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Feature

The power and politics of collaboration in nurse practitioner role development

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The power and politics of collaboration in nurse practitioner role development

This health services study employed participatory action research to engage nurse practitioners (NPs) from two health authorities in British Columbia, Canada, to examine the research question: How does collaboration advance NP role integration within primary health-care? The inquiry was significant and timely because the NP role was recently introduced into the province, supported by passage of legislation and regulation and introduction of graduate education programs. In separate and concurrent inquiry groups, the NPs discussed their practice patterns, role development progress and understanding of collaboration and role integration. The inquiry revealed the political nature of the NP role and the extent to which NPs relied on collaborative relations at all levels of the health system to advance role integration. Given that NP role development is still at an early stage in this province, as well as other provinces in Canada, this study provides important insights into the power and politics of role development, and offers direction for future role advancement.

Key words: collaboration, nurse practitioner, politics, role development.

Nurse practitioner (NP) role development in British Columbia (BC) is part of a Canada-wide nursing strategy to formalize the NP role and ensure its sustainability (Canadian Nurses Association (CNA) 2003). Official sanction of NPs is significant because the NP role is intended to catalyze a team approach in primary health-care (PHC), and thereby increase access to primary clinical care, as well as extend service availability of preventive screening and early detection of disease, wellness and health promotion, health education and counselling, outreach to vulnerable populations, and community engagement (DiCenso et al. 2007).

A health services dissertation study was undertaken in 2008, at a relatively early stage of NP role development, to investigate the research question 'How does collaboration advance NP role integration within PHC?' A participatory action research (PAR) approach was employed to engage NPs from two BC health authorities in group dialog. The inquiry groups uncovered tensions related to role development and thus certain taken-for-granted assumptions were exposed (McIntyre and McDonald 2010). At the provincial level, government officials assumed that with NP legislation and regulation in place, the six regional health authorities responsible for service delivery, would be set to implement NP roles; yet there were many uncertainties to resolve in the regions regarding deployment decisions and policies. Health authority leaders assumed there was readiness for NP roles to be implemented into PHC sites; yet settings lacked technical and procedural infrastructure, and managers and team members were often unprepared to welcome and support the new NP. And finally, NP graduates assumed their role would be focused on direct client care, yet there was a political side to NP role development and the new NPs were ill-equipped for the strategic leadership required to navigate the complexities of role development.

However, the inquiry groups also highlighted the resilience of NPs to rise above the tensions, cultivate

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collaborative community and collegial partnerships, and develop strategic capacity, and in so doing the NPs were better able to address the power and politics of role development. In this paper, we provide a brief history of the NP role from a Canadian and BC perspective; we outline the PAR methodology used in the inquiry; and we report on study findings particular to the effects of collaboration on NP role integration. Discussion of the tensions and challenges of NP role development raises particular concerns about the lack of resources and supports for NPs, and about the incongruence between role expectations and health system realities. The troubles of NP role development in many ways mirror the tribulations of PHC renewal and to this extent NPs continue to suffer, because their practice is counter to the neo-liberal view of health-care.

CONTEXTUAL BACKGROUND OF NP ROLE DEVELOPMENT

The NP role in Canada has a discontinuous history, in which lack of legislation, regulation, remuneration mechanisms, and public-policy support has hindered role development progress (DiCenso et al. 2007; McIntyre and McDonald 2010). NP pioneers date back to the 1970s, with initiation of early educational programs to prepare NPs for deployment in northern nursing stations. NPs later moved into urban area practice, mostly into community health centers, and secured local physician oversight for delegated authority of advanced medical acts. Despite the lack of official sanction, the small cadre of NP pioneers survived by ‘flying under the radar’ and keeping a low profile in the politics of health-care; instead their strategy was to gain the confidence and respect of patients, colleagues, and local communities (Draye and Brown 2000; Fairman 2002; Brown and Draye 2003).

