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Résumé

Analyse critique de l'évolution du rôle de l'infirmière praticienne au Canada

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Cet article propose une analyse critique de l'évolution du rôle de l'infirmière praticienne (IP) au Canada, en prenant pour exemple la province de l'Ontario. Il repose sur deux modèles théoriques choisis dans le but de mettre en évidence son développement historique et de dégager des pistes pour l'avenir. L'évolution du rôle d'IP comporte deux stades essentiels : le lancement et l'interruption (du début des années 1970 au milieu des années 1980); l'établissement et l'impasse (début des années 1990 à aujourd'hui). Parmi les obstacles actuels à la pleine intégration des IP en soins primaires, on souligne l'absence de plan de financement réaliste et stable, les contraintes limitant l'étendue de la sphère d'exercice, les tensions professionnelles entre médecins et IP et la piètre connaissance qu'ont le public et les professionnels du rôle en question. Pour surmonter ces obstacles, les infirmières praticiennes devront plaider leur cause, exercer des pressions et sensibiliser la population.

Mots clés : infirmière praticienne, histoire de la profession infirmière, soins primaires

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Critical Analysis of the Evolution of a Canadian Nurse Practitioner Role

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The purpose of this paper is to critically analyze the evolution of a nurse practitioner (NP) role in Canada using the province of Ontario as an example. Two theoretical models are used to highlight the historical development of this role and provide direction for further NP role development. The evolution of the NP role encompasses 2 critical phases: initiation and discontinuation (early 1970s to mid-1980s) and establishment and impasse (early 1990s to the present). Current barriers to the full integration of NPs within primary health care include the lack of a workable and stable funding plan for NPs, restrictions on scope of practice, work-related tensions between physicians and NPs, and lack of public and professional awareness of the role. Nurses can address these barriers through advocacy, lobbying, and public education.

Keywords: nurse practitioners, history of nursing, professional role, primary health care

In the early 1970s a physician shortage limited access to primary health care in the Canadian province of Ontario (Angus & Bourgeault, 1999; LeFort & Kergin, 1978; Mitchell, Pinelli, Patterson, & Southwell, 1993). The nursing profession seized the opportunity to fill this service gap through the education and establishment of a new class of nurses called nurse practitioners (NPs) (Angus & Bourgeault; LeFort & Kergin; Mitchell et al.). Although research evidence justified the NP role in health care, government funding of NP programs was discontinued in 1983 (Angus & Bourgeault; LeFort & Kergin; Mitchell et al.). Remarkably, in 1998 the Ontario legislature established Primary Health Care NPs as a new class of Registered Nurse (College of Nurses of Ontario [CNO], 2000b).

This paper examines the movement within the Canadian nursing profession towards implementation of an NP role using Ontario as an example. Two theoretical models are used to provide critical insight into the development of the role. Abbott's (1988) socio-historical theory of professional development situates professions within an interdependent system characterized by competition and conflict against a broad cultural, political, and economic context. The resulting analysis reveals tensions opposing the NP movement and the distinctive nature of their resolu-

Table 1 *Conceptualization of the Nurse Practitioner Role*

Role Component	First Critical Phase: Initiation and Discontinuation (early 1970s–mid-1980s)	Second Critical Phase: Establishment and Impasse (early 1990s–present)				
Title	Nurse Practitioner	Primary Health Care (PHC) Nurse Practitioner	Acute Care Nurse Practitioner	Neonatal Nurse Practitioner	Specialty Nurse Practitioner	Family Nurse Practitioner
Legislative protection of title	None	Yes	None	None	None	None
Protected title	None	RN (Extended Class) or RN (EC)	None	None	None	None
Regulatory body	College of Nurses of Ontario	CNO	CNO	CNO	CNO	CNO
Registration class	General	Extended Class	General	General	General	General
Independent authority to initiate three additional controlled acts	Not applicable. The *Regulated Health Professions Act* (1991) was not in effect during this phase.	Yes	No	No	No	No

Source: Adapted from Dacres & Clarke (2003).

tion. Freidson's (2001) theory extends Abbott's framework by crystallizing these tensions within a model of three competing ideologies. Superimposing ideologies of consumerism, managerialism, and professionalism, as defined by Freidson, upon the socio-historical analysis evokes a new understanding of the past. Lessons learned from this analysis of the evolution of the NP role provide insights with regard to development of the NP role in other provinces.

