

Le programme de pratique infirmière en régions éloignées : la pratique infirmière et le personnel infirmier praticien considérés sous l'angle de la justice sociale

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Le programme de pratique infirmière agréée en régions éloignées [Remote Nursing Certified Practice (RNCP)] a été créé en 2010 dans le but de réglementer la pratique infirmière dans les collectivités éloignées de la Colombie-Britannique, au Canada, qui sont formées en grande partie de Premières nations. Ces collectivités vivent souvent des inégalités en matière de santé et de soins de santé. Les infirmières et les infirmiers sont généralement les principaux fournisseurs de soins de santé de ces collectivités. À l'aide d'une grille d'analyse critique se fondant sur la justice sociale, les auteures explorent les répercussions cliniques et éthiques de la RNCP sous l'angle de l'accès à des soins de santé primaires équitables et de haute qualité. Elles examinent la correspondance entre le niveau et l'étendue des services de santé fournis par le personnel infirmier autorisé qui travaille conformément à la RNCP et les besoins de santé des collectivités des Premières nations en région éloignée. Ce faisant, elles font des comparaisons d'une part entre les infirmières praticiennes et les infirmiers praticiens (IP) et d'autre part les infirmières et les infirmiers en régions éloignées jouant le rôle d'IP qui ont été employés historiquement pour fournir des soins de santé dans ces collectivités. Les auteures concluent en demandant qu'une réglementation de la pratique infirmière soit adoptée afin de soutenir la prestation de soins primaires équitables de grande qualité à toute la population de la Colombie-Britannique.

Remote Nursing Certified Practice: Viewing Nursing and Nurse Practitioner Practice Through a Social Justice Lens

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Remote Nursing Certified Practice (RNCP) was introduced in 2010 to regulate nursing practice in remote, largely First Nations communities in British Columbia, Canada. These are communities that often experience profound health and health-care inequities. Typically nurses are the main health-care providers. Using a critical social justice lens, the authors explore the clinical and ethical implications of RNCP in terms of access to equitable, high-quality primary health care. They examine the fit between the level and scope of health services provided by registered nurses working under RNCP and the health needs of remote First Nations communities. In doing so, they draw comparisons between nurse practitioners (NPs) and outpost nurses working in NP roles who historically were employed to provide health care in these communities. The authors conclude by calling for nursing regulations that support equitable, high-quality primary care for all British Columbians.

Keywords: Aboriginal health, health disparities, nursing roles, primary health care, rural and remote health care, vulnerable populations

In 2010 a new category of registered nurse (RN) regulation was implemented in the province of British Columbia, Canada, created specifically to regulate the practice of RNs employed in remote communities: Remote Nursing Certified Practice (RNCP). As of March 31, 2010, nurses employed in remote First Nations communities in British Columbia are required to be RNCP-certified. The RNCP initiative was preceded by the implementation of the nurse practitioner (NP) role in British Columbia following legislative and regulatory changes made in 2005.

As formal recognition of the NP role has been rolled out in recent years through legislation and regulation in jurisdictions across the country (Canadian Institute of Health Information, 2010), most jurisdictions have recognized the need to ensure that the residents of remote communities continue to have access to nurses who have advanced¹ and

¹ *Advanced nursing practice* is defined by the College of Registered Nurses of British Columbia (CRNBC; 2011a) as “an umbrella term to describe an advanced level of

expanded scopes of practice and who are well prepared to provide high-quality primary care² within primary health care (PHC) settings.³ Such nurses are now identified and regulated as NPs in all Canadian provinces and territories. The educational preparation; knowledge, skills and competencies; and scope of practice are much broader for NPs in all jurisdictions than for RNs working under RNCP in British Columbia. However, few NPs are employed in British Columbia's remote First Nations communities. These positions are instead filled by RNs with RNCP designation.

It seems paradoxical that, now that highly qualified NPs are formally recognized and licensed to practise in British Columbia as primary care providers, RNCP has been implemented as a new regulatory model that, we argue, may in fact obfuscate the need for nurses in remote settings to have NP-level competencies and scope of practice — thereby perpetuating the inequities in access to high-quality primary care historically experienced by First Nations people in remote communities. We wish to be clear that we support the principle of ensuring that nurses providing health services in remote communities are adequately educated and prepared to deliver high-quality primary care while concurrently working in a community health role. We appreciate the critical importance of ensuring that standards for nursing competencies are met. We are not critiquing the quality of nursing care or the competency of nurses working in RNCP, nor are we dismissing RNCP as unimportant. However, in the context of remote First Nations communities in British Columbia, and using the lens of critical social justice, we believe that the scope of

registered nursing practice that maximizes the use of in-depth nursing knowledge and skills in meeting the health needs of clients (individuals, families, groups, populations, or entire communities). In this way, advanced nursing practice extends the boundaries of registered nursing's scope of practice and contributes to nursing knowledge and the development and advancement of the profession.”

² *Primary care* is defined by the CRNBC (2011a) as “the first point of contact with a health care provider for diagnosis, treatment and follow-up for a specific health concern.”

Primary care providers are defined as “health professionals who take primary responsibility for an established group of patients for whom they provide: longitudinal person-focused care; comprehensive care for most health needs; first contact assessment for new health care needs; and referral and coordination of care when it must be sought elsewhere. A primary care provider is ideally chosen by an individual to serve as his or her health care professional to address a wide variety of health issues including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury.”

³ *Primary health care* is defined by the CRNBC (2011a) as “essential health care (promotive, preventive, curative, rehabilitative, and supportive) that focuses on preventing illness and promoting health with optimal individual and community involvement. It is both a philosophy and an approach that provides a framework for health care delivery systems. The five principles of PHC are accessibility, public participation, health promotion, appropriate technology and intersectoral collaboration.”

RNCP is inadequate to support safe, equity-oriented primary care. It is therefore timely to take a critical look at what we see as the implications of RNs working under RNCP.