In recent years, the federal and provincial governments' focus on PHC renewal, coupled with the limited numbers of and access to family physicians, has compelled more formal support for NP role development (Romanow 2002). Leadership from the CNA has played a significant part in shaping policies for successful role introduction (CNA 2003, 2006, 2008a). As well, the Canadian Nurse Practitioner Initiative funded by Health Canada and sponsored by the CNA, provided role development guidance including this role description:

> NPs are experienced registered nurses with additional education who possess and demonstrate the competencies required for NP registration or licensure in a province or territory. Using an evidence-based holistic approach that emphasizes health promotion and partnership development, NPs complement, rather than replace other healthcare providers. NPs, as advanced practice nurses, blend their in-depth knowledge of nursing theory and practice, with their legal authority and autonomy to order and interpret diagnostic tests, prescribe pharmaceuticals, medical devices and other therapies, and perform procedures. (CNA 2006, iii)

Introduction of the NP role has now occurred in all Canadian provinces and territories (NPCanada.ca). Most provinces have legislated provision for title protection of the NP role, and have mandated nursing regulatory bodies to regulate NPs and set standards, conditions, and limitations for practice (Canadian Institute for Health Information and CNA 2005). While educational programs still vary, most have adopted or are moving toward graduate level designation. The majority of NPs licensed in Canada practice in PHC settings, although payment issues are still a significant barrier to advancing the NP role. The issue of funding is constrained by provincial-regional politics. The funds for primary care services are generally accessed through provincial fee-for-service mechanisms; however, these funds are restricted for physician payment, and regulators have been reluctant to allow payment access for NPs. Instead NP funding is expected to be covered by health regions or health organizations; however, health regions are not particularly compelled to use their strained budgets for NP primary care services, when such services can be covered by provincial physician coffers. These politics of jurisdictional responsibility leave NPs without a sound funding mechanism and this is a critical issue to resolve to ensure NP sustainability.

Development of the NP role in BC began with and benefitted from a stakeholder consultation and a provincial-based study (College of Registered Nurses of BC (CRNBC) 2005; MacDonald et al. 2005; Schreiber et al. 2005). Government funding was subsequently provided for NP graduate level education programs, and in 2005 the NP role was officially launched with legislation that amended the BC Health Professions Act and gave regulatory authority to the CRNBC (BC Ministry of Health Services 2005). Three-year start-up budgets to initiate NP roles were later allocated to health authority regions responsible for healthcare delivery; however, these funds have now been expended, and an ongoing NP funding mechanism is uncertain.

Despite the systematic approach used at the BC provincial level to prepare legislation and regulation for effective NP role *introduction*, there was limited time and direction given to the six health regions for role *implementation*, and consequently the regions gave little guidance to programs at the practice level to ensure NP role *integration*. However, the issues of implementation and integration were not to be unexpected. A number of barriers beyond the introductory stage had been reported by leaders of early adopter provinces,

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such as Ontario. Barriers to implementation and integration include failure to clarify role function and set appropriate goals, ineffective utilization of NPs, insufficient funding mechanisms, inadequate collaborative team relations, and limited evidence to guide role development and evaluation (DiCenso and Paech 2003; Bryant-Lukosius et al. 2004; Jones and Way 2004; DiCenso and Matthews 2005; DiCenso et al. 2007). These early lessons indicate the complexity of NP role development with respect to identified stages of introduction, implementation, integration and sustainability, and highlight the extent to which the NP role is enmeshed in dynamic and interdependent health system politics (Begun, Zimmerman, and Dooley 2003; Burgess 2009). Research is thus helpful to gain insight into these complexities and to provide recommendations for future success.

METHODOLOGY

Participatory action research offered a dynamic and empowering methodology to bring NPs together, in order to counter the inequities of knowledge, power, and resources, address theoretical and practical interests of participants, and create collective capacity (Burgess 2006; Reason 2006). Hall's (2001) definition of PAR, which highlights three dimensions of social investigation, education, and action, served to direct the inquiry method. These dimensions also provided three-point criteria to validate the quality and integrity of the inquiry (Bradbury and Reason 2001). The social investigation or participatory stage of the inquiry encouraged participants to share stories, engage in critical and collective reflection, and become co-authors and co-constructors of their everyday work life (Reason and Bradbury 2001). The educative or informative stage elicited the formulation of meaning, where new knowledge was generated and theorizing took place to advance practice (Bradbury and Reason 2003). The action or transformative stage of PAR uncovered power relations and political processes, and helped to mobilize the NP collectives (McTaggart 1991). Thus, PAR supported the NPs to critically reflect on the taken-for-granted assumptions of the social world, interpret the meaning of cultural, historical and social conditions, and mobilize actions to effect individual and social transformations (Kemmis and McTaggart 2005; Kincheloe and McLaren 2005). The reflexive participatory process empowered the NPs 'to investigate reality in order to change it and to change reality in order to investigate it' (Kemmis and McTaggart 2005, 567).

