, only on a smaller scale. It stands to reason that if nursing itself is not considered worthy of notice, by extension, rural nursing is considered even less worthy.

Peplau (1965/2003) suggests that specialties in any discipline emerge as public need brings attention to a previously unnoticed situation or problem. This circumstance is exactly what has happened in rural Canada over the past several years. As technology has increased, the needs and concerns of rural residents have become known. The rural population has pushed to indicate their particular concerns regarding health. It is interesting to consider if the health concerns of rural Canada might have been noticed earlier if rural nurses had written about their practice. Peplau (1965/2003) points out that any big increase in the amount of knowledge in a field of study tends to lead to specialization. An increase in the amount of knowledge regarding rural nursing practice in Canada is very small. On a wider scale even the amount of knowledge worldwide is not particularly large. Obviously to gain any amount of movement toward being recognized as a specialty requires more research and an increase in rural nursing knowledge.

Other influences may also be implicated in keeping rural nurses from gaining specialty status. Nurses make up the largest single group of health care workers in Canada. This is particularly true in rural areas where health care facilities are frequently the largest local employer. In Canada, if rural nurses organized and became a cohesive group, they would be able to influence health care policy to a much greater extent than at

present. The ability to influence those in political power could be of grave concern to other stakeholders who remain the gatekeepers of the Canadian health care system. This could be particularly threatening to some groups as this country undergoes a shift in the way health care is visualized. Ironically, role diversification, one of the hallmarks of rural nursing practice, is also one of the reasons that rural nurses are not considered specialists, "...as nursing specialists, like medical specialists are known to work in one discrete area, for example, diabetes, pediatrics, midwifery, or intensive care" (Hegney et al. 1997, p. 83). This paradox would appear to have no resolution in that the rural nurse is expected to be proficient in multiple areas but cannot be considered a specialist because of the multiplicity. Additionally, the rural nurse is expected to acquire a broad range of advanced practice skills from other specialties but cannot be considered a specialist in her own area.

It is likely that the relational concepts such as multiple personal associations and lack of anonymity are the elements that make rural nursing practice truly unique. These relational concepts, which assist the rural nurse in developing a deep therapeutic association, require the presence of so called "soft-skills" such as warmth, empathy, genuineness and respect (Balzer-Riley, 1998). These "soft-skills" are generally undervalued in present day "male-as-norm" western society which continues to value detachment and disconnection (Crooks, 2001, p. 19). Moreover, the "soft-skills" do not lend themselves to study in a society that continues to value quantifiable "hard" evidence. The "soft-skills" ultimately are relegated to a subordinate position.

The nurse's ability to navigate relational concepts insures the success or failure of a rural nursing practice. Failure to recognize the importance of these elements to successful rural nursing practice is a critical reason that in Canada rural nursing is not understood to be a specialty.

I am not sure that nursing in rural and remote Canada will ever receive the distinction it deserves. I am sure that the nurses who work in those areas deserve to be recognized; if not for their generalist practice then for the unique relational knowledge they possess.

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