

Singing from the Same Songbook: The Future of Advanced Nursing Practice in British Columbia

Rita Schreiber RN, DNS
Professor, School of Nursing
University of Victoria, BC

Marjorie MacDonald, RN, PhD
Associate Professor, School of Nursing
University of Victoria, BC

Bernadette Pauly, RN, MN
School of Nursing
University of Victoria, BC

Heather Davidson, PhD
Director, Strategic Policy and Research
BC Ministry of Health Planning
Victoria, BC

Jane Crickmore, RN, MPA
Public Health Nursing Consultant
Disease and Injury Prevention Branch
BC Ministry of Health Planning
Victoria, BC

Lesley Moss, RN, MA
Director, Adult Critical Care/Rehabilitation Services
Vancouver Island Health Authority
Victoria, BC

Janet Pinelli, RN, DNS
Professor, School of Nursing/Department of Pediatrics
McMaster University
Clinical Nurse Specialist/Neonatal Practitioner
McMaster Children's Hospital
Hamilton, ON

Sandra Regan, RN, MSN
Nursing Policy Consultant
Registered Nurses Association of British Columbia
Vancouver, BC

Abstract

In Phase III of a three-phase study, an invitational think tank was held to explore advanced nursing practice (ANP) outside British Columbia, to determine its potential usefulness in the province and to identify barriers to its implementation there. Participants expressed support for expansion and development of ANP roles in the province and identified the following issues to be addressed: (a) defining the role and role clarity, (b) public relations, (c) financial considerations, (d) legislation and regulation and (e) education.

A key challenge for researchers and policy makers is the integration of research findings into the formation of policy that contributes to and reflects growing popular consensus (Jennings 2001; Lomas 2000a,b; Rist 2000). As researchers and decision-makers who are studying and implementing advanced nursing practice (ANP) roles in British Columbia, we approached this challenge in the third and final phase of a study designed to inform policy direction regarding ANP roles in the province. The first two phases of this study were reported previously in this journal (Schreiber et al. 2005; MacDonald et al. 2005). In this paper we report findings from Phase III, in which we continued our exploration of models of advanced nursing practice in other jurisdictions, determined their potential usefulness and feasibility in British Columbia, identified barriers to implementing new nursing roles in that province and recommended future policy directions for new nursing models there.

Background

Although researchers often hope to inform policy, actual utilization and uptake of findings is uneven (Jennings 2001; Lomas 2000a,b; Plouffe 2000; Weiss 1980). Researchers publish in academic journals that policy makers may read irregularly, with the result that important findings may be read and valued only by other academics. Too often the result is two solitudes, a situation we hoped to avoid by collaborating widely throughout this research project and, in particular, in Phase III. This intent is in line with one mandate of the study's key funder, the Canadian Health Services Research Foundation (CHSRF): to build bridges between researchers and policy makers to increase the probability that policy and research can develop concurrently and inform each other (Lomas 2000a,b). For CHSRF, knowledge exchange is as important as the study's design, and to this end, the links between researchers and decision-makers, as well as with the wider nursing and healthcare communities, have been strengthened throughout the study.

The original impetus for this study arose from an identified gap in policy regarding ANP and related roles, making it difficult for decision-makers to develop policy and move forward with their implementation. Although clinical nurse specialists have worked as advanced practice nurses in Canada for more than 30 years, interest in the role of nurse practitioners has increased. Nurse practitioner initiatives in Canada have been spearheaded by governments (e.g., the registered nurse (extended class) in Ontario), by the nursing profession (e.g., nurse practitioners in Alberta) and by interdisciplinary or intersectoral collaborations (e.g., the acute care nurse practitioner and clinical nurse practitioner–neonatal practitioner in Ontario) (Manning 1999; Schreiber et al. 2003). Because the original need in British Columbia arose from within the policy realm, members of the research team wanted to contribute to the development of nurse practitioner policy that would be both informed by relevant research findings and supported by key stakeholders. To this end, over the course of this project we cultivated an ongoing collaboration among representatives from government, academia, the nursing regulatory body, employers, nursing and other disciplines (pharmacy, medicine, midwifery) and the public.

