RURAL NURING IN CANADA: A VOICE UNHEARD

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Keywords: Marginalization, The Rural Setting, Rural Nursing Practice, Health Care Policy

ABSTRACT

Historically, in Canada, rural nurses provided health care that incorporated not only care of disease processes and acute illness but also care related to social and political aspects of need and advocacy. With the advent of urbanized, acute hospital care and the focus of disease and cure, the role of the rural nurse was diminished. The purpose of this paper is to explore the role of the rural nurse within the context of the Canadian rural populations for whom they care and more specifically to examine how the effects of marginalization and health policy and decision making processes contributed and may continue to contribute negatively to marginalization. The implications of not recognizing or marginalizing rural nurses may once again remove or negate their voice, affect their health care influence and impact the central role of the rural nurse in providing holistic care for and with the rural populations they serve.

INTRODUCTION

In Canada, nursing as a professional practice is often thought of from a collective perspective. Invariably, the collective dialogue entails descriptors of nursing as that of nurses providing care for individuals in acute care settings, with an acute disease focus. Gortner (2004) states' nursing has been depicted at various times as a series of tasks and technology. This particular way of thinking can be viewed as a throwback to the medical model, which inhered an overwhelmingly physical focus. The medical model defines health in a physiological way, with physiological characteristics (Potter & Perry, 2006). Nurses were required to adhere to this medical model, predominant in the 1950s during which time medical and, by default; nursing care was transferred from community to hospital settings. In the Canadian post war economic growth, increased funding was directed primarily to the building of new hospitals (p.4). This process centralized the care of people to a single setting and institution, for the purpose of efficiency which promoted care in large institutional settings (Baumgart & Larsen, 1992; Canadian Nurses Association, 2005). The era of the (rural) district nurse or community nurse thus became obsolete. The large hospital institutions were touted as centres for the provision of the most advanced and leading technical care. Indeed, the advances in modern medicine allowed enormous progress to be made in treating diseases that were physical and acute in origin. The evolution of modern medicine and the development of antibiotics and other 'wonder drugs' contributed to the belief that there would be a cure for every disease/illness, thus shifting the emphasis away from prevention to cure (Allemang, 1995; Newman, 1975; Bramadat, & Saydak, 1993; Kulig, 2005; Reed, 2004). The diminished role of the nurse providing care in the community, however, had an effect on the lives of these people and the nurses who cared for

them. Nurses who were particularly affected were those who provided care for people in rural Canadian areas (Ross-Kerr, 1998; Paul, 2005). These nurses not only cared for the rural populations but also lived and experienced rural living in a holistic way (McKay, 2005). The nursing care included a focus on social and political issues in addition to providing care to patients with physical illness (Whall, 2004).

In some ways, it could be said that this segment of the Canadian population, vis a vis the rural nurse and patient became the forgotten element in the name of progress, with their vital role devalued and eroded. The purpose of this paper is to explore the historic and current role of the rural nurse and the contribution of that role in providing health care to rural populations. In this paper the authors further explore how health care delivery, collective thinking and decision-making processes incorporating rural nursing affect and continue to affect rural care. They examine how health care decisions and issues have had an impact on the role of the rural nurse. They explore the concept of marginalization and how it may influence the role of the rural nurse and the ability of the rural nurse to provide nursing care.

MARGINALIZATION

The concept of marginalization has often been described as one of 'not belonging' to the collective majority. Hall, Stevons & Meleis (1994) describe marginalization as a situation or state in which individuals live on the periphery, away from the dominant group. It is not the spatial aspects or geographic distance that causes a sense of isolation but rather the lack of social support and lack of inclusiveness that cause individuals to feel disconnected from the majority (Managhan, & Lavioe, 2008). They are excluded from the social and political realms which in turn precipitates a sense of powerlessness. This becomes a voice that goes unheard.

In the literature it is contended that marginalization is associated with oppression and lack of control or an absence of rights. Historically, those who have less economic wealth or who are fewer in numbers can be subject to marginalization. Those in rural Canadian communities have, at times, expressed feelings of being disassociated from the greater political and social climate. Because the rural population represents less in census numbers than its urban counterpart there is a perception and actuality of less power in voicing concerns and less political representation and advocacy (Canadian Nurses Association (CNA), 2002, 2005). Rural populations often have less economic wealth within their communities, in turn precipitating a devaluing of the peoples' voice. With social and political isolation emerge health consequences. The evidence would suggest rural populations do not have equitable access to the determinants of health including social, economic, and physical and human resources that in turn would allow them to experience the same health and well being outcomes as those of urban populations (Health Canada, 2001).

