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

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### ABSTRACT

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

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The nursing profession has been impacted by health system restructuring over the last three decades. The increasing cost of healthcare, human resource shortages, and a demand for health spending accountability has influenced a shifting focus toward health system efficiencies and cost saving measures [1]. Nurses are tasked to meet these demands, placing pressure on them to develop a productive and cost-effective system of care. Primary care is pivotal in the development of a performing health system [2]. Nurse practitioners (NPs) have played key roles in increasing access to primary care, particularly in rural settings for individuals with complex health conditions and have addressed multiple social issues such as homelessness, frail seniors or new immigrants care [3–6]. In the acute care settings, NPs have been employed to offset shortages of physician residents in multiple settings such as neonatal intensive care units, emergency rooms and inpatient units [7]. In Canada, NPs are autonomous healthcare professionals with advanced expertise in nursing theories and practice, health management and promotion, disease/injury prevention and they possess in-depth knowledge and advanced clinical decision-

making skills which support their role in the provision of comprehensive health services [8]. Nurse practitioners align themselves with their practice by positioning their advanced nursing skills within nursing paradigms. Therefore, we recognize how important is the knowledge NPs must possess to accomplish their goals. But what factors have influenced the development of their advanced practice and where does this place NPs in the context of the healthcare system? Abbott's theory on the system of the profession provides a framework to answer these questions. The concepts explored in his theory help understand the power relationship and knowledge legitimization of certain professions [9].

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

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## 1. Historical background

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

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

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

In Canada, the roles and responsibilities are divided between the federal and provincial and territorial governments. Each province and territorial governments are responsible for planning, organizing, and delivery of health and social services for their residents. NPs currently practice in diverse settings under different models of care following the regulations of their province or territory of practice. With the above in mind, our paper is oriented to investigate the context of the development of the NP role in the province of Ontario. Historically, in Ontario, the socio-political climate in the 90s led many nursing organization to advocate for revitalizing the role of NPs. In 1998, the role was formally incorporated in the provincial legislation through the Expanded Nursing Services for Patients Act [10]. Such legislation defined further the scope of practice and the protection of the title RN (extended class) [19]. Once the role was recognized by the legislation, the Ontario Ministry of Health and Long-Term Care began to fund NPs in Community Health Care Centers and Family Health Care Teams [2,7]. Ontario was one of the first provinces in recognizing the NP role and today is the province with the highest percentage of NPs in Canada [21]. Despite the provincial government's initiative to increase access to care, many regions remained underserved [22]. A

new model of care was proposed by NPs to address the needs of underserved communities and increase access to quality PHC and in 2007, the Nurse Practitioner-Led Clinic (NPLC) model was introduced in Ontario. At the time, the Ontario Medical Association (OMA) was strongly opposed to the NPLC model [23]. The OMA and the Ontario College of Family Physicians argued that NPs would be more expensive to the healthcare system and that the evidence to support the utilization of NPs was flawed [24]. The OMA stated "only doctors should be the ones leading teams of other healthcare professionals, not nurse practitioners" [25]. In spite of this opposition, NP leaders in Sudbury gained support from public and professional associations, and in 2008 opened the first NPLC. The government voiced strong support for this initiative with Ontario Premier Dalton McGuinty, during his visit to the Sudbury NPLC in April 2008, stating "I have seen the future of healthcare, and it is in Sudbury" [22]. To date, Ontario is the only Canadian province recognizing NP-led clinics as a team-based delivery care model to access primary health care.

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

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

## 2. Understanding the tension

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

de Witt & Ploeg illustrate Abbott's theory by exposing how external forces such as the enactment of new legislations weakened the jurisdiction of medicine and strengthened that of the NP by providing them with more prescribing, diagnosing, admitting and consulting authority [29]. With ongoing efforts from various nursing associations and the CNO, legislation framing the NP scope of practice continues to be modified to provide more autonomy. As reflected in the Practice Standards from the CNO, the implementation of Bill 179 in 2011 provided NPs with significant gains in regards to autonomy in their practice [30]. Although the role is legitimized in public and legal arenas [29], its realization must occur in the workplace. Medicine, as the dominant healthcare profession, has successfully demonstrated the notion that only doctors can fulfill certain functions thereby weakening nursing jurisdiction. Following Abbott's theory, these changes in legislation are affecting the relationship between the two professions. The question remains as to how the NP will define roles and values with this new found freedom.