Participant recruitment took place in two BC health authorities. As health authorities (HAs) had only 10–12 NP employees at the time of recruitment, participant numbers were limited. Ethics approval was required separately from each HA, and was thus obtained from the joint review board of the University and one HA, and from the review board of the second HA. Approval from the chief of professional practice of each region was acquired for NPs to have employment release time for the inquiry. A strategic sampling approach was used (Mason 2002), whereby an invitation to the introductory research meetings was prepared by the researcher, and e-mailed out by each HA to their employed NPs. The introductory meetings, in which the research questions were outlined, consent forms reviewed, and inquiry meeting dates and locations set, resulted in recruitment of 11 of 12 NPs employed in one HA and 6 of 12 employed in the other HA. The variance in HA recruitment rates was later attributed to the different approaches used by the HAs to cultivate a collective grounding and presence for their NPs. Each HA had organized a NP community of practice to support role development; however, recruitment was more successful in the HA with a well established community of practice, and less so in the HA that had a newly formed community of practice. Demographics specific to the HAs and NP participants were unreported in the study to protect anonymity of those involved.

The inquiry data sessions in each HA were held in conjunction with the NP community of practice meetings; five data sessions and two action meetings were held in each HA. The inquiry produced a combined total of 22 hours of audio-taped data. For each inquiry session, questions were prepared to journey participants through a group dialog. The participatory stage of the inquiry included developing community of inquiry principles, sharing journal articles for grounding of group knowledge, clarifying roles and responsibilities, and fostering informal interactions and trusting relations. The informative stage focused on inquiry discussion of everyday practice patterns of NPs, the ups and downs of role development progress, and factors that contributed to collaboration and NP role integration. The transformative stage unfolded as two action strategies taken up within each inquiry group. The first action strategy, particularly relevant to this paper, was to invite the respective HA leaders responsible for NP implementation to an audio-taped data session to discuss organizational planning of the NP role. A second action strategy was to host a research action day, in which a researcher with evaluation expertise helped to design a research template for NPs to initiate inquiry and analysis within their own practice settings.

Following each data session, the audio-tapes were transcribed and preliminary analysis undertaken. QSR NVivo 7 electronic software was used to index data into initial codes

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(free nodes), create sub-themes (tree nodes), formulate themes, and make conceptual correlations (Mason 2002). Data analysis took the form of constant comparative analysis, drawn from analytic techniques of grounded theory, which supports examination of plausible interrelationships (Schwandt 2001; Charmaz 2005). Yet the intention was not to produce a grounded theory result, but instead correlate and extend knowledge development between and across the two HAs (Charmaz 2005; Coghlan 2002; Eaves 2001; Strauss and Corbin 1998). The emergent codes, sub-themes, and themes were continually shaped and re-shaped as stronger associations were cataloged. Sub-theme analysis and thematic interpretations were translated into written text and power point presentations, and taken back to NP inquiry meetings for further discussion and analysis. HA data sets were initially kept separate to compare results and then later integrated to capture common themes and findings. Inquiry participants received and commented on dissertation chapters as they were drafted. The final dissertation was released to NPs and health leaders; dissemination strategies and the co-authoring of publications are underway.

The promise of PAR was realized by the findings and outcomes of the study. The inquiry opened up communicative space for NPs to investigate their experiences and foster more democratic relations (Reason and Bradbury 2001). The NPs determined that collaboration was foundational to their everyday practice and to the advancement and integration of their roles. Analysis of NP stories created shared learning, and this educational process helped to theorize the NP world, and reconstitute their collective understanding (Reason 2006). The NPs revealed the value of their communities of practice for fostering informative learning, inquiry and knowledge development. By exploring the meaning of role integration, NPs articulated steps forward, and gained confidence to engage in actions to co-construct their sustainability (Burgess 2009). NPs came to realize the significance of cultivating strategic capacity and collaborative alliances; thus the emergent nature of PAR created potential for enduring consequences as part of the transformative stage of the study (Bradbury and Reason 2001). The findings section outlines the extent to which the NPs relied on collaborative relations at all levels of the health system to advance role integration and in so doing engaged in the power and politics of role development.

