

Finding a Balance:
Participatory Action Research with Primary Health Care Nurse Practitioners
on the Relevance of Collaboration to Nurse Practitioner Role Integration

by

Judith Burgess
R.N., Galt School of Nursing, 1972
B.N., University of Calgary, 1982
M.N., University of Victoria, 1995

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Supervisory Committee

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Abstract

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This health services study employed a participatory action research (PAR) approach to engage nurse practitioners (NPs) from two health authorities in British Columbia in separate and concurrent inquiry groups to examine the research question: How does collaboration advance NP role integration within primary health care (PHC)? The inquiry with NPs is significant and timely, because the introduction of the NP role was only recently formalized in BC, supported by the passage of legislation and regulation, and the introduction of graduate education programs. For this PAR study, a first-, second-, third-person action research framework was adapted and applied to facilitate graduate student research. PAR fostered an iterative process of social investigation, education, and action, in which NPs strengthened their relations, shared and generated practice and policy knowledge, and engaged in collective visioning and action to improve health care delivery.

The findings of this PAR study include design and substantiation of an ecological framework about collaborative health care culture. This collaborative culture framework was applied to and substantiated by the NP inquiry discussions. NP practice patterns were examined and found to parallel the PHC principles, indicating the importance of the NP role to PHC renewal efforts. The meaning of role integration was explicated and collaboration was found to be foundational to NP practice. The study revealed the political nature of the NP role and the extent to which NPs are reliant on collaborative relations at all levels of the health system to attain role integration. Given that NP role development is still at an early stage in this province, this study provides important information about the current progress of role implementation and direction for future role advancement.

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Finally, special thanks and appreciation goes to Annie, an NP pioneer and friend, for sharing with me a vision of what could be!!

Dedication

I would like to dedicate my academic achievements to my Dad, GDB
Glenn Dewey Burgess (1921-2007)
For giving me the inspiration to aim high yet take my own unique path

And much thanks to my Mom, Kathy
For giving me the determination to see it through

Frontispiece

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Chapter 1

Situating the Nurse Practitioner Context for a PAR Study

As more research on the role of the Nurse Practitioner (NP) accumulates, there will be opportunities to improve the policy and decision-making of governments and employers about the integration of NPs. The dissemination of this evidence needs to be given priority. (Canadian Nurse Practitioner Initiative, 2006b, p. 37)

This dissertation study is about preparing for and carrying out research with nurse practitioners (NPs) from two health authorities in British Columbia, who practice in the health services context of primary health care (PHC). For purposes of clarification, the Canadian Nurses Association (CNA) defines nurse practitioner as:

A nurse practitioner is an advanced practice [registered] nurse whose practice is focused on providing services to manage the health needs of individuals, families, groups and communities. The NP role is grounded in the nursing profession's values, knowledge, theories and practice and is a role that complements, rather than replaces, other health care providers. NPs have the potential to contribute significantly to new models of health care based on the principles of PHC. NPs integrate into their practice, elements such as diagnosing and treating health problems and prescribing drugs. NPs work autonomously, from initiating the care process to monitoring health outcomes, and they work in collaboration with other health care professionals. NPs practice in a variety of community, acute care and long-term care settings. These include, but are not limited to community health centres, nursing outposts, specialty units and clinics, emergency departments and long-term care facilities. (CNA, 2003, p. 1)

The aim of this study was to examine the relevance of interprofessional collaboration (IPC) in advancing the integration of the NP role. A participatory action research (PAR) approach was employed, as a way to foster relations with and amongst NPs, share and generate practice knowledge, and engage in collective visioning and action to improve health care delivery. The study is significant and timely, because the introduction of the NP role was only recently formalized in BC, supported by the passage of legislation and regulation, and the introduction of graduate education programs. Given that NP role development is still at an early stage in this province, the study provides

information about the current progress of role implementation and offers direction for future role advancement.

My determination of the focus of this study was guided by certain beliefs and assumptions. I have a fundamental belief in the promise of PHC and its inherent principles of equitable access, public participation, health promotion, intersectoral collaboration, and appropriate technology. I chose to foster a research partnership with NPs, because I foresee that the formalized NP role has a valuable contribution to make to PHC renewal. I focused on IPC as a way to advance NP role development and enhance the NP teamwork environment in PHC. I chose PAR as an inquiry approach for its capacity to elicit collective dialogue about current health care conditions and generate commitment to future improvements. These understandings were derived from my practice experience and were reinforced through my learning and scholarship. I thus brought to the research process a certain worldview, which shaped my learning plan, and in turn my scholarship development reflexively shifted my views, and further spawned my curiosity.