### 3. Integration ... or not

A historical perspective helps us to understand why initial research in the field of NP role development focussed on studies of validation of the role and its integration within the healthcare system. The circumstances under which NPs were received by physicians made it essential to demonstrate role validity. To achieve jurisdictional settlement against a dominant profession one must legitimize the professional role in the public, legal and workplace sectors [9].

Attempting to establish a role that would overlap the skills and knowledge of medicine, a profession sitting at the top of the hierarchy in the healthcare system, is not an easy task. Work pertinent to the implementation of the NP role has been a center of interest of multiple studies [31–34]. Sangster-Gormley et al. (2011) identified three concepts that significantly influence NP role implementation in PHC: involvement, acceptance and intention [34]. These concepts lay the framework to reflect on the NP role while understanding the context in which the role has been implemented.

Involvement means actively participating in the early stages of role implementation. It is recommended that physicians, administrators and other allied healthcare providers be involved in mentoring new NPs [34]. Acceptance is defined as recognition of the role and the willingness to work with the NP, and includes awareness and appreciation for the role by team members. The concept of intention relates to how the role is defined [34]. Reflecting on these concepts, one must wonder how the true nature of the NP is transparent in its role development? These concepts still leave room for physicians, administrators and other healthcare providers to dictate NP practice. The NP is a professional who has demonstrated his/her value to healthcare over the past forty years and should not be required to endure the process of "acceptance" and "role definition by others". It would be an unlikely scenario to observe physicians sitting at a table waiting for someone to tell them how their role will be integrated and what their role will be within the team.

Communication, role definition, and role understanding are critical processes, however, in these processes, NPs must be treated as autonomous professionals, rather than as ones who must "fit in". Would a process of "fitting in" aim to shape the NP role within the medical paradigm? As nurses, we must question ourselves as to what we desire for our profession, as well as the healthcare system as a whole. If becoming part of the medical paradigm is the goal, then integration it is, but what if we wish to be recognized for who we are, for the expertise we bring and for the way we practice? We could then participate in the design and transformation of the

healthcare system.

### 4. Being at the margin

It is necessary to consider a feminist perspective as a lens to view how NPs faced these struggles. The oppression group behaviour model has been used to examine how it can empower and aid NPs to control their own practice [35]. Nurses can be viewed as an oppressed group under the assumption that nurses have internalized the values of physicians and the medical model to the extent that they can be said to be "marginal" [35]. Being marginal refers to the attempt to look like the oppressor by trying to deny one's own characteristics and by taking on as many of those of the oppressor as possible. Although not all NPs fit this description, Roberts suggests that many NPs can be viewed as seeking to become doctors in order to gain autonomy and achieve a higher income [35]. From this perspective, marginality is imposed by oppressive structures, and the margin is viewed as a place to be avoided.

bell hooks' philosophical discourse on marginality offers a different perspective on the margin [36]. From her perspective, marginality gives the opportunity to be a site of resistance. Being at the margin is still being part of the whole but on the outside of the main body. It permits one to see reality from the inside out and outside in. Those at the margins survive by knowing both what constitutes the margin and the center. In her discourse, hooks states that the center does not know much about the outside but that the outside knows much about what is on the inside. She challenges the notion of the desire to be at the center to claim freedom from oppression and instead suggests that the margin offers a place that supports resistance, a location of radical openness and possibility. Being at the margin allows an individual to remain critical of the domination [36]. This notion is crucial for the nursing discipline and the NP as it opens a door to embrace the opportunity to advocate for social justice within our ever-changing healthcare system.

Nurse Practitioners have demonstrated an important role in addressing the healthcare needs of those who do not have access to healthcare. The majority of NPs are providing care to a marginalized population [37]. The movement towards a re-engineered healthcare system in Canada favouring cost efficiency has a negative impact not only on the nursing discipline but also on patient outcomes [1]. The impact of the social determinants of health on disparities and inequities is recognized as a complex issue that necessitates the involvement of diverse actors, including nurses [38]. In a socio-political climate in which social and health disparities persist, the role of the NP should continue to embrace a social justice practice [39]. hooks' discourse on marginalization cautions NPs from diving into the middle of the circle, and encourages NPs to maintain their position on the margin where they maintain their place to advocate for social justice in healthcare. Nurse Practitioners must nourish themselves from that which constitutes the margin and speak from a place of resistance, not of domination. Interestingly the concept of liberation of oppression by Roberts [35] reveals a notion similar to the one described by hooks [36]. To liberate themselves, NPs should dream of a new system consistent with nursing, explore the oppression with colleagues, revalue characteristics of women and nursing, re-join nursing colleagues and critique nursing education [35].