FINDINGS

Collaboration advances role integration

Nurse practitioners portrayed themselves as being a nurse first and practitioner second. As nurses, the NPs were grounded in disciplinary values, theories, and knowledge. As practitioners they integrated advanced competencies and skills into everyday practice. The NPs discussed collaboration as foundational to the ethics of practice. This is consistent with NP policy documents that guide practice, such as the CNA (2008a) Advanced Nursing Practice Framework and the CRNBC core competencies (Registered Nurses Association of British Columbia 2003). Collaboration was viewed by the NPs as both a philosophy and a practice. As a philosophy, collaboration denoted NP commitment to egalitarian power relations, whereby all team members were valued for their unique and significant contributions to decision-making. As a practice, collaboration signified the enactment of this philosophy, in which NPs fostered and modeled the sharing of knowledge and expertise. The NPs discussed how they utilized a full range of people and resources in the provision of complex client care. Collaboration was considered by the inquiry participants to be central to advancing role integration. One NP commented:

> When I think about being a new NP, I think about how do I collaborate with other people? What does the cohesiveness of our team look like in order for me to enact my role? How can I work with a community to identify needs so I can target myself as a resource to help meet those needs ... And how do I build relationships and partnerships within the system that are going to help me enact this role.

The NPs cultivated collaborative relations with clients, colleagues, and healthcare leaders to address concerns of role autonomy and role clarity, extend holistic client-centered care and team capacity, and create strategic alliances to promote innovation and system change. These characteristics of role autonomy, role clarity, holistic client-centered care, team capacity, and strategic alliance were determined to be indicators of NP role integration, and thus potentially useful for evaluating the progress of role integration.

Collaboration facilitates NP autonomy for role enactment

Nurse practitioner commitment to collaboration facilitated role autonomy. The intention of legislation and regulation in BC was to provide NPs with extended scope of practice to allow for increased autonomy and flexibility, and facilitate safe and responsive health-care (CRNBC 2005). The issue of autonomy is discussed by MacDonald (2002) with respect to profession-based scope and professional-based discretion. Profession-based scope refers to structural factors, such as legislation, that enables self-government and self-regulation; while professional-based discretion refers to individual fac-

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tors, in which professionals engage in personal agency to control their practice and decision-making.

However, the inquiry found the dynamics of autonomy to be more complex than this. The NPs also required the understanding and endorsement of policy and program leaders within their health organizations. For instance, a few of the NPs experienced an undercurrent tension of being likened and compared to a physician style of practice, and scheduled accordingly, which limited their role flexibility and constrained role development. One NP commented,

> I think we have to do everything we can to hang on to that thing that we call time, and not sacrifice it by seeing 20 or 30 patients a day … we need to step back and say, 'how is that meeting my goals and objectives for my client population?' … We have to be really careful that we don't become assimilated into the existing [primary care] system.

Yet other NPs reported cultivating collaborative relations with program leaders and colleagues in order to enhance role understanding; this in-turn extended NP autonomy and enabled them to design their roles in response to assessed client and community needs. An NP stated:

> I feel, for the first time in my work life, I don't have someone overseeing my moment-to-moment interactions in the day. And I feel that I'm a grown up and I'm a good time manager, and I don't need someone telling me how I should do it. So, I'm grateful for that [autonomy].

The NP discussions of their everyday work and practice patterns revealed that the design of their roles had emerged with much diversity; each role and site was different and the notion of a uniform NP role seemed a paradoxical idea. Collaboration fostered NP autonomy to explore new practice approaches, cultivate new partnerships, and be responsive to clients and communities. And NP autonomy enabled NPs to construct innovative collaborations to advance PHC practice. In this way, collaboration and autonomy had reciprocal effects, in which the NPs were enabled to more fully enact their roles. The idea of reciprocal effects adds to Way, Jones, and Busing's (2000) conclusions that collaboration and autonomy are complementary.

Collaboration fosters role clarity

Collaboration helped NPs to bridge the professions of nursing and medicine. NPs reflexively discovered and articulated how the NP role was distinctly different from other roles, such as that of a registered nurse or of a physician. The literature refers to the importance of establishing professional identity and role clarity to ensure effective utilization of NPs (Bryant-Lukosius et al. 2004; Pauly et al. 2004; Bailey, Jones, and Way 2006). NPs employed various communication strategies, from informal interactions to formal presentations, in order to clarify scope of practice and negotiate role overlap with other health providers. One NP commented:

> I think about collaboration as being the how we do our interaction – so collaboration is all about mutual respect, we have an understanding about how we are going to make the decisions … it really comes down to good patient care.

As respect and trust developed by way of collaboration with clients, colleagues, and managers, NPs gained recognition for their knowledge, skills, and unique contributions, and role acceptance was cultivated. This acceptance enabled NPs to develop their role as multi-faceted, and thus carry out complex client and community assessments, apply evidence-based guidelines, prescribe and provide treatment for a wide-range of health conditions, and initiate health promotion and prevention programs, all with the aim of improving population health.

