Society of Rural Physicians of Canada
Annual Policy Conference

Nurse Practitioners and Rural Medicine:
Voices From the Field

Delta St. John's Hotel and Convention Centre
St. John's, NF
May 5, 1998
8:15 a.m. to 5:00 p.m.

Five resolutions approved by the conference participants

1. There should be a national process to develop guidelines for the scope of practice of nurse practitioners.
2. There is an enhanced skill set and education required by nurse practitioners.
3. The activities within the role of nurse practitioners are location specific.
4. Funding models must be developed to enhance cooperative and collaborative care.
5. Innovative education is needed to provide core competency and an enhanced skill set.

Proceedings

Keith MacLellan, MD, outgoing President of the Society of Rural Physicians of Canada (SRPC), called the conference to order and welcomed the 132 attendees (see end of document for alphabetical list of those who attended).

Dr. MacLellan introduced **The Honourable Joan Marie Aylward, Minister of Health for Newfoundland and Labrador**. He noted that she brings impressive credentials to the position, including eight years as president of the Newfoundland and Labrador Nurses' Union (NLNU) and has served on many provincial and national committees. Dr. MacLellan remarked on the desirability of government, physicians and nurses, who are working together on the problems currently facing health care delivery, to "get things right."

The Minister commented on the challenges of providing rural health care in a province with over 10,000 miles of rugged coastline and a population less than the city of Winnipeg. She extended greetings and a very warm welcome to visitors from outside the province on behalf of Premier Brian Tobin.

The Minister gave a brief overview of the process of establishing the nurse practitioner program in Newfoundland and Labrador. The program was passed unanimously on December 19, 1997. Three multi-disciplinary pilot sites have been established with the help of the federal government's Health Transition Fund and the provincial government, where nurse practitioners, registered nurses, physicians and allied health care professionals work in a teaching capacity in a "clustered" environment.

The Minister addressed the lifestyle issues facing rural physicians and efforts made by rural communities to develop packages and support systems that will encourage physicians to remain in rural areas. In dealing with remuneration issues, stakeholders must find creative ways to deliver services. The introduction of bills such as Bill 37 in the Alberta Legislature, which deals with the establishment of private hospitals, may well spell the death knell of publicly funded health services in Newfoundland. She awaits Alan Rock's decision as to whether or not such hospitals violate the Canada Health Act.

The Minister acknowledged the help and support that government received from rural physicians in the development of the nurse practitioner program. She recognized that rural physicians know best the challenges of providing health care services in an isolated environment, and expressed the hope that physicians and nurses can work with government toward the goal of delivering better health services in all areas, with a special focus at this conference on areas of rural practice.

Ken Babey, MD, SRPC gave a brief history of the Society of Rural Physicians of Canada (SRPC), which has grown considerably since its incorporation in 1992.

The main goals of the conference were stated as:equitable treatment of rural communities and their population, and sustainable working conditions for rural physicians.

Employment opportunities, remuneration, registration issues, stability of funding for training programs, private agendas of organized medicine, organized nursing and government are all in conflict. Dr. Babey advised conference attendees to take comfort from the words of Lili Tomlin "We are all in this together . . . by ourselves." He would like to see this problem remedied.

Nurse Practitioner-Doctor Relationship. Who should do what? Where? Panel Discussion with audience participation

Lydia Hatcher, MD, CCFP Newfoundland and Labrador Medical Association (NLMA) & physician representative from Newfoundland, described her practice in Whitbourne, Newfoundland, which is a small town west of St. John's with a population of 1,500 and a catchment area of approximately 10,000. She is a consultant physician to the Youth Corrections Service and has worked with outpost nurses and with nurse practitioners in Goose Bay, Labrador. Dr. Hatcher sat on the Working Group for the Development for the Scope of Practice for the Nurse Practitioner Guidelines, which produced the guidelines currently being examined by the Minister.

Dr. Hatcher summarized the position of the NLMA regarding the nurse practitioner program:

Expectations: The NLMA supports a primary care expanded role that contributes to an enhanced level of care and assists physicians in rural and remote areas. The clinical scope of practice must be clearly defined and physicians must remain as coordinators of care. Patient referrals to a specialist physician must remain a function of the family physician, within his/her role as coordinator of care.

Beliefs: Nurse practitioners should work cooperatively with physicians and vice versa. The NLMA supports the Canadian Medical Association's position that "primary medical care is best delivered by a physician educated in comprehensive care". The NLMA believes that nurse practitioners will not solve the shortage of rural physicians and that nurse practitioners are not physicians. It is vital that physicians, and especially their medical boards, colleges and associations, have appropriate consultation mechanisms.

Sharon Dore, RN, McMaster University- Nursing representative - Ontario, started her career as a community nurse in an under-serviced area of Ontario, performing many functions not usually done by a nurse and in collaboration with two physicians. She appeared at the conference to represent a broader, more national view from the perspective of the rural nurse and has been involved in many of the national initiatives. She has been integrally involved in midwifery and nurse practitioner movements in the Hamilton area.

She addressed the academic issues facing the establishment of nurse practitioners. Available programs differ from province to province, including masters, baccalaureate, diploma and certificate programs. There is much confusion as to what functions should be performed by whom and where.

It must be established as to whether the role of the nurse practitioner is to be supportive or collaborative. Will nurse practitioners be supervised by physicians or will physicians and nurse practitioners work as a team, each performing functions within their area of expertise? Historically, nursing expertise has been in the area of health promotion. The statement has been made that nurse practitioners would function toward maintaining optimal health.

What roles do nurses want?

This varies from person to person. Some are physician "wanna-be's"and some are looking towards the advanced practice of nursing. The Canadian Nurses Association in Alberta has called the term 'nurse practitioner' itself one of the biggest sources of confusion because all nurses are practitioners. The 1994 French to English translation of the Canada Health Act added to the confusion by translating the term 'profession' to 'practitioner.'

What do communities want?