The evolution of the NP role encompasses two phases. The first, characterized by initiation and discontinuation of the role, extends from the early 1970s to the mid-1980s. The second, characterized by establishment of the role and an impasse in its evolutionary momentum, extends from the early 1990s to the present.

A conceptualization of the NP role by critical phase is summarized in Table 1. Presently, only Primary Health Care NPs are eligible for registration with the College of Nurses of Ontario's Extended Class (CNO, 2000b; Dacres & Clarke, 2003). The following application of Abbott's (1988) theory provides a critical analysis of the evolution of the primary health care NP role in Ontario.

Socio-historical Analysis: Tensions and Their Resolution

Abbott's (1988) theory situates professions within an interdependent system. Each profession functions within boundaries known as jurisdictions. These jurisdictions are perpetually in conflict, triggered by events called system disturbances.

System Disturbances

Abbott's (1988) theory accentuates two complex socio-historical events that merged to become triggers for the initial system disturbance between medicine and nursing, leading to the initiation of the NP role: implementation of universal publicly funded medical insurance (Torrance, 1998), and a perceived physician shortage (Angus & Bourgeault, 1999; Canadian Institute for Health Information [CIHI], 2001; Haines, 1993; LeFort & Kergin, 1978; Mitchell et al., 1993). Table 2 shows the relationship between each system disturbance and critical phase.

The implementation of universal publicly funded medical insurance challenged successive Canadian provincial and federal governments (Torrance, 1998). The *Hospital Insurance and Diagnostic Services Act* (1957) protected the public's right to insurance coverage for hospital care, including physician services (Madore, 2001; Torrance). By 1972 all existing provincial and territorial health insurance plans provided universal coverage for insured physician services, in both hospital and

Table 2 ***System Disturbances Influencing Evolution of the NP Role***

System Disturbances (Abbott, 1988)	**First Critical Phase (early 1970s–mid-1980s)**	**Second Critical Phase (early 1990s–present)**
Completion of the implementation of universal publicly funded medical insurance (Torrance, 1998)	✓	
Perceived physician shortage (Angus & Bourgeault, 1999; CIHI, 2001; Haines, 1993; LeFort & Kergin, 1978; Mitchell et al., 1993)	✓	
Increased complexity and acuity of patients admitted to Ontario hospitals (Sidani et al., 2000)		✓
Decrease in number of medical residents in Ontario hospitals (Bajnok & Wright, 1993; Sidani et al., 2000)		✓

community settings (Torrance). In 1972 recommendations for the NP role were put forward in a national report (Boudreau, 1972). Universal medical insurance vastly increased the potential workload of physicians in the form of a mass sheltered labour market (Abbott, 1988; Coburn, 1993; Freidson, 2001).

The second event that triggered the initial system disturbance was a concurrent nationwide physician shortage (Angus & Bourgeault, 1999; CIHI, 2001; Haines, 1993; LeFort & Kergin, 1978; Mitchell et al., 1993). This shortage occurred in the context of the World Health Organization's efforts to address mounting concern over the gap between the availability of health human resources and population health needs in both developed and developing countries (Gordon, 1971). Population characteristics such as a marked increase in birth and immigration rates and a shift from rural to urban living contributed to this concern in Ontario (Spaulding & Spitzer, 1972). A trend towards medical specialization added to the physician shortage (Haines). In Ontario, between 1961 and 1971, the proportion of family physicians and general practitioners dropped by 6% (Spaulding & Spitzer). Furthermore, such doctors were in shorter supply in northern compared with southern areas of the province during this decade (Spaulding & Spitzer).

The combination of two factors resulted in excess jurisdiction causing a system vacancy: a potential marked increase in physicians' workload resulting from universal medical insurance, and a potential decrease in physicians' output (an insufficient number of physicians to do the work) (Abbott, 1988). This rendered the jurisdictional boundary of medicine within the health-care system vulnerable to what Abbott calls an "invasion" by nursing. The door was open to the utilization of NPs.

Increasing the number of practitioners in a profession is an effective strategy for blocking jurisdictional encroachment (Abbott, 1988). However, the structural demographic rigidity of medicine's lengthy education program prolongs the time between the identification and alleviation of a system disturbance (Abbott). In 1967 an Expert Committee of the World Health Organization issued a report concerning the training and use of medical assistants to address the physician shortage (Gordon, 1971). Programs in six countries, including a program for medical corpsmen in the US Army, were studied (Gordon). Canadian governments and health professionals looked for alternative ways to address the system disturbance (Abbott; Haines, 1993).