The inquiry also revealed that collaboration with clients was key to establishing role clarity. NPs were very much aligned with clients and communities, and this enhanced role clarity and public awareness of the NP role. Clients, knowledgeable, empowered, and confident in their health-care, were reportedly better able to determine when the NP was the right practitioner to address their health concerns. NP–client interactions thus helped clients to gain power in decision-making about their health-care by sharing empowering information, advocating for improved care, and linking clients to various community resources. An NP commented:

> As the leader in my visit and as client-centered, I'm always going back to the client and affirming with them – is this what's going to work for you? Or does this idea work for you? And that's how I involve them and make it client-centered … Sometimes I do say we're partners in this, or it's a team effort – we're both going to have to work at this.

Role clarity is an important step in gaining acceptance of clients, collegial partners, organization leaders and the general public; in turn acceptance of the NP role upholds incremental deployment of NPs and thus improves access to PHC (CNA 2006; Keith and Askin 2008). Access to care is particularly significant for our most marginalized populations who are often underserved by PHC. The NP's alignment with clients and communities is a finding that supports Browne and Tarlier's (2008) argument for examining the NP role from a critical social justice perspective.

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Collaboration enhances holistic client-centered care

Nurse practitioners countered the tensions of role development by developing strong collaborative partnerships with their clients and communities. This was a strategy within their control, and fit with a fundamental belief that clients were partners in care. Clients as partners signified the dual expertise of clients and NPs combining their respective knowledge, where NPs applied theory and practice to client care, and clients contributed the personal lived experience of managing a health condition. The aim of this partnership was to provide holistic client-centered care. NPs drew upon a nursing philosophy and integrated this with advanced clinical education to extend their ability to provide holistic care. For instance, an NP described a home visit to a frail senior, where she carried out a full assessment using various geriatric measurements, identified the diagnostics needed, collected a urine culture, faxed a prescription to pharmacy, liaised with the physician, and made a referral to community care, all in one visit. A holistic approach is consistent with findings from a study by Gould, Johnstone, and Wasylkiw (2007), in which NP practice was noted to be clearly different than that of medical care. Keith and Askin (2008), in a discussion paper of factors influencing effective collaboration, also recognized the holistic client centered care approach of the NP role.

Nurse practitioners discussed and conveyed practice patterns that demonstrated how they integrated advanced clinical practice with health promotion and preventive education. One NP reported:

> NPs focus their practice to particular client health conditions, populations, etc. I think the whole concept of wellness and health promotion is something that's really important in what we do, because we bring that into every client encounter.

Nurse practitioners also developed their roles in unique ways and in diverse settings so as to improve health access for marginalized and underserved populations. By being sensitive to cultural and local differences NPs fostered mutual respect and trust and cultivated client confidence in healthcare. NPs shared power and engaged clients as active participants and decision-makers in their own health-care. Another NP reflected:

> Well-rounded provision of care for that patient, it shifts power, it shifts knowledge, it shifts language, and so the patient does start to take on a lot more power as a benefit of the NP role.

The NP commitment to social justice and social determinants of health is consistent with the view taken up by Browne and Tarlier (2008). The aim of increasing healthcare accessibility and redressing health gaps was considered a value-added contribution of the NP role.

Collaboration generates team capacity

All NP participants reported either being in a team, or part of an extended team network. Some NPs described team experiences as effective and satisfying, while others reported team difficulties. Collaborative teams embodied a sense of team spirit; they were full of life and there was energy, laughter, noise, and a general sense of well-being. On the other hand, teams in struggle were depicted as quiet, sullen, private, and tense. The 'dance of teamwork' was somewhat elusive for NPs to describe, yet it was a very tangible experience. An NP commented:

> When you feel you're actually being cared for as a person it's amazing how that plays into how you work … there's some quality, some sort of sensibility. Some sort of feeling of connectedness that isn't created, isn't manufactured … And it's a safe environment; its the climate, its culture.

Teams with a common vision and client-centered focus seemed to fare better. Hiring well and having effective team leadership was important to sustain a collaborative milieu. Good team leaders were able to manage administrative duties well and make tough decisions; yet also be altruistic, draw on team member expertise, and generate capacity for shared leadership. The NPs as advanced practice nurses contributed to modeling this kind of leadership, and willingly shared and exchanged knowledge, and mentored others. One of the NPs stated,

> I've always worked in a collaborative environment; I've always been part of a team. Even though I'm out doing my thing I'm always connecting with social workers, nutritionists, other nurses, physicians … I don't know what it's like to not work that way.