So what of those who are responsible and accountable to caring for these rural communities? Where does their role lie in providing care for these people or are they themselves subject to marginalization by living and caring within these areas? Are rural nurses, by living and working in their rural communities marginalized by their professional and personal experience? Historically, Canadian rural nurses have provided holistic care to rural communities, an approach that embraced the type of individualized care needed. This care, however, was subject to change, enforced by social and political dominance at particular points in time (Eldrige, & Jenkins, 2003; Elliot, Stewart, & Toman, 2009). Some would argue this approach has been instrumental in creating marginalization for rural communities and those who serve these populations.

THE RURAL SETTING

The History of the Canadian Rural Nurse in the Provision of Health Care

Historically, the role of the rural nurse has been one of importance and one that has been essential to the provision of care to the rural population. Without nursing, in many rural areas, care would have been compromised or nonexistent (Baumgart & Larsen, 1992; McPherson, 2006). This was the case in Alberta, as in other Canadian provinces. The work and political advocacy of rural nurses with organizations such as the United Farmers Women's Association in Alberta is a case in point (Cashman, 1966). In many instances access to physician care was not an option for rural populations. It was the nurses who filled the void for the role of health care provider. Many of these nurses lived, worked and raised families in rural settings. They understood the demands of and the type of care required. These nurses provided complete care that included not only treatment of diseases but also encompassed expanded roles such as the delivery of babies. They taught the importance of health promotion and worked with the people in social and political contexts (Ross-Kerr & Wood, 2003). Before the expansion of the concept of health many of these nurses were advocating for people in the Canadian rural context. They believed that rural populations should be entitled to adequate health care and a social system that provided such care (Ross-Kerr, 1998; McPherson, 2006). With the technological advancement of the treatment of acute disease and the transference of care to urban hospital settings, however, the historic role and influence of the rural nurse was significantly diminished (Longford, 2000; McKay, 2005). Not only had rural nurses been marginalized but they were now removed from their role and rendered powerless to resist.

In Canada, the then federal health mister Lalonde (1974) issued a report that expanded the concept of health to include lifestyle, biology, environment and organizations of health care. Disease continued to be the focus of health professionals, in particular the medical profession, but chronicity emerged as being central to that focus. This emphasis on chronicity suggested that acute treatment and cure could not be viewed as a panacea for health care. Examination of chronic conditions and the concomitant lifestyles of people living with various diseases had to be explored. In Canada, because of influence of the World Health Organization (WHO) (1986) and the then Minister of Health's report, the concept of health expanded to include more than acute physical disease processes. Leading the discussion concerning care were those in the nursing profession. They promoted nursing care as being holistic (George, 1990). Nursing scholars and clinicians concurred with the concept of health relating to not only physical aspects but to the psychological and social influences, included in the newly developed WHO determinants of health (Newman, 1972). These determinants stated that health was significantly impacted by socio-economic issues, such as social support and egalitarianism, related to income and place in society (Potter & Perry, 2006). This type of discussion, at national and international levels, explored factors regarding health and how health could be impacted by positive and negative factors. People were living longer but many were living with chronic conditions that needed to be treated multiple times and in multiple ways. Treatments were no longer exclusively related to surgical interventions or drug therapies. Even with these interventions, individuals continued to encounter issues concerning their health or well being, social issues such as unemployment, inadequate housing, insufficient income; psychological influences such as stress, including lack of social support from family and community, which all played a role in health. The WHO endorsed models such as the Primary Health Care Model (PHC) (1986). In Canada, the PHC

model was adopted as being valuable to the provision of health care to all people, in all settings. There was recognition of the limitations of a disease focus for health care. With the advent of the delineation of health determinants for promoting and maintaining a person's ability to a healthy lifestyle, together with the expansion of the concept of health to encompass well being, a new dialogue of health as a human right was adopted. Health determinants were expanded to include social and economic factors as well as employment, physical and social environments, culture and health services (Reutter, 1995). Principles regarding the PHC model included public and community input and participation, intersectoral and interprofessional collaboration, appropriate technology that was affordable and accessibility to health care resources and services. There was a distinct focus on empowering individuals to have control of decisions about their health (Roger & Gallagher, 1995; Petrucka, & Smith, 2005). Nurses who previously had not been able to influence the discussion regarding health care became advocates of a person's individual right to health care and all that such rights entailed (Doering, 1992).