Canada considered two health-care roles that were being developed in the United States, the physician assistant and the nurse practitioner (Haines, 1993). Ultimately the NP role was chosen (Haines). The Committee on Nurse Practitioners, a national body consisting of representatives of both medicine and nursing, gave NP pilot and demonstration projects its highest priority (Angus & Bourgeault, 1999; Boudreau, 1972; Haines; Mousseau, & Hall, 1997). In 1972 six Canadian universities initiated programs to prepare NPs for primary health care in isolated, far northern outposts and remote communities, and in 1976 they added urban family practice (LeFort & Kergin, 1978; Mitchell et al., 1993; Robertson, 1973). In 1973 physician under-service was evident in Canada's far north, in areas within some large cities, and in remote communities in every province (Robertson).

The year 1993 saw the convergence of new system disturbances that had been gaining momentum within the health-care system: increased complexity and acuity of conditions among patients admitted to hospital, and a decrease in the number of medical residents (see Table 2). These disturbances altered the balance of work between medicine and nursing (Abbott, 1988) in Ontario hospitals (Bajnok & Wright, 1993; Sidani et al., 2000).

NPs were poised to "invade" medicine's jurisdiction. However, according to Abbott (1988), multiple external forces simultaneously merge with the complex events that trigger a system disturbance through opposing pressures with the potential to alter the jurisdictional boundaries between the professions. These external forces, summarized in

Table 3, gained momentum during the two critical phases in the evolution of the NP role, exerting a profound impact on its outcome.

External Forces

Although a physician shortage was forecast in the late 1960s and early 1970s, the forecast was based on the mistaken assumption that the birth rate among the baby boom cohort would remain constant; in fact, there was an oversupply of physicians (Angus & Bourgeault, 1999; CIHI, 2001; Mitchell et al., 1993). The demand for NPs was found to be closely linked to the decision of physicians to employ them in their solo or group practices (Imai, 1974). However, the Ontario ministry of health did not provide direct funding for NP salaries, and remuneration of NPs from physicians' salaries became a financial disincentive (King, 1978; Mitchell et al.; Spitzer et al., 1974). While sympathetic to the NP role (Angus & Bourgeault), the president of the Ontario College of Family Physicians registered the dissatisfaction of the College's members in an open letter published in *The Canadian Nurse*:

> On the part of the private physician — many enjoyed the new expanded role of the nurse and the new relationship. However, after some years of experience it became evident that, by and large, physicians who had nurse practitioners were not doing as well financially. Our provincial Ministries of Health did not provide the necessary funding mechanism so that the nurse could earn her keep so to speak and at the same time the physician not suffer a loss.
>
> In Ontario, for example, an OHIP [Ontario Health Insurance Plan] card could not be forwarded for collection unless the physician also personally reviewed each and every case with the nurse and patient.... In more recent years both the medical and nursing professions have witnessed a catching up and surpassing of the manpower needs in their respective professions. In a large way this has diminished the need for the development of the nurse practitioner.
>
> I still think there is a very important role for such a person in situations such as the Sioux Lookout Zone of Northern Ontario. (King, p. 21)

Towards the end of the initiation and discontinuation phase, the nature of the conflict between medicine and nursing shifted, from one of excess jurisdiction to a direct attack by the nursing profession on medicine's monopoly, on the grounds that it was providing an equivalent service (Abbott, 1988). A key strategy used by an invading profession in seizing a heartland area in this type of conflict is to provide more effective service (Abbott). Rigorous research demonstrated positive care outcomes for NPs and justified their role in health care (Sackett et al., 1974; Spitzer et al., 1974). The Nurse Practitioners' Association of

Ontario (NPAO), founded in 1973, lobbied government officials and conducted media interviews to promote the NP role (NPAO, 2004a), but it was no match for the powerful medical profession (Haines, 1993; LeFort & Kergin, 1978; Mitchell et al., 1993). Physicians lobbied the government to discontinue the NP education programs, and the last program was discontinued in 1983, marking the end of the first phase in the evolution of the NP role (Angus & Bourgeault, 1999; Haines; Mitchell et al.).