Please see the first paper of this study describing Phase I (Schreiber et al. 2005) for our rationale in using the term “advanced nursing practice” rather than the more recently preferred term, “advanced practice nursing.”

Purpose and Objectives

Phase III consisted of an invitational think tank whose purpose was twofold. First, it was a communication strategy to disseminate the results of the first two phases of the study. Second, it was a data collection strategy in which we brought together stakeholders to discuss findings from Phases I and II and to provide guidance to the research team in formulating policy recommendations for new and/or advanced nursing practice roles in British Columbia. Specifically, we addressed the following objectives: (a) to explore and describe models of advanced nursing practice in other jurisdictions and determine their potential usefulness and feasibility in British Columbia, (b) to identify barriers to implementing new nursing models in that province and (c) to identify and recommend future policy directions for new nursing models there.

Method

A two-day think tank was held in October 2002 during which we brought together nurses, physicians, other providers (e.g., midwives, pharmacists), employers, researchers, policy makers, educators and representatives of professional organizations to discuss the findings from Phases I and II. Participants were selected on the basis of their affiliation with relevant organizations (e.g., the medical association, schools of nursing, government departments, etc.) or because of their interest and involvement in the implementation of ANP roles in the province. A total

of 95 participants attended. The think tank consisted of formal presentations and small-group discussions of seven models of nursing practice, the majority of which we considered to be advanced. The models chosen were those studied in Phase II (MacDonald et al. 2005), as well as the clinical nurse specialist role and a nurse practitioner-type role from British Columbia:

- nurse practitioner (registered nurse [extended class]; RN[EC]) in an urban community health centre;
- clinical nurse specialist–neonatal practitioner (CNS-NP) in a neonatal intensive care unit;
- acute care nurse practitioner (ACNP) in a tertiary oncology setting;
- nurse practitioner (NP) in an urban BC community health centre; and
- clinical nurse specialist (CNS).

US models included:

- certified registered nurse–anaesthetist (CRNA); and
- advanced rural nurse practitioner (ARNP) in a rural clinic.

Data collection and analysis

Researchers recorded data from the discussions on flipcharts and in field notes and conducted a preliminary thematic analysis at the end of Day 1. The preliminary analysis, which was presented to participants on Day 2, formed the basis for further group discussion and exploration of identified issues and related strategies. Again on Day 2, data from discussions were recorded on flipcharts and in field notes.

One member of the research team who was not present at the think tank conducted a detailed content analysis by returning to the raw data without referring to the preliminary thematic analysis results. She analyzed the data using line-by-line coding, constantly comparing the text in each code with other related text and then with other codes until all data were categorized under five final categories or themes. At this point, she compared her results with the preliminary analysis and found a remarkable congruence. She then modified and refined her own categories, moving items within categories to achieve a better fit of the data with the categories. Two other members of the research team reviewed the analysis throughout the process, and all team members reviewed and confirmed the final results.

Findings

Despite diverse stakeholder representation and interests, think tank participants strongly endorsed the models of ANP presented and saw potential for expansion of these and other roles to meet health services needs in British Columbia. Analysis of the data from the think tank revealed five themes that were issues to be addressed

in order to implement new ANP roles in the province: (a) defining the role and achieving role clarity, (b) public relations to promote and market the role, (c) financial considerations, (d) legislation and regulation and (e) education.

Role and role clarity

Participants identified the need for clear and consistent role definitions to clarify possible misunderstandings regarding collaboration and to distinguish between ANP and medicine, as well as between ANP and expert/specialized practice.

Participants believed that clear, relevant role definitions were necessary to promote understanding of ANP by the public, by other providers and among the nursing population. Several challenges associated with defining the role were identified, including the breadth of potential practice, role complexity, contextual issues, specialization, collaboration, health human resource planning and the risk of marginalizing advanced nursing practice.