Although NPs conveyed a natural comfort in collaborating, attaining effective collaboration required continual education of colleagues about their capabilities. Being a pioneer in this new role created a lot of unexpected work and emotions, and at times eroded NP self-confidence. One NP described feeling hurt and uncertain when colleagues did not utilize her as a resource:

> So, when you actually do reach out to someone to get an answer, or some support, or collaborate, and they're not willing, it feels hurtful. It feels like grade 9 all over again when you were the girl that no one wanted to hang out with.

The challenges of NP–physician collaboration are reinforced by Keith and Askin (2008) who identified a number of

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influencing factors, such as communication, competition, funding, liability, and scopes of practice. However, for the most part, the NPs in the inquiry expressed enthusiasm about the culture of collaboration that was developing within their teams, and spoke of the increased capacity of their teams to provide quality care and engage in innovations. This sense of team spirit and capacity is referred to by Jones and Way (2004) as synergy, in their characterization of team collaboration, and is noted to be a defining feature of effective interprofessional teams.

Collaboration promotes strategic alliances

Collaborative alliances between the NPs and HA leaders also served to advance the NP role. NPs relied on the HA leaders to help remedy start-up problems, develop needed infrastructure and policies, and negotiate additional resources, such as gaining access to diagnostics, electronic health records, decision-making tools, and data tracking. However, the NPs also expressed a sense of power inequity with HA leaders and at times had to tread softly in addressing their issues and interests. Nonetheless HA leaders were a link to the power structure of the organization and could help NPs develop strategic capacity. A strategic alliance between NPs and HA leaders fostered development of NP communities of practice, and through this collective interaction, NPs formed a provincial association. The BCNPA is now the provincial 'go to' group for strategic and political action. One NP commented:

> We have to think systems, and at the provincial level too; we have to think beyond our practice. If we are all working together with our strengths, if we can somehow get synergy happening … I think the community of practice is a really important place for us to start strategizing as a group.

From the perspective of HA leaders, the alliance with NPs was important for advancing PHC renewal efforts. NPs had capacity to generate health innovations, and as change agents could catalyze and actualize a population-focused vision for PHC. Pogue (2007) similarly discussed the transformational effects of the NP role in health system change. HA leaders made an early strategic decision to delineate the NP role for PHC. NPs were located one by one into PHC settings, where there was physician support, and gradual inroads were made to procure other physician sponsors. This incremental strategy was anticipated as a way to shift the medical profession toward a more interprofessional perspective. HA leaders saw the NP role as highly political and were prepared to invest extra time and effort to role development. However, in return they needed NPs to be strategic and to steward the PHC cause well. One HA leader stated:

> I honestly have to say our priority is rural PHC, and it will be more so in the future … NPs, in our view, are a key piece of the solution to the challenges we have around access, continuity, coordination of care … the role needs to be out there at the interface with the population to improve health in populations, and communities … The NP role is much more than a resource; it's a whole different philosophical orientation and way of providing care.

However, some NPs said they lacked the political savvy to be effective change agents and requested strategic mentorship from the HA leaders. The meetings, in which HA leaders participated with the NPs in data collection, were very informative for both parties. The HA leaders expressed their expectations of NPs to be strategic leaders in their local communities for enhancement of PHC initiatives, and also to become a strategic collective at regional and provincial levels, so as to contribute to PHC renewal efforts, and advance the NP role development agenda. The inquiry highlighted the collaborative and reciprocal relationship needed between HA leaders and the NPs, in order to move forward in PHC, and to secure the NP role and sustain it in the long term. This reciprocal relationship was a salient finding of the inquiry, and is not well articulated as an issue in the literature.

DISCUSSION

This participatory inquiry revealed the inherent capacity of NPs to champion collaborative relations at all levels of the health system and thereby foster role development. The stories of NP participants offer illustrations of collaboration with organization leaders, site managers, clients and communities, other practitioners and professions, and provincial and national stakeholders. In cultivating collaborative relations and partners, the NPs facilitated their own autonomy, fostered role clarity, enhanced holistic client care, generated team capacity, and promoted strategic alliances, all of which have served to advance NP role integration.