This article is intended to contribute to a dialogue on the implications of implementing the recently established RNCP for RNs working in remote First Nations communities in British Columbia. In forming our analysis we draw on philosophical and ethical perspectives grounded in notions of critical social justice. The concept of critical social justice offers a useful lens through which to examine the policy, practice, and power dynamics that lie behind inequities in the access of First Nations people to health and health care (Anderson et al., 2009; Browne & Tarlier, 2008; Reimer Kirkham & Browne, 2006). Although discourses of social justice have become commonplace in the nursing and health-services literature, critical analyses of how nurses' roles and scope of practice articulate with social justice issues have received little attention (Browne & Tarlier, 2008). Critical interpretations of social justice shift the analysis beyond distributive paradigms of justice to issues of equity versus equality in health-care access, access to health care as a human right, the role of neoliberal policies in health-care planning and policy decisions, and the social and political contexts that shape health and health-care inequities (Browne & Tarlier, 2008; Reimer Kirkham & Browne, 2006). With epistemological roots in critical, feminist, and postcolonial theoretical perspectives, a critical social justice lens facilitates the development of contextual knowledge, which is "crucial to fostering the planning of socially just and equitable healthcare across different population groups" (Anderson et al., 2009, p. 287). A critical social justice lens in relation to nursing and NP roles raises morally significant questions (Sherwin, 2002) such as the following: Why do health and health-care inequities persist for certain groups or populations such as Aboriginal peoples? What is the role of nursing in responding to persistent inequities? What health-care planning and policy decisions will be useful in addressing such inequities? The concept of critical social justice thus provides an ethical lens through which to consider inequities in the resources needed for health, as well as inequities in decisions affecting health-care access. In this article, we apply this lens to consider the implications of introducing new regulations regarding RN practice in remote First Nations communities in Canada.

Our purpose in writing this article is to examine the fit between the level and scope of health services provided by NPs compared to RNs working under RNCP and the health needs of remote First Nations communities in British Columbia. We specifically focus our arguments on RNCP in the context of remote First Nations communities, recognizing that other certified practices such as Reproductive Health and

RN First Call may be well suited to a variety of other practice contexts. Our arguments are presented with a view to opening up a dialogue around an initiative that has both practical and ethical implications for equitable health-care delivery and therefore the health of First Nations people residing in remote BC communities.

The Context of Nursing Practice in Remote First Nations Communities

Renewal of and investment in PHC continue to be identified as key pathways to achieving health equity, particularly for populations experiencing health inequities (Starfield, 2006; World Health Organization [WHO], 2008a, 2008b). In Canada, nurses have been providing high-quality PHC and filling a gap in health-care access in remote First Nations and Inuit communities for decades. The role of nurses working and living in indigenous communities has particular significance, given the long history of health and health-care inequities that continue to affect indigenous peoples in Canada and globally (Adelson, 2005; Reading, Marsden, Kurbanova, & Link, 2009). These inequities have their roots in colonial policies and practices, systemic racism and discrimination, and limited access to the resources needed for health: income, employment, self-determination, education, adequate housing, and, notably, health care (Bourassa, McKay-McNabb, & Hampton, 2004; Kubik, Bourassa, & Hampton, 2009; WHO, 2008a). Moreover, inequities in access to needed health services and resources persist and continue to challenge the health of many indigenous people in Canada (Adelson, 2005; Health Council of Canada, 2008; Luo et al., 2010). First Nations and Inuit residents in remote, isolated, and northern communities are often further marginalized in terms of access to health resources and providers, and their health outcomes are still often among the poorest in Canada. For example, a recent study of birth outcomes and infant mortality in rural and remote populations in Manitoba found that First Nations populations in that province still experience a relative risk of infant mortality (one of the most sensitive indicators of population health) almost twice that of non-First Nations populations (Luo et al., 2010). This finding echoes the results of a similar study conducted in British Columbia several years ago (Luo et al., 2004) and confirmed in 2009 (British Columbia Provincial Health Officer [BCPHO], 2009).

These historical and current social and political realities form the backdrop against which nurses have traditionally worked to provide PHC services in many First Nations communities. Nurses working in remote communities across Canada have traditionally been referred to as “outpost” nurses. This outpost nursing role has, in the Canadian context

and prior to the recent formalization and regulation of NP roles in Canada, historically been identified as that of an NP. For example, in a 2009 position statement on NPs, the Canadian Nurses Association (CNA) acknowledged the outpost nursing roots of contemporary Canadian NPs:

The origin of the NP role in Canada lies in the work of nurses who, decades ago, provided care that was otherwise unavailable in rural and remote areas. The first education program for NPs was developed to prepare nurses to work in nursing stations in remote areas of northern Canada. Nurses working in these northern communities were pioneers, and their work was integral to the evolution of the NP role as NPs began to be employed in other parts of the healthcare system. (CNA, 2009)

Thus, even going back several decades, outpost nurses were identified as NPs. When possible (given the shortage of NP education programs at the time) such nurses were prepared as NPs, to fulfil a role that was viewed as that of an NP.

Filling a Gap in Health-Service Access: Early NP Roles in Northern and Remote Canada

Traditionally, nurses working in an expanded nursing role have provided PHC, including primary care services, in northern and remote First Nations and Inuit communities. In these communities access to physician services has been, and continues to be, typically on an intermittent “visiting” doctor basis, with the bulk of ongoing primary care provided by nurses who reside in the community.⁴ Thus, nurses employed in the outpost nursing role filled a critical gap in access to needed health services by functioning in an expanded scope of practice that demanded competency in primary care as well as public health and urgent/emergent acute care (Tarlier, Johnson, & Whyte, 2003). Moreover, the everyday contexts of nursing practice in remote First Nations communities impelled experienced outpost nurses to integrate broader PHC perspectives into their practice, to better address the social determinants that influenced health in the communities in which they lived and worked (Brumwell & Janes, 1994; Doucette, 1989; Tarlier et al., 2003). In these

⁴ Notably, most of the few positions that do exist for NPs to work with remote First Nations communities in British Columbia appear to be following this “visiting” doctor model, wherein the NP visits communities, while RNCP RNs live in the community and attend to the day-to-day health needs in the community. This in itself may have significant implications for the ability of the NP to build the trusting, reciprocal relationships with community residents that are integral to both client-centred and community-centred care (Tarlier et al., 2003; Vukic & Keddy, 2002). However, a full discussion of these implications is beyond the scope of this article.

ways, outpost nurses operated from a social justice stance in relation to working with communities to address community-defined priorities (Brumwell & Janes, 1994; Tarlier et al., 2003). For example, nurses worked with community members to advocate for local stores to carry nutritious foods, worked closely with Community Health Representatives on health promotion and prevention activities that were contextualized to the needs of the community, and advocated for families to have access to adequate housing and clean water.

