

From the Editor-in-Chief

Nurse Practitioner Role: Nursing Needs It

By happenstance more than good planning, we found ourselves with three research reports on nurse practitioners reviewed and ready for publication in this issue. That led us to decide to abandon our usual policy of not having thematic issues and to focus on nurse practitioners in this one. We asked Pam Pogue to write a column on her view of the status of nurse practitioners in Ontario and Canada, and we're rounding out the issue with this editorial.

Nurse practitioners have been part of the nursing scene in Canada for a long time. In the Canadian North and in the remote regions of Newfoundland and Labrador and other provinces, nurses have always functioned as nurse practitioners. Midwives also functioned in northern nursing stations, usually in First Nations and Inuit communities, long before midwives were trained and licensed to practise in populated areas in Canada. Dalhousie University offered a program to prepare nurses for northern nursing stations for many years; they were not called nurse practitioners, but they carried out most of the responsibilities associated with nurse practitioners' practice.

Formal preparation of nurse practitioners was introduced in Ontario in 1971, and five universities eventually developed programs. The program was over one year at the post-diploma or post-baccalaureate level and prepared primary care nurse practitioners. The impetus behind the initiative came from a shortage of family physicians, particularly in rural and remote locations. The programs produced good practitioners, but the initiative was plagued by a lack of funded positions, resistance by many family physicians and opposition by the Ontario Medical Association. Those physicians who did support a team approach to the delivery of primary care found that if they employed nurse practitioners in their practices, in order to cover the cost of the nurses' services, they had to see the patients as well and bill for their own time. For the most part, only community health centres with a centralized budget and salaried healthcare providers were able to provide ongoing employment.

Nurses were prepared to locate in underserved communities that needed a healthcare provider. But unless a physician was prepared to work with the nurse, and the community was able to negotiate a salary from the government for the

nurse practitioner, the position could not be established. No legislation was passed that legitimized the role or defined its scope of practice. Licensure as a nurse practitioner was not available. These issues sounded the death knell for the educational programs; the last one closed in 1983. Some of the nurse practitioner graduates continued to practise in community health centres, but most returned to usual nursing roles.

The reintroduction of primary care nurse practitioner (PCNP) preparation in Ontario occurred in the mid-1990s through a consortium of the 10 university programs jointly offering an online program supplemented by periodic group practice sessions and blocks of supervised clinical practice. For political reasons that require more explanation (but not justification) than this editorial can accommodate, the program was offered at the post-baccalaureate and post-RN baccalaureate levels, not at the more appropriate master's level. The provincial

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Ministry of Health was the impetus behind the initiative and funded the costs of the program. I believe this program has not received the attention and recognition it deserves. Where else do we have an example of 10 different universities agreeing on and building one curriculum that is offered in French and English, on a full- and part-time basis, in which the teaching is shared among

them, with each recognizing the contributions of others? The College of Nurses of Ontario demonstrated exemplary leadership by creating the conditions that enabled these graduates to become registered (in Ontario as RNs Extended Class) as nurse practitioners with expanded role functions. The history of this program needs to be written, because it broke many barriers and created alliances that had not ever been forged previously. Despite these exemplary beginnings, creating and funding PCNP positions has not been easy, echoing many of the same issues that undermined the earlier abortive effort. Many of these barriers have been resolved and the role has grown well beyond Ontario, with many graduate programs providing the required preparation across the country. The Ontario program moves to the graduate level in the fall of 2007.

Acute care nurse practitioners (ACNPS), who are prepared at the master's and post-master's levels, first came on the scene in neonatal intensive care units in the late 1980s to help offset a shortage of medical specialists. McMaster University

established the first program, which it still offers. In the mid-1990s, ACNPs became part of the fabric of specialty areas of teaching hospitals, initially in Toronto and London, Ontario, and over the next decade they spread across the country. The impetus was a shortage of medical residents in most specialty areas, but the initiative was also driven by the recognition that there was a serious lack of continuity of care for seriously ill patients who frequently had long lengths of stay. ACNPs brought continuity and much more, and have become indispensable in most teaching environments. Across the country, educational programs to prepare both primary care and acute care nurse practitioners are popular, and nurses compete for admission. Most provinces now have licensure for nurse practitioners or are in the process of enacting it. Unlike the earlier aborted effort, this time nurse practitioners are here to stay as an essential part of the Canadian healthcare scene. According to a fact sheet published by the Canadian Nurses Association (2002), nurse practitioners are found in every state in the United States and now number more than 100,000. They have been introduced in Australia, and legislation is under development in the United Kingdom and New Zealand.