Little is known about the activities of NPs in the years between the first and second phases. Discontinuation of the education programs, combined with the absence of NP registration and certification in Canada and Ontario, interfered with statistical data collection concerning their location and clinical practice (Patterson, Pinelli, & Markham, 1997). One author estimates that 250 NPs continued to practise in community health centres and northern outpost nursing stations in Ontario from the mid-1980s into the 1990s (NPAO, 2004b). Another suggests that during those years NPs practised in three employment settings in Ontario: in physicians' private practices; in agencies providing salaries rather than fee-for-service payments to all health professionals, including physicians; and in their own private practices (van der Horst, 1992).

The valued right to universal access to medically necessary physician and hospital services was protected by the *Canada Health Act* (1984). Prior to this legislation, a series of changes in the federal funding of provincial health insurance plans led to extra billing and direct patient billing by physicians in some provinces, including Ontario, thus threatening the principle of universal access to medical care (Madore, 2001). The *Canada Health Act* penalizes provinces that do not comply with its terms, by withholding federal transfer payments in whole or in part (Madore).

At the beginning of the second critical phase in the evolution of the NP role, the oversupply of physicians masked the geographical disproportion of family doctors that had developed in Ontario (Angus & Bourgeault, 1999; Chan, 1999; Haines, 1993; Mitchell et al., 1993). Health-care under-service, further threatening the value of access, spread from northern to rural southern Ontario, establishing additional jurisdictional battlefronts for NPs (Abbott, 1988; Chan; Haines; Mitchell et al.).

During the first phase, the *Declaration of Alma-Ata* (World Health Organization [WHO], 1978) presented a new vision for primary health care, recognizing the role of social and economic influences upon health attainment (Ogilvie & Reutter, 2003) and respecting the autonomy of each nation regarding the provision of primary health care (Ogilvie & Reutter; WHO, 1978). Since that time, the definition of primary health

Table 3 *External Forces Influencing Evolution of the NP Role*

External Force	First Critical Phase: Initiation and Discontinuation (early 1970s–mid-1980s)	Second Critical Phase: Establishment and Impasse (early 1990s–present)	Effect of External Force on Relative Jurisdictional Strength (Abbott, 1988) of Medicine and Nursing
Physician supply	Perceived shortage to oversupply (Angus & Bourgeault, 1999; CIHI, 2001; LeFort & Kergin, 1978; Mitchell et al., 1993; Robertson, 1973)	Poor distribution, creating under-service (Angus & Bourgeault, 1999; Chan, 1999; Haines, 1993; LeFort & Kergin, 1978; Mitchell et al., 1993)	Medicine *strengthened* Nursing weakened
Slowly changing cultural values	Universal access to health care (*Canada Health Act,* 1984)	Universal access to health care (*Canada Health Act,*1984) Health-care cost containment (Angus & Bourgeault, 1999; Haines, 1993; Madore, 2001; Mhatre & Deber, 1998; Mousseau & Hall, 1997)	Medicine weakened Nursing *strengthened*
Health-policy shifts	Primary *medical* care → Primary *health* care (Mhatre & Deber, 1998; Mousseau & Hall, 1997; Ogilvie & Reutter, 2003; WHO, 1978)		Medicine weakened Nursing *strengthened*

Fiscal pressures	Extra billing (Madore, 2001) Direct patient charges for physician services (Madore, 2001) Physician loss of income (King, 1978; Mitchell et al., 1993; Spitzer et al., 1974)	Rising health-care costs (Madore, 2001; Mhatre & Deber, 1998) Economic recession (Haines, 1993; Mhatre & Deber, 1998) Reduction in federal health transfer payments (Madore, 2001; Mhatre & Deber, 1998)	Medicine weakened Nursing *strengthened*
Public input	Beginning of increased public role	Significantly increased public role	Medicine weakened Nursing *strengthened*
Legislative changes	*Canada Health Act* (1984)	*Regulated Health Professions Act* (1991) and *Nursing Act* (1991), both enacted in 1993 (CNO, 2000b) *Expanded Nursing Services for Patients Act* (1997), proclaimed in 1998 and amending the *Nursing Act* (1991) (CNO, 2000b)	Medicine weakened Nursing *strengthened*

care and its influence in shaping federal and provincial health policy have been extensively debated in Canada (Ogilvie & Reutter): "In the development of health initiatives, government provides the vision, goal, and direction for promoting the health of its people through public policy" (Mousseau & Hall, 1997, p. 187). During the second phase, slowly developing changes converged in an environment of fiscal pressures and health-care cost containment and reform (Angus & Bourgeault, 1999; Haines, 1993; Mousseau & Hall) that culminated in a health-policy fit with the NP role. For example, a gradual policy shift towards primary health care (Angus & Bourgeault; Mhatre & Deber, 1998; Mousseau & Hall; Ogilvie & Reutter; WHO) guided the Ontario government's reintroduction of the NP role in primary health care community settings (Mousseau & Hall). While this government initiative facilitated evolution of the role, according to Abbott state power is also a limiting factor in the exertion of professional power. Lobbying efforts by provincial nursing associations, such as the NPAO, for concurrent implementation of the NP role in secondary and tertiary care settings (NPAO, 2004a) have been unsuccessful.