Tarlier et al. (2003) found that experienced outpost nurses shared the domains and competencies of NP practice identified by Brykczynski (1989) in her influential study of NP practice competencies, which built on Benner's (1984) foundational work describing the domains and competencies of nursing practice. For example, the experienced outpost nurses who participated in Tarlier et al.'s (2003) study described competencies comparable to the domain of NP practice competencies, Management of Patient Health/Illness in Ambulatory Care Settings, identified by Brykczynski (Tarlier, 2001). As Tarlier et al. (2003) note, the findings of this study suggest "that outpost nurses share domains and competencies of practice with NPs, as identified by Brykczynski, a finding that may have relevance for the development of the NP role in Canada" (p. 183). However, in the same study Tarlier (2001) identified a domain of outpost nursing practice that did not appear in Brykczynski's NP framework. The new domain was described as "caring for the community" and included the following competencies: building and maintaining responsive relationships with communities; partnering with the community (collaborating, facilitating, negotiating; facilitating community action); and working over the long term (Tarlier, 2001, p. 104). These competencies were described by study participants as integral to the PHC orientation that evolved through experience in the outpost nursing role (Tarlier et al., 2003).

Ideally, nurses had the benefit of intensive, high-quality post-basic education beyond their basic nursing programs, to prepare them for the requirements of this complex, challenging nursing role. While not every nurse employed in an outpost setting received additional education, many of those who did were educated in the available NP programs of the time. These included the program offered at Dalhousie University, which opened in 1967 (Nurse Practitioner Association of Ontario, 2010), and the several universities (including McGill and the Universities of Alberta and Toronto) that offered the Clinical Training of Nurses Program from 1972 until the early 1980s (University of Alberta Faculty of Nursing and Faculty of Medicine, 1980). For example, the program offered at the University of Alberta in the early 1980s was officially named the Nurse Practitioner Program. Thus, historically, and up until very recent times

and the advent of formal regulatory mechanisms, the Canadian outpost nursing role was widely recognized in Canada as an NP role (CNA, 2009; De Witt & Ploeg, 2005).

Lacking the legislation required to enable regulation and autonomous practice, outpost nurses functioning in these early NP roles formally practised under medical delegation and by protocol. In reality, isolation and remoteness imposed a high level of autonomy and independent decision-making, which nurses often were initially unprepared for in taking up the role but became comfortable with as they developed the competencies required for primary care practice (Tarlier et al., 2003; Vukic & Keddy, 2002). A consulting physician, for example, might be located several hundred kilometres away and have little familiarity with the local community context. This meant that the nurse was de facto responsible for interpreting and modifying medical advice to ensure that it was implemented in a locally acceptable and appropriate manner. Additionally, even today, in the age of satellite-based telecommunication, communication is notoriously unreliable in some remote communities, as is transportation in and out of many communities (Tarlier, Browne, & Johnson, 2007), thus imposing a high level of independence in practice. In other words, those employed in the traditional outpost nursing role functioned in an autonomous role that demanded independent clinical decision-making, knowledge on how to influence the social determinants of health in local contexts, and knowledge of how to work with communities in ways that conveyed respect for cultural protocols (Tarlier et al., 2003; Vukic & Keddy, 2002). This practice was consistent with what we now recognize as NP-level competencies. Moreover, the isolated nature of practice in remote communities has not changed significantly and continues to demand practitioners who are well prepared to engage in independent practice and clinical decision-making and who are committed to fostering equity by providing primary care that is consistent with the principles of PHC, as NPs are prepared to do (Browne & Tarlier, 2008).

An Overview of Contemporary NP Roles in Canada

Alberta was the first province to pass legislation recognizing NP roles, in 1996, and Yukon was the last jurisdiction, in December 2009 (Canadian Institute for Health Information, 2010; Yukon Registered Nurses Association, 2009). While it has taken 15 years, NP roles are now recognized and legitimized through legislation in all provinces and territories. Although the requisite level of educational preparation and licensing for NPs continues to vary across the provinces and territories, there is a commitment on the part of most jurisdictions to move towards consistency at the pan-Canadian level (Canadian Nurse Practitioner Initiative,

2006). For example, while there is now a commitment to recognize master's-level nursing education as the standard for advanced practice, including NP practice (CNA, 2008), many jurisdictions formalized the NP role back when post-BSN preparation was the standard expectation for NPs in community-based roles. This discrepancy across jurisdictions may reflect the evolutionary nature of nursing education in general — not unlike the inconsistency experienced as jurisdictions moved towards the BSN as the standard for entry to practice.

In British Columbia, legislative changes in 2005 opened the door to NP regulation and practice. Nurses seeking NP licensing in the province are required to be master's-prepared. The College of Registered Nurses of British Columbia (CRNBC) introduced a rigorous licensing process for master's-prepared NPs that includes an Objective Structured Clinical Examination as well as a written examination (CRNBC, 2011b).

Currently there are approximately two hundred NPs licensed to practise in British Columbia (CRNBC, 2011f). A significant number of NPs registered in the province remain unemployed or underemployed in NP roles, largely due to a lack of provincial funding to create new NP positions through the six health authorities (Watts, 2010). The province lacks alternative reimbursement mechanisms for NPs, meaning that there are few options for employment outside of the funded health authority positions (Watts, 2010). In British Columbia, in contrast to regions such as Manitoba, First Nations, Inuit and Aboriginal Health (the federal government department that is the largest employer of health providers in remote First Nations and Inuit communities) has not developed NP positions independent of the health authorities. Thus, most licensed NPs in British Columbia practise in urban or suburban settings, while the bulk of health care in remote First Nations communities continues to be provided by RNs functioning in an NP-like role, now regulated under the RNCP. Notably, British Columbia is the only jurisdiction in Canada to have implemented this new regulatory model.

British Columbia: Remote Nursing Certified Practice

RNCP is one of three certified practices developed by CRNBC in response to the 2001 recommendation of the Health Professions Council of British Columbia (2001) that “legislative or regulatory mechanisms be established to enable [CRNBC] to develop a formal regulatory system” for advanced practice and primary care nursing. Reproductive Health and RN First Call⁵ are the two other areas of certified practice. The rec-

⁵ RN First Call is defined by the CRNBC (2011a) as “nursing practice that occurs in small acute care hospitals, diagnostic and treatment centres and other settings where there is physician service available in the community.”

ommendation arose from the Council's concern regarding inconsistency in the education of RNs for advanced practice and primary care roles. One outcome of the recommendation was the creation of a new class of CRNBC registrant: RN certified practice. Certified practice provides a regulatory mechanism for RNs to carry out a certain number of the restricted activities that are included in the NP scope of practice but are not within the RN scope of practice (CRNBC, 2011e). While all three certified practice areas require nurses to undertake some additional training and to rely on Decision Support Tools (DSTs) to guide their clinical decision-making, RNCP is significantly broader in scope, and in fact encompasses both the Reproductive Health and RN First Call certified practices (CRNBC, 2010b). CRNBC began the process of certifying RNs for RNCP in late 2009, with a mandate to ensure that all nurses practising in an expanded role in remote communities (which in British Columbia comprise mostly First Nations communities) be certified by March 31, 2010. There are currently about one hundred RNs certified in RNCP.