Rural health care in Alberta, Canada, in the 1970s and 1980s

The re-evaluation of health care to include individual and community participation in the decision making process suggested that requests for equitable access to health care services in communities, at a cost that was affordable to the community ought be acknowledged. Individuals had a right to health care services, regardless of location (Kulig, 2000; Kulig, 2005). However, rural communities continued to experience an array of health problems that included poverty, unemployment, cardiovascular disease, cancers and hypertension in higher numbers than their urban counterparts (Canadian Institute for Health Information, 2002; Stewart & Langille, 1995; Sorenson, & DePeuter, 2002). These communities were often left to face their health problems with limited resources and inaccessible or inadequate resources (Anderson & Yuhos, 1993; Thomlinson et al, 2004). In Alberta, Canada, in the 1970s there was a political climate during which economic growth began to assume a significant impact on the provision of health care services. Large acute care urban centres became the focus of technically advanced care. These centres were designated as tertiary care centres, in which those who were the most acutely ill were treated. Those individuals who had chronic and less acute episodes, however, also continued to require access to appropriate care. The social and political climate became ripe to allow for the building or re-building of rural hospitals (Church & Smith, 2008). Many small towns received new hospitals and community health care centres. Those in the rural settings who had suffered from a lack of access to health care services and care on a daily basis and within a reasonable geographic distance voiced their need for health care services and health care providers. The political climate, will, and economic growth further ensured that some of these needs were met in rural communities. Nurses provided rural nursing care within the confines of these settings. Physicians began to migrate to the rural settings. Where physician shortages existed, these were supplemented with physicians trained in other countries who set up practices in rural towns (Tyrell & Dauphine, 1999; Henry, Edwards, & Crotty, 2009). Rural nurses provided care primarily in rural hospital settings, except for the most remote rural areas, where on-site physician services were not available. It was the nurses who lived in these communities who provided expanded care. The provision of care encompassed more than a medically acute focus. Holistic care included social and political activism to allow resources and services to be requested as a need and a right (Kulig, Nahachewsky, & Thomlinson 2004; MacLeod, 1998; MacLeod et al, 2008).

Rural nurses by virtue of their geographic location and their experiences embraced the values of primary health care nursing and the role of community in the provision of health care (Ross-Kerr & Wood, 2003). They recognized their role in the provision of acute care, often deemed by government to be the most legitimate care. Nurses, however, continued to explore the social aspects of rural care, especially in relation to population health issues such as access to adequate food, water, shelter, education, immunization programs, and health education programs (Ross-Kerr, 1998; Pang, & Russel, 2003). Health care services and political will dictated the particular types of care the rural nurses provided, but living in the community also influenced rural nurses, as members of that community. They contended that being politically active and voicing the rural needs on behalf of their rural communities ought to be heard and acknowledged (McIntyre, Thomlinson, & McDonald, 2006). In many ways they were obdurate to allowing marginalization to be an accepted or inevitable position.

Rurality

The concept of rurality has been described from many different perspectives (Malpas, 1998; Pitlado, 2005; Racher, Vollman & Annis, 2004)). It has been described as a geographic location (Andrews, 2003). There has been further articulation concerning the terms remote and/or rural as meaning further, or extreme distance from an urban setting (MacLeod et al. (a), 2004). Rural geographic determinations are located, in a physical and verbal sense, around an urban perspective. In relation to health care services, the term rurality has been linked to what is 'absent' or 'missing' in the services and personnel needed to provide acceptable care. Terms such a 'lack of health services' or 'gaps' in the ability to provide services continue to focus on the negative aspects of rural health care, without acknowledgement of any positive aspects in relation to rural health (Thomlinson et al, 2004; Stewart et al, 2005. The manner in which language is used to describe rurality may be seen to relegate it to the margins, away from the urban majority, signalling that it may be less important and less powerful.

Freire (1997) would contend that to exist as humans we name the world, we explore it, we re-name it and we create new meaning. The examination of new names and meaning generates action and transformation. Saying or re-saying the 'word' is not the privilege of some but the right of everyone. Language can influence meaning and can lead to action and necessary change. The ability of rural communities to seek health care for their communities and to voice the rewarding aspects of living in such communities creates a language of pride and positive connotations' rather than a language of lesser than or inequity. This re-wording of the language in reference to rurality denotes the positive elements of rural living and experiences and not merely the challenges faced.

