

GUEST EDITORIAL

The Long and Winding Road: Integration of Nurse Practitioners and Clinical Nurse Specialists Into the Canadian Health-Care System

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We are honoured to be co-guest editors of this issue of *CJNR* focused on advanced practice nursing (APN). In Canada, advanced practice nurses include nurse practitioners (NPs) and clinical nurse specialists (CNSs) (Canadian Nurses Association [CNA], 2008). It is fitting that *CJNR* is publishing this APN-focused issue given the leadership that Moyra Allen, founding editor of the Journal, demonstrated in her early writings about “the expanded role in nursing” (Allen, 1977). The research pieces and feature articles in this issue reflect the growing contribution of APN roles to the health of Canadians and highlight areas where further work is required to maximize their integration into the health-care system.

NPs are “registered nurses with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice” (CNA, 2009b, p. 1). Those who are registered as family/all-ages or primary health care NPs typically work in the community, in settings such as community health centres, family physician offices, and long-term-care facilities, with a focus on health promotion, preventive care, diagnosis and treatment of acute common illnesses and injuries, and monitoring and management of stable chronic diseases. Those who are registered as adult, pediatrics, or neonatal NPs (also known as acute-care NPs) typically provide advanced nursing care across the continuum of acute-care services for patients who are acutely, critically, or chronically ill with complex conditions. They work in areas such as oncology, neonatology, and cardiology. In 2008, there were 1,626 licensed NPs in Canada (Canadian Institute for Health Information [CIHI], 2010).

CNSs are registered nurses who have a graduate degree in nursing and expertise in a clinical nursing specialty (CNA, 2009a). Their primary responsibilities include varying amounts of clinical practice, consultation, education, research, and leadership activity. CNSs mentor nurses, contribute to the development of nursing knowledge and evidence-based practice, and address complex health-care issues for patients, families, other disciplines, administrators, and policy-makers. They are leaders in the development of nursing and interprofessional policies and practice guidelines. Specialty practice areas for CNSs are usually defined by a population, setting, disease, medical subspecialty, type of care, or type of problem. In 2008, there were 2,222 self-identified CNSs in Canada (CIHI, 2010).

While both of these advanced roles have existed in Canada for more than 40 years, role implementation has been a long, winding, bumpy journey characterized by gains and losses in momentum. The destination of full integration into the Canadian health-care system has not yet been reached. For example, although primary health care NPs were introduced in urban Canada in the early 1970s, the role virtually disappeared in the mid-1980s, for a variety of reasons, including reduced physician income, lack of NP role legislation, inadequate support from policy-makers, and an oversupply of physicians. However, in the mid-1990s, to enhance health promotion and improve health-care access, the federal government and the provinces invested in primary health care infrastructure and interdisciplinary health-care teams. This in turn prompted the revival of government interest in the primary health care NP role and initiated the second wave of its implementation. Numerous legislative, policy, funding, regulatory, and education initiatives have since facilitated implementation in all Canadian provinces and territories (DiCenso et al., 2009). Many challenges to full integration of NPs into primary health care settings remain, including restrictive legislation and regulation, inconsistencies in educational preparation across Canada, and a tenuous relationship between NPs and family physicians, both of which are autonomous clinicians with substantial overlap in scope of practice (DiCenso et al., 2009). For NPs in acute-care settings, challenges include difficulty implementing non-clinical dimensions of the role, limited scope of practice due to hospital restrictions on NPs' autonomous ordering and prescribing, inconsistent team acceptance, and difficulty funding the role due to tight hospital budgets (DiCenso et al., 2009).

Unlike that of the NP, the CNS role has continued to formally exist over the 40 years; however, hospital budget cutbacks in the 1980s and 1990s led to the elimination of many of these positions. In early 2000, interest in the CNS role returned, the intention being to bring clinical leadership back into health-care environments with the emphasis on

helping staff nurses apply evidence to practice. Some of the significant challenges that currently face the CNS role in Canada include lack of a common vision and understanding of the role, limited access to CNS-specific graduate education programs, and lack of title protection or credentialing (DiCenso et al., 2009).

This issue of the Journal includes four articles on advanced practice nursing roles, two focused on NPs in primary health care settings, one on NPs in acute-care settings, and one on CNSs. The researchers have used quantitative, qualitative, and mixed methods designs and have studied NPs and CNSs in a variety of provinces.

In their role-delineation study, Ruth Martin-Misener and colleagues use a mixed methods approach combining qualitative interviews and self-administered surveys to systematically collect data from key stakeholders (rural health board chairpersons and health-care providers) on the health needs of rural communities, service gaps, and expectations for the NP role in rural Nova Scotia. Their study illustrates the importance of obtaining input from key stakeholders and maintaining a patient focus to guide role development. Historically, the ad hoc and often crisis-driven approach to the introduction of APN roles has hindered role sustainability due to failure to use a systematic approach to establish the foundation for role delineation, implementation, and evaluation.