In response to the recommendation of the Health Professions Council of British Columbia (2001), in 2005 the CRNBC also developed and implemented the regulatory process to approve NP licensure, education, and educational programs. Thus, in British Columbia there now exist two standards of educational preparation and two different regulatory models to regulate nurses functioning in what we assert are substantively similar scopes of practice: NPs, and RNs in remote First Nations communities working under RNCP. No other province or territory in Canada has so far seen a need to follow British Columbia in implementing a certified practice model of regulation for nurses practising in remote areas. Rather, other jurisdictions actively recruit NPs to work in remote First Nations communities (e.g., Health Canada, 2010).

The Health Professions Council of British Columbia (2001) mandated a formalized process for regulating nurses in advanced practice and primary care nursing roles. However, it is not clear why, in British Columbia, this nursing role has been conceptualized as two distinct roles requiring different levels of preparation and different regulatory processes. In other jurisdictions the advanced practice primary care nursing role is conceptualized as a single role — that is, the NP role. Implicit among the questions we pose in this article are the following two: Why is British Columbia the only jurisdiction to have implemented the certified practice model? What are the assumptions underlying this initiative?

A comparison of the CRNBC RNCP (CRNBC, 2009) and NP competency (CRNBC, 2010a) statements suggests that both NPs and RNCP RNs assess, diagnose, interpret laboratory data, implement treatment, and make decisions about drug therapy (see Table 1). Thus, the two

Table 1 Comparison of RNCP and NP Competencies and Level of Accountability in Practice

RNCP Competencies	NP Competencies
<ul style="list-style-type: none"> • Assessment • Diagnosis • Interpreting laboratory reports • Treatment • Administering and dispensing drugs (CRNBC, 2009) 	<ul style="list-style-type: none"> • Assessment • Diagnosis • Interpreting laboratory reports • Treatment • Prescribing drugs (CRNBC, 2010a, 2011d)
<ul style="list-style-type: none"> • “Certified practices are carried out independently and the registered nurse is solely accountable for the diagnosis and treatment of the client. Certification allows registered nurses to: <ul style="list-style-type: none"> – Diagnose some diseases and disorders (as set out in decision support tools) – Carry out some restricted activities independently (as set out in decision support tools) that would otherwise require an order (e.g., administering, compounding or dispensing Schedule I medications)” (CRNBC, 2011c) 	<ul style="list-style-type: none"> • “Nurse practitioners diagnose and manage diseases, disorders and conditions within the limits of the nurse practitioner’s legislated scope of practice, individual competence within that scope of practice, and the stream in which the nurse practitioner is registered to practice (family, adult or pediatric).” (CRNBC, 2011d, p. 13) • “Nurse practitioners are solely accountable for their prescribing decisions.” (CRNBC, 2011d, p. 20) • “Nurse practitioner practice is grounded in the five World Health Organization principles of primary health care: accessibility, public participation, health promotion, appropriate technology and intersectoral collaboration.” (CRNBC, 2010a, p. 7) <p>Advanced Practice Competencies (CNA, 2008)</p> <p>An advanced practice nurse integrates extensive clinical experience with theory, research, and in-depth nursing and related knowledge to:</p> <ul style="list-style-type: none"> • develop multiple advanced assessment and intervention strategies within a client-centred framework for individual clients, communities, and populations

<p><i>An advanced practice nurse demonstrates leadership by:</i></p> <ul style="list-style-type: none">• advocating for individuals, families, groups, and communities in relation to treatment, the health-care system, and policy decisions that affect health and quality of life• advocating for and promoting the importance of health-care access and advanced nursing practice to nurses and other health professionals, the public, legislators, and policy-makers• contributing to and advocating for an organizational culture that supports professional growth, continuous learning, and collaborative practice• evaluating programs in the organization and the community and developing innovative approaches to complex issues• understanding and integrating the principles of resource allocation and cost-effectiveness in organizational and system-level decision-making• identifying gaps in the health-care system and developing partnerships to facilitate and manage change• developing and clearly articulating a vision for nursing practice, influencing and contributing to the organization's and the health-care system's vision and implementing approaches to realize that vision• advising clients, colleagues, the community, health-care institutions, and policy-makers on issues related to nursing, health, and health care• identifying problems and initiating change to address challenges at the individual, organizational, or system level• understanding legislative and sociopolitical issues that influence health policy and building strategies to improve health, health-care access, and healthy public policy	
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roles require the same basic primary care competencies — and, by extrapolation, individuals presumably would need the same level of education and clinical experience to engage in such competencies. Moreover, both NPs and RNCP RNs carry out these competencies independently and with sole accountability for their practice, as shown in Table 1 (CRNBC, 2010a, 2011c). NPs licensed in British Columbia base their practice on an extensive theory and knowledge base (i.e., one that supports clinical competencies in primary care) developed through substantive additional graduate education (i.e., usually a master's degree in nursing in an NP program). Similar to physicians, NPs utilize clinical practice guidelines and “best evidence” to inform clinical judgement and decision-making. In addition, as part of the NP graduate education, NPs are prepared at an advanced level (i.e., beyond the baccalaureate level) to engage critically with literature, be exposed to ideas related to cultural safety and the philosophy of PHC, and practise with an awareness of how profoundly the social determinants of health affect health and health-care inequities. In contrast, the RCNP educational preparation is one six-credit course taken over 18 weeks (University of Northern British Columbia, 2010). RNCP RNs follow DSTs that have been developed by CRNBC to direct their practice (CRNBC, 2010b). NP practice is significantly broader in scope than RNCP, and, as we argue, a broad scope of practice is fundamental to the provision of safe, effective — and in other words, ethically defensible — community-based primary care.

To illustrate the breadth of primary care that is required of providers in remote First Nations settings, we draw on the example of respiratory system diagnoses. Within the respiratory system, NPs may independently diagnose and manage a wide spectrum of common diseases, as supported by their broad knowledge base as well as personal competency (CRNBC, 2011d). In comparison, under RNCP a RN may (relying on the DSTs) diagnose only one condition of the respiratory tract: acute bronchitis (CRNBC, 2011c). Yet the reality is that there is a high prevalence of respiratory ill health in many remote First Nations communities (BCPHO, 2009; Reading, 2009) — in large part due to the inadequate housing and crowded living conditions in some on-reserve communities (Adelson, 2005; BCPHO, 2009). This raises the question of how a narrow scope of RNCP would allow nurses, as the main primary care providers in a community, to adequately address the wide range of respiratory conditions they are likely to encounter in their practice. Similarly, none of the DSTs for RNCP addresses the prenatal or postpartum primary care of women or infants, yet recent research suggests that this continues to be a critical area of health inequity in First Nations populations (Adelson, 2005; BCPHO, 2009; Reading, 2009; Tarlier et al., 2007). Maternal and infant health is, again, largely influenced by social inequities such as poverty, lack

of access to adequate nutrition, and inadequate housing. Thus, this is a clinical practice area that demands access to well-qualified primary care providers who can offer essential prenatal, postpartum, and infant primary care, as well as respond to the complex health and social needs in these communities.