The seven roles discussed at the think tank each span a breadth of practice possibilities. For example, clinical nurse specialist roles vary from institution to institution, and clinical nurse specialists encounter role ambiguity and difficulty developing specific job descriptions because of that breadth of practice and the variety of needs. Participants said that nurse practitioner roles should not focus solely on patient care but should include protected time for other aspects of the role, such as research and education.

ANP roles were viewed as embedded within the context and should emerge from the needs of the population or the practice area, although Bryant-Lukosius et al. (2004) argue that client needs are paramount. Participants identified as a key issue to be addressed “Which healthcare needs will advanced nursing practice address, who decides and how?” Participants also recognized a need to address the evolution of roles over time in response to changing health needs.

Participants stressed a need to distinguish between expert/specialized and advanced practice in developing ANP roles. They thought it important to consider the trend towards greater specialization in nursing and healthcare that is being driven by increasing levels of acuity in both hospital and community. This trend conflates the meaning of expert/specialized practice with advanced practice, adding to role confusion. With more nurses developing expertise by working in narrow specialties, it is easy to define advanced practice in that way. However, advanced practice is defined by more than the experience of the nurse and the narrowness of the area in which she or he works. The trend towards specialization may also distort the image of primary healthcare providers. Primary healthcare, itself, may be viewed as an area of specialization.

A final concern was the potential to marginalize ANP roles by making the scope of practice too narrow or by restricting the role to particular practice settings or populations. For example, participants indicated that nurse practitioners in community healthcare centres should not be restricted to caring for underserved and marginalized groups, and that the role should not be limited to these settings. Similarly, participants expressed concern that the practice of nurse anaesthetists not be limited to providing care for certain concerns such as pain management, or to services during off hours. Overall, participants sent a strong message that such marginalization would reduce public access to necessary healthcare and compromise the potential benefits of advanced nursing practice.

Participants raised particular concerns about potential resistance to ANP roles from other healthcare providers, particularly physicians. There was a feeling that some physicians may resist implementation of ANP roles because of perceived legal concerns, for example, being held accountable for nurses' work if nurses work under delegation. This concern highlights the importance of having an appropriate legislative and regulatory framework enabling autonomous advanced nursing practice. Participants identified the powerful medical lobby as a possible source of resistance because of pre-existing beliefs about provider roles and potential loss of personal income from fee-for-service sources. At the same time, participants thought that some physicians, such as surgeons, might support the idea of nurse anaesthetists because it could give them better access to operating room time (Schreiber and MacDonald 2003). In all phases of our study, we have found that initial physician resistance to advanced practice roles gave way to strong support once physicians had an opportunity to work closely with these nurses and experience the benefits to clients and to their own practice (Schreiber et al. 2003).

Participants viewed collaboration as a central feature of all professional roles, including advanced nursing practice. Collaboration was understood as providers working together as autonomous professional colleagues to ensure the best patient care. Participants identified several challenges to collaboration, including resistance to ANP roles from other providers, inequities within healthcare teams (especially related to payment mechanisms and professional socialization) and lack of understanding of the roles. Research has demonstrated that physicians often misunderstand the ANP role and are not aware of the full scope of practice (Martin and Hutchinson 1997, 1999; Schreiber et al. 2003; Bryant-Lukosius et al. 2004).

The group identified inequities arising from a number of sources that may create a particular challenge to collaboration. Within a healthcare team, for example, both physicians and nurses should be expected to be on call equally. Differences in terms and conditions of work for providers (e.g., fee-for-service physicians, salaried or unionized RNs) were seen as interfering with collaborative relationships.

Participants pointed out that a lack of understanding of ANP roles was another challenge to collaboration. In order to facilitate collaboration, it will be important to help physicians and others understand what advanced nursing practice can contribute to care, including demonstrating evidence-based outcomes of ANP. It was recognized that members of different professions can often do the same job equally well, although each one might approach a problem from a slightly different perspective. Participants underscored the need to move away from defining roles and tasks as discipline-specific and towards recognition of shared contributions.