Once advanced practice nurses are introduced in a jurisdiction, regular tracking studies inform progress in role implementation by detailing and comparing practice in a variety of settings. Irene Koren and colleagues analyze data from a 2008 survey of Ontario primary health care NPs to explore differences in demographic, employment, and practice characteristics across settings. This survey provides a picture of current employment and practice at a time when new primary health care models such as family health teams and NP-led clinics are being introduced in Ontario, and at a time when NPs are beginning to work in non-traditional settings such as emergency departments, long-term-care settings, and public health units. Regular tracking studies can facilitate health human resource planning and identification of strategies to promote optimal role utilization by comparing APN characteristics and deployment across time and jurisdictions.

Also with a focus on role implementation, Judy Rashotte and Louise Jensen report on an in-depth qualitative study of NPs working in acute care in four adult and pediatric academic teaching hospitals in Quebec, Ontario, and Alberta. These authors describe a transformational journey from which emerge five principal themes experienced by the NPs as they become established in their new role. Rashotte and Jensen draw on the meaning of the term “bridge” to describe the NPs (often labelled “physician replacements”) as “a space between nurse and physician, one

part of the health-care system and another taking an active part on both sides and having an identity that is both and not-both.” There have been few cross-provincial studies of the implementation of APN roles.

The fourth article in this issue is a qualitative study focused on a specific dimension of CNS role implementation. Maria-Helena Dias and colleagues interviewed CNSs working with adult populations in a large, urban university hospital in Quebec to learn more about the consultation component of their role. This is an important article, for a number of reasons. First, while there have been more than a hundred primary studies or reviews published over the past 40 years about the NP role in Canada, there have been only a few about the CNS role. Consistent with this gap, we received few CNS-focused manuscripts for this issue of the Journal. CNSs and nurse leaders are struggling to establish the mandate of the CNS role in the Canadian health-care system. There is a pressing need for health services research to inform the continued development and sustainability of this role. Second, most articles about NPs and CNSs tend to centre more on direct patient care activities than on the other components of the APN role. Indeed, there is little mention of the consultation, education, research, and leadership components of the NP role in primary health care settings in the articles by Martin-Misener and colleagues and Koren and colleagues. Rashotte and Jensen note the tensions and struggles experienced by the NPs in acute care in adding extra role functions to their clinical practice responsibilities. Involvement of NPs in these other components of the APN role is an important area for future research.

Over the 40 years since the introduction of APN roles in Canada, support for their implementation has fluctuated and has been dependent on the changing political agendas shaping the health-care system. While much progress has been made, challenges to their full utilization and acceptance remain. One major challenge to role integration that surfaces in all four articles is role ambiguity or confusion, sometimes caused by role overlap with other members of the health-care team. Martin-Misener and colleagues found potential overlap in the role of NPs and public health nurses and family practice nurses in areas such as health promotion, well woman and child care, immunization, chronic disease management, and community health. Koren and colleagues found that NPs reported that their relationships with physicians “needed work” when physicians were unfamiliar with the full scope of NP practice. Rashotte and Jensen describe the NPs in acute care as “living in the in-between space” of nursing and medicine, which can cause confusion for health-care colleagues. Finally, Dias and colleagues describe CNSs as having to “constantly adjust their roles and adapt their competencies in order to meet the new demands,” causing role ambiguity and confusion.

The issue of APN role ambiguity surfaces often in the literature and is one that demands attention.

In addition to these four original research articles, this issue contains a number of other features. There are two discourses that challenge us to think about the future of APN roles in Canada. Each discourse is accompanied by a brief commentary from leaders implementing these roles in clinical settings. Ruth Martin-Misener, an NP and faculty member at Dalhousie University, was invited to share her views about whether NPs will achieve full integration into the Canadian health-care system. In her thoughtful piece, she addresses legislative/regulatory, education, and practice issues. The accompanying commentary is written by Lynn Stevenson and Linda Sawchenko, both of whom have responsibility for implementing NP roles in their respective health authorities in British Columbia. Denise Bryant-Lukosius, a CNS and a faculty member at McMaster University, was invited to share her views about the dearth of research on the CNS role in Canada and implications for the sustainability of the role. The accompanying commentary is written by Patricia O'Connor and Judith Ritchie, administrators currently implementing CNS roles at their university health centre in Quebec. Two of our Canadian nurse researcher colleagues review new editions of important APN-related sourcebooks. Marjorie MacDonald offers a comprehensive review of the fourth edition of the classic text by Ann Hamric and colleagues, and Joan Tranmer provides a thoughtful review of the second edition of a volume on outcome assessment by Ruth Kleinpell. Finally, the Happenings piece, written by the APN Chair Program staff, describes six resources created by the team to support the conduct and application of APN-related research.

The road to integrating APN roles into the Canadian health-care system over the past 40 years has indeed been long and winding. While great strides have been made, the full contribution of advanced practice nurses has yet to be realized. Much remains to be done. Key priorities include standardizing APN regulatory and educational requirements across the country, developing communications strategies for health-care colleagues and the public to promote awareness of the role, protecting funding support for APN positions, and conducting further research on the added value of these roles for the health-care system (DiCenso et al., 2009).

We have enjoyed participating in the compilation of this issue and have appreciated the excellent support provided by the *CJNR* team. We are grateful to our peer-review panel, which consisted of researchers, decision-makers, clinicians, and students, and to the authors of the various pieces that make up this issue.

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