Some need a nurse to help with the physician shortage, some need a nurse to increase the quality of care and focus more on the determinants of health. Standards vary and the question has become who should determine what the standards are and what process is to be followed? As hospitals have been downsized, many nurses have taken their expertise into the community, setting up their own practices and being paid directly by clients. How do they relate to the nurse practitioner working in a collaborative model with physicians and other health care professionals?

Current research and literature is mainly from other countries, although there have been some Canadian studies. American research predominates and in the U.S. masters preparation is the standard required. 'Advanced practice nurse' is used as an umbrella term for both clinical nurse specialists and nurse practitioners.

Who will pay nurse practitioners?

The salary model is generally considered the best option and has been used with midwives in Ontario and BC, but the question remains as to who will fund these salaries?

Liability insurance:

Does it need to be different than standard nursing liability insurance to allow for the different scope of practice?

Ms Dore concluded by stating that while there is general support for the nurse practitioner program, confusion exists over educational requirements and practice standards for nurses and nurse practitioners and clarification is needed.

Shari Glenn, Nurse Practitioner, Practising nurse practitioner representative - Ontario, practises with two physicians at a county community health centre in Lannark, about 70 miles northwest of Ottawa. She acknowledged that the terminology is most confusing and offered the following definition of nurse practitioners: a registered nurse with advanced knowledge in assessment, diagnosis and health care management, with expertise acquired through both education and experience.

In common with physicians, nurse practitioners must address similar concerns such as health promotion, preventive medicine, prevention of disease & injury rehabilitation and support. The difference between

medicine and nursing is that each situation is addressed within a different context due to the different educational processes and socialization of physicians and nurses. These different paradigms, when used together, can only enhance patient care.

As a nurse practitioner, Ms Glenn performs a variety of roles, interacting with clients, families and community members and handling episodic illness, triage, strains and sprains. If a situation is outside of her nursing expertise she relies on a clinical guideline for nurse practitioners devised by herself, her two physician colleagues and their administrative staff. It is reviewed annually.

Case in point : a 17 year old single mother of a 2-month old son whose weight was falling off the growth curve. Based on examination, family history and previous involvement with the family she suspected a nutritional problem. Given the child's age, she consulted with one of her physician partners who, in turn, consulted a pediatrician. This team approach kept the family out of the emergency room and reduced the stress for the child's mother.

Ms Glenn concluded by stating that the type of collaborative team effort that she has experienced came about only after two to three years of discussion and of understanding of each partners' scope of practice and areas of expertise.

Jeanne Keegan-Henry, MD, SRPC, Physician Representative, British Columbia, first trained as a nurse and then received her medical degree. She has worked with nurses given an expanded role in the rural setting of Mayne island, BC, an island 14 minutes by helicopter from Vancouver.

She originally considered herself 'radically' in support of the expanded role for nurses and has learned much over the years from nurses with whom she has worked, particularly in the areas of obstetrics and emergency management. Her experiences working with nurses in an expanded role have subsequently been largely negative.

Approximately one year ago, as part of the BC Department of Health's 'Closer to Home' program, the Registered Nurses' Association of British Columbia hired a 'nurse in an expanded role' to perform community and other work, as well as to provide Dr. Keegan-Henry, the sole physician, with time off. Based on the rather unsatisfactory events of the last year, which included two occasions where serious conditions were diagnosed and initially treated without consultation with a physician, she has become very wary of working with nurses in an expanded role.

What went wrong?

The collaborative effort was lacking and there was no structure for the team. Dr. Keegan-Henry was not informed of the health care model the expanded role nurse intended to follow, too many assumptions were made by both nurse and physician regarding the functions of an expanded role nurse and liability issues were not properly addressed. The nurse assumed that the doctor would cover any liability problems.

The Honourable Joan Marie Aylward, Minister of Health for Newfoundland and Labrador Government representative remarked that Dr. Keegan-Henry's experiences point out the importance of co-operation among all stakeholders in the establishment of guidelines for nurse practitioners.

Newfoundland has moved towards a nurse practitioner program because of public demand, made clear both privately and publicly. In any complex system, there must be more than one way of delivering a service. Nurse practitioners are not meant to replace physicians. It is unfair to expect any individual to be on-call 24 hours a day, seven days a week. Nurse practitioners should be used wherever they can improve services in conjunction with physicians, health care boards and the public.

Issues currently being addressed by government include: the definition of the scope of practice for nurse practitioners and any regulations that will be necessary; the question of salaried nurse practitioners working with fee-for-service physicians; and how this method of health care delivery can be implemented. Scope of practice regulations are being examined with a view to covering three schedules:

1. diagnosing schedule - discretionary diagnosis versus mandatory consultation with a physician
2. drug schedule - discretionary prescribing and renewing versus mandatory consultation with a physician
3. diagnostic tests - discretionary ordering versus mandatory consultation with a physician

There are different challenges for urban and rural primary health care providers. The legislation does not preclude nurse practitioners from working in an urban centre, but includes the condition that a nurse practitioner must work in collaboration with physicians, thus preventing practice in urban centres without clear collaboration with physicians.

The Newfoundland Government plans to have nurse practitioners work as salaried professionals. Pay schedules are currently being negotiated between the Newfoundland and Labrador Nurses' Union and Treasury Board.

Our health care system must begin to work in a clustered model to meet the lifestyle needs of physicians and other practitioners in the rural environment. A nurse practitioner in a collaborative, multi-disciplinary practice will definitely help address some of the lifestyle issues and problems made clear to government by physicians and the public. The government's goal is to improve health care delivery, rural physicians' lifestyle and to create new models of health care delivery.

Question Period - Morning Session

In opening the question period, **Dr. Ken Babey** thanked the panel and encouraged attendees to participate.

Dr. Michael Green,Director of Family Medicine and instructor with Queens University Family Medicine, Moose Factory, ON, asked whether it would be possible to draft prototype guidelines tailored to different settings similar to the Ontario Ministry of Health hospital by-law guidelines, which are based on the size of the hospital. This would enable local communities to review their circumstances based on a provincial consensus.