The CRNBC (2011c) states that DSTs “provide direction for registered nurses who have been certified by CRNBC to carry out specific certified practices. They assist these registered nurses in making clinical decisions, but are not a substitute for clinical judgment.” Similarly, NPs rely on clinical judgement to implement practice guidelines appropriately and safely. Thus, “clinical judgement” is key to the safe enactment of both the NP and the RNCP role.

We would argue that a comprehensive, substantive knowledge base is prerequisite to sound clinical judgement — and this, in fact, was recognized throughout the process of developing the competencies and scope of practice for NPs in British Columbia. We appreciate that CRNBC’s goal in limiting the scope of practice and requiring RNCP RNs to adhere to DSTs is to ensure safe practice, in keeping with the College’s mandate to protect the public. However, Vukic and Keddy (2002), in their study exploring outpost nursing practice in northern Canada, suggested that a substantive knowledge base is a prerequisite for practitioners to implement practice guidelines safely and effectively:

These guidelines can be significantly problematic as the assumption, when referring to these guidelines, is that the nurse has identified the appropriate “medical” diagnosis when treating patients. These guidelines can be the major source for prescribed practice if nurses are not adequately prepared. (p. 546)

Thus, while safe, equity-oriented practice is unequivocally paramount, we suggest that enabling nurses to practise as primary care providers within a strictly delimited scope of practice and by protocol, without ensuring that they have the requisite knowledge base to support broad-based, socially and culturally relevant primary care practice, is not a model that promotes safe practice. Considering that the recipients of care delivered by nurses working under RNCP are largely First Nations people living in rural or remote communities, we also ask whether the RNCP model represents high-quality, equitable, and socially just primary care.

Implications: Certified Practices

Recognizing that the stated goal of RNCP is to ensure public safety through regulation, the implementation of certified practices for RNs practising in a broad primary care role in remote First Nations commu-

nities has created a situation of two different standards of preparation and licensure for nurses practising in substantively similar roles:

1. NPs working with primarily non-First Nations people in urban and suburban settings
2. RNs working under RNCP in remote First Nations communities

While we have concerns, as described above, about the fit between the level and scope of primary care offered by RNs working under RNCP and the primary care health needs of people living in rural and remote First Nations communities, RNCP raises several additional ethical questions from a critical social justice perspective.

What are the implications of providing primary care through the mechanisms of RNCP to populations whose health is influenced by systemic inequities? At a community and population health level, the complexity of health issues in many remote First Nations communities demands nurses who are equipped not only to provide comprehensive primary care services but also to engage in the full range of advanced nursing practice — as are NPs — to work with communities in ways that both take into account and address the root causes of poor health, and thereby begin to shift the picture of health in remote communities. Disparities in access to the social determinants of health, such as adequate housing, secure supplies of safe food and water, education, and employment, are now universally recognized as the “causes of the causes” of poor health, in First Nations as well as indigenous populations globally (Reading, 2010). Nurses working in First Nations communities must practise in ways that take into account the social, political, and historical contexts of health — and must find ways of fostering greater equity in the provision of primary care while fulfilling the broader ideals of PHC.

Inadequate access to the resources needed for health not only directly influences the health of individuals but also complicates the provision of primary care. For example, the primary care of an individual with diabetes, which may be relatively straightforward in an urban, more affluent setting, can be complicated in a remote First Nations community, due to lack of access to affordable healthy food choices or lack of access to socially and culturally relevant diabetes-education programs. The often more complex nature of primary care calls for practitioners who are attuned to the complexities of practice in such settings and who are equipped for the challenges of offering primary care in the context of health and social disparities. As we continue to argue, both nurses and NPs working in First Nations communities need knowledge of primary care, and knowledge that can support critical analyses of the social pathways that sustain health inequities, so that they can work towards mitigating those inequities, and address people’s biomedical needs in the

everyday contexts of their lives (Browne & Tarlier, 2008). We are not suggesting that effecting improved access to the determinants of good health is the responsibility of any one health-care provider; we are referring to community engagement and development work that is most effectively addressed by health practitioners working in partnership with communities to address community-defined priorities in ways that support self-determination. This level of community engagement is what Orchard and Karmaliani (1999) identify as complex nursing work requiring advanced practice knowledge and skills — as provided by NPs.

Have the potential implications of the RNCP model at a disciplinary and professional level been fully considered? We speculate that RNCP — particularly in such a broad and complex role in terms of providing primary care — could represent a slippery slope for nursing practice. From a professional stance, we question whether it is sound ethical policy to place nurses in a role where practice is directed by protocol rather than guided by a comprehensive base of substantive advanced practice nursing theory and knowledge and by an advanced level of knowledge of how health practitioners can mitigate the impact of systemic inequities on people's health. Moreover, what might be the legal and ethical implications for RNs practising by protocol and from a less than comprehensive knowledge base, yet “independently and with sole accountability” (CRNBC, 2011c)? We ask: Is this a safe and ethical position in which to place nurses?

As we have established, nursing practice in remote communities is considered to be the predecessor of present-day NP roles, and NP education has historically been identified as necessary for filling these roles. The question is whether RNCP will enable RNs (including those with only basic experience and education) to practise in what is essentially, and historically recognized to be, an NP role, without gaining the broad base of substantive knowledge that is considered necessary to support NP practice. From a temporal perspective, the level of such NP education has consistently been viewed as above and beyond what was considered “basic” nursing education for the time. For instance, NP education was offered at a post-diploma level when the majority of nurses were diploma-prepared and at a post-BSN level when, increasingly, nurses were prepared at the BSN level. Now that the BSN is the standard for entry to practice in the majority of Canadian jurisdictions, the standard for NP education is widely recognized as a master's degree in nursing (CNA, 2008). Creating a new role, such as RNCP, that enables nurses without the requisite education to practise in remote First Nations communities in a role that is substantively similar to the NP role seems to run counter to this longstanding philosophy underlying our understanding of appropriately preparing nurses for safe and efficient practice. This obser-

vation raises the question of what factors may be driving the RNCP model in British Columbia, if not nursing's own longstanding beliefs about appropriate nursing preparation. While many factors influence inequity in health and access to health care, "it is the political and policy aspects that require most attention, both because of their inherent importance as a fundamental antecedent and their high relevance to policy decisions and because of the historical absence of attention to them in research" (Starfield, 2001, p. 553).

