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NURSE PRACTITIONERS: A CALL FOR IMPLIMENTATION IN MANITOBA

By

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Abstract

Nurse practitioners (NPs) are an underutilized resource in Manitoba. The purpose of this literature review was to provide an overview of the current situation of nurse practitioners in Manitoba, and to provide research-based recommendations for the implementation of nurse practitioners in Manitoba. The recommendations are:

1. The current regulating body of Registered Nurses in Manitoba (College of Registered Nurses of Manitoba, or CRNM) must recognize nurse practitioners as expert nurses, in following Benner's (1984) stages of nursing practice. This recognition would require a graduate degree as an entry-level educational requirement.
2. NP licensure must be required in order to provide a standardized professional designation to the public and to provide a means for regulation and disciplinary action (Bennett, 2001).
3. Lastly, legislation must be enacted that allows nurse practitioners to have an autonomous practice within a defined scope of practice, in line with their graduate education (Hall, 2000).

Implementation of these research-based recommendations would allow Manitoba residents to have greater access to effective, cost-efficient primary care.

Introduction

In the past, physicians have been the main providers of primary health care in Canada. With the sustainability of the Canadian health care system coming into question, nurse practitioners (NP's) are in a position to provide a partial economic solution to Canada's health care crisis. Romanow (2002), in his report to the Queen entitled The Future of Health Care in Canada, states that Canada must "address the need to change the scopes and patterns of practice of health care providers to reflect changes in how health care services are delivered, particularly through new approaches to primary health care" (p. xxvii). In order to sustain Canada's health care system, Romanow's message of including innovative approaches to primary care must be taken seriously. Nurse practitioners are one way to implement Romanow's recommendation.

Nurse practitioners are currently being utilized in the United Kingdom, Australia, and the United States as well as in other Canadian provinces, such as Alberta and Ontario. Much international research has been published on

the effectiveness, regulation and entry-level requirements needed for nurses to practice at an advanced level.

In order to produce research-based recommendations for the implementation of nurse practitioners in Manitoba, a review of the literature was completed. This literature review produced three main recommendations for the implementation of nurse practitioners in Manitoba.

The recommendations are:

1. The current regulating body of Registered Nurses in Manitoba (College of Registered Nurses of Manitoba, or CRNM) must recognize nurse practitioners as expert nurses, in following Benner's (1984) stages of nursing practice. This recognition would require a graduate degree as an entry-level educational requirement.
2. NP licensure must be required in order to provide a standardized professional designation to the public and to provide a means for regulation and disciplinary action (Bennett, 2001).
3. Lastly, legislation must be enacted that allows nurse practitioners to have an autonomous practice within a defined scope of practice, in line with their graduate education (Hall, 2000).

Implementation of these research-based recommendations would allow Manitoba residents to have greater access to effective, cost-efficient primary care. The above recommendations are in congruence with the five principles of the Canada Health Act (1977, repealed 1995), as well as in accordance with the recommendations put forth by Roy Romanow (2002) in his report to the Queen.

Purpose/Problem

Nurse practitioners (NPs) are an underutilized resource in Manitoba. NPs are in a position to significantly assist with more timely access to primary care. The purpose of this independent project was to:

1. Provide a review of the literature in the area of NP utilization,
2. Discuss the current status of NP's in Manitoba, and,
3. Provide research-based recommendations for NP implementation in Manitoba.

Conceptual/Theoretical Framework

The theoretical framework used for this independent project is Patricia Benner's model From Novice to Expert. Benner asserts that there are five stages of skill acquisition and development (1984)

- Novice
- Advanced Beginner
- Competent
- Proficient, and
- Expert.

When moving through these stages there is: a change from use of abstract principles to the use of a concrete experience, a change from rule-based thinking to intuition, and movement from holistic thinking and change to being fully engaged in the situation (Benner, 1984).

Benner goes on to state that her theory "takes into account increments in skilled performance based upon experience as well as education" (1982, p. 402). Education and experience are two major requirements in attaining expert status in Benner's model of skill acquisition. Benner views education more as a process of discovery than as an exercise in compliance. The purpose of education is to develop a self-confidence that makes it possible to discuss solutions to problems respectfully and critically (Joel, 1997).