As a registered nurse, I came to the academy with many years of leadership and practice experience in PHC. This PHC experience provided me with first hand knowledge about the vital community role of a pioneer NP, as she modeled an *art and science* of nursing and demonstrated collaboration and innovation. I also had come to know the benefits and challenges of teamwork. As a PHC team we had the best intentions; we aspired to develop and sustain a responsive approach to the community, offer a diversity of programs and services, and persevere with our progressive vision. Yet our team was confounded by external political tensions, in which there was incongruence

between the expectations of those in governance positions and what we could actually be accountable for. This disconnect resulted in internal conflicts and pressures that disrupted professional relations and team culture. I returned to school to learn about and understand these complexities, with the optimism that I could contribute in a different way to a better health care.

My scholarship work as a doctoral student at the University of Victoria offered me the privilege of becoming involved in two significant networks. The Health Canada Interprofessional Education for Collaborative Patient Centred Practice (IECPCP)¹ network was newly initiated and I was selected for the role of Education Coordinator for the Vancouver Island Interprofessional Education Project. The CHSRF/CIHR Advanced Practice Nursing (APN) Research Chair², under Dr. Alba DiCenso, was underway, and I was accepted as a student of the APN Chair program. I also had the good fortune to be a recipient of the Canadian Institutes of Health Research doctoral award program³, which supported my course work and research learning. In addition, I had the benefit of doctoral supervisors and committee members whose extensive knowledge and encouragement nurtured my research creativity.

¹ The Interprofessional Education for Collaborative Patient Centred Practice (IECPCP) Initiative falls under the auspices of Health Canada's Office of Nursing Policy. A national expert committee was commissioned to report on literature and national and international trends, and subsequently designed a developmental framework, and set recommendations for funding provincial/territorial project demonstrations (Health Canada, 2004).

² The Canadian Health Services Research Foundation / Canadian Institutes of Health Research (CHSRF/CIHR) Advanced Practice Nursing Research Chair was awarded to Dr. Alba DiCenso, who established an education and mentoring component for nursing research students that accepts 3 graduate nursing students each year from across Canada.

³ The Canadian Institutes of Health Research (CIHR) provide competitive scholarship and research awards to support the training and development of graduate students. I was fortunate to receive a three-year doctoral research award under the Clinical Research Initiative.

A Road Map for Understanding the Reflexive Nature of this Study

This participatory study addresses particular knowledge gaps in health services research. Although there is a sizable literature on NP role implementation, there is limited information in the literature about what will foster long-term integration and sustainability of the NP role. A new role might well be implemented in a particular setting, but whether it is actually integrated into the day to day functioning of the program and sustained in the organization over the long-term is open to question and the research is not clear on this. There is also limited understanding as to what constitutes IPC, yet my experience suggested that NP role integration in PHC depends on effective patterns of collaboration and teamwork. The literature indicated a real need for studies to conceptualize and explore both IPC and NP role integration. I set out in this PAR study to understand the context of NP role development, explore the theory and practice of IPC, and then explicate the relevance of IPC to advancing NP role integration. However, in order to explore these interrelated contexts and concepts, I needed to first understand this new formalized role of NPs and then conceptualize the concepts of IPC and NP role integration, as well as be clear about my view of PHC. Through a reflexive inquiry process, I examined the context of PHC, in which NPs in BC are for the most part situated, and characterized PHC as a principle-based approach to health services delivery. I explored the historical and political contexts of NP role development and, on the basis of the literature, differentiated four stages of NP role development: introduction, implementation, integration, and sustainability. I explored and explained the concept of IPC, and on the basis of my experience and an extensive review of the literature, I expanded the concept to comprise a broader conceptual framework, which I named as

collaborative culture. This framework guided part of my participatory inquiry with NPs and was subsequently revised in light of the inquiry. Finally, I addressed the research question: How does collaboration advance NP role integration within PHC? This study adds to the knowledge base of NP role development, and specifically uncovers NP practice patterns relevant to PHC, generates understanding about the meaning of NP role integration from the perspective of NPs, reveals the relevance of collaboration to NP role integration, and provides an analysis about the significance of the NP role to the profession of nursing and to health system improvement.