The Honourable Joan Marie Aylward stated that one of the reasons for coming together as a group of stakeholders was to identify the scope of practice and regulations in just that way. The guidelines are focused at present on meeting the needs of the three pilot sites referred to earlier, which are all in rural areas. The nurse practitioners in these projects are community-based primary health care practitioners.

Ms Sheri Glenn noted that there are two schools of thought:

- Rural care should be no different from urban care, therefore should the guidelines be different for urban and rural settings or should they reflect the same standards?
- Guidelines must be established based on availability of facilities and personnel.

There has to be some agreement as to whether or not guidelines will be the same across the province or whether exceptions are made for rural versus urban settings. What does this mean for the quality of care and services delivery?

Dr. Lydia Hatcher noted that the Working Group on the Scope of Practice for Nurse practitioners were very aware that when standards are set they are not lowered for an area due to geographic location.

Dr. Jill Konkin, Board of Directors, Alberta Medical Association, Jasper, AB , invited the Minister of Health to come to talk to the Alberta Minister of Health on some of these issues. Right to title and a few restricted practices will remain in physicians' hands, but changes are happening in a rather autocratic and dictatorial fashion in Alberta. Government seems to favour less expensive alternatives even if that means professionals with less training. Physicians in Alberta would like to practise in a collaborative role with all of their collegial and professional organizations, but the Alberta government seems to be doing a very good job of setting groups against each other.

The Honourable Joan Marie Aylward expressed concern with events in health care delivery in other areas of the country. She referred to the previously mentioned Bill 37 legislation for private hospitals in Alberta and noted that at the meetings of provincial health ministers, the Alberta Health Minister is pushing for provincial interpretation of the Canada Health Act. The Honourable Joan Marie Aylward stated that if the Canada Health Act is opened up to provincial interpretation, it would be disastrous for health care services in Newfoundland.

Ms Sharon Dore stated that caution must be exercised with all the changes and expansions in health care delivery and asked what will happen if we all move up. Will the bottom move up too? Will nursing assistants perform nursing functions or health care aides assume more independence? Part of what has to be decided is who is going to fill the positions that are being vacated.

Dr. David Howe, Parsboro, NS, stated that the position he vacated in rural Newfoundland has yet to be filled. He asked if it is the policy to place nurse practitioners in areas that can no longer attract rural doctors and also, once a nurse practitioner has been hired, will the community cease to attempt to recruit a physician?

The Honourable Joan Marie Aylward advised that physician recruitment is taking place at three levels: departmental level, regional health board level and an advisory committee of the strongest lobbying areas of the province.

She stressed that it makes no sense to recruit a sole practitioner who will be expected to work 24 hours a day, seven days at week. It is more reasonable to ask people to work in clusters and to give support to the nearest clinic or hospital as well as working in the community.

Dr. John Wootton, Shawville, QC, asked if there is a move toward more practice by protocol. Health care providers must be careful to hear what communities ask for and realize that when communities ask for more services, they may not be aware of some of the consequences of protocol care.

Laurie Panagiatou, Nurse Practitioner, Dundas, ON, explained that she is now in the process of challenging the fact that she has been grandfathered into the extended class. Less time should be spent worrying about guidelines and the potential for nurses' mistakes. Nurse practitioners are educated in physical assessment, health promotion and population health, counselling and support skills during menopause and breastfeeding, well infant and child care and parenting issues, teen health and sexuality and the research shows that nurses do these things as well, or better than, physicians.

Dr. Bob Martel, Port Williams, NS, asked the Minister of Health to comment on the national initiatives regarding nurse practitioners at the deputy and ministerial levels, and whether the position she espoused at the conference is a unique position compared to other ministers across the country. In reference to her comments that it is inappropriate for a physician to be placed in a solo practice, does this extend to nurse practitioners as well?

The Honourable Joan Marie Aylward advised that she has put forth a proposal at the health ministers' table to develop working groups to examine health issues that Canadians are discussing. To date, the provincial health ministers have been unable to do this due to other commitments. Solo practice is not advisable but is sometimes unavoidable.

Dr. Bob Martel suggested if government does develop a national initiative on nurse practitioners that rural physicians be invited to that table.

The Honourable Joan Marie Aylward advised that she would be happy to pass this request along.

Dr. Fred French, Norris Point, NF, asked Dr. Hatcher to clarify the position of the NLMA on nurse practitioners working in areas other than rural or remote areas of Newfoundland.

Dr. Lydia Hatcher said that the NLMA sees nurse practitioners working in areas of need, which at the present time are mostly rural and remote areas. She stated that the guidelines do not preclude a nurse practitioner from setting up with a group of physicians in an urban centre.

Dr. Fred French asked if the 1:2 or 1:3 call done by most rural physicians is such a terrible lifestyle for a physician, how can it be acceptable for a nurse?

The Honourable Joan Marie Aylward advised that the government is trying to put together a nurse practitioner project that will prepare nurse practitioners to function as members of multi-disciplinary teams.

Dr. Ken Babey redirected the discussion to questions or comments specifically on the doctor-nurse practitioner relationship.

Ms Paulette Critchley, Student, Nurse Practitioner Program, Port Saunders, NF, asked Dr. Hatcher how area needs assessments are done. She works in an area assessed as needing three physicians, which at the present time has only one. If two physicians were recruited, would the NLMA still assess her area as being in need of a nurse practitioner?

The Honourable Joan Marie Aylward stated that if Newfoundland ever gets to the day when all physician positions are filled, it will have the best preventative, early intervention, health care system ever seen. The government would definitely look forward to that issue.

Dr. Michael Green inquired as to whether supervision of a nurse practitioner in an institution would be considered the responsibility of nursing supervisory or medical supervisory staff, or is there a way to formalize these two processes to work together?