Benner couples education and experience as requirement to gain expert status. This places NPs in the expert category as NPs usually have a number of years of nursing

experience before they become NP's (Cole et al., 2002), and most US states require a graduate education as a minimum requirement of NP entry to practice (Pearson, 2000). Therefore, nursing experience coupled with graduate preparation place the NP in Benner's expert nurse category (Daly & Carnwell, 2003).

Expert nurses are described as:

- Having good clinical grasp and resource-based practice
- Embodied know-how
- Ability to see the big picture, and
- Seeing the unexpected (Tomey & Alligood, 2002).

Recognizing NPs as expert nurses is substantiated in the literature by research that indicates that NP's have the same efficacy of care for similar procedures, as do general practice physicians (Mundinger et al. 2000; Brown & Grimes, 1995; Moody, Smith & Glenn, 1999). As well, patient compliance rates and patient satisfaction scores for primary health care are high (Brown & Grimes, 1995). Acknowledging NPs as expert nurses strengthens the nursing profession by reinforcing the importance of education and experience.

Definitions

In order to ensure that the concepts and titles used in this paper are clearly understood, definitions are provided below.

Nurse Practitioner (NP) - NPs arise from the nursing profession, are independently licensed, nationally certifiable and authorized to practice under Nurse Practice Acts. The theoretical foundation of NPs is within the nursing profession (Mahoney-Feeney, 1988).

Advanced Nursing Practice - This is an umbrella term used to describe an advanced level of nursing practice that maximizes the use of nursing knowledge to meet the health needs of clients and can include clinical nurse specialist as well as nurse practitioners (CNA, 2002).

Autonomous Practice - Autonomous practice is the freedom to make binding decisions that are based on expertise and clinical knowledge within the scope of practice (Urlich, Soeken & Miller, 2003). Nurse Practitioners who are properly educated and stay up-to-date can be considered independent primary care providers who consult when needed (Knight-Buppert, 1995). "Nurse practitioner practice

autonomy means prescribing medication and treatment based on graduate nursing education and credentials, without physician supervision" (Pruitt, Wetsel, Smith & Spitler, 2002, p. 56).

Regulating Body - An organization made up of professional members who control registrations and licensing standards, ongoing competency assessment and practice standards (Romanow, 2002). "Regulatory agencies are concerned about the individual's preparation for practice, ie, the specialty knowledge and skills obtained in a formal educational program, as well as the competency of the individual" (Bennett, 2001).

Scope of Practice - A document that is used as a guideline for practice. The guidelines are usually not disease specific protocols because they are practice limiting and require constant revision in light of new research (Nejedly, Broden, Knox et al., 1999; Sidani, Irvine & DiCenso, 2000). The scope of practice is determined by the nursing profession, but enacted through law (Bennett, 2001).

Licensing body/License - Licensure "involves the identification of qualifications necessary to safely perform a unique scope of practice and an evaluation to determine whether an individual meets the qualifications" (Bennett, 2001). A licensing body permits the use of a specific title. The licensing body also has the authority to take disciplinary action if members violate the defined scope of practice (Bennett, 2001).

Certification - Certification recognizes specialty knowledge in nursing that is beyond the entry-level basic nursing knowledge measured by the registered nurse exam (Bennett, 2001).

Literature Review

Canada's health care system is publicly funded and based upon the Canada Health Act (1977, repealed in 1995). The five main tenets of the Canada Health Act (CHA) are: public administration, comprehensiveness, universality, portability and accessibility.

Public administration requires that the health care insurance plan of a province be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province (CHA, 1977). To fulfill the criterion for comprehensiveness, the

province must guarantee insured health services provided by hospitals and medical practitioners as well as other health services, as the law permits. Universality guarantees the entitlement to health care of 100% of the insured persons in the province. Portability allows Canadian citizens to carry their health coverage outside of the province of residence, including international services. Accessibility ensures that all insured persons must have reasonable access to health services (CHA, 1977). The five tenets of the CHA are still valued by the majority of Canadians. Many Canadians also feel that public health care is one of the hallmarks of Canadian citizenship (Romanow, 2002).