The need for long-term strategic planning, including health human resource planning, was seen as necessary for introducing and sustaining ANP roles. Participants identified a number of deployment issues to be addressed, including creation and funding of ANP positions, creating infrastructure to support ANP and addressing issues related to recruitment, retention and quality of work life. Repeatedly, participants stressed the importance of not educating and regulating nurse practitioners without concurrently creating jobs, as occurred in Ontario.

Public relations

Participants underscored the need to communicate information about ANP roles to facilitate understanding, valuing and acceptance of them. There was a strong belief that in order to implement additional ANP roles, a major education campaign would be needed to market these roles to the public, other providers, administrators and policy makers. Participants stated that the main message should be that advanced practice nurses are independent, autonomous and regulated providers, who provide primary healthcare and specialized services and practise within their own level of competency based on what they have been educated to do.

Participants acknowledged the importance of identifying and publicizing existing and future data on outcomes of ANP in order to establish the value and credibility of the role. They specifically identified the desirability to build on, rather than repeat, existing research (e.g., comparisons of nurse practitioners and physicians) and to develop new outcome indicators, particularly nurse-sensitive outcomes.

Participants identified the importance of the provincial government's work with professional groups and health authorities to foster peer networks, identify champions and facilitate coalition building to support implementation of the nurse practitioner role. The government was viewed as having a role in shaping public expectations. For example, the expectation of seeing a physician for every ailment could be countered with the key message that a nurse practitioner's care is demonstrably equal to or better than a physician's care (Brown and Grimes 1993; CHSRF 2002; Horrocks et al. 2002).

Financial considerations

Participants found financial considerations to be difficult to address in isolation from consideration of the ways in which the healthcare system is organized and financed. Within financial considerations, participants identified four sub-themes: funding methods and models, remuneration, collective agreements and availability of financial resources.

In general, fee-for-service as a funding model was thought to make the implementation of new models of nursing practice in the province more difficult and to create disincentives to providing high-quality care. Participants recommended a population-based block-funding model based on health needs and characteristics of the population for healthcare services, including ANP. In moving to a new model of funding, considerations include attention to population health needs, geographic differences, implications for changing practice patterns and fiscal accountability. Particular attention is needed to ensure that the health needs of people living in rural and remote regions are met. Participants recognized that shifting to a new funding model would not be easy and would likely engender resistance. They argued, however, that government would have to “bite the bullet” and do what was necessary if implementation of new ANP roles is to be successful.

Participants strongly endorsed salaried positions for advanced practice nurses and other providers, with assurances that compensation would be appropriate to the value of the work. Salaried employment for nurse practitioners was viewed as providing flexibility in promoting professional practice and collaboration; however, a few participants expressed fear that it could lead to inefficiencies. If government is the payer, it is easier to ensure fairness than if an independent physician is hiring and paying a nurse practitioner. There was strong agreement that it was not desirable to have nurse practitioners hired and salaried by physicians. The danger in this payment method is that nurse practitioners' practice would be defined by the employing physicians, who may not understand the nursing aspects of the role. Such physicians might define the job as a physician-substitute role, so that the advantages and benefits of the nursing role would not be realized. Such a relationship would also perpetuate the status hierarchy between physicians and nurses that has been historically problematic. Participants agreed on the desirability of identifying appropriate incentives to foster innovation, efficiency and effectiveness. There was diversity of opinion regarding inclusion of advanced practice nurses within bargaining units.

Strong belief was expressed that government should fund the development (legislation, regulation, deployment) and implementation (education, public relations) of ANP roles. Participants expressed concern that the necessary new funding to ensure implementation and sustainability of ANP roles might not be forthcoming, and

that having to compete for existing funds for the development of ANP roles would jeopardize their viability.

Legislation and regulation

Participants identified that the provincial government has an important leadership role to play in the development and implementation of legislation for ANP. There was overwhelming agreement that legislation should be consistent with health system and client needs and should be enabling rather than restrictive, to permit full development of the role in a variety of settings. Participants identified three sub-themes, including definition and principles of legislation, boundaries of legislation and public safety.