Of course the advances with respect to role autonomy and clarity did not occur in isolation from the structuring environment within which the role was established. BC legislation in 2005 provided NPs with title protection and a clearly articulated (although contentious and debated) scope of practice that defined some limits for role autonomy. Through the legislative process the former BC nursing association was restructured to become the College of Registered Nurses of BC. The CRNBC was given the authority to regulate nurses and NPs, while maintaining their historical mandate to protect the public. The legislative changes did, however, require an explicit relinquishing of any advocacy

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function for registrants (Cartmel 2009). This left NPs without official, professional representation to assist them in addressing the significant and challenging issues of role development. NPs countered this lack of representation by forming collaborative relations with health leader champions, most often from their own employment context, in order to mediate early start-up concerns and ensure autonomy to fully enact their roles. Health leader champions also provided NPs with a certain amount of strategic mentoring. The initiation of NP communities of practice was a good example of this mentoring partnership, in which NPs were supported to manage their concerns and challenges as a collective. NPs subsequently formed a provincial association, which was an important collective strategy to re-build the advocacy function that was no longer available from the provincial nursing body. The challenges of NP role development are well documented in the literature (DiCenso and Paech 2003; Bryant-Lukosius et al. 2004; Jones and Way 2004; DiCenso and Matthews 2005); and although provinces/territories have made legislative and regulatory provisions, the discontinuous history of NPs signifies a caution to not be overly complacent, and instead, take up a vigilance to make certain that the necessary supports and resources are provided for NP sustainability.

Despite the structuring effects of legislative authority, the inquiry uncovered that NPs still needed to engage in efforts to clarify and articulate their role as separate and different from that of primary care physicians. NPs clearly stated they were not physician replacements, yet they expressed concerns of being compared to physicians and measured according to physician parameters. The current lack of measurements in relation to NP practice standards and the absence of infrastructure to support the NP role were noted as real cause for concern. NP role expectations identified through the inquiry included efforts to improve access to health-care, extend clinical and complex care, address social issues of clients and communities, assess community needs and design responsive programs, enhance public and community engagement, champion teamwork and intersectoral collaboration, steward the cause of PHC, and be a strategic agent for health-care policy change. The inquiry revealed the tall order placed on NPs to deliver PHC, and the disjuncture between NP role expectations and available resources. NPs have only elementary tools, measures, and infrastructure to draw upon in the provision of PHC to clients and communities. As well, NPs have only a young association to advocate on their behalf. Their experience stands in significant contrast with primary care physicians, who are well resourced by provincial funding, have access to numerous quality assurance initiatives, and are supported by a strong association and infrastructure. The study identified that NPs require significant resources and endorsement from system and organization leaders, in order to address the current inequities and strengthen NP capacity to meet the obligations and opportunities of this multifaceted role. NPs and healthcare leaders need to collaboratively and strategically determine and shape the fundamentals necessary for NPs to effectively practice. This view is consistent with the CNPI report (CNA 2006) that outlined numerous resource recommendations to ensure role integration and sustainability.

The inquiry revealed that NPs are uniquely situated to be leaders of holistic client and community care. They are also constructing diverse and responsive roles to improve population health and address underserved and marginalized communities. Browne and Tarlier's (2008) paper discusses the NP role from a critical social justice perspective. They argue that NPs must demonstrate practice that reaches beyond physician functions of illness care to mitigate healthcare inequities. Health inequities, they contend, arise out of neoliberal political agendas and policies that emphasize individual responsibility and self-reliance, yet neo-liberalism does not account for effects of gender, ethnicity and socioeconomic status. It is important to recognize that momentum for NP role development has emerged within this neo-liberal political context. The accompanying politico-economic climate buttresses expectations for a less expensive physician 'replacement', while demanding comparable service delivery. The NPs who contributed to this study occupied a space in which, on a moment-to-moment basis, they experienced themselves as not measuring up to their physician mentors while, at the same time, they attempted to fulfill their own ambitions of developing a unique and comprehensive PHC role. The conflicts inherent in their occupational stance seriously undermined NPs capacity to effectively address health inequities and social justice. This was particularly evident for NPs working in and with marginalized or impoverished communities, such as First Nations communities or homeless street populations. In these settings, NPs practiced in a very different fashion from the typical fee-for-service or profit-oriented walk-in clinics. Their client-centered commitment to increasing access, improving care, and addressing social inequities flew up against an ideological neo-liberal perspective of health-care. For instance, the delivery of culturally responsive services to underserved communities required a much more holistic approach than that of conventional primary care, in which structured clinical offices, time constrained appointment processes, and preconceived outcomes, such as compliance of blood sugar levels for persons living with diabetes, served as a proxy for quality patient care. So, while the inquiry reinforced the NP role as multi-

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faceted and consistent with the aims of PHC as a population-focused service, it also demonstrated the significant barriers faced by NPs in their ambitions to offer holistic client and community care, in an effort to advance the social justice agenda and actualize a broader and more principle-based vision of PHC.