In order to receive their full share of federal funding, the provinces must ensure that their health insurance programs meet the conditions of the Canada Health Act. The provinces must also formulate an annual report to the federal government indicating how they have attempted to meet the conditions put forth in the CHA (Romanow, 2002).

While the tenets of the CHA are valued, the sustainability of the Canadian health care system has come into question. Sustainability refers to "ensuring that there are available resources over the long term to provide timely access to quality services that address Canadian's

evolving health care needs" (Romanow, 2002, p. 1). Sustainability will become more difficult in the future, as Canada's population is aging. Demographic trends show that the proportion of Canadians 60 years and older is expected to grow from 17% in 2002 to 28.5% in 2031 (Romanow, 2002). In order to sustain public health care while the population is aging, provinces will need to implement innovative solutions to promote cost effective primary care.

For the aging US population, the Veterans Affairs system currently employs more than 600 master's-prepared, nationally-certified NPs to deliver high-quality care to its veteran population (Mohler et al., 1998). More so, in the US, federal policies and state legislation encourage the use of nurse practitioners (Hooker & McCaig, 2001) as a cost-effective means of providing quality primary care. In Canada, NPs can be seen as 'adding value' to the current level of practice, and have expertise in the areas of patient education, health promotion and disease prevention (Drummond & Bingley, 2003).

NPs are widely utilized in the US partially due to research that has demonstrated that NPs provide competent care to a majority of primary care patients at a lesser cost than traditional physician services (Brown & Grimes, 1995). The US public is also accepting of the NP role

(Baldwin, Sisk, Watts, McCubbin, Brockschmidt & Marion, 1998), as are physicians who have been exposed to NPs (Bergeson, Cash, Boulger & Bergeron, 1997).

The situation in Manitoba is somewhat different than in the US. As described earlier, Canada's health care system is publicly funded. Annually, the province of Manitoba must justify the health care services provided to Manitobans in order to renew federal funding (Romanow, 2002). The addition of licensed and regulated nurse practitioners would be an innovative and cost effective method of promoting the CHA tenet of accessibility within Manitoba (Jackson, 2003).

The Canadian Nurses Association also feels that advanced nursing practice "will provide an essential service in meeting the health needs of Canadians" (CNA, 2002, p. 14). Nurse practitioners are in a prime position to lower health care costs and increase primary care accessibility to Canadians both now, and as the population ages.

In Manitoba, there are a handful of nurses working in extended practice roles, but there is no designation in the Registered Nurses Act (RNA) of Manitoba for nurse practitioners. Legislation for extended practice (EP) nurses is expected to pass in the Manitoba Legislative

Assembly in April 2005. This EP legislation is outlined below. To use the EP designation, the nurse must be registered with the College of Registered Nurses of Manitoba in the EP category. In order to attain EP registration, the RN must demonstrate competency in four areas (Registered Nurse Act - Extended Practice Regulation, 2003):

- Assessment and Diagnosis of Client Health/Illness Status;
- Pharmacotherapeutics and other Therapeutic Interventions in Client Care Management;
- Population Health and Illness/Injury Prevention;
- Professional Responsibilities and Accountabilities.

As outlined in the RNA-Extended Practice Regulation of Manitoba (2003), extended practice is regulated by an Extended Practice Advisory Committee. This committee has no governing authority. Rather, the purpose of the EP Advisory Committee is to provide recommendations to the CRNM regarding EP practice. The Extended Practice Advisory Committee consists of (Registered Nurse Act-Extended Practice Regulation, 2003):

- Two people appointed by CRNM board

- Two people appointed by the College of Physicians and Surgeons of Manitoba
- Two people appointed by the Manitoba Pharmaceutical Association, and
- One non-voting person from the Faculty of Nursing at the University of Manitoba who is Faculty in the Advanced Nursing Practice stream of the Master of Nursing Program.