Promoting social justice and health equity is integral within the historical and philosophical roots of nursing practice [38]. By embracing one another at the margin, articulating our perspective on healthcare, and bringing to light nursing values, we have the capacity to halt the current trajectory that is drawing us towards a system that is not consistent with our professional

conceptualization of healthcare. Implementation of the NPLC model represents an example of how NPs may liberate themselves from oppression within the medical paradigm. The question is, how do nurses maintain the momentum, and continue to drive forward the liberation movement?

## 5. Towards the liberation

The PHC discourse supports patient centered care embracing a holistic care approach with a focus on health promotion and prevention, moving some of the core nursing values into view. Although this discourse has been around for 40 years, minimal progress has been made within a medically dominant healthcare system. Medical professionals offer valuable skills and expertise, however, a solely medically focused profession lacks the holistic approach to health that is required to lead and manage a primary care system within a framework of PHC. The emergence of NPs offers potential through collaboration in providing superior means of care delivery in addition to palliating the physician shortage [40]. Patient centered care encompassing responsive care, holistic approaches, health promotion and prevention through a team-based model are at the core of the most recent health reform [41]. This emergence of the collaborative care model, established during the NP movement, has created a shift in paradigms within PHC and positions the NP as a vital component of the system as these reflect their care philosophy [18].

Nurses must become involved in the political arena and serve as leaders to challenge dated paradigms and advocate for changes in healthcare. Unfortunately, nurses have traditionally been viewed as being a powerless profession, lacking social prestige and with limited financial remuneration for services provided [42]. From the philosophical perspective of marginalization, nurses need not aspire to power but must simply act on behalf of the profession and the population for whom they care.

## 6. The liberation: governmentality, parrhesia, care of the self

Foucault's philosophical discourse on governmentality can help explore NPs potential to be advocates for the nursing discipline and the patient. Foucault describes a more complex relationship amongst individual, society, government and the various forms of power. The notion of government is seen as an activity to achieve multiple goals, it is not about imposing the law. Instead, Foucault expresses the idea that governing is a question of employing tactics and arranging elements to serve the ones to be governed [43]. Within governance, various types of power could be utilized. Disciplinary power is important when we refer to the profession of nursing and is defined as a way to exercise power over someone or many persons to affect conduct, attitudes and/or habits in order for the individual to achieve new skills, new ways of thinking and subsequently to be ready for instruction [42]. In this context, the word "power" is described as being constructive and not limited to repression. A Foucauldian interpretation reveals caring as related to control of the patient and of the environment, and to the creation of knowledge that empowers nurses [44]. We can understand from this discourse that the actions of nurses within the healthcare system "helps the state to govern at a distance" [22 p53].

This concept could be further advanced through the NP role. We argued that NPs, having the authority to diagnose and prescribe, possess the enhanced position that could be used to manage individuals, families and populations and therefore, influence politics. Nurse Practitioners need to be aware of their extended impact in the political arena, beyond that of their individual care. From this philosophical reflection, it would be interesting to see how NPs could become more involved in their role by being politically

motivated in the re-organization of the healthcare system. We have an example of that capacity with the implementation of the NPLCs in Ontario. Much can be drawn from this experience to inspire future nursing innovations in primary care. How can NPs challenge even further the current healthcare system and support the development of a system oriented towards nursing core values?

Perron [45] provides interesting concepts from Foucault's discourse on "practice of self-formation" that could be utilized to explore how nurses could free themselves to engage actively in politics in the pursuit of influencing healthcare change. She discusses the difficulty of nurses in engaging with politics and addresses the belief that political positioning is anti-ethical to quality nursing care as the nurse's focus is on the relationship with the patient rather than on the "big picture". For nurses the relationship with the patient is where nursing occurs, not on its periphery. The place of research and advocacy is at the immediate care encounter rather than on the outside [45].