Participants reinforced the importance of developing clear definitions of advanced nursing practice and roles. They recommended title protection and clear standards for both clinical nurse specialists (CNSs) and nurse practitioners (NPs). Participants stressed the importance of legislation that would enable autonomous practice rather than enshrine lists of activities, drugs or diagnoses. Perhaps the loudest single message coming from the think tank was “no lists.” In particular, participants supported a professional practice model in which each provider has sole authority for his or her own practice, responsibility for decision-making and maintenance of competencies, and assessment of limitations and areas for professional development. Participants strongly expressed the view that professional collaboration and consultation are part of professional practice and should not be legislated.

Participants recognized the limitations of legislation and identified that it cannot address all issues related to implementation of advanced nursing practice. Regulations, bylaws and policies are needed that complement legislation. Participants identified the need for an evaluation plan with particular attention to developing outcome indicators and evaluating long-term outcomes, prescriptive authority and reserved acts.

Participants identified the need for clearly defined standards for entry to advanced nursing practice to ensure that all advanced practice nurses have met the relevant competencies. They suggested consideration of a challenge process for entry to advanced nursing practice by currently unregulated NPs, with attention paid to ensuring that all advanced practice nurses meet the standards. Time limits on the challenge process could be considered within the legislation. Participants also identified the need to develop clear standards and accreditation processes for ANP programs, as well as for continuing education. The regulatory body was seen as having an important role in creating the structures for regulation of nurse practitioners' practice.

Education

On both days of the think tank, issues and challenges related to education for advanced practice roles were identified and discussed. Five sub-themes were identified within the theme of education: standardization of programs, development of educational programs, curriculum content, ongoing competency and continuing education and transitional issues.

Participants identified the need for advanced practice nurses to achieve a consistent level of education in order to demonstrate the competencies necessary for practice. Standardization was seen as facilitating the ability of graduates to work across the country, enhancing public understanding of the role(s), promoting public protection and enabling peer support networks. Participants identified the particular need to make educational programs accessible to nurses working in rural and remote communities.

Participants agreed that ANP roles require graduate-level preparation, with a strong practice focus, to facilitate the breadth and depth of knowledge required. It was acknowledged that faculty development is needed to ensure the availability of doctorally prepared faculty with NP competencies who can teach in ANP programs. Appropriate practice placements for students would need to be developed. It was agreed that the curriculum should be based on a strong practice component, including content related to collaborative practice. Participants recommended that the curriculum be sufficiently flexible to allow eventual development of sub-specialties, and that national coordination and rationalization of such programs would ultimately be needed.

Participants identified that new practitioners require time to develop within their new roles as advanced practice nurses. To reach their full potential, advanced practice nurses need both experience and education. Participants felt that an important aspect of professional development is continuing education that is appropriate, timely and accessible, and which nurses are supported to attend.

There was consensus that educational programs should be both accessible and flexible, with multiple entry points. Although the educational competencies to be achieved are clearly defined, different options for achieving them should be explored. Participants recommended that educational programs be prepared to accommodate nurses already in the workforce. In addition, participants recognized a need for targeted funding for specific educational programs, as well as funding incentives (such as forgivable loans) to encourage nurses to work in underserved areas.

Discussion and Implications

The findings from Phase III that related to lack of role clarity mirror findings from earlier studies (Alcock 1996; Knaus et al. 1997; Manning 1999; Martin and Hutchinson 1997, 1999; McFadden and Miller 1994; Bryant-Lukosius et al. 2004) and reflect ongoing confusion about nursing in general and ANP specifically. Think tank participants expressed concern that the public, as well as other healthcare providers, could have difficulty understanding the differences between nurse practitioners and physicians. As Safriet (2002) noted, role and scope-of-practice difficulties arising in nursing and other health professions are strongly influenced by the fact that medicine was the first health profession regulated in North America, thus forcing other professions to define themselves in relation to it. This situation has influenced the degree to which nursing has been able to enshrine its full scope of basic and advanced practice in legislation and regulation.