In Manitoba the designation of EP will be used for nurse practitioners, but the Canadian Nurses Association uses the umbrella term of advanced nursing practice (ANP) to describe the functions of the nurse practitioner.

While at first glance it appears that the scope of practice in the EP designation of the RNA correlates well with the NP designation, there are four areas that should differentiate NPs from RN(EP). These are:

1. EP nurses have no educational entry to practice requirements, whereas in most US states graduate preparation is a minimum requirement to achieve the NP designation (Pearson, 2000; Price et al., 1992).
2. EP nurses hold a RN license, while most NPs in the US are required to have a separate NP licence (Pearson, 2000).

3. EP nurses are regulated under the CRNM. In most US states, NPs are regulated by NPs. US "legislators recognize that NPs and other APNs are capable of controlling their own practice" (Pearson, 2000, p. 16).
4. Lastly, EP nurses are not able to maintain an independent or autonomous practice. Conversely, NPs have the educational preparation to work within a defined scope of practice in an autonomous practice.

As can be seen, education, licensure/regulation and autonomous practice differentiate EP nurses from NPs. Each of these three items will be discussed in more detail.

Education

The US National Task Force on Quality of Nurse Practitioner Education has put forth the *Criteria for Evaluation of Nurse Practitioner Programs* (National Task Force on Quality Nurse Practitioner Education, 2002). This document was an attempt to standardize education and to ensure that graduates of NP programs in the US are qualified to provide safe and effective care to their patients. This document assumes that the nurse practitioner program being evaluated is at a graduate level, as well as accredited or working towards

accreditation from a nationally recognized nursing accrediting body.

The Canadian Nurses Association has been working towards advanced nursing practice standardization, and has compiled a national framework to direct the formation of advanced practice roles within the provinces and territories of Canada. The CNA framework addresses educational requirements, regulation, scope of practice, legislation and APN roles (CNA, 2002).

The CNA advocates for graduate preparation as the minimum requirement for ANP as they feel that the NP role is an advanced nursing practice role and, the appropriate educational preparation is at the graduate level (CNA, 2003). However, there is currently no standardized entry-level education required for EP nurses in Manitoba. To be placed on the EP register in Manitoba, the applicant must simply have completed an advanced level program of nursing education approved by the board, or the applicant must demonstrate their competency to the board through an assessment process (RNA, 2003). Therefore, if a nurse in Manitoba passes the competency assessment, no educational training past a two-year RN is required to attain EP status. In the US, the American Nurses Association requires a master's preparation in order to apply for NP

certification (Price et al., 1992). The UK also requires a graduate degree in order to attain the title of advanced nurse practitioner (Daly & Carnwell, 2003). Neither current international trends nor research support Manitoba's lack of standardized education as entry to practice. The following is a review of the relevant literature in this area.

Wilson-Barnett, Barriball, Reynolds, Jowett & Ryrie (2000) completed a qualitative study of 19 nurses working in advance practice roles. They found that there is a "consensus that advanced practice should consist of a clinical practice component and set the pace for changing practice as well as be underpinned by educational experiences beyond the level required for initial registration" (p. 390). This study was descriptive in nature and generalizability may be limited due to narrow inclusion criteria and small sample size.

Debra Fairly (2003) composed a discussion paper addressing factors that are perceived to affect role implementation of advanced practice nurses in critical care. She asserts that graduate education enables the autonomous practitioner the credibility to make independent treatment decisions.

Bergeron, Neuman and Kinsey (1999) conducted a survey of 285 rural hospitals to assess the benefit of NPs in the hospital. The survey data were triangulated with case studies of 36 of the surveyed hospitals. Of the 36 case studies, 31 of the hospitals were visited. Of the 31 visited hospitals, 29 reported no problems in the quality of care provided by nurse practitioners. In the background section of this paper, the authors state that advanced practice nurses met advanced clinical practice requirements and most obtained a master's degree in specialized nursing in addition to their basic nursing education (Bergeron et al., 1999).