Ms Sharon Dore advised that she has been supervised by both nursing and medical staff, but that she is paid by nursing and that is sometimes the bottom line as far as accountability is concerned. She stated that because nurse practitioners overlap nursing and medical roles, they must be accountable to both.

The Honourable Joan Marie Aylward commented that the hierarchy must be changed.

Ms. Shari Glenn advised that at her clinic, nursing and medical staff report to the same person. Nurse practitioners primarily perform nursing skills, but when performing one of the 13 control acts, responsibility is designated by a physician.

Dr. Jeanne Keegan-Henry said that none of these issues were discussed when she agreed to take part in the pilot project on Mayne Island re: the expanded role of nurses. Unfortunately the BC government has publicly stated its agenda to replace physicians with nurses and is using this as a strike-breaking tactic.

Ms Madge Applin, Coordinator, Nurse Practitioner Program, Centre for Nursing Studies, St. John's, NF, commented that working in collaborative practices does not happen just because we say it is desirable and that it is the right thing to do. She stated that the NLMA position that physicians should be the coordinators of care and that nurse practitioners should be assistants does not foster an interteam approach to health care delivery. She asked if, in an environment that is not committed to interdependence, the participants are being set up for a non-collaborative practice?

Ms. Shari Glenn advised that in her previous situation, there was not a collaborative approach and the team did not work well together.

Dr. David Moores, Professor and Chair of Family Medicine, University of Alberta, Edmonton, AB, expressed concern about the either/or comments being made. He suggested that, in order to provide effective health care, a need exists to foster the nurse practitioner/doctor relationship. Doctors who work in hospitals are privileged to have the support of other health care professionals, but unfortunately, once a physician moves out into the community that support is lost unless the physician wants to hire another health professional. He suggested the Minister challenge the other ministers to think about the collaborative relationships throughout the whole health care system. He suggested government start investing in community practice so that family doctors can count on the support of other health care professionals to have an even greater impact in primary care reform.

The Honourable Joan Marie Aylward stated that improvement is needed in the types of services delivered in the community to bring them up to the level of that in tertiary centres. Strengthening the social model and melding it with the medical model is a good starting point to address some of the issues alluded to by Dr. Moores.

Ms Linda Jones, Family Nurse Practitioner, Ottawa, ON stated that she has been in a very successful collaborative family practice with physicians for the last 10 years. She said that the nurse practitioner role is an interdependent one where application of both the medical and nursing paradigms, in collaboration, can only improve delivery of primary health care.

It is clear that nurse practitioners are not physician replacements or substitutes but are there in their own right with their own way of practising health care that improves primary health care. She stated nurse practitioners and physicians should be able to enter into clinical and shared practices together, not in an employer/employee relationship, but as equal partners.

Dr. Dale Dewar, Rural Coordinator for the Department of Family Medicine, Saskatoon, SK, addressed the topic of the difficulties involved in combining fee-for-service physicians with salaried nurse practitioners. She described her experiences in northern Canada, where nurse practitioners would handle the less complicated cases and refer the more complex ones to her. By contrast, in her current situation as a part-time fee-for-service physician in a less isolated area, the 'bread and butter' of her overhead comes from the high volume, short patient visits, which were handled by nurse practitioners up north. The challenge is going to be for physicians to decide how they want to be paid and how they see themselves fitting into the new system and how the government is going to tackle this issue.

Dr. Lydia Hatcher stated that physicians have traditionally been seen as the cost-drivers of the system. This view has resulted in measures such as global caps and audits. Many physicians fear that the addition of a new layer of health care provider will take away some of the potential for income from fee-for-service physicians, while potentially increasing costs to the system.

She feels there is a paradigm shift in how medicine is being practised, that patient-centred models can only improve the practice of medicine, but care must be taken to look after the financial bottom line.

Dr. Ken Babey announced a break before the start of the next panel discussion.

Training And Maintenance Of Competence
Who does the training? What should be taught? How is competence maintained?
Panel Discussion with audience participation

Dr. Ken Babey urged attendees to consider submitting research papers to the Canadian Journal of Rural Medicine (CJRM) for publication and gave a brief description of the e-mail discussion group, RuralMed and outlined the category of associate membership in the society.

Conleth O'Maonaigh, MD, SRPC Rural Physician Representative, Fogo island, NF, prefaced his presentation by saying that his comments are based solely on his own experiences working in rural Newfoundland and that he has done no formal training or research on the topic of nurse practitioners, but is certainly in favour of, and supportive of, nurse practitioners. He is a member of the Working Group to Examine the Scope of Practice of the Nurse Practitioner.

Dr. O'Maonaigh stated that in Newfoundland, the development of the nurse practitioner program was driven by problems of geographically isolated communities and significant rural physician shortages. He was not comfortable with the comments made earlier which gave the sense that GPs have not approached medicine from a holistic basis and has never seen himself as being medicine or disease oriented.

Dr. O'Maonaigh felt that the emphasis should be on teaching nurse practitioners the skills required to perform the medical tasks which are now lacking due to a shortage of rural physicians. Dr. O'Maonaigh felt rural physicians would be the best individuals suited to teach these skills to nurse practitioners, as they have the clinical skills themselves. There has to be a formal, collaborative relationship between the nurse practitioner program and medical schools.

Gertie Bromley, RN, Practising Nurse Practitioner, Conche, NF, described her working conditions in a health centre that serves seven communities with a total population of approximately 3,500. She works in collaboration with two physicians and four nurses. An established scope of practice and drug protocols are used by the nurse practitioners to screen and assess patients. 24-hour on call is covered by the five nurses, with the nurses being first on call and the physicians being called if needed. The nurses do their best to decrease the workload when only one physician is available, to help avoid physician burnout. Ms Bromley stated that these nurses prefer to work with a physician on-site, rather than being left to work solo.

Training consists of self-directed teaching models for such procedures as suturing, IV therapy, PAP smears, etc. Initial certification is done by a physician and maintenance of certification is done on a yearly basis by either a physician or a previously certified nurse.