The example of the NPLC does offer an opportunity to see how NPs permeate into the political arena, however, many NPs remain hesitant to engage in politics, despite being encouraged to do so. Perron [45] suggests that by using Foucault's notion of care of the self and parrhesia, nurses can engage in the political sector while maintaining ethical provision of care. Care of the self and care of others are not anti-ethical but in fact, the former is a necessary, fundamental condition for the latter. Perron refers to care of the self as a way of being in the world that requires extensive self-knowledge and self-governance [45]. One sees how one is governed and how this governs the other. It is a relationship between subjectivity, truth and freedom [45]. By knowing ourselves first, by practicing self-examination as a subject in the world and by exploring truths about ourselves, this permits us to be authentic. Being authentic allows one to act within one's systems of beliefs and values. By engaging in this practice of self-examination we are positioned to act on the possibilities for choice and self-determination that are open to us [46]. Self-reflection could define NPs true nature and therefore help us exercise power over ourselves in order to govern ourselves in an ethical and truthful manner. Liberation can be achieved by self-reflection on the forces of power within our practice and the healthcare system. This endeavour can aid NPs to locate themselves on the margin as described by bell hooks and encourage NPs to engage in the social justice discourse.

To move forward, to care for others and to govern their role, NPs must first take care of themselves. This paper provides a reflection on the medical and nursing paradigms that overlap the practice. What should make NPs authentic? Expanding the NP role to include historically medically dominant acts may, in fact, undermine NP independence through increased regulation (professional bodies and institution) and further subjection to the biomedical discourse [47]. Further, this expansion may create a "double bind" for nurses. To achieve more durable, consistent, and ethical self-rule, nursing must engage in care of the self and parrhesia [45]. In achieving this important quest of knowledge of self, NPs will be able to engage more freely in political action and meaningfully shape the future of the health care system.

The notion of parrhesia constitutes a practice of speaking openly and frankly without fear or favour regarding one's true thoughts. In a critical justice paradigm, parrhesia gives the voice to those in a position of vulnerability. In speaking the truth, parrhesia challenges what has been established as being the truth in an open arena [46]. Practices, politics, and systems that have been taken for granted in the dominant discourse can be subjected to critique. Nurses are bound by and to various discourses such as evidence based, public health, national security, scientific advances, etc. [45]. To be able to find truth, NPs would have to distance themselves from these



powerful discourses and participate in a reflection of the self. If NPs could achieve this they could then utilize competencies acquired through their graduate studies and engage in various form of scholarship activities supported by their true nature.

## 7. Conclusion

Globalization and neo-liberalism are contributing to growing health inequities and disparities, and thus, it is imperative for NPs to challenge current healthcare system ideologies. NPs are a group of professionals defined by others, but who have assumed healthcare responsibilities where others have failed to in similar roles. They have been nurturing their profession by reflecting on the needs of society and historically have been available for those in need of healthcare offering primary care to the marginalized. This position gives the profession a precious point of view. Being at the margin, NPs can appreciate not only the system as a whole but also the needs of those located on the periphery and working within marginality the NP can support social justice. Nurse practitioners need to espouse to the margin and use it to empower the profession. They must reflect on their identity, values, what makes NPs unique, and what is true self, and must express these concepts through research, knowledge development, and practice. Ultimately NPs must express their authenticity in their practice. As the healthcare system now promotes inter-professional collaboration, where role definition is crucial, NPs must define what nourishes and defines them. This philosophical perspective serves as a platform to initiate reflections on the NP's true nature and ability to engage in change and for their realization to be leaders in healthcare reform.