A number of thorny issues discussed at the think tank will require careful attention. For example, financial issues are complex and interrelated, requiring multiple concurrent changes. Participants had difficulty strategizing about funding models because of current funding structures and payment mechanisms embedded in and shaping the healthcare system. Current policy documents, such as the Romanow report (Commission on the Future of Health Care in Canada 2002) and Patients First (British Columbia Select Standing Committee on Health 2001), support implementation of nurse practitioners, but do not identify mechanisms for ensuring funds and creating structures for development and implementation of education, deployment, public relations, legislation and regulation. Recommendations in policy documents, however, do not always translate into policy and practice; thus, one of the key recommendations of this study is: *Legislation, regulation and deployment of nurse practitioners should not occur unless and until stable funding to support implementing and sustaining the role is in place* (Schreiber et al. 2003: 109).

After considering the complexity of nurse practitioners' work, think tank participants endorsed the importance of appropriate graduate preparation to enable nurse practitioners to enter practice. This recommendation is consistent with the overall trend in Canada, as reflected in recent changes to the Canadian Nurses Association (CNA) framework on advanced nursing practice (CNA 2002). It also reflects the experience in the United States, where graduate preparation is now required for all ANP roles (Geyer et al. 2002). The requirement for graduate preparation, however, stands in contrast to legislation in other Canadian provinces (e.g., Ontario, Saskatchewan, Newfoundland), where graduate preparation is not yet required. Interestingly, in the development of acute care nurse practitioner roles in Ontario, a minimum of master's-level preparation as a requirement was never questioned.

The recommendation of graduate preparation for ANP in British Columbia is congruent with developments in Australia and New Zealand (Australian Nursing Council 2002), where graduate programs to prepare APNs are increasingly available and required for entry to practice. This approach enshrines recognition of the importance of practice learning, which was also highly valued by study participants. The importance of practice in the education of advanced practice nurses is widely recognized in the literature (Geyer et al. 2002; Gibson 2000; Gunn 1998).

Participants identified a number of issues related to the quality of work life for nurses working in advanced practice roles, particularly new roles. Concern was expressed regarding on-call schedules for nurses working in anaesthesia or those in remote locations. These concerns were largely related to the terms and conditions of work, such as payment structures, scheduling, vacations and so forth. Issues such as these might be addressed through collective agreements; however, this could compromise the ability of the advanced practice nurse to effect change and provide leadership at an organizational level. Because leadership and change are explicit competencies of ANP recognized by the CNA, nurses practising in ANP roles must have the ability to demonstrate and use these competencies.

The effectiveness of ANP roles has been well established (see, for example, Brown and Grimes 1993; Safriet 1992, 2002); however, there is further need to develop indicators that are sensitive to the nursing components of practice that are often invisible (Schreiber 1994), such as health education, counselling and support. In addition, evaluation of ANP roles should be expanded to include larger segments of the population, because many extant studies have focused solely on provision of services to the underserved (Anderko and Kinion 2001). Of particular importance, however, is to build on, rather than replicate, existing research.

A final word is warranted about the utility of the think tank as a research method in this study. We conceptualized the think tank as both a dissemination strategy and an approach to data collection. This unusual combination was driven, in part, by the funding organization's commitment to emphasizing knowledge dissemination and transfer. We wanted to involve all relevant stakeholders in determining the strategic direction in the province related to implementing ANP roles. The think tank provided the opportunity to meet both needs and, in the end, was highly effective in achieving these goals. This success was demonstrated by the active involvement of all stakeholders in the process and in the rich discussions of participants, in which it was clear that knowledge of the research findings was guiding their input and recommendations. Analysis of the think tank data was consistent with the findings and conclusions of the first two phases of the project, which served, in some ways, to corroborate the validity of the research process.

Summary and Conclusions

Several important ideas emerged from the think tank participants' contributions. Perhaps most important was the strong support for ANP roles in British Columbia, particularly those of clinical nurse specialist and nurse practitioner. This strong endorsement came from representatives of multiple stakeholder groups with multiple interests, including (but not limited to) physicians, pharmacists, midwives, nurses, government decision-makers, health authorities, practising nurses, nurse educators and regulatory bodies.