Analysis of Ontario health-policy reforms from 1987 to 1991, immediately prior to the second critical phase, reveals a shift in emphasis from curing illness to promoting health and preventing disease, as well as a shift from institutional to community-based care (Mhatre & Deber, 1998). Abbott contends that dominant professions gradually and publicly define cultural values based on the successful outcomes of their own work. For example, before the advent of primary health care, health was synonymous with visiting the doctor. Abbott (1988) calls this *consummatory legitimacy*. The shift towards primary health care challenged this notion, because access to health was no longer linked solely to access to cure (Mhatre & Deber). Changes in Ontario legislation further eroded consummatory legitimacy by allowing the public to achieve health by accessing the health-care system directly through NPs.

Public collaboration with professionals in health-care decision-making and policy formation (Coburn, 1993; Mhatre & Deber, 1998) increased throughout the second critical phase, facilitated by the *Regulated Health Professions Act, 1991* (RHPA), enacted in 1993 (CNO, 2000c). The public assumed a prominent role in the regulation and governance of the professions, including medicine and nursing. The governing councils of professional colleges (CNO, 2000a) almost doubled their lay representation, from 25% to nearly 50% (Coburn; Steinecke, 2003). A new Health Professions Regulatory Advisory Council, composed entirely of lay members of the public, was created (Angus & Bourgeault, 1999; Coburn; RHPA, 1991; Steinecke). The RHPA weakened medicine's jurisdiction by preventing any single profession from monopolizing health care

(Angus & Bourgeault; Coburn). Instead of a profession's having authority over whole areas of work, key tasks were organized into specific acts (Angus & Bourgeault; CNO, 2000c, 2000d; Coburn). In 1998 primary health care NPs secured the legal authority to *independently* initiate three controlled acts that were previously monopolized by medicine — diagnosis, prescription, and treatment (CNO, 2000c, 2000d; Coburn), thus directly attacking what Abbott (1988) calls a profession's "cognitive cultural heartland."

Another value that gradually gained prominence in Canada during the second phase was health-care cost containment (Angus & Bourgeault, 1999; Mousseau & Hall, 1997). During the 1980s, economic recession gripped Canada and the federal government focused on reducing its massive deficit (Haines, 1993; Mhatre & Deber, 1998). Cost containment moved to the forefront of public consciousness. Canadian consumers questioned the way that the tax dollars they contributed to health insurance programs were being used (Madore, 2001).

Continuously rising health-care costs accounted for an increasing proportion of provincial budgets, concurrent with a reduction in federal transfer payments to the provinces (Mhatre & Deber, 1998). A policy trend towards capping physicians' salaries and developing alternatives to fee-for-service payment of physicians emerged in Ontario (Mhatre & Deber). Physician strikes and service withdrawals in the mid-1980s and the 1990s, the beginning of the phase of establishment and impasse, contributed to the public's perception of the medical profession as a significant barrier to the achievement of cost-effective health care (Angus & Bourgeault, 1999; Coburn, 1993).

Table 3 summarizes the complex external forces that emerged between the first and second critical phases. The resulting tensions shaped the relative jurisdictional strength of medicine and nursing during the evolution of the NP role in Ontario. Slowly changing cultural values underpinned a policy shift from primary *medical* care to primary *health* care, increased public participation in health-care regulation and governance, and focused public attention on economic accountability. The enactment of new legislation institutionalized these changes by protecting universal access to health care and changing professional regulation. The momentum of these external forces peaked during the establishment and impasse phase, weakening the jurisdiction of medicine and strengthening that of nursing. External forces provide the context of a jurisdictional contest. We now turn to the nature of the jurisdictional claim in and of itself.

The Jurisdictional Claim and Settlement

Jurisdictional claims are a profession's way of asking society for the exclusive right to control the performance of certain tasks (Abbott, 1988). Abbott locates jurisdictional claims in three arenas: public, legal, and workplace.