Brenda FitzGerald, MHSc, Assistant Deputy Minister of Health, Newfoundland and Labrador, Government representative, stated that Government, in conjunction with the MUN Faculty of Medicine, Newfoundland Medical Board, NLMA, and Association of Registered Nurses of Newfoundland (ARNN) have put a collaborative framework in place to establish formal practice guidelines to assure quality of nursing practitioner practice and quality of services to patients. Training and maintenance of competence are critical issues. The relationship between nurse practitioners and physicians must move from one of dependence to interdependence, with mutual referral and consultation.

Government's role is to ensure that the legislation contains a requirement for appropriate certification and registration, as well as appropriate formal educational programs of high quality.

Lydia Hatcher, MD, CCFP, NLMA & physician representative - Newfoundland, stated that Newfoundland's physicians had serious concerns that the nurse practitioner program was put into place with very little input from the medical profession. The scope of practice guidelines have been submitted to the Minister of Health and the working group has now become an advisory committee to the Minister. This committee will be instrumental in the development of the three nurse practitioner pilot projects.

Dr. Hatcher presented the NLMA Policy Statement, which includes:

- training program with national accreditation
- admission criteria of BN or equivalent
- minimum of 2 years rural nursing experience
- admission contingent on agreement of future employment
- physician involvement in training related to acute care services
- internship in accredited academic rural site
- initial and ongoing assessment of competency, based on national standards
- maintenance of training and internship programs for medical students and residents
- comprehensive exit exam
- issues of liability must be addressed
- independent evaluation protocols.

Dr. Hatcher concluded by saying that there is significant support from the medical profession in Newfoundland for these types of standards and that they need to be in place province and nation-wide.

Madge Applin, RN, Centre for Nursing Studies, Nursing representative, restricted her comments to curriculum, faculty and maintenance of competence issues. Criteria for the maintenance of competence for nurse practitioners in Newfoundland will be finalized over the next few weeks.

The role of the nurse practitioner is curative, promotive and supportive and it should include rehabilitative and palliative care in hospital, in health centres and at home. Curative measures are only one component of health care. Nurses have been involved in all other aspects for a long time. It is very important to recognize that the expertise needed to provide the full scope of practice to patients cannot be provided independently by solo practitioners. There is no substitute for training in a clinical setting and interdisciplinary training is necessary.

Nurse practitioner program curriculums must teach:

- strong history-taking and physical examination skills
- good working knowledge of pharmacology
- management of patient health and illness in ambulatory care settings
- clear understanding of how to remain within the scope of practice
- ability to identify need for consultation
- stabilization and transfer of patients in emergency situations
- how to work as a collaborative team member
- how to work as a partner with families in communities

It is essential that the medical and nursing professions accept the challenge to examine the nurse practitioner role and work together in a collaborative fashion, to articulate a workable nurse practitioner model for the province and to ensure these programs go forward in the positive way in which they have been envisioned.

Question Period - Afternoon Session

Dr. Ken Babey opened the second question period by thanking members of the panel and expressed a hope that programs to get nurse practitioners out into the community will soon be put in place across the country.

Dr. Fred French commented that collaboration has to occur at all levels. He also commented that practical clinical experience is vital and cannot be replaced by any amount of academic education. He stated that it is paramount that nurse practitioners develop the ability to identify the need for consultation.

Dr. Roger Thomas, Chair of Family Medicine, Memorial University of Newfoundland, commented that lifelong learning is a common challenge for all professionals and posed the question as to whether any components of the nurse practitioner program address the collaborative model to tackle the issue of lifelong learning.

Ms Madge Applin said that the 'roles and issues' course in the nurse practitioner program stresses the importance of being current and requires students to critique literature for presentation in class. There is no answer to ensure every learner continues life long learning, but the nurse practitioner program puts a high emphasis on that concept in an attempt to make sure students appreciate the value of continued learning.

Ms Phyllis Murray, Nurse Practitioner, Moncton, NB, took issue with views expressed earlier that defined the nurse practitioner as a physician assistant role and took issue with the suggestion that guarantee of employment should be an entry requirement for nurse practitioner programs. No other educational programs require participants to provide a guarantee of employment before they can be accepted into the program.

In response to Dr. Hatcher's comments that the nurse practitioner program in Newfoundland started up prior to development of a curriculum, she expressed disbelief that government funding could be obtained for a program that did not have a curriculum.

With respect to the fear expressed that nurse practitioners will not engage in life long learning, she expressed disdain for this idea and she stated that no one could survive in the modern work place without life long learning.

Dr. Michael Green suggested existing Practice Based Small Group Continuing Education might be suitable for nurse practitioners

Ms Madge Applin advised that she would personally support this method. She requested an opportunity to address some misunderstandings generated by some of Dr. Hatcher's comments relative to the nurse practitioner program in Newfoundland.

Dr. Eugene Leduc, Creston, BC, stated that he is in favour of expanded roles for nurses but even after listening to today's discussion is still unclear on exactly what a nurse practitioner is or what the scope of practice should include.

Dr. Ken Babey directed the discussion away from development of scope of practice as this will be the topic of discussion for one of the break out groups.

Dr. Con O'Maonaigh does not see the nurse practitioner as a physician replacement, but rather as a way of allowing Newfoundlanders in rural and remote areas access to a primary care provider without having to travel significant distances.

Ms Laura Penney, Hamilton, ON, stated that, if an equal level of care is to be provided, an equal level of education must be provided. It is very important to have roles and issues courses that stress a movement away from this imbalance. This can be achieved in part by a change in lingo to move away from such phrases as 'doctor's orders' and 'my' nurse.

Dr. David O'Neill, Trochu, ON, stated that it is arrogant of physicians to presume to tell nurses how to educate themselves. He noted that two nurse practitioner courses have been introduced in Alberta. Internships should stress the learning of skills and mutual respect that enables this professional relationship to work well. He expressed doubt that this experience will be available in suburban or large rural certified teaching practices.