I employed PAR as the methodological approach for this study, and drew on a particular conceptualization of PAR to guide the study process. PAR as defined by Hall (2001) is “an integrated three-prong process of social investigation, education, and action designed to support those with less power in their organization or community settings” (p. 171). Thus, the study was a social investigation with NPs, to generate education and knowledge on collaboration and NP role integration, and to elicit action toward advancing NP role integration within PHC. However, in choosing PAR for a doctoral study, there were certain challenges. Participatory inquiry is an unfolding process with many uncertainties, and academic programs favor a definitive plan and course of action. As a student I experienced these tensions of endeavoring to honor the emergent process of PAR, while attending to academic requirements. To mediate these tensions, I adapted and applied Reason and Torbert’s (2001) framework of first-, second-, third-person action research.

In this modified form, first-person action research denoted a process of scholarly learning and self-inquiry that I refer to as *community of scholarship*⁴. This involved establishing my substantive knowledge base with respect to NP role development, PHC and IPC. And it included learning about PAR as an approach to research, and exploring assumptions and views that I brought to a participatory inquiry. Second-person action research was taken up in planning and implementing the study design in collaboration with NPs. This is where I entered into *community of practice*⁵, cultivated partnerships with relevant stakeholders, and formulated and initiated a realistic research plan. Third-person action research was about the *community of inquiry*⁶, in which I as researcher participant and NPs as participants came together as co-researchers in a collective process to add to the knowledge base of research and practice, and generate actions to transform practice and policy related to NP role integration in PHC.

Writing up of this dissertation study reflects my adaptation of the first-, second-, third-person action research framework for graduate study. The study is organized into eight chapters, and is written as an iterative translation that parallels the recursive nature of PAR, and is not a linear account of proceedings. Thus I have provided here a road map for the reader, as the research was taken up and written up in somewhat of a different format than typical doctoral studies.

⁴ Community of scholarship is a term coined by the author and in this study is associated with first-person action research to describe student scholarly efforts within the learning environment of an academic community (Burgess, 2006).

⁵ Community of practice is a term used in action research and in this study is associated with second-person action research to describe the student entering into a research partnership with practitioners who share a common interest (Reason & Bradbury, 2001; Friedman, 2001).

⁶ Community of inquiry is a term used in action research and in this study is associated with third-person action research to describe the student and practitioners engaged in collective inquiry (Reason & Bradbury, 2001; Friedman, 2001).

In Chapter 1, an overview of the study is presented, the reader is provided with a road map of this dissertation journey, and the context and issue of NP role development within PHC is introduced. I draw upon various knowledge bases to frame the NP context, and this includes my own practice reflections, as well as literature sources. I begin by summarizing PHC renewal efforts with respect to Canada and British Columbia, review historic and present day NP role development issues, and present the research question. Chapter 1 thus highlights the significance of this study, and the importance of explicating the interrelatedness of collaboration and NP role integration.

Chapter 2 is about first-person perspectives of a graduate student within a community of scholarship. In this chapter, I explore literature to formulate my understanding of PAR. The PAR inquiry framework of first-, second-, third-person action research is introduced. PAR is examined with respect to ontology, axiology, and epistemology and my self-reflective learning is documented. Chapter 2, as a first-person inquiry, provides theoretical grounding for Chapter 3, in which I outline the methodological design of the study.

Chapter 3 is about second-person perspectives and the entering into community of practice, in which I design and prepare for an inquiry with NPs. I discuss the process of situating myself as a researcher in the practice and policy contexts of advanced practice nursing and interprofessional initiatives. The promises and perils of PAR are uncovered and I explore parameters of research validity. The methodological design of the study is outlined, including methods I used, participant recruitment, inquiry logistics, and processes employed for data collection and analysis. Chapter 3 prepares the reader for three subsequent findings chapters generated by way of the study.

In Chapter 4, I examine the substantive topic of IPC. Through a reflexive progression of knowledge development, I integrated my practice experience with knowledge gained from a scoping review of the literature to re-conceptualize the concept of IPC. The literature has generally dealt with the concept of IPC as being about teamwork, but through this inquiry process, I transformed my understanding of IPC as a team concept to one that reflected a broader ecological framework. This understanding guided my inquiry of IPC with the NPs as part of the third-person stage of the research and was further refined on the basis of the findings from the NP inquiry. I have named this re-conceptualization of IPC as *collaborative health care culture*. A graphic of the final framework is provided and I describe the framework in detail. The chapter concludes with a description of collaboration with respect to collaborative culture.