Cole et al. (2002) completed a survey study of the demographics of Advanced Practice Nurses (APNs) in Emergency Care settings, with 166 APNs completing the questionnaire. Their findings were consistent with current educational and certification requirements, and indicated that the vast majority (94.3%) of APNs held a masters degree (Cole et al., 2002). It was not documented whether this sample size was representative, but this study provides a useful cross-sectional look at the demographics of APNs in emergency care settings.

It is evident from current research that graduate-level preparation is required and expected of most nurse

practitioners in the US. In Canada, the Canadian Nurses Association is also in favor of graduate level education, as graduate level education would provide a standardization that could be evaluated for equivalency across jurisdictions (CNA, 2002).

The EP designation is confusing to the public as it encompasses a nurse with any educational background and scope of practice deemed acceptable to the EP board and CRNM. Patients receiving care from EP nurses would not know if the nurse is educationally qualified to fulfill a specified scope of practice as there is no standardized entry-level educational requirement or license required to practice as an EP nurse. The CRNM has a minimum educational requirement for licensure as an RN (RNA, 2001). But, there is no minimum educational requirement, other than RN licensure, that is required by the CRNM for a nurse to be placed on the EP registry. A separate NP designation would provide standardization to the public, and would also provide a more defined scope of practice based on educational preparation. The research supports a specific scope of practice for NPs and that this designation be regulated by licensure.

Licensure and Self-Regulation

The duty of licensure falls onto the shoulders of the professional organization, which in the case of Manitoba would be the CRNM (Romanow, 2002). To date, the only licensure within the province is for registered nurses. Nurse practitioners do not have a separate license, but rather fall under the RN extended practice category of the RNA-Extended Practice Regulation (Registered Nurse Act, 2003). The Alberta Association of Registered Nurses feel that "nurse practitioner roles require further regulation (beyond registered nursing practice) for the safety of the public" (2002, p. 3). As in Manitoba, Alberta's NP regulation is through the extended practice register.

A license is a legal document that states that the holder has attained the minimum requirements needed to hold the license. The holder of a license is required to practice within the specific scope of practice as indicated by the license. "Licensure is used when regulated activities are complex and require specialized knowledge and skill and independent decision-making" (Bennett, 2001, p. 170). While the EP designation extends the traditional scope of practice of nurses to include advanced skills, the regulation of these advanced skills is difficult, as EP

nurses have no licensure requirement. A licensing examination for EP nurses would provide a minimum practice standard that could be directly used for regulation and discipline purposes. The Canadian Nurses Association (CNA) is developing a national NP examination "which the provincial/territorial regulatory authorities may decide to administer" (Canadian Nurses Association, 2004, p. 2). An NP examination would "protect the public by ensuring that the entry-level nurse practitioner possesses the competencies required to practise safely and effectively" (CNA, 2004, p. 2). A national NP examination would promote entry-level competency standardization. However, title confusion would still exist, as the NP title is not protected. Any person, regardless of passing a NP examination, is still able to legally call himself or herself an NP. In this way, public safety is not addressed by an NP exam. In order to fully protect public safety, the NP designation must become a legally protected title. "With title protection of Nurse Practitioner, only members who have met the minimum educational requirements and who completed satisfactorily the specific entry to practice examination for RNs in the Extended Class would be able to refer to themselves by the title Nurse Practitioner" (College of Nurses of Ontario, 2003, p. 3). One way to

accomplished title protection is through licensure. This view is supported by the Canadian Nurses Association. They agree that it is vital to "clarify ANP for the public, other health care providers and governments" (2002, p. 2).

A NP designation with licensure would standard nursing titles to decease title confusion in both the public and within the ranks of nurses themselves (Castledine, 2001). NP licensure is very important because it "permits the use of a particular title and defines a scope of practice for the profession" (Bennett, 2001, p. 170). The United Kingdom, United States and Australia all use the designation of nurse practitioner (Turner & Keyzer, 2002; Daly & Carnwell, 2003). In Manitoba, the EP designation is so broad that a well-defined scope of practice is difficult to produce.