Dr. Ken Babey stated that some clarity was emerging from these discussions but that it is as yet difficult to fit the topic into the whole picture. He commented on the impression given in the literature that the more time an individual spent training in rural areas, the more likely they would be to return to rural areas to practise. The evidence now appears to show that the more time you spend training in academic health science centres, the less likely you are to practise in rural areas.

Ms Pamela Baker, President-Elect, Association of Registered Nurses of Newfoundland, outlined the process of involvement of her professional association thus far. The ARNN fully supports collaboration with the medical profession at all levels within the nurse practitioner program and has approved the draft regulations submitted to the Minister of Health for review. Standards of practice for the primary care nurse practitioner are in the process of being developed. Development of the levels of competency required for nurse practitioner practice are in progress and the registration process is in place. Testing of competency will include those who have completed a nurse practitioner program as well as those who have not. The ARNN recognizes the current program as transitional, to be evaluated for approval in the fall of 1998. The ARNN supports the baccalaureate degree as the entry to practice by the year 2000, as well as the entry to practice for nurse practitioners with credit towards a Master of Nursing degree.

Maintenance of competence will be evaluated at two levels: the professional or association level through the criteria for licensure, and the regional level by the regional health boards.

The ARNN believes a nurse practitioner is autonomous within his or her approved scope of practice and competency level and this scope of practice is outlined in the draft regulations for nurse practitioners. A number of concepts must be discussed and integrated. These include: supportive, collaborative and interdependent practice.

Dr. Paul Patey, St. John's, NF, asked Ms FitzGerald and Ms Applin to describe their long-term vision for the nurse practitioner program. He inquired as to whether this was a short-term solution in response to a crisis situation or an effort to develop the expanded role of the nurse in primary care. He stated that this would be accomplished by examining the most appropriate strengths that nurses can bring to the provision of primary health care, not by providing substitutions based on circumstantial necessity of geography, resources, or crises. How do you avoid the risk of creating a temporary substitution program that will fail to appropriately introduce the broad expanded role of the nurse? How will you avoid having the current physician shortage distort your programs inappropriately?

Ms Brenda FitzGerald noted that the Department of Health and Community Services will have to continue with human resource planning. Newfoundland historically has been weak in bringing all the providers to the table to examine the models for health care delivery and to identify the necessary providers, rather than simply dealing with crisis intervention. This is one of the strategic directions identified by the Minister of Health.

Ms Madge Applin stated that for the first time regulations and legislation exist to legitimize and define the scope of practice for nurse practitioners. The predominant causes of morbidity and mortality are

largely related to preventable illnesses and health issues. The nurse practitioner, in collaboration with physicians, makes the possibility of expanding those measures real.

Ms Harriet McCready, Nova Scotia Department of Health, inquired as to whether the evaluation plan for the nurse practitioner program was developed in collaboration with other disciplines. Is there an intention to find the one best model for primary care delivery or is there recognition that there may be a number of appropriate models?

Ms Madge Applin first addressed some of the comments made by Dr. Hatcher regarding the development of the nurse practitioner program curriculum. She advised that two committees with broad stakeholder representation were put into place by the Centre for Nursing Studies to guide the development and approve all of the courses prior to registration of students.

She reported that evaluation of the program is ongoing. Students evaluate every course being offered and an evaluation will be done at the end of the program, using student, provider and client feedback. As the program is in its first year, evaluation has not been finalized.

The curriculum advisory and program advisory committees are developing the remaining components of the overall program evaluation. Ms Applin stated that it is not likely that one best model could be found which would suit all situations, but that models will have to vary from region to region, tailored to suit the needs of that region. She expressed the hope that the three pilot projects will result in some decisions for appropriate models to be developed for various parts of the province.

Dr. Keith MacLellan responded to Dr. Patey's comments, stating that, like most rural physicians, he has no problem with nurse practitioners providing primary care. The mission statement of the Society of Rural Physicians of Canada is almost identical to those of many nurse practitioner organizations. Rural GPs must be trained in specialist skills as well as primary care skills and he would see it as an advantage to have someone help him with primary care.

Dr. Jill Konkin expressed concern that governments see nurses as a cheap alternative to physicians. She feels nurse practitioners should question whether they are being set up as replacements for physicians. Until that issue is revolved, it will be very difficult to get physicians and nurse practitioners to work together. Governments have more control over those they pay than those who are self-employed. Education and social services programs are being cut across the country and these are having an effect on health care. We must protect those of us who can still say no.

Dr. Ken Babey thanked the participants and closed the formal presentations section of the policy conference.

Break-Out Group Discussions

Reports of Group Discussions and Resolutions
Moderator: **Ken Babey**

Dr. Keith MacLellan apologized to francophone participants for the lack of French material or translation services. He advised that the society is taking steps to have all materials translated into French.

Dr. Ken Babey opened the session on reports of group discussions by requesting that each group present their findings.

Reports

Group 1: Nurse-doctor duties and relationships
Facilitator: Dr. Jeanne Keegan-Henry
Presenter: Dr. David O'Neill

Problems and Barriers: There are several problems and barriers to collaborative relationships between nurse practitioners and physicians. These include financial competition, especially within the fee-for-service environment and concerns regarding job security, with physicians fearing they will be replaced.

Professional relationship: Currently, there is a lack of definition of the nurse practitioner/physician relationship. Should nurse practitioners and physicians have an employer-employee relationship or can it be of a more collegiate nature? Who functions as supervisor and takes responsibility? Skill sets and roles must be defined clearly.

Duties and Relationships: Do not place the two professions in a position of financial competition. Establish national or provincial legislation or regulations to define the scope of practice, with local or regional guidelines for further clarification. Medically delegated tasks require a provincial list with local delegation.

Liability, accountability and responsibility need to be defined and a strategy to build a relationship of trust and confidence among the professionals must be established.