The findings of this chapter had important implications for the research question guiding the study. As my understanding of IPC shifted to this broader conceptualization of collaborative culture, so did my understanding of the effects of collaboration and collaborative culture on NP role integration. Consequently, the study question shifted from “how does *IPC* advance NP role integration” to “how does *collaboration* advance NP role integration”. This change in the research question during the course of a study is not unusual in qualitative research (Glaser & Strauss, 1967; Marshall & Rossman, 1999) and reflects the evolving understanding of the phenomenon in question.

In Chapter 5, the model of *communities of practice* is examined. The two regional health authorities involved in the study employed communities of practice as an implementation strategy to support NP role development. A brief review of literature on communities of practice is provided to set the stage for the inquiry process and its

findings about the centrality of community of practice to foster role implementation and integration. Because the communities of practice were taken up differently by each health authority, a comparative analysis is carried out to explicate these differences. A collaborative model for communities of practice is described and implications for cultivating communities of practice are discussed.

In Chapter 6, the research question of “how does collaboration advance NP role integration” is examined by way of three queries. The NP inquiry first explores practice patterns of NPs in their diverse settings and positions. Findings show that NP practice patterns are closely aligned with PHC principles. Secondly, the inquiry explicates the meaning of NP integration, from the perspective of the NP participants and their organization leaders, and delineates characteristics and indicators. Thirdly, NP stories of collaboration uncover its foundational importance to NP role integration. Analysis reveals NPs are leaders of holistic client and community care, stewards of PHC renewal, and champions of collaborative culture.

Chapter 7 is about third-person perspectives and reflects on the actual community of inquiry process. The inquiry of two concurrent NP communities of practice is described and validity criteria to measure the quality and integrity of the inquiry are outlined. Inquiry criteria applied to the study include relational and participatory dynamics that enhance NP discussions, interpretation of participant data for knowledge development and educative outcomes, and significance of emergent actions taken up by the NP inquiry groups. Unexpected occurrences and limitations of the inquiry are disclosed; as well, my reflections about the PAR inquiry are shared.

In Chapter 8, I examine the political nature of the NP role. I examine my findings in relation to the larger body of relevant literature, and correlate how my study findings support, contradict, and add to the knowledge base. I bring forward the study title of “Finding a Balance” and review its significance to the findings of the inquiry. I translate these findings into recommendations for advancing NP role development. I also summarize the contributions this study makes and discuss the implications for the domains of research, education, practice and policy. Finally, I suggest possibilities for disseminating findings and creating enduring consequences for the study.

NP Role Development in BC

NP role development in BC is part of a national nursing strategy to formalize introduction of the NP role and ensure sustainability (Canadian Nurses Association [CNA], 2003c). However, the NP role is not new in Canada. NPs have made significant contributions to health concerns of rural and local communities for many decades, yet official sanction of the NP role has been fraught with barriers. In recent years, significant dynamics have transpired to compel national-provincial coordinated efforts in upstream health care (Canadian Institute for Health Information [CIHI], 2003; Health Canada, 2002; Kirby, 2002; Romanow, 2002; World Health Organization, [WHO] 2003, 2006). The NP role has consequently gained the favour of governments as part of a compelling agenda for PHC renewal, thus effecting support for a more formalized approach to NP role development. To account for the BC context of NP role development I draw upon various knowledge bases. I begin by reflecting on my own nursing practice experience, I use Canadian and BC literature sources to summarize PHC renewal efforts, and I examine historic and current-day NP role development issues from this national and

provincial perspective. Through this knowledge synthesis process, I make a case for the significance of this NP study and its focus on collaboration.

One of the difficulties in discussing NP role development is the interchangeable and confusing language used in the literature. Therefore, in the following discussion, I use the more generic and umbrella term of *role development*. With respect to this study, role development refers to the current formalized process of introducing, implementing, integrating and sustaining the NP role. Later in the chapter I provide a descriptive framework to delineate these various terms associated with NP role development.

Reflections from Practice

As a registered nurse and director of a community health centre (CHC) for many years, I participated in early BC developments and national networking related to the emerging NP role. The CHC model that we endeavoured to sustain signified our commitment to community participation and partnership, accessible clinical and social care, health promotion and community development, teamwork and intersectoral collaboration, and promoting these CHC ideals. These