As we move to develop new nursing roles for the province, participants identified issues that will need to be addressed to support successful implementation. First, the roles need to be clarified and marketed to the public to ensure a clear understanding of the expectations, their relationship to existing roles and their potential benefits. Second, given the complexity of the proposed roles, participants agreed that graduate preparation is required for entry to practice. Third, a professional practice model of regulation is needed that will allow practitioners to practise under their own authority within the guidelines established in nonrestrictive legislation that protects the role titles. "No lists" was the overriding message. Finally, the group strongly believed that the government needed to take a leadership role in working with relevant stakeholder groups to support the development and implementation of ANP roles. This leadership role includes providing adequate funding for educational programs, a supportive infrastructure and job creation. It also means taking a strong position against opposition to ANP roles.

Correspondence may be addressed to Rita Schreiber, School of Nursing, University of Victoria, P.O. Box 1700, Victoria, BC V8W 2Y2; phone: 250-721-6462; email: rschreib@uvic.ca.

Acknowledgments

Funding for this study was provided by Canadian Health Services Research Foundation (#RC1-0533-10), the Nursing Research Foundation, the British Columbia Health Research Foundation, the British Columbia Ministry of Health Planning and the University of Victoria School of Nursing. The authors thank Dr. Lyn Davis for her assistance in preparing the final manuscript.

References

- Alcock, D.S. 1996. "The Clinical Nurse Specialist, Clinical Nurse Specialist/Nurse Practitioner and Other Titled Nurses in Ontario." *Canadian Journal of Nursing Administration* 9(1): 22–43.
- Anderko, L. and E. Kinion. 2001. "Speaking with a Unified Voice: Recommendations for the Collection of Aggregated Outcome Data in Nurse-Managed Centres." *Policy, Politics and Nursing Practice* 2(4): 295–303.
- Australian Nursing Council. 2002. "Nurse Practitioner Development: A Comparative Analysis of Nurse Practitioner Development from the Nurse Regulatory Authorities of Australia and New Zealand." Retrieved August 16, 2003. <http://www.anci.org.au/news_p.htm>.
- British Columbia Select Standing Committee on Health. 2001. *Patients First: Renewal and Reform of British Columbia's Health Care System*. Victoria, BC: Legislative Assembly of British Columbia.
- Retrieved May 3, 2005. <<http://www.legis.gov.bc.ca/cmt/37thparl/session-2/health/reports/healthtoc.htm>>.
- Brown, S.A. and D.E. Grimes. 1993 (March). Nurse Practitioners and Certified Nurse-Midwives: A Meta-analysis of Studies on Nurses in Primary Care Roles. *American Nurses*