Group 2: Entry to Primary Care
Facilitator and Presenter: Ms Linda Jones

The issue of changing public access to the health system is ongoing and inextricably linked to changes in the remuneration system or models that will allow for collaborative practice and provision of integrated services along the continuum of care.

Group 3: Emergency care
Facilitator: Dr. Keith MacLellan
Presenter: Dr. Mary Johnston

This group did not reach a consensus, but did agree upon the areas of concern, which are outlined below.

Triage: Policies and guidelines for triage must be established to address the following concerns:

- performed by a doctor or a nurse practitioner?
- should guidelines be instructive versus limited in nature?
- remuneration for advice
- who assumes responsibility for phone advice?
- volume and competence
- confidence
- initial training ability

What is an emergency?

Emergency services must be available 24 hours a day. Ultimately, the patient decides what constitutes an emergency.

Who is responsible?

Criteria for assumption of responsibility must be set. Information should be given clearly and interpretations clarified.

Call

Call schedules must set out the following conditions:

- relief/time out
- set standards
- level of responsibility
- contract limits

Liability : issues included the following:

- understaffing/funding
- evidence-based income
- level of responsible/backup

Transport: Guidelines for transport of patients must address the following conditions:

- time frames
- weather permitting
- skills of the transport team
- protocols for initiating treatment

Availability of Personnel:

This is always a concern. Without the personnel to staff the ER, development of these guidelines is futile.

Group 4: Obstetrics
Facilitator and Presenter: Ms Sharon Dore

Role of nurse practitioners should be based on location and specific patient needs.There is a need for national guidelines for education, standards of practice, certification and evaluation for nurse practitioners. Enhanced skills are needed to provide perinatal care. Low volume of patients has a detrimental effect on the maintenance of competence.

Group 5: Training issues
Facilitator: Dr. Con O'Maonaigh
Presenter: Dr. David Topps

Situation in Newfoundland:

The previous family practice nurse education program ended in the 1970s and the outpost nursing program ended in the 1980s. The discontinuation of these programs was greatly influenced by increases in medical school enrollment.

The current nurse practitioner program consists of three semesters. The first semester consists of classroom instruction and clinical simulations in assessment, pathophysiology and pharmacology. The

second semester deals with community health nursing and the third consists of a dedicated practicum paired with a rural physician.

Entrance requirements:

These consist of possession of an RN diploma with two or more years experience. A BN is not required, as it was decided this would restrict the applicant pool. To date, 85% of the applicants are RNs. There is no evidence so far that would suggest that BN training is significantly helpful to the rural nurse practitioner, although expert opinion suggests that there is benefit.

Terminology:

Semantics are creating some problems. Do we need to define what these roles are by title?

What are we training them to do?

What are the desires of those who enroll in nurse practitioner programs?The group felt interested individuals would like the challenge and freedom of a nurse practitioner position and that it takes a certain mindset to be interested in this type of practice.

What are the needs?

Training will be predicated on the intended role, with individualized training and curriculum. Sufficient elective time must be allowed to cater to these needs. Training methods should be largely practice-based.

Standardization:

The group recommended that curricula not be focused on the upper end, concerned with limiting what nurse practitioners are allowed to do, but rather focus on a minimum set of knowledge, skills and attitudes. Generalists need more training than specialists do and clinical assessment skills need more emphasis. Therapeutic trends change more rapidly than other criteria. It is easy to consult on trends long distance. Modularised training is recommended, especially for special skills.

Who decides on the content?

Group members recommended curricula developers take a leaf from residency training, allowing content to be decided by the learners. It should also be patient-centered and take into consideration what is wanted by patients.

Who does the training?

The group suggested residents be incorporated as teachers in certain areas and in certain roles. This would obviously not be appropriate for all areas. Residents tend to have a different perspective and are very tertiary care based because that's where their experience lies. There is also much value to be gained in the opposite direction: having nurse practitioners teach residents. Collaboration and communication is a very important component of this process and, as discussed this morning, for this whole area of practice.

Where are we training them?

Nurse practitioners should be educated in the same type of location where they will practise.

Principles:

The future practice role is a major determinant of a relevant educational program, and is determined by needs, resources, available methods and circumstances. The closer to the end of the program, the closer the role should approximate the actual practice environment.

Group 6: Recruitment and Retention
Facilitator and Presenter: Ms Bonnie Johnson

This is presently an issue regarding physicians but will in future apply to nurse practitioners as well.

Problems

Clarity of Roles:	The need exists to provide specific education for rural practice for both the nurse practitioner and the physician. Training for multidisciplinary practice needs to start early in the professional training process.
Starting:	Life style issues become important early in rural practice. Support systems need to be in place for safety purposes. Accessibility to nurse practitioner programs is vital.
Solutions:	Immediate needs include sufficient funding for support staffing and well-screened locum pools.
Long term goals:	These include job sharing for nurse practitioners and physicians, with flexible working arrangements. A large group practice in a large centre, where individual members travel to outlying areas, may be the best system to meet the needs of both professionals and the public.

Nurse practitioner & MD administration must recognize basic needs and recognize the work done.

The following five resolutions were approved by participants

1. There should be a national process to develop guidelines for the scope of practice of nurse practitioners.

2. There is an enhanced skill set and education required by nurse practitioners.

3. The activities within the role of nurse practitioners are location specific.

4. Funding models must be developed to enhance cooperative and collaborative care.

5. Innovative education is needed to provide core competency and an enhanced skill set.

Final Remarks and Conclusions

Dr. Ken Babey thanked participants for their time, expertise and involvement in the infant stages of what will be a beneficial, yet time-consuming process. He recognized the need to continue collaborative discussions among all the stakeholders.

The conference adjourned at 5:00 p.m..