We, as observers external to the decision-making process, cannot be certain of the precise nature of the political and policy aspects that are driving the uptake of the RNCP role in preference to the NP role in remote First Nations communities in British Columbia. However, we speculate that in the current climate of health reforms, efficiency discourses, and incentives to streamline human resources, the creation of RNCPs may represent an initiative that, although founded on good intentions, is representative of the axiom underpinning many health-care decisions — to do more with less (Varcoe & Rodney, 2009). RNs are less costly to hire than NPs, at least over the short term. We argue that this may prove a false economy over the longer term. For example, a high rate of nursing turnover in remote communities has long been acknowledged as one of the most significant and recalcitrant health-service delivery issues in remote First Nations communities. But, notably, studies have long suggested that the main reason given by nurses for leaving their jobs in remote communities is lack of adequate preparation for the role (e.g., Morewood-Northrop, 1994). Chaytor (1994) found that nurses with adequate preparation (i.e., the Dalhousie Outpost and Community Health Nursing program) remained in outpost nursing longer than nurses with less preparation. As highly qualified primary care providers with the advanced practice knowledge and skills to work in ways that are consistent with and that support community development, contemporary NPs embody the level of preparation that has long been acknowledged as necessary to decrease nursing turnover and increase continuity in remote First Nations communities. Despite the advantages that NPs could clearly bring to health care in these settings, employers in British Columbia have created few NP positions in remote First Nations communities. We speculate that one argument driving the RNCP model in British Columbia is the belief that it will be challenging to recruit and retain NPs in remote First Nations communities, just as it has traditionally been challenging to recruit and retain nurses. However, the few NP positions that have been created have been successfully filled, suggesting that more NPs could be recruited if more NP positions were made available. Also, NPs are recruited for positions in remote First Nations and Inuit communities in other jurisdictions, so why not in British Columbia?

What are the implications of RNCP for the newly emerging role of NPs in British Columbia and other jurisdictions? As has been the case in other jurisdictions, implementation of the NP role in British Columbia is not progressing without setbacks; currently there is a dearth of funding for new NP positions in the province, leaving many new graduates unemployed or underemployed. At a time when the evolution of the role in British Columbia and elsewhere may still be vulnerable, will RNCP inadvertently serve to detract from the potential of the NP role to contribute to the health of First Nations people in British Columbia? How might the RNCP model shape future expectations around meeting health human resource needs — and needs for equitable access to high-quality primary care services — in remote First Nations communities? As stated above, RNs are less costly to hire than NPs. Will this, plus the fact that RNs are now “certified” as being adequate to function in the role (albeit in a limited scope, as we have described), institutionalize a lower standard of preparation, and in consequence will the vision of nursing practice in remote settings as the quintessential Canadian NP role be diluted and lost from view? For example, will employment opportunities for NPs in remote community practice be limited in favour of employing less costly RNs?

We also speculate that there may be a risk for RNs working under certified practices being placed in an NP-replacement role, analogous to NPs being placed in a physician-replacement role (Browne & Tarlier, 2008). Just as placing NPs in a physician-replacement role might erode the “value added” aspects of the NP role (Browne & Tarlier, 2008), placing RNs in a NP-replacement role might erode the unique aspects — and, we would argue, the unique strengths — of the RN role. Could this lead to denigration of RN practice, creating further tensions and perceived injustices or inequities between nurses? We propose the creation of practice models that support RNs and NPs working together collaboratively in roles that complement one another. Moreover, where is the incentive for a nurse working in or interested in working in a remote community to do so as an NP, when the investment is considerably less, in terms of both time and finances, for nurses to become certified, especially in times of economic uncertainty as well as uncertainty around the future role of NPs in remote community practice?

What are the implications of RNCP from the “big picture” perspective of the health-care system? We do believe that there will continue to be a role for RNs working under RNCP in remote communities, as well as RNs working within the scope of RN practice. We also recognize that it is unrealistic to think that NPs alone will be able to meet all of the health human resource needs in remote First Nations communities. Nor would we advocate for this as an appropriate model of health-care deliv-

ery, particularly given the evidence suggesting that health outcomes are improved with interprofessional collaborative team approaches (Barrett, Curran, Glynn, & Godwin, 2007; Health Council of Canada, 2008). But by the same token, these are valid reasons why a model that relies on RNCP RNs as sole primary care providers in remote First Nations communities is flawed. From an ethical and social justice perspective, we believe that the aim must be to develop models of health-service delivery that move us beyond the traditional model of nurses, RNCP or otherwise, as the sole primary care providers in remote First Nations communities. As long experience tells us, this has not been a successful model in terms of either addressing health disparities or working with communities to foster greater health and health-care equity through improved access to high-quality, socially relevant care. Our aim must be to develop a model that more closely reflects the collaborative, interdisciplinary PHC team approaches that research suggests are integral to redressing the longstanding health and health-care inequities within communities (Starfield, 2006; WHO, 2008a, 2008b).

Shifting the Status Quo

In putting forward these discussion points, we emphasize that there are roles for RNs working in an expanded role in collaboration with NPs to ensure more equitable access to high-quality primary care. This could represent an ideal model of health-service delivery in remote communities — that is, if RNCP practice were presented as part of a strategic vision of an expanded, innovative model of health care, one that could start to shift the status quo of health in remote communities. However, propagation of the traditional model wherein RNs, regardless of certification status, are used to fill the gap in health services in remote First Nations communities seems to be short-sighted and will, we argue, do little to redress the complex health and social inequities that shape health and illness, and primary care needs, in remote communities. In our view, it is equally short-sighted to not create space for NPs to practise in remote First Nations communities at a time when British Columbia has finally recognized the NP role and has clearly committed to implementing it as an advanced practice role in PHC settings, in particular with a mandate to fill gaps in primary care needs in underserved and marginalized populations.

In considering the health needs of remote First Nations communities and the implications of RNs working under RNCP in these settings from a critical social justice perspective, we are left with several important questions. We believe it would be timely to engage First Nations community leaders, the health-care community, and those in decision-

making positions related to the deployment of nurses in addressing these questions.