According to Abbott (1988), the public's perception of a given profession is that of a homogeneous group represented by an archetype. In nursing, that archetype is the nurse working in a hospital. Although the percentage of nurses working in a hospital or a similar institution in Ontario decreased greatly between 1972 (80%) and 1998 (59.2%), a clear majority of nurses worked in such a setting during both critical phases (CNO, 2002; Statistics Canada, 1974). However, commencing in 1972, NPs were prepared for employment in less traditional settings, such as outpost and under-served areas and urban family practices (LeFort & Kergin, 1978; Mitchell et al., 1993). Lack of public recognition of and demand for NPs is a significant factor in the failure of the role during the first phase (Angus & Bourgeault, 1999; Haines, 1993; Mitchell et al.).

The strategy of sharing professional insights and terminology to attract public support facilitates the process of changing a profession's public image (Abbott, 1988). In 1994 the Ontario government appointed a publicity and public relations committee to raise the profile of NPs (Angus & Bourgeault, 1999; Mousseau & Hall, 1997). Medicine's public profile, meanwhile, became tarnished. The contrasting images reached a peak in 1996, when physicians withdrew their services and the provincial government announced its intention to introduce NP legislation (Angus & Bourgeault).

Abbott (1988) maintains that changes in the public arena build pressure in the legal arena, which encompasses both laws and administrative structures. Although the literature offers no explanation for the absence of legislation legitimating the NP role during the first critical phase, this absence is viewed as a key contributor to the demise of the role in 1983 (Angus & Bourgeault, 1999; Haines, 1993; Mitchell et al., 1993). However, a minister of health with a personal interest in NPs is credited with receptivity to lobbying efforts of provincial nursing associations, beginning in 1993, and the subsequent establishment of new nursing leadership positions within the ministry (Angus & Bourgeault), thus strengthening nursing's jurisdictional claims during the second phase. The recommendations of two reports were instrumental in the establishment of NP legislation in 1998 (Haines; Mitchell et al.). The first was commissioned by the Canadian Nurses Association in anticipation of renewed government interest in the NP role (Mousseau & Hall, 1997). The second, a needs assessment for NPs in Ontario, was prepared by

McMaster University at the request of the ministry of health's Nursing Coordinator (Mousseau & Hall).

Although a given professional role is legitimized in the public and legal arenas, according to Abbott (1988), its realization occurs in the workplace arena. Abbott maintains that there are large discrepancies between public and workplace realities in the system of professions. Abbott's theory that dominant professions successfully conceal the extent of workplace assimilation of professional knowledge through consummatory legitimacy supports the notion that only doctors can fulfil certain functions. This concealed discrepancy weakened nursing's jurisdictional claim in the first critical phase. In the second critical phase, nursing confronted the issue in an increasingly outspoken manner. "Nurses are giving notice that they are tired of the nonsense of doing something, prescribing, treating, sending the patient home," declared the provincial Nursing Coordinator, "and then the next morning walking pieces of paper down the hall for the doctor to sign" (Birenbaum, 1994, p. 77).

Abbott (1988) calls the process of resolving jurisdictional conflict *jurisdictional settlement*. Thus the settlement of the jurisdictional contest in the initiation and discontinuation phase was a return to the *subordination* of nursing to medicine. The settlement of the establishment and impasse phase is a hybrid of two types of settlement: *client differentiation* and *advisory jurisdiction* (Abbott). NPs diagnose and treat clients with common conditions within their scope of practice (CNO, 2003; Ontario Medical Association [OMA], 2002). Physicians who work with NPs report a relative increase in the acuity and severity of client conditions in their own workload (OMA). Since the level of acuity distinguishes clients who are seen by doctors from those who are seen by NPs, a settlement by client differentiation is apparent (Abbott). However, an elaborate set of guidelines for collaboration and consultation with and/or referral to physicians is outlined in the standards of practice for RN(EC)s (CNO, 2003). The nuance of medicine's advisory capacity creates the hybrid in this client settlement. The need for an intra-organizational division of labour between the two professions reveals a dialectical tension between respecting the independence of the NP and the expectation of mandatory consultation with and referral to the physician (CNO, 2003; OMA).

This analysis has thus far considered the external forces affecting the claim and the claim itself. It will now address the contribution of internal professional characteristics to the NP movement.

