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Canadian nurse practitioner's quest for identity: A philosophical perspective

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ABSTRACT

The role of nurse practitioners in primary healthcare has been validated over the years and is now being considered as a key solution in various primary healthcare settings to the provision of comprehensive care. The context in which the role has been established positions nurse practitioners' practice within medical and nursing paradigms. As the healthcare system evolves, nurse practitioners must define their identity to advocate for roles that reflect their professional values. A historical overview highlighting the context in which the NP role expanded will guide a philosophical discussion regarding role identity. After exposing tensions between the nursing and medicine disciplines, Abbots' theory of profession will be utilized to understand the foundations leading to initial research on nurse practitioner integration within the healthcare system. Feminist philosopher bell hooks' discourse on marginality will serve as a platform to reflect on the nurse practitioner identity within the current social context. Foucault's notions of governmentality, parrhesia and care of the self will then guide reflections regarding ways for nurse practitioners to locate themselves as a profession.

The nursing profession has been impacted by health system restructuring over the last three decades. The increasing cost of healthcare, human resource shortages, and a demand for health spending accountability has influenced a shifting focus toward health system efficiencies and cost saving measures [1]. Nurses are tasked to meet these demands, placing pressure on them to develop a productive and cost-effective system of care. Primary care is pivotal in the development of a performing health system [2]. Nurse practitioners (NPs) have played key roles in increasing access to primary care, particularly in rural settings for individuals with complex health conditions and have addressed multiple social issues such as homelessness, frail seniors or new immigrants care [3–6]. In the acute care settings, NPs have been employed to offset shortages of physician residents in multiple settings such as neonatal intensive care units, emergency rooms and inpatient units [7]. In Canada, NPs are autonomous healthcare professionals with advanced expertise in nursing theories and practice, health management and promotion, disease/injury prevention and they possess in-depth knowledge and advanced clinical decision-making skills which support their role in the provision of comprehensive health services [8]. Nurse practitioners align themselves with their practice by positioning their advanced nursing skills within nursing paradigms. Therefore, we recognize how important is the knowledge NPs must possess to accomplish their goals. But what factors have influenced the development of their advanced practice and where does this place NPs in the context of the healthcare system? Abbott's theory on the system of the profession provides a framework to answer these questions. The concepts explored in his theory help understand the power relationship and knowledge legitimization of certain professions [9].

In this philosophical paper, we will review the social and political contexts in which the Canadian NP role has evolved. Utilizing Abbott's theory on the system of the profession, we will expose the nature of tensions between the medical and nursing disciplines. A feminist philosophical framework will be applied to explore reasons why NPs must begin to reflect on their professional identity. By employing a Foucauldian analysis of the concepts of care of self, parrhesia and governmentality, we will understand how the nursing discipline and NPs must unite to define the NP's role and knowledge base and, subsequently, engage in leadership roles within the healthcare system.

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1. Historical background

At the end of the 19th century to palliate ongoing physicians shortages in isolated regions of Canada, outpost nurses worked in an expanded scope of practice establishing the role of the Advanced Practice Nurse (APN) [10]. During this time APNs did not have clearly defined regulations to guide their practice resulting in a lack of recognition of the role. The APN role practiced by outpost nurses is the root of the emergence of the NP role in Canada [11,12]. In the mid 1960's, new socio-political forces influenced NP role development and implementation which included the introduction of the Canadian Medicare system, perceived physician shortages, increased emphasis on Primary Health Care (PHC) and a trend toward increased medical specialization [10]. A report tasked by the Department of National Health and Welfare in the early 1970's proposed that NPs should be trained to meet PHC needs and should be the first contact for people entering the healthcare system in Canada [13]. At the time, a number of nurses felt the profession was not ready to accept more specialty training and advanced skills, while others felt it was a great opportunity to develop and promote nursing practice [10]. Members of the nursing discipline voiced concern that this shift would result in the medicalization of nursing and the subsequent loss of nursing philosophies [10].

In the early 1970s, several studies contributed to the validation of the NP role. A landmark randomized control trial comparing NPs' practice to family physicians' practice in Burlington found that the NP provided primary care as safely, effectively and with as much satisfaction from the patient as the family physician [14,15]. However, in spite of such evidence the NP role failed to be established and in the mid 1980's most NP educational programs were terminated with the exception of a preparation for registered nurses working in remote areas [16]. Lack of legislation to support the NP role and reduced physician income contributed to these changes, but ultimately, the absence of support from the medical community created major tensions surrounding NP role implementation [10].