- Is there evidence to support the supposition that RNs working under RNCP will provide safe and efficient primary care, particularly when working in a more broad-based community health role?
- Is it possible that implementation of RNCP, while well-intentioned, risks the perpetuation of historic inequities in access to health services for residents of remote First Nations communities?
- Is it possible to reconcile the RNCP model with nursing's philosophical, social, and ethical commitment to enacting the principles of social justice in relation to fostering greater equity in health care?
- Are there ways of thinking beyond the ostensible efficiencies of RNCP, and if so, what alternatives are there to foster greater equity in the provision of nurse-led primary care in remote and rural First Nations communities?

Canadian nurses have a remarkable history in providing health care within the unique contexts of remote First Nations communities. Nurses have ensured that the residents of these communities have been able to access essential PHC. While there have been some significant gains in the health status of First Nations people in British Columbia, health continues to deteriorate on several key health indicators (BCPHO, 2009), suggesting that traditional models of primary care delivery are insufficient to shift the status quo of health disparities. In closing, we therefore ask: Can nursing demonstrate the leadership needed now to explore new models of health-care delivery and new models of partnering with communities in ways that have the potential to shift the status quo, and, ultimately, contribute to creating more equitable health with First Nations people living in remote communities?

References

- Adelson, N. (2005). The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*, 96, S45–S61.
- Anderson, J. M., Rodney, P., Reimer Kirkham, S., Browne, A. J., Khan, K. B., & Lynam, J. (2009). Inequities in health and healthcare viewed through the ethical lens of critical social justice: Contextual knowledge for the global priorities ahead. *Advances in Nursing Science*, 32(4), 282–294.
- Barrett, J., Curran, V., Glynn, L., & Godwin, M. (2007). *Canadian Health Services Research Foundation synthesis: Interprofessional collaboration and quality primary healthcare*. Ottawa: Canadian Health Services Research Foundation. Retrieved June 2, 2011, from http://www.chsrf.ca/Migrated/PDF/ResearchReports/CommissionedResearch/SynthesisReport_E_rev4_FINAL.pdf.
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.

- Bourassa, C., McKay-McNabb, K., & Hampton M. (2004). Racism, sexism, and colonialism: The impact on the health of Aboriginal women in Canada. *Canadian Woman Studies*, 24(1), 23–29. Retrieved June 2, 2011, from <http://www.yorku.ca/cwscf/>.
- British Columbia Provincial Health Officer. (2009). *Pathways to health and healing – 2nd report on the health and wellbeing of Aboriginal people in British Columbia. Provincial Health Officer's Annual Report 2007*. Victoria: Ministry of Healthy Living and Sport. Retrieved June 2, 2011, from <http://www.health.gov.bc.ca/pho/>.
- Browne, A. J., & Tarlier, D. S. (2008). Examining the potential of nurse practitioners from a critical social justice perspective. *Nursing Inquiry*, 15(2), 83–93.
- Brumwell, A., & Janes, C. (1994). Primary health care in Rae-Edzo. *Canadian Nurse*, 90(3), 37–38.
- Brykczynski, K. A. (1989). An interpretive study describing the clinical judgment of nurse practitioners. *Scholarly Inquiry for Nursing Practice*, 3(2), 75–104.
- Canadian Institute for Health Information. (2010). *Regulated nurses: Canadian trends 2005–2010*. Ottawa: Author. Retrieved June 2, 2011, from http://secure.cihi.ca/cihiweb/products/regulated_nurses_2004_2008_en.pdf.
- Canadian Nurse Practitioner Initiative. (2006). *Nurse practitioners: The time is now. A solution to improving access and reducing wait times in Canada*. Ottawa: Author. Retrieved November 5, 2010, from http://www.cna-aiic.ca/CNA/documents/pdf/publications/cnpi/tech-report/section1/01_Integrated_Report.pdf.
- Canadian Nurses Association. (2008). *Advanced nursing practice: A national framework*. Ottawa: Author. Retrieved June 2, 2011, from http://www.cna-nurses.ca/cna/documents/pdf/publications/anp_national_framework_e.pdf.
- Canadian Nurses Association. (2009). *Position statement: The nurse practitioner*. Ottawa: Author. Retrieved June 2, 2011, from http://www.cna-aiic.ca/CNA/documents/pdf/publications/PS_Nurse_Practitioner_e.pdf.
- Chaytor, K. (1994). *Preparing for outpost practice: An evaluation of the Outpost and Community Health Nursing Program at Dalhousie University*. Halifax: Chaytor Educational Services.
- College of Registered Nurses of British Columbia. (2009). *Competencies for Remote Area Certified Practice*. Retrieved May 14, 2011, from <https://www.crnbc.ca/Standards/CertifiedPractice/Documents/RemotePractice/472CoreCompetenciesRemoteNursingPractice.pdf>.
- College of Registered Nurses of British Columbia. (2010a). *Competencies required for nurse practitioners in British Columbia*. Vancouver: Author. Retrieved May 11, 2011, from <https://www.crnbc.ca/Registration/Lists/RegistrationResources/416CompetenciesNPs.pdf>.
- College of Registered Nurses of British Columbia. (2010b). *CRNBC – certified practices overview*. Vancouver: Author. Retrieved May 11, 2011, from <https://www.crnbc.ca/Standards/Lists/StandardResources/485CertifiedPracticesOverview.pdf>.
- College of Registered Nurses of British Columbia. (2011a). *Glossary*. Retrieved May 11, 2011, from <https://www.crnbc.ca/glossary/Pages/Default.aspx>.