Internal Differentiation

Differentiation within the medical profession weakened medicine's jurisdiction in primary health care. In the 1960s medical school graduates

began to develop an interest in specializing and general practice became stigmatized (Haines, 1993; Mitchell et al., 1993; Robertson, 1973). Between 1992 and 2000 the proportion of graduates beginning their careers as general or family practitioners declined by almost 50% (CIHI, 2003).

The trend towards medical specialization is an example of what Abbott (1988) terms *professional regression*. Since a profession is based upon a valued body of knowledge, an internal hierarchy develops, thus conferring higher status upon those peers who work most closely with this knowledge. Family physicians hold a frontline position with low intraprofessional status.

Application of Abbott's (1988) theory also reveals an increase in differentiation within the nursing profession in Ontario during the establishment and impasse phase. For example, the RN(EC) class was created specifically for primary health care NPs who have successfully completed an approved primary health care program and registration examination (CNO, 2003; Dacres & Clarke, 2003). Furthermore, as demonstrated in Table 1, the number of NP titles reflecting specialty practice areas, including some acute-care settings (Dacres & Clarke), also increased during this phase. A trend towards increasing specialization within the NP role is thus evident.

Abbott's (1988) theory offers a useful and illuminating framework for the historical development of the NP role. By framing its evolution in sociological terms, we can discover critical explanations of the *past*. However, this framework is limited in its ability to account for *present-day* developments in the role. The evolution of the NP role has reached an impasse, because there are a number of barriers to full integration of NPs in the current health-care system (Ontario Ministry of Health and Long-Term Care [OMHLTC], 2003). We can narrow the gap in our understanding of these barriers by building upon the socio-historical analysis using Freidson's (2001) theory of ideal-typical models of organizing and controlling work.

Competing Logics of Work: Reframing the Tensions

Freidson (2001) situates the professions within the broader context of the sociology of work. Freidson proposes three ideal-typical models, or logics, that organize and control work: *free labour markets*, *rational-legal bureaucracies,* and *professionalism*. Each logic characterizes work in a unique way. The logics create tensions or pressures that compete with each other in the world of work. The logics are summarized in Table 4.

The emphasis on freedom of discretion in controlling work is a hallmark of ideal-typical professionalism (Freidson, 2001). Whereas the

Table 4 *Overview of Freidson's (2001) Ideal-Typical Model of Work*

Ideal-Typical Model	Principles	Controlling Power	Ideology	Opposing Pressure
Free labour market	Competition	The consumer	Consumerism	Populous generalism
Rational-legal bureaucracy	Efficiency through standardization	Administrative hierarchy	Managerialism	Elite generalism
Professionalism	Monopoly	The occupation	Professionalism	Freedom of discretion in controlling work

logics of free labour markets and rational-legal bureaucracies are well defined in Western culture, the logic of professionalism is not. These logics hold the key to understanding the impasse in further development of the NP role.

The logic of *professionalism* places a greater value on commitment to performance than on monetary gain (Freidson, 2001). The notions of independence of judgement and freedom of action form the basis of the professional ideological claim to and privilege of control over discretionary specialized work. The opposing generalist logics of *consumerism* and *managerialism* limit the amount of control that occupations have over the work they do.

Resistance to specialized knowledge and skill is realized by the logic of *consumerism,* in the form of what Freidson (2001) calls *populist generalism*. Consumers claim that general everyday knowledge is superior to, and capable of evaluating and directing, special expertise. Populist generalism is Freidson's explanation for the logic underpinning increased public participation in and legislative reforms to professional regulation in Ontario. Correspondingly, *elite generalism* is associated with the ideology or logic of *managerialism*. Bureaucrats claim to possess an advanced but general knowledge that is superior to the knowledge of both consumers (generalists) and professionals (specialists) because of their ability to organize work more rationally and efficiently.

Freidson (2001) locates a source of power within each of his logics. In professionalism, for example, the occupation holds the power of exclusive jurisdiction and control over work. However, these sources of power are constrained by forces, such as the state, that he terms contingencies. The main coercive power of the state is the law.

During both critical phases in the evolution of the NP role, medical professionalism faced mounting pressures linked to populist and elite generalism: changes in professional regulation; the implementation of state-administered universal health insurance with negotiated fee schedules; and an emphasis on cost containment, efficiency, and rationalization of health care (Angus & Bourgeault, 1999; Coburn, 1993; Leicht & Fennell, 2001; Madore, 2001; Mhatre & Deber, 1998; Mousseau & Hall, 1997; Torrance, 1998). The medical profession struggled to control the terms and conditions of its work (Hafferty & Light, 1995; Leicht & Fennell). Medicine became regarded as self-serving rather than as having a transcendent value, because when the medical profession defended itself against salary encroachments, monopoly of practice became confused with monopoly of wealth (Freidson, 2001). Moreover, the NP role struck deep into the professional soul of medicine, targeting the core of its economic privilege — the exclusive right to diagnose, prescribe, and treat (Freidson).