Ontario also uses an extended class designation for NPs. "In Ontario, the term 'nurse practitioner' is not a protected title and, theoretically, anyone can call himself or herself an NP" (Drummond & Bingley, 2003). Irvine, Sidani, Porter et al. (2000) found in their descriptive, correlational study of NP role implementation that many NPs in Ontario found that their role was not well formalized or clearly defined. This lack of scope of practice formalization led to frustration on the part of some NPs.

Conversely, "roles within the United States were well defined, and responsibilities within the health care team were very clear" (Gibson, 1999, p. 92). Most US states also require graduate level education, certification and licensure as a NP (Pearson, 2000).

Daly & Carnwell (2003) looked in depth at the new nursing roles that are developing in the United Kingdom (UK). They reported that advanced nurse practitioners in the UK are required to have a masters or doctorate level preparation. Daly & Carnwell (2003) also indicate a need for a "coherent approach to establishing a new career structure that reflects discrete roles, levels of practice and autonomy based on relevant programmes of preparation and evolving expertise" (p. 166).

It is very important to have a well-defined scope of practice under a specific licence because it is the licensing body that has the authority to take disciplinary action if the scope of practice is violated (Bennett, 2001). If there is no well-defined scope of practice, disciplinary action and regulation of EP nurses is difficult. Both licensure and a clearly defined scope of practice are imperative if patient safety is to be upheld. Cole, Ramirez & Luna-Gonzales (1999) also reiterate that

advanced nursing practice is regulated to protect patient safety.

Licensure and self-regulation are also imperative to good professional practice. Brush and Capezuti (1997) assert that "organization leads to empowerment and to autonomy; autonomy provides the means to professional control and self-regulation" (p. 269).

Therefore, in order to fully utilize nurse practitioners, NP licensure must be enacted to:

- Clarify professional designations,
- Ensure public safety by the use of disciplinary action if there is a violation in the NP SOP,
- Promote autonomous practice within a designated scope of practice.

Autonomous Practice

Autonomous practice is within the scope of practice of graduate-prepared nurse practitioners. Practice autonomy "means prescribing medication and treatment based on graduate nursing education and credentials without physician supervision. NP advancement and optimal professional practice depends on autonomy" (Pruitt et al., 2002, p. 56). To deny autonomous practice of graduate-prepared NPs would be to promote a sub-optimal professional practice, as the NP would not be utilizing all of the

skills and knowledge gained through their education. The following review of the literature also provides significant research supporting the use of nurse practitioners in an independent role.

Nurse practitioners (Wilson-Barnett et al., 2000; Daly & Carnwell, 2003) have proven effective at providing competent patient care (Mahoney-Feeney, 1988; Moody, Smith & Glenn, 1999; Mundinger et al., 2000). In the Mahoney-Feeney (1988) article on economic analysis of the NP role, it was found that NPs can not only lower overall health care costs, but may be the most appropriate health care provider for clients with chronic diseases.

Hooke, Bennett, Dwyer, van Beek & Martin (2001) completed a descriptive, cross-sectional study of 1046 clients as well as health center staff at the Kirketon Toad Centre in Australia. They found that 'nurse practitioners were professionally appropriate in all aspects of expected 'best practice' in over 95% of consultations' (2001, p. 20).

Moody, Smith and Glenn (1999) randomly selected 115 NPs from a state database in Tennessee to complete their survey of the demographic characteristics of NP clients, health problems seen by NPs, and therapeutic services provided by NPs. They found that NPs tended to have more

female patients, have more younger clients, perform fewer office surgical procedures, and to provide more health teaching (Moody et al., 1999). Two limitations of this study were the relatively small sample size and the fact that a third of the office-based physicians surveyed were specialists, whereas the entire population of NPs surveyed were practicing in primary care (Moody et al., 1999).

Venning, Durie, Roland, Roberts & Leese (2000) used a randomized control trial of 1292 patients requesting same day care in England and Wales. They found that there was no significant difference in patterns of prescribing or health status outcomes for patients treated by NPs rather than general practitioners (GP). NP visits were longer than GP visits, with patients being more satisfied with NP consultations.