From the mid 1990's to the early 2000's Canadian and provincial governments reports called for PHC reform where nurses and allied healthcare professionals were once again identified as key contributors to improving patient access to health services and enhancing health promotion activities [17]. This shift away from a strict biomedical approach to healthcare and a renewed emphasis on PHC, including improved access to preventative health services, favoured a re-introduction of the NP role, a profession embracing comprehensive care and collaboration [18].

In Canada, the roles and responsibilities are divided between the federal and provincial and territorial governments. Each province and territorial governments are responsible for planning, organizing, and delivery of health and social services for their residents. NPs currently practice in diverse settings under different models of care following the regulations of their province or territory of practice. With the above in mind, our paper is oriented to investigate the context of the development of the NP role in the province of Ontario. Historically, in Ontario, the socio-political climate in the 90s led many nursing organization to advocate for revitalizing the role of NPs. In 1998, the role was formally incorporated in the provincial legislation through the Expanded Nursing Services for Patients Act [10]. Such legislation defined further the scope of practice and the protection of the title RN (extended class) [19]. Once the role was recognized by the legislation, the Ontario Ministry of Health and Long-Term Care began to fund NPs in Community Health Care Centers and Family Health Care Teams [2,7]. Ontario was one of the first provinces in recognizing the NP role and today is the province with the highest percentage of NPs in Canada [21]. Despite the provincial government's initiative to increase access to care, many regions remained underserviced [22]. A new model of care was proposed by NPs to address the needs of underserviced communities and increase access to quality PHC and in 2007, the Nurse Practitioner-Led Clinic (NPLC) model was introduced in Ontario. At the time, the Ontario Medical Association (OMA) was strongly opposed to the NPLC model [23]. The OMA and the Ontario College of Family Physicians argued that NPs would be more expensive to the healthcare system and that the evidence to support the utilization of NPs was flawed [24]. The OMA stated "only doctors should be the ones leading teams of other healthcare professionals, not nurse practitioners" [25]. In spite of this opposition, NP leaders in Sudbury gained support from public and professional associations, and in 2008 opened the first NPLC. The government voiced strong support for this initiative with Ontario Premier Dalton McGuity, during his visit to the Sudbury NPLC in April 2008, stating "I have seen the future of healthcare, and it is in Sudbury" [22]. To date, Ontario is the only Canadian province recognizing NP-led clinics as a team-based delivery care model to access primary health care.

While the need to improve access to PHC supported the re-introduction of the NP role in the community, in the late 80's, increased workload of specialists, especially in the neonatal field, opened the door to NPs in acute care settings to ensure continuity of care (Paes et al., 1989). While research to date has focused primarily on the inter-professional relationship between NPs and physicians in primary care, acute care NPs face similar challenges with role acceptance, scope of practice and utilization of full role components [7,26,27].

With the passing of Bill 179, *Regulated Health Professions Statute Law Ammandment Act* in 2009, and proclaimed in 2011, NPs have been slowly gaining authority within their scope of practice [28]. The legislation provides NPs with an expanded role in prescribing, diagnosing, and consulting, however, most NPs continue to experience pressure to practice under the medical paradigm. Resistance to NPLC implementation in Ontario reveals the physicians reluctance to share the primary care mandate with NPs, a profession oriented to health promotion, injury/disease prevention, and disease management.

2. Understanding the tension

In Ontario, NPs gained the legal authority to independently diagnose, prescribe, and treat with the implementation of the Expanded Nursing Services for Patients Act and Regulated Health Professions Act [20]; responsibilities previously exclusive to the medical profession. Abbott's theory of the profession discusses concepts and processes within interprofessional interaction. This theory offers a discourse to aid in understanding the tensions existing between NPs and the medical discipline. Concepts relevant to knowledge appropriation and power are explained through the negotiation of jurisdictions [9]. Jurisdiction is a central concept in the theory and includes the social and cultural structures that outline a profession. The cultural aspect refers to the knowledge and skills that define the profession while the social structure of the jurisdiction refers to claims made in public, legal and workplace arenas. Professions exist within a system and are developed from interrelations with one another, with these two jurisdictional boundaries overlapping. The overlap is where settlement between professions is realized. Jurisdictional boundaries are constantly being disputed and the settlement between NP and physician in this case could entail the concepts of subordination or advisory control [9]. Settlement by subordination is demonstrated through the initial *Practice Standard for Nurse Practitioner* published in 1998 by the College of Nurses of Ontario (CNO) where collaboration and consultation processes with the physician are clearly outlined as a requirement for practice [29].