## References

- Shannon V, French S. The impact of the re-engineered world of health-care in Canada on nursing and patient outcomes. *Nurs Inq* 2005;12:231–9. <https://doi.org/10.1111/j.1440-1800.2005.00272.x>.
- Wilson MG, Reid RJ, Lavis JN, Moat KA, Guta A. Evidence brief: building a primary-care “home” for every ontarian. *McMaster Heal Forum*; 2016.
- Roots A, MacDonald M. Outcomes associated with nurse practitioners in collaborative practice with general practitioners in rural settings in Canada: a mixed methods study. *Hum Resour Health* 2014;12:69. <https://doi.org/10.1186/1478-4491-12-69>.
- Leipert BD, Delaney JW, Forbes D, Forchuk C. Canadian rural women's experiences with rural primary health care nurse practitioners. *Online J Rural Nurs Health Care* 2011;11:37–53.
- Sangster-Gormley E, Canitz B. An evaluation of the integration of nurse practitioners into the british columbia healthcare system. 2015.
- Heale R, James S, Garceau ML. A multiple-case study in nurse practitioner-led Clinics : an exploration of the quality of care for patients with multimorbidity. *Nurs Leader* 2016;29:37–45. <https://doi.org/10.12927/cjnl.2016.24891>.
- Kilpatrick K, Harbman P, Carter N, Martin-Misener R, Bryant-Lukosius D, Donald F, et al. The acute care nurse practitioner role in Canada. *Nurs Leader* 2010;23. <https://doi.org/10.12927/cjnl.2013.22271>. Spec No:114–39.
- Canadian Nurses Association. Canadian nurse practitioner core competency framework. [http://www.cno.org/globalassets/for/rnec/pdf/competencyframework\\_en.pdf](http://www.cno.org/globalassets/for/rnec/pdf/competencyframework_en.pdf); 2010.
- Abbott AD. The claim of jurisdiction. In: *The system of professions: an essay on the division of expert labor*. Chicago, IL: University of Chicago Press; 1988.
- Kaasalainen S, Martin-Misener R, Kilpatrick K, Harbman P, Bryant-Lukosius D, Donald F, et al. A historical overview of the development of advanced practice nursing roles in Canada. *Nurs Leader* 2010;23:35–60. <https://doi.org/10.1016/j.avsg.2010.03.038>.
- MacLeod ML, Kulig JC, Stewart NJ, Pitblado JR, Knock M. The nature of nursing practice in rural and remote Canada. *Can Nurse* 2004;100:27–31.
- Canadian Nurses Association. Advanced nursing practice a national framework. Framework 2008:1–53.
- Boudreau TJ. Report of the committee on nurse practitioners. Ottawa: Department of National Health and Welfare; 1972.
- Spitzer WO, Kergin DJ, Yoshida MA, Russell WA, Hackett BC, Goldsmith CH. Nurse practitioners in primary care. 3. The southern Ontario randomized trial. *Can Med Assoc J* 1973;108. 1005 passim.
- Chambers LW, West AE. The St John's randomized trial of the family practice nurse: health outcomes of patients. *Int J Epidemiol* 1978;7:153.
- DiCenso A, Bryant-Lukosius D. The long and winding road: integration of nurse practitioners and clinical nurse specialists into the canadian health-care system. *Can J Nurs Res* 2010;42:3–8.
- Donald F, Martin-Misener R, Bryant-Lukosius D, Kilpatrick K, Kaasalainen S, Carter N, et al. The primary healthcare nurse practitioner role in Canada. *Nurs Leader* 2010;23:88–113. <https://doi.org/10.12927/cjnl.2013.22271>.
- Canadian Nurse Association. CNA position statement: the nurse practitioner. *Can Nurses Assoc* 2016;8. [https://www.cna-aicc.ca/~media/cna/page-content/pdf-en/the-nurse-practitioner-position-statement\\_2016.pdf?la=en](https://www.cna-aicc.ca/~media/cna/page-content/pdf-en/the-nurse-practitioner-position-statement_2016.pdf?la=en).
- Legislative Assembly of Ontario. 36:1 Bill 127, expanded nursing services for patients act, 1997; 1997.
- Ontario NPA of. NP History in Ontario 2017.
- Canadian Institute for Health Information. Registered nurses/nurse practitioners. 2018. <https://www.cihi.ca/en/registered-nurses-nurse-practitioners>.
- Heale R, Butcher M. Canada's first nurse practitioner – led Clinic : a case study in healthcare innovation. *Nurs Leader* 2010;23:21–9.
- Heale R. Overcoming barriers to practice: a nurse practitioner-led model. *J Am Acad Nurse Pract* 2012;24:358–63. <https://doi.org/10.1111/j.1745-7599.2012.00737.x>.
- Evans C, Jones DW L, BP. Is there room for both NPs and MDs? In: Patterson C, editor. *Visions voices nurse pract*. Today. second ed. Troy, ON: Newgrange Press; 1999. p. 101–49.