Rural Nursing in Canada

Historically, or by current standards for that matter, the role of the rural nurse is not a role that has been uniform in its articulation and understanding. At times, the role of the rural nurse is complex and ambiguous (MacLeod et al (b), 2004; Stewart et al., 2005). Indeed, the role of the rural nurse differs significantly from the role of a nurse in an acute tertiary care setting. The particular role has, at times, been lost in the assumptions of the majority. Assumptions abound regarding urban settings as the best option to access health care. Technological, political and social power serve to influence the assumption that care can only adequately occur in urban

centres. The rural population has experienced a less collective and powerful voice socially and politically and therefore their specific and genuine needs become lost in the powerful collective of the majority. In the 1990s and into the millennium, as a consequence of the powerful influences of globalization and technology, Canadian government policy called for an approach to health care that was leaner in its social supports and obligations (Saul, 1995). Centralization of care to urban settings was the policy of choice. This political development in turn resulted in division within social and cultural communities, including urban and rural communities (Pal, 2001). The role of the rural nurse was perceived as less valuable (Crooks, 2004). Assumptions were made regarding the type of care required, the facility and technical support needed, but from a pre-dominantly urban perspective (Shellian, 2002; Pitblado, 2005).

Reed (2004) contends that service needs, physician demands, political interests and employers still generate a proliferation of technical 'nursing' that can exploit nursing's vision. The role of the rural nurse has not been well understood or communicated. This role is both unique and multicentered (MacLeod et al (a), 2004). Without clear and appropriate articulation and understanding of the role of the rural nurse there is a distinct danger that rural nurses, and those for whom they are responsible, becomes marginalized in a geographic, social and political sense. While the role of the rural nurse continues to be vital to the existence of rural communities, it is essential to create dialogue regarding the essence of such a role, in all its complexity (Shellian, 2002; Managhan, & Lavioe, 2008).

It is in the language that social connotations are derived in positive or negative way. The language used to describe 'nursing' is paramount in creating and influencing who we are as nurses and how we practice and care for people. The term 'nurse' itself inheres some essential and collective attributes. Nursing is perceived to be concerned with the care of human beings (Mitchell & Cody, 1999). Central to that focus of care is the person receiving the care. Nurses must be able to individualize their care for specific populations. It is with this broader understanding of nursing that they can implement and advocate for just and specific care. Not all nursing care, for all populations, however, will be a mirror image of replication. Only by being connected with and open to specific needs can the nurse come to understand and advocate with those s/he cares about (Kulig et al, 2006).

If rural nurses were merely described as 'nurses providing care in rural Canadian settings' this perception could create, distort and distance the essential embodiment of rural nursing (Bowman, & Kulig, 2008). The rural location has, at times, been described in a negative fashion. Concomitantly, rural nurses have been unacknowledged for their rural nursing role as one of a positive and influential lived experience. Their personal/ professional connection to rural nursing gives them an affinity with the rural community that differs from the nursing role in an urban setting. These differences should not allow for marginalization. Care in urban settings as opposed to rural settings are distanced by physical space but should not be distanced by lack of understanding or discrimination (MacLeod et al (b), 2004). Nursing care cannot be articulated from a singular perspective. Rural nursing has a rightful and much needed role and place in nursing care and should be acknowledged as such.

CONCLUSION

Invariably, Canadian nursing, practice, resources and curricula are discussed in terms of urban availability, access and care. Such rhetoric does not, however, inform the nursing profession or the public about the true role of the rural nurse. Without specificity, these dominant

urban overtones, regarding the practice, skills and resources necessary, are only vicariously linked to rural nursing. Rural nursing has to be perceived and represented as being important and acknowledged as such. Rural nurses know the needs of the rural population because they are a part of the population ergot the communities they serve. Such recognition of the rural nursing role can provide a critical awareness of kinds of challenged and solutions that are germane to rural nursing (DeGroot, 1988; MacLeod et al, 2008). All nurses need to understand the history of rural nursing and how it has in its past, been marginalized. (Baumgart & Larsen, 1992; Ross-Kerr, 1998; Paul, 2005). Rural nurses themselves need to articulate what they do that is unique and why their role is so pivotal to rural health care. Rural nurses are in the position to politically assume the mantle of nurse and community member. Rural nurses can articulate the role of social and economic needs as influencing care. They can highlight the need for equity of the rural populations regardless of geographic location. Nurses need to circumvent the dangers of marginalization through dialogue and political advocacy as well as direct nursing care (McIntyre, Thomlinson, & McDonald, 2006). They must create a strong voice to counteract and at times resist what the majority or government, with political power, may insist upon, to effectively eliminate the negative cost to them and their rural communities. Rural nurses are in a prime position to create a climate where being on the margin is not an option, where equality of voice regarding health care is an expectation and a reality.

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