There are lots of reasons why healthcare systems have embraced the role of nurse practitioner and are heavily promoting it: it's effective, efficient, accepted by the public and offsets, to some extent, a shortage of both primary care and specialist physicians. But why has the role of nurse practitioner been embraced by nurses? In fact, nurses championed it before many in the nursing establishment because of fears that it was more a physician assistant than a nursing role. That concern has largely been erased by the strong nursing foundation that grounds those in the role.

I believe that both nurses and nursing as a profession need the nurse practitioner role as much as the healthcare system needs nurse practitioners. Nursing is a difficult career. It's hard to be a good bedside nurse for 35 to 40 years. The daily demand to be responsive, empathic, safe, efficient and effective in terms of selecting and providing the most appropriate care to sick, sick patients in a rigid system that provides too few opportunities for independence and creativity takes a toll. Nurses need lots of career opportunities available to them to apply their knowledge, skills and experience. In the 1970s, clinical nurse specialist roles allowed nurses for the first time to remain clinically focused while taking on leadership positions. Until then, the only advancement available to nurses was through administrative or teaching roles. Clinical nurse specialists have migrated over the years into roles in program development or knowledge translation; both are needed and valued by the healthcare system, but such roles do not suit every nurse. The nurse practitioner role adds to the repertoire of career options available to nurses. We have not sufficiently exploited and explained the wide range of career opportunities available within nursing as a recruitment strategy. In a study

that we undertook (Pringle and Green 2004) to better understand why nursing did not attract sufficient numbers of particular groups of potential recruits – i.e., men, and Aboriginal and Black Canadian men and women – we were told by successful young people from these groups that job opportunities available within nursing were emphasized by recruiters but not lifelong career opportunities, and they were looking for the latter. Most had little exposure to nurses other than those they met in school, or relatives who toiled as staff nurses throughout their careers. These young people knew nothing about the opportunities to be a clinical nurse specialist or a nurse practitioner. They could see themselves in those roles, but not as a staff nurse with a career at the bedside.

I worried for several years that in promoting the nurse practitioner role, nursing was helping to offset the shortage of physicians (and I acknowledge that as only one element of the NP advantage) while exacerbating the acute shortage of nurses to fill more traditional nursing roles. I no longer worry about this. By creating as many interesting career options for nurses as possible, we can attract more people into the profession. Meanwhile, nurses can apply their nursing talents in a number of avenues that will meet their needs for fulfillment and, in many cases, give them more autonomy than is available in traditional roles. And the healthcare system is better for it. Nurse practitioners are a wonderful addition to the repertoire of career options for nurses.

The United States has had much more experience with these roles than we in Canada have, and we have learned a great deal from their experience. It's ironic that while the Canadian healthcare system serves its population much better than the American system serves its people (a huge generalization, I acknowledge), the Canadian healthcare system in some significant ways serves its nurses less well than the American system serves its nurses. Our single-payer system, which places healthcare access under the control of physicians, creates significant obstacles to the development of new nursing roles. Medicine, like all disciplines including nursing, is territorial and does not embrace new roles for nurses that overlap with physicians', even in the face of evidence that the role benefits everyone, including them.

Nurse anaesthesiologists are a case in point. While they are the major deliverer of anaesthesia in the United States, the role has yet to be developed in Canada. In Canadian provinces, governments are frequently central in determining the new nursing roles that get created, because without government funding, financing such positions is extremely difficult. It is important to note, however, that when the new adult and child acute care nurse practitioner positions were developed in Toronto, government played no role. Hospitals created and funded the positions.

In fact, they lobbied the University of Toronto Faculty of Nursing hard to have educational programs developed to produce the required ACNPs, and paid for the education of the first cohort of practitioners.

The deciding factor in the development of new nursing roles should be the needs of patients that are not being adequately met by the healthcare system with its current configuration of roles. Let's be creative and brave, and create roles that nurses can fill that will meet patients' needs and offer even more exciting opportunities within nursing careers.



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