Mundinger, Kane, Lenz & Totten (2000) used a prospective, experimental design to study the outcomes in patients treated by nurse practitioners and physicians. There was a random assignment of the 1,316 subjects into one of two groups to be followed by either a physician or nurse practitioner after an emergency department or urgent care visit. Both the NPs and the physicians served as primary care providers in the same environment with the same authority. No significant difference in patient

health status outcomes was found between the physician and NP groups.

Rudy, Davidson, Daly, Clochesy et al. (1998) completed a descriptive, longitudinal study comparing the characteristics of patients cared for by NPs, physician assistants (PA) and resident physicians. It was found that resident physicians care for patients who are older and sicker than the NP and PA patients. Resident physicians also spent more time in conferences, rounds, and lectures, than did NPs and PAs.

Brown and Grimes (1995) compiled a meta-analysis of NPs and midwives in primary care. They found that NPs practiced primarily in community-based or hospital-based ambulatory care settings (Brown & Grimes, 1995; Crosby, Ventura & Feldman, 1987). Patient compliance and patient satisfaction scores were higher for NPs. Health outcome measures of diastolic blood pressure, blood sugar levels, otitis media and symptom relief were all better managed by NPs as compared to the physician group.

Hooker & McCaig (2001) completed a probability sample survey of physicians over a five-year time span. NPs and PAs provided care in 11% of office visits. This study found that PAs and NPs provide primary care in a way similar to that of physicians. A limitation of this study

was that only NPs and PAs whose supervising physician was chosen for this study were included in the study.

The Canadian Nurses Protective Society also agrees that "studies conducted over the last 25 years suggest that the quality of primary care provided by NPs is equal to or, in some cases, better than that of physicians" (2004, paragraph 3).

Research justifies independent NP practice. While much of the current research compares the efficacy of NPs and physicians, it is important for NPs to maintain an alliance with the nursing profession by using a nursing model of care (O'Keefe & Gardner, 2003). NP's professional identity needs to be united with a nursing rather than a medical paradigm (Manley, 1997; Pruitt et al., 2002). This concept is reiterated by Brown & Draye (2003) who state that " building on their nursing expertise and additional education, NPs advanced their autonomy, assumed a central role in primary care, enhanced quality of care, and increased access for the underserved" (p. 391).

After reviewing the literature, there are three main recommendations for the implementation of nurse practitioners in Manitoba.

The recommendations are:

1. The current regulating body of Registered Nurses in Manitoba (College of Registered Nurses of Manitoba, or CRNM) must recognize nurse practitioners as expert nurses, in following Benner's (1984) stages of nursing practice. This recognition would require a graduate degree as an entry-level educational requirement.
2. Licensure must be required of NP's in order to provide a standardized professional designation to the public and to provide a means for regulation and disciplinary action (Bennett, 2001).
3. Lastly, legislation must be enacted that allows nurse practitioners to have an autonomous practice within a defined scope of practice, in line with their graduate education (Hall, 2000).

Implementation of these research-based recommendations would allow Manitoba residents to have greater access to effective, cost-efficient primary care. The above recommendations are in congruence with the five principles of the Canada Health Act (1977, repealed 1995), as well as in accordance with the recommendations put forth by Roy Romanow (2002) in his report to the Queen.

Significance of the Independent Project

Historically, the Canadian Health Act was devised to give Canadians a publicly administered, comprehensive,

universal, portable and accessible health care system (CHA, 1977). As a result of the aging population, the sustainability of the health care system has come into question (Romanow, 2002). Nurse practitioners are in a prime position to provide effective, cost-efficient primary care (Mundinger et al. 2000; Brown & Grimes, 1996; Moody et al., 1999). In order to ensure competent and safe practice, licensure, self-regulation, and graduate education must be required of NPs (Brush & Capezuti, 1997; Castledine, 2001; Pearson, 2000; Romanow, 2002).