The NP inquiry brought to light how collaboration is foundational to NP practice, yet collaboration is influenced and cultivated by a broad context of healthcare culture. Keith and Askin (2008) reported collaboration optimized the NP role and improved PHC team delivery. NP role development is integral to advancement of PHC, and although both have suffered from a discontinuous history, together the political forces of NP role development and PHC renewal have potential for synergistic effects. The World Health Organization (1978) on the 30th anniversary of the Declaration of Alma Ata has called attention to the need for further clarification of PHC, as a community-based full-service approach that emphasizes social justice, equity, and solidarity. The NP role is particularly suited to advance PHC and its associated principles, demonstrate a full-service approach, champion team collaboration, and influence collaborative healthcare culture. In this view, the NP role is significant to all populations and must not be confined to, or worse pigeonholed for, underserved populations or remote regions where physicians choose not to practice. Instead, the NP role must be championed as a complementary function with suitable funding mechanisms put in place, in order to truly realize the breadth and comprehensiveness of PHC. Thus, the inquiry uncovered the importance of the NP role to steward the cause of PHC. However, to do so, NPs must extend the political nature of their role, gain strategic capacity, and become a strong collective voice in PHC renewal efforts.

The credibility of an inquiry is enhanced by managing the unexpected and weighing in the limitations of the study (Bradbury and Reason 2001; Reason 2006). Indeed, a few unexpected occurrences may have affected the quality of the study. The ethics review process required indirect recruitment of NPs to minimize the possibility of researcher coercion, yet PAR relies on relational engagement. One HA was particularly proactive in helping to recruit NPs, while the other was less so. As a result the inquiry groups were not equally represented, which may have compromised the quality of comparative analysis (Brydon-Miller and Greenwood 2006). When the inquiry began, a number of NPs were still practicing under temporary registration, and preoccupied with preparing for final written and oral exams. The newness of the role and the NP's focus on the 'here and now' made it difficult for them to envision what role integration 5 years ahead would look like. As well, the NPs had little reflective experience about the politics of role integration, and were somewhat unprepared for this dialog, so the depth of discussion may have been limited. For most participants, this was a first experience as co-researchers unsure of site manager support for their involvement in the study, they expressed concern about taking time away from practice and thus declined participation in data coding and analysis. The NPs full involvement as co-researchers was compromised by these circumstances and may have caused limitations to the quality of analysis (Reason and Bradbury 2001). Finally, the study was relevant to the NP role in PHC and specific to BC healthcare politics and context. BC legislation, regulation, and education have afforded NPs a high degree of autonomy and a broad scope of practice, relative to many of the other provinces in Canada and to some other countries. The NP study findings can therefore be generalized to those jurisdictions, in which NPs have similar expanded autonomy and scope, but are less applicable to those places where NPs are more restricted in practice. Because the study was informative and qualitative by nature, it has certain limitations for generalizability; however, according to Friedman (2001) knowledge produced in one setting can be applied as a template to other settings for evaluating similarities and differences, and in this way the study can be translated for broader application.

CONCLUSION

The inquiry revealed the NP role in PHC to be decidedly political and this aspect of the role has been underestimated and undervalued, particularly in full cognizance of the challenges posed in implementing a new role into an already political and, at times, fractious professional environment. In education, NP curricula have not adequately prepared the NPs for change agent responsibilities. In practice, NPs have lacked professional advocacy to foster autonomy and strategic capacity. In policy and political circles, NPs have not had enough opportunity to participate in policy development. And in research, NPs have been limited in measurements and ways to evaluate their value-added contributions. NPs have instead experienced and learned about the politics of role development the hard way, from the ground up. Some NPs have shown political savvy and awakened to the need to cultivate their collective strategic capacity, whereas others have kept their heads down to work harder in practice as a way to offset the challenges.

The recent CNA (2008b) Preferred Future 2020 vision reported that in order to move forward and actualize a better healthcare system, collaborative efforts are required by

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nurses, other professionals, policy-makers, and the public. Survival of the health system is noted to be reliant on implementing new delivery models, multiple access sites, and team approaches to care, along with appropriate funding levels to support these strategies (CNA 2008c). PHC is viewed as a significant feature of this future vision and NPs are noted to play an increasingly important role in the delivery of PHC. However, to advance NP role development and ensure its sustainability, collaborative efforts are needed to effectively prepare and support NPs and their collectives to manage the power relations inherent in health organizations and to engage in strategic political action for healthcare improvement.

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