- College of Registered Nurses of British Columbia. (2011b). *Nurse practitioner application: Eligibility*. Retrieved May 11, 2011, from <https://www.crnbc.ca/Registration/NPApp/NPRregistration/Pages/Step1.aspx>.
- College of Registered Nurses of British Columbia. (2011c). *Remote Area Certified Practice. Decision support tools*. Retrieved May 14, 2011, from <https://www.crnbc.ca/Standards/CertifiedPractice/Pages/Remote.aspx>.
- College of Registered Nurses of British Columbia. (2011d). *Scope of practice for nurse practitioners: Standards, limits, and conditions*. Vancouver: Author. Retrieved May 11, 2011, from <https://www.crnbc.ca/Standards/Lists/StandardResources/688ScopeforNPs.pdf>.
- College of Registered Nurses of British Columbia. (2011e). *Scope of practice for registered nurses: Standards, limits, and conditions*. Retrieved May 5, 2011, from <https://www.crnbc.ca/Standards/Lists/StandardResources/433ScopeforRegisteredNurses.pdf>.
- College of Registered Nurses of British Columbia. (2011f). *Statistics*. Retrieved May 11, 2011, from <https://www.crnbc.ca/CRNBC/Statistics/Pages/Default.aspx>.
- De Witt, L., & Ploeg, J. (2005). Critical analysis of the evolution of a Canadian nurse practitioner role. *Canadian Journal of Nursing Research*, 37(4), 116–137.
- Doucette, S. (1989). The changing role of nurses: The perspective of Medical Services Branch. *Canadian Journal of Public Health*, 80(2), 92–94.
- Health Canada. (2010). *First Nations, Inuit and Aboriginal health: Nursing profiles*. Retrieved May 14, 2010, from <http://www.hc-sc.gc.ca/fniah-spnia/services/nurs-infirm/empl/profil-eng.php>.
- Health Council of Canada. (2008). *Rekindling reform: Health care renewal in Canada, 2003–2008*. Toronto: Author. Retrieved May 11, 2011, from [http://www.healthcouncilcanada.ca/docs/rpts/2008/HCC%205YRPLAN%20\(WEB\)_FA.pdf](http://www.healthcouncilcanada.ca/docs/rpts/2008/HCC%205YRPLAN%20(WEB)_FA.pdf).
- Health Professions Council of British Columbia. (2001). *Health Professions Council reports. Post hearing update of preliminary report: Registered nurses*. Victoria: British Columbia Ministry of Health. Retrieved May 5, 2011, from <http://www.health.gov.bc.ca/professional-regulation/hpc/review/part-i/update-regnurse.html>.
- Kubik, W., Bourassa, C., & Hampton, M. (2009). Stolen sisters, second class citizens, poor health: The legacy of colonization in Canada. *Humanity and Society*, 33, 18–34.
- Luo, Z. C., Kierans, W., Wilkins, R., Liston, R., Uh, S. Z., & Kramer, M.S. (2004). Infant mortality among First Nations versus non-First Nations in British Columbia: Temporal trends in rural versus urban areas, 1981–2000. *International Journal of Epidemiology*, 33(6), 1252–1259.
- Luo, Z. C., Wilkins, R., Heaman, M., Martens, P., Smylie, J., Hart, L., et al. (2010). Birth outcomes and infant mortality by the degree of rural isolation among First Nations and non-First Nations in Manitoba, Canada. *Journal of Rural Health*, 26(2), 175–181.
- Morewood-Northrop, M. (1994). Nursing in the Northwest Territories. *Canadian Nurse*, 90(3), 26–31.

- Nurse Practitioner Association of Ontario. (2010). *History of NP role development in Ontario*. Retrieved May 11, 2011, from <http://www.npao.org/history.aspx>.
- Orchard, C. A., & Karmaliani, R. (1999). Community development specialists in nursing for developing countries. *Journal of Nursing Scholarship*, 31(3), 295-299.
- Reading, J. (2009). *The crisis of chronic disease among Aboriginal peoples: A challenge for public health, population health, and social policy*. Victoria: Centre for Aboriginal Health Research. Retrieved May 11, 2011, from <http://www.cahr.uvic.ca/docs/ChronicDisease%20Final.pdf>.
- Reading, J. (2010, October 14). *An introduction to Aboriginal health: What determines Aboriginal health in Canada and around the world*. Centre for Aboriginal Health Research, University of Victoria Speaker Series Presentation #1. Retrieved May 11, 2011, from <http://cahr.uvic.ca/speaker-series/>.
- Reading, J., Marsden, N., Kurbanova, D., & Link, R. (2009). *Global Indigenous Health Research Symposium report. Papers and presentations: Directions and themes in international indigenous health research 2008*. Victoria: Centre for Aboriginal Health Research. Retrieved May 11, 2011, from http://www.cahr.uvic.ca/docs/CAHR_Book1_OUT_rev.pdf.
- Reimer Kirkham, S., & Browne, A. (2006). Toward a critical theoretical interpretation of social justice discourses in nursing. *Advances in Nursing Science*, 29(4), 324-339.
- Sherwin, S. (2002). The importance of ontology for feminist policy-making in the realm of reproductive technology. *Canadian Journal of Philosophy*, 28, 273-295.
- Starfield, B. (2001). Improving equity in health: A research agenda. *International Journal of Health Services*, 31(3), 545-566.
- Starfield, B. (2006). State of the art in research on equity in health. *Journal of Health Politics, Policy and Law*, 31(1), 11-32.
- Tarlier, D. S. (2001). *Voices from the wilderness: An interpretive study describing the role and practice of outpost nurses*. Unpublished master's thesis, University of British Columbia.
- Tarlier, D. S., Browne, A. J., & Johnson, J. L. (2007). The influence of geographical and social distance on nursing practice and continuity of care in a remote First Nations community. *Canadian Journal of Nursing Research*, 39(3), 126-148.
- Tarlier, D. S., Johnson, J. L., & Whyte, N. B. (2003). Voices from the wilderness: An interpretive study describing the role and practice of outpost nurses. *Canadian Journal of Public Health*, 94(3), 180-184.
- University of Alberta Faculty of Nursing and Faculty of Medicine. (1980). *Education objectives for the Nurse Practitioner Program*. [Description of Nurse Practitioner Program and the Clinical Training of Nurses, Medical Services Branch, Health and Welfare Canada.] Copy in possession of D. Tarlier.
- University of Northern British Columbia. (2010). *Remote Nursing Certified Practice*. Retrieved May 11, 2011, from http://www.unbc.ca/nursing/remote_nursing.html.

- Varcoe, C., & Rodney, P. (2009). Constrained agency: The social structure of nurses' work. In B. S. Bolaria & H. D. Dickinson (Eds.), *Health, illness and health care in Canada* (4th ed.) (pp. 122–150). Toronto: Nelson Education.
- Vukic, A., & Keddy, B. (2002). Northern nursing practice in a primary health care setting. *Journal of Advanced Nursing*, 40(5), 542–548.
- Watts, R. (2010). Part nurse, part doctor, no job. *Victoria Times Colonist*, March 11. Retrieved May 11, 2011, from http://www2.canada.com/victoriatimes-colonist/news/capital_van_isl/story.html?id=0ee01466-887c-4e9d-bf86-e750bcdce3be.
- World Health Organization. (2008a). *Closing the gap in a generation: Health equity through action on the social determinants of health. Commission on Social Determinants of Health final report*. Geneva: Author.
- World Health Organization. (2008b). *The World Health Report 2008 – Primary health care (now more than ever)*. Geneva: Author.
- Yukon Registered Nurses Association. (2009). *Legislation opens door for nurse practitioners*. [Media release.] Retrieved May 14, 2011, from <http://www.yrna.ca/assets/NPLegrelease.pdf>.

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