SRPC Annual Policy Conference Registration Listing

Affleck, Ewan,	Rainy River	ON
Andrews, Jeanette,	St. John's	NF
Anstey, Cathy,	Twillingate	NF
Applin, Madge,	St. John's	NF
Avery, Granger	Vancouver	BC
Aylward, Joan Marie	St. John's	NF
Babey, Ken	Mt. Forest	ON
Baisley-Moffatt, Shirley	McAdam	NB
Baker, Pamela	St. John's	NF
Bell, Marnie	Yellowknife	NT
Bowerman, Brian	Kenora	ON
Brar, Harpreet	St. John's	NF
Briffett, Paul	Burgeo	NF
Bromley, Gertrude	Conche	NF
Brown, Glenn	Kingston	ON
Carroll, Karen	St. John's	NF
Chamberlain, Dawn	St. John's	NF
Chouinard, Joe	Ottawa	ON
Clarke, Annette	St. Anthony	NF
Clarke, Mona	Port aux Basques	NF
Cohen, Mike	St. John's	NF
Critchley, Paulette	St. John's	NF
Croteau, Pascal	Quyon	QC
Cuthbert, David	Brantford	ON
Daigle, Lise	Fredericton	NB
Danilkewich, Alanna	Saskatoon	SK
Danquad, Lynda	Ottawa	ON
Dewar, Dale	Wynyard	SK
Dobbin, Patrick	St. John's	NF
Dore, Sharon	Hamilton	ON
Dubeaugrave, Carole	Ottawa	ON
Dutoit, Regina	St. John's	NF
Ehman, William	Nanaimo	BC
Fagner, Glenda		NF
Fast, Richard	Faro	Yukon
Fine, Jonathan	Quesnel	BC
Fitzgerald, Brenda	St. John's	NF
Forward, Debbie	St. John's	NF
French, Fred	Norris Point	NF
Furlong, Madonna	St. Brendan's	NF
Gilboe, Brenda	Edmonton	AB
Glenn, Shari	N. Lanark County	ON
Graham, Wendy	St. John's	NF
Gray, Sharon	St. John's	NF
Green, Marcy	St. John's	NF
Green, Michael	Moose Factory	ON
Guthrie, Bing	Hay River	NT
Hamilton, Linda	Dartmouth	NS
Handley, Thomas	Vancouver	BC
Harris, Victoria	Ottawa	ON

Hatcher, Lydia	St. John's	NF
Hayhow, Barbara	Calgary	AB
Haynes, Marilyn	St. John's	NF
Horton, Jan	Whitehorse	YK
Horwood, Karen	Happy Valley-Goose Bay	NF
Howe, David	Parsboro	NS
Humber, Nancy	Lillooet	BC
Irvine, Hal	Sundre	AB
Johannessen, Jane	St. Anthony	NF
Johnson, Bonnie	Westmeath	ON
Johnston, Mary	Revelstoke	BC
Johnston, Stuart	Vanderhoof	BC
Jones, Linda	ON	ON
Jong, Michael	Goose Bay	NF
Keegan-Henry, Jeanne	Mayne Island	BC
Keith, Patty	Vancouver	BC
Kelly, Colleen	St. John's	NF
Kelly, Len	Sioux Lookout	ON
Kelsall, Pat	Goose Bay	NF
Kelsall, Patricia	Goose Bay	NF
Kennedy, Alice	St. John's	NF
Kingsmill, Suzanne	Shawville	QC
Kirby, Fran	St. John's	NF
Konkin, Jill	Jasper	AB
Larsen Soles, Trina	Golden	BC
Leduc, Eugene	Creston	BC
LeFort, Sandra	St. John's	NF
Leslie, Neil	Revelstoke	BC
Longley, Cathy	Ottawa	ON
Lortie, Paola	Ottawa	ON
MacAfee, Michelle	St. John's	NF
MacIsaac, Bev	Port aux Basques	NF
MacKinnon, Sarah	Sudbury	ON
MacLellan, Keith	Shawville	QC
MacNeil, Chuck	Inuvik	NT
Martel, Robert	Port Williams	NS
McCallum, Karen	Portugal Cove	NF
McColl, Mary	Clarion	IOWA
McCready, Harriet	Halifax	NS
McHugh, Janet	St. John's	NF
Mercer, Marjorie	St. John's	NF
Miller, Katherine	Brighton	ON
Moores, David	Edmonton	AB
Murray, Phyllis	Moncton	NB
Noseworthy, Ronald	Halifax	NS
O'Maonaigh, Conleth	Fogo	NF
O'Neil, David	Edmonton	AB
O'Neil, David	Trochu	AB
Ouellet, Barbara	Ottawa	ON
Panagiotou, Laurie	Dundas	ON
Park, Ian	Whitney	ON
Parsons, Donna	Port aux Basques	NF
Parsons, Wanda	St. John's	NF
Patey, Paul	St. John's	NF

Peddle, John	St. John's	NF
Pelley, Angela	Twillingate	NF
Rashed, George	St. Anthony	NF
Reddoch, Allon	Whitehorse	YT
Ribeiro, Violeta	St. John's	NF
Richards, Tony	Change Islands	NF
Rideout, Carolyn	Twillingate	NF
Rideout, Nancy	Fredericton	NB
Rowsell, Joan	St. John's	NF
Royle, Catherine	St. John's	NF
Salette, Helene	Montreal	QC
Samuels, Lewis	St. John's	NF
Scrimshaw, Cathy	Pincher Creek	AB
Simms, Joanne	St. John's	NF
Squires, Bruce	St. John's	NF
Strachan, Jill	Ottawa	ON
Teasdale, Catherine	Toronto	ON
Thomas, Roger	St. John's	NF
Thompson, Jim	Sundre	AB
Tilley, George	St. John's	NF
Topps, David	Calgary	AB
Vann, Patty	Dryden	ON
Wacko, Marilyn	Edmonton	AB
Warren, Trina	St. Anthony	NF
Way, Daniel	Ottawa	ON
Wickson, Robert	Glerchen	AB
Wilson, Perclavanthi	Labrador	NF
Wootton, John	Shawville	QC

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