Assumptions and Limitations

As in any Independent Project, there are inherent assumptions and limitations. In this project, the assumptions and limitations are:

- It is assumed that the research completed in the US, Australia and UK is somewhat generalizable to the Canadian population.
- A limitation of this project is that most research presented was conducted in the United States (US) or United Kingdom (UK), due to the scarcity of Canadian data in this area. The health care systems of the US and UK are substantially different than the Canadian health care system. As a result, it is unknown if the

research done in other countries is generalizable to the Canadian system.

Implications For Nursing

There are a number of implications of this project for the profession of nursing with regards to practice, education, research and policy. Firstly, research clearly indicates that nurse practitioners provide safe, competent and cost-effective care (Brown & Grimes, 1995; Mundinger et al., 2000). The implementation of the designation of nurse practitioner in Manitoba would afford clear boundaries in practice and provide a greater level of legal safety, as the NP scope of practice would be succinctly defined.

Part of the legal designation of nurse practitioner would include a graduate level entry to practice. Graduate level entry to practice is considered by many nurse practitioners to be the minimum requirement to achieving NP designation (Pearson, 2000). Requiring graduate level entry to practice would also be in keeping with Benner's model of Novice to Expert, which requires advanced experience coupled with advanced education to proceed through the stages to expert nursing (Benner, 1984).

While there is a substantial amount of US research in the area of nurse practitioner efficacy, role and utilization, there is little Canadian research in these areas. The

health care system of the United States is a private enterprise. The Canadian health care system, very different from that of the United States, holds the main tenets of public administration, comprehensiveness, universality, portability, and accessibility (CHA, 1977). As a result, nurse practitioner studies from the United States may or may not be generalizable to the Canadian population. The need for further Canadian research on nurse practitioner efficacy, role and utilization is required.

This project also raises issues that relate to policy. Currently, there is no nurse practitioner designation or licensure in Manitoba. As a result, there are numerous areas for policy development. The scope of practice, legal designation, licensure and regulation are some examples of areas that require policy development.

Implementation of nurse practitioners in Manitoba has far-reaching implications. These implications directly affect practice, education, research and policy development. As there is no current legislation or designation for nurse practitioners in Manitoba, this is an exciting and dynamic area.

Recommendation for Further Study

As stated earlier, there is little Canadian research on nurse practitioners. Due to the differences between the Canadian, UK and US health care systems, it is unknown whether findings from the US and UK can be generalized to Canada. Therefore, there are many recommendations for research. One recommendation would be to compile the role and demographics of the nurses currently practicing in an expanded role. How much of the nurse's time is spent in primary care, health promotion, etc.? Where are most expanded practice nurses working in Manitoba? What gender, ethnicity and age are the clients served by the extended practice nurses? How autonomous is their current practice? What is their educational background? This information would provide a basis on which to build further research.

It would also be important to investigate the attitudes of nurses, physicians, other professionals and the public regarding nurse practitioners. This would provide insight into the acceptability of the nurse practitioner role within the health care field, and within society as a whole.

Summary

In the past, physicians have been the main providers of primary health care in Canada. The sustainability of

the Canadian health care system has into question, and nurse practitioners (NP's) are in a position to provide a partial economic solution to Canada's health care crisis. Research validates the use of Nurse Practitioners as a safe, cost-effective means to provide primary health care.

A comprehensive review of current literature has produced three main recommendations for the implementation of nurse practitioners in Manitoba.

The recommendations are:

1. The current regulating body of Registered Nurses in Manitoba (College of Registered Nurses of Manitoba, or CRNM) must recognize nurse practitioners as expert nurses, in following Benner's (1984) stages of nursing practice. This recognition would require a graduate degree as an entry-level educational requirement.
2. NP licensure must be required in order to provide a standardized professional designation to the public and to provide a means for regulation and disciplinary action (Bennett, 2001).
3. Lastly, legislation must be enacted that allows nurse practitioners to have an autonomous practice within a defined scope of practice, in line with their graduate education (Hall, 2000).

Implementation of these research-based recommendations would allow Manitoba residents to have greater access to effective, cost-efficient primary care. The above recommendations are in congruence with the five principles of the Canada Health Act (1977, repealed 1995), as well as in accordance with the recommendations put forth by Roy Romanow (2002) in his report to the Queen.

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