- DiCenso A, Bourgeault I, Abelson J, Martin-Misener R, Kaasalainen S, Carter N, et al. Utilization of nurse practitioners to increase patient access to primary healthcare in Canada - thinking outside the box. *Nurs Leader* 2010;23: 239–59. <https://doi.org/10.12927/cjnl.2010.22281>.
- El-Jardali F, Lavis JN. Addressing the integration of clinical nurse specialists and nurse practitioners in acute healthcare settings in Canada. *Issue Brief, McMaster Health Forum*; 2011. <https://www.mcmasterforum.org/docs/default-source/product-documents/issue-briefs/clinical-nursing-specialists-in-acute-care-in-canada-ib.pdf?sfvrsn=2>.
- Kilpatrick K, Lavoie-Tremblay M, Lamothe L, Ritchie JA, Doran D. Conceptual framework of acute care nurse practitioner role enactment, boundary work, and perceptions of team effectiveness. *J Adv Nurs* 2013;69:205–17. <https://doi.org/10.1111/j.1365-2648.2012.06046.x>.
- College of Nurses of Ontario. FAQs: Bill 179. 2014.
- de Witt L, Ploeg J. Analysis of the evolution of a canadian nurse practitioner role. *Can J Nurs Res* 2005;37:116–37.
- Ontario C of N of. Practice Standard- Nurse Practitioner 2017:1–16.
- Bryant-Lukosius D, DiCenso A. A framework for the introduction and evaluation of advanced practice nursing roles. *J Adv Nurs* 2004;48:530–40. <https://doi.org/10.1111/j.1365-2648.2004.03235.x>.
- Carter N, Martin-Misener R, Kilpatrick K, Kaasalainen S, Donald F, Bryant-Lukosius D, et al. The role of nursing leadership in integrating clinical nurse specialists and nurse practitioners in healthcare delivery in Canada. *Nurs Leader* 2010;23. <https://doi.org/10.12927/cjnl.2010.22274>. Spec No:167–85.
- DiCenso A, Bryant-Lukosius D, Martin-Misener R, Donald F, Abelson J, Bourgeault I, et al. Factors enabling advanced practice nursing role integration in Canada. *Nurs Leader* 2010;23:211–38.
- Sangster-Gormley E, Martin-Misener R, Downe-Wamboldt B, Dicenso A. Factors affecting nurse practitioner role implementation in Canadian practice settings: an integrative review. *J Adv Nurs* 2011;67:1178–90. <https://doi.org/10.1111/j.1365-2648.2010.05571.x>.
- Roberts SJ. Breaking the cycle of oppression: lessons for nurse practitioners? *J Am Acad Nurse Pract* 1996;8:209–14. <https://doi.org/10.1111/j.1745-7599.1996.tb00648.x>.
- Hooks b. Choosing the margin as a space of radical openness. In: *Yearning: race, gender ad cultural politics*. Toronto: Between the Lines; 1990.
- van Soeren M, Hurlock-Chorostecki C, Goodwin S, Baker EC. The primary healthcare nurse practitioner in Ontario: a workforce study. *Nurs Leader* 2009;22:58–72. <https://doi.org/10.12927/cjnl.2009.20798>.
- Reutter L, Kushner KE. Health equity through action on the social determinants of health. *Nurs Inq* 2010;17:269–80.
- Browne A, Tarlier D. Examining the potential of nurse practitioners from a critical social justice perspective. *Nurs Inq* 2008;15:83–93.
- Edwards N, Rowan M, Marck P, Grinspun D. Understanding whole systems change in health care: the case of nurse practitioners in Canada. *Pol Polit Nurs Pract* 2011;12:4–17. <https://doi.org/10.1177/1527154411403816>.
- Ministry of Health and Long-term Care. Patients first : action plan for health care. 2015.
- Holmes D, Gastaldo D. Nursing as means of governmentality. *J Adv Nurs* 2002;38:557–65. <https://doi.org/10.1046/j.1365-2648.2002.02222.x>.
- Burchell G, Gordon C, Miler P, editors. *THE FOUCAULT EFFECT: STUDIES IN GOVERNMENTALITY* with two lectures by and an interview with Michel Foucault. Chicago, IL: The University of Chicago Press; 1991.
- Gastaldo D, Holmes D. Foucault and nursing: a history of the present. *Nurs Inq* 1999;6:231–40. <https://doi.org/10.1046/j.1440-1800.1999.00042.x>.
- Perron A. Nursing as “disobedient” practice: care of the nurse's self, parrhesia, and the dismantling of a baseless paradox. *Nurs Philos* 2013;14:154–67. <https://doi.org/10.1111/nup.12015>.
- Clinton ME, Springer RA. Foucault's legacy for nursing: are we beneficiaries or testate heirs? *Nurs Philos* 2016;17:119–31. <https://doi.org/10.1111/nup.12113>.
- Perron A, Fluet C, Holmes D. Agents of care and agents of the state: bio-power and nursing practice. *J Adv Nurs* 2005;50:536–44. <https://doi.org/10.1111/j.1365-2648.2005.03432.x>.