Nursing professionalism, in contrast, was affected by elite and populist generalism in a way that facilitated the establishment of what became the RN(EC) role during the second phase (Freidson, 2001). For example, nursing adopted the ideology of populist generalism. A subcommittee that included representatives of professional nursing associations, the nurses' union, and the College of Nurses of Ontario was formed to increase public awareness and understanding of the NP role (Mousseau & Hall, 1997). This strategy contributed to the successful establishment of the role (Angus & Bourgeault, 1999). Moreover, research evidence justifying the NP role fit with the elite generalist valuing of safe and effective care (Horrocks, Anderson, & Salisbury, 2002).

Current barriers to the full integration of NPs in primary health care include lack of public and professional awareness of the role, exclusion of NPs from the fee-for-service funding model of health care, and tensions concerning the distribution and expectations of work between physicians and RN(EC)s (OMHLTC, 2003). Situating these barriers within Freidson's (2001) three competing logics is key to recognizing the professional strategies that are needed as the third critical phase — full versus incomplete realization of the NP role — carries its evolution into the future.

Discussion and Implications

This critical analysis of the evolution of the nurse practitioner role contributes to our understanding of the inherent issues and gives direction for the formulation of proactive strategies that will position

nurses for further development of the role in Ontario and other provinces. The analysis explicates the slowly but continuously changing nature of public values and the crucial role of the public in health-care policy-making. The public is an influential ally for nurses in lobbying the government for changes that will overcome the barriers to full realization of the NP role. Nurses must be vigilant in monitoring further changes in public values, seizing every opportunity to work *with* the ideology of consumerism (Freidson, 2001). Renewed nursing leadership in the public arena (Abbott, 1988), to market the NP role by strengthening public valuing of and expectations for its present use in health care, is essential. The inclusion of marketing skills in NP education programs may facilitate this strategy.

The power of the law evident in this critical analysis reinforces the need for nursing leadership in the legal arena (Abbott, 1988). The fee-for-service model of health-care funding in Ontario persists as a significant barrier to full realization of the NP role (OMHLTC, 2003). Professional nursing organizations have a responsibility to work *with* the ideology of managerialism (Freidson, 2001), lobbying the government for changes to the system of funding.

This critical analysis also illustrates that changing public values and legislation takes time — 20 to 50 years, according to Abbott (1988). Evolution of the NP role in Ontario has so far taken more than 30 years. Therefore, a patient, persistent, professional strategy that sustains the vision of full realization of the NP role for successive cohorts of nurses is required. Additionally, it may be more pragmatic to approach lobbying for legislative changes across the spectrum of nursing practice areas one setting at a time, in order to achieve full realization of the role.

The workplace is a critical arena for full realization of the NP role (Abbott, 1988). Lessons learned from this analysis of the NP movement forecast that issues of salary and control over work will test nursing professionalism against the competing ideology of managerialism (Freidson, 2001). The workplace will be a pivotal context for research aimed at resolving sensitive issues, such as work distribution, time allocation, and role expectations (OMHLTC, 2003). Finally, professional nursing organizations have an essential part to play in promoting optimal work-environment policies that will enhance the NP role.

Situating these intraorganizational issues within the broader context of work, beyond the perimeter of health care, provides a new perspective that raises new questions. What are the optimum terms and conditions of NP work? Which organizational models of primary health care delivery ensure full realization of the NP role? What community characteristics enhance these successful models?

Conclusion

This critical analysis has shown that the evolution of the nurse practitioner role in Ontario provides an insightful example of the movement within Canadian nursing towards implementation of such roles. Sociohistorical analysis (Abbott, 1988) evokes sensitivity to phases in the momentum of this movement, characterized by dialectical tensions working for and against continued development of the NP role. Reframing the tensions within Freidson's (2001) competing ideologies carries the evolution forward. Organizing identified barriers within this framework provides clear direction for proactive strategies in the form of nursing leadership within regulatory, policy, education, and research initiatives to ensure full realization of the role. The evolution of the NP role in Ontario would thus become a model for successful implementation in other provinces.

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