- Association Publ.* #NP-85 5M: i-xx, 1-105.
- Bryant-Lukosius, D., A. DiCenso, G. Browne and J. Pinelli. 2004. "Advanced Practice Nursing Roles, Part I: Factors Influencing Role Development, Implementation and Evaluation." *Journal of Advanced Nursing* 48(5): 519-29.
- Canadian Health Services Research Foundation (CHSRF). 2002. "Seeing a Nurse Practitioner Instead of a Doctor is Second-Class Care." Mythbuster #8. Ottawa: Author. Retrieved May 3, 2005. <http://www.chsrf.ca/mythbusters/pdf/myth8_e.pdf>.
- Canadian Nurses Association. 2002. *Advanced Nursing Practice: A National Framework* (rev. ed.). Ottawa: Author.
- Commission on the Future of Health Care in Canada. 2002 (November). Building on Values: The Future of Health Care in Canada. Final Report. Ottawa: Commission on the Future of Health Care in Canada. Retrieved May 1, 2005. <http://www.hc-sc.gc.ca/english/pdf/care/romanow_e.pdf>.
- Geyer, N., S. Naude and G. Sithole. 2002. "Legislative Issues Impacting on the Practice of the South African Nurse Practitioner." *Journal of the American Academy of Nurse Practitioners* 14(1): 11-15.
- Gibson, F. 2000. "Focus Group Interviews to Examine the Role and Development of the Clinical Nurse Specialist." *Journal of Nursing Management* 9: 331-42.
- Gunn, I.P. 1998. "Setting the Record Straight on Nurse Anesthesia and Medical Anesthesiology Education." *CRNA: The Clinical Forum for Nurse Anesthetists* 9(4): 163-71.
- Horrocks, S., E. Anderson and C. Salisbury. 2002. "Systematic Review of Whether a Nurse Practitioner Working in Primary Care Can Provide Equivalent Care to Doctors." *British Medical Journal* 324: 819-23.
- Jennings, B.M. 2001. "The Role of Research in the Policy Puzzle: Nurse Staffing Research As a Case in Point." *Research in Nursing and Health* 24: 443-45.
- Knaus, V.L., S. Felten, S. Burton, P. Fobes and K. Davis. 1997. "The Use of Nurse Practitioners in the Acute Care Setting." *Journal of Nursing Administration* 27(2): 20-27.
- Lomas, J. 2000a. "Connecting Research and Policy." *ISUMA: Canadian Journal of Policy Research* 1(1): 140-44.
- Lomas, J. 2000b. "Using 'Linkage and Exchange' to Move Research into Policy at a Canadian Foundation." *Health Affairs* 19(3): 236-40.
- Manning, N. 1999. *An Environmental Scan of Advanced Nursing Practice*. Victoria: British Columbia Ministry of Health and Ministry Responsible for Seniors.
- Martin, P.D. and S.A. Hutchinson. 1997. "Negotiating Symbolic Space: Strategies to Increase NP Status and Value." *The Nurse Practitioner* 22(1): 89-102.
- Martin, P.D. and S.A. Hutchinson. 1999. "Nurse Practitioners and the Problem of Discounting." *Journal of Advanced Nursing* 29(1): 9-17.
- McFadden, E.A. and M.A. Miller. 1994. "Clinical Nurse Specialist Practice: Facilitators and Barriers." *Clinical Nurse Specialist* 8(1): 27-33.
- Pearson, L. 2002. "Fourteenth Annual Legislative Update: How Each State Stands on Legislative Issues Affecting Advanced Nursing Practice." *The Nurse Practitioner* 27(1): 10-52.
- Plouffe, L.A. 2000. "Explaining the Gaps between Research and Policy." *ISUMA: Canadian Journal of Policy Research* 1(1): 135-39.
- Rist, R.C. 2000. "Influencing the Policy Process with Qualitative Research." In N.K. Denzin and Y.S. Guba, eds., *Handbook of Qualitative Research* (2nd ed., pp. 1001-7). Thousand Oaks, CA: Sage.
- Safriet, B. 1992. "Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing." *Yale Journal of Regulation* 9: 417-88.
- Safriet, B.J. 2002. "Closing the Gap between 'Can' and 'May' in Health Care Providers' Scope of Practice: A Primer for Policymakers." *Yale Journal of Regulation* 19(2): 301-34.
- Schreiber, R. 1994. "Pay Equity for Nurses: Comparable Worth and Gender Neutrality." *Health Care for Women International* 15(6): 577-86.
- Schreiber, R. and M. MacDonald. 2003. "The Time Has Come: Boldly Advancing the Nurse Anesthetist Role for Canada." *Canadian Nurse* 99(6): 20-23.
- Schreiber, R., M. MacDonald, H. Davidson, J. Crickmore, L. Moss, J. Pinelli, S. Regan, B. Pauly and C. Hammond. 2003. *Advanced Nursing Practice: Opportunities and Challenges in British Columbia. Final Report*. Victoria: School of Nursing, University of Victoria. Retrieved May 3, 2005. <<http://web.uvic.ca/nurs/ANP%20Final%20Report.pdf>>.
- Weiss, C.H. 1980. "Knowledge Creep and Decision Accretion." *Knowledge: Creation, Diffusion, Utilization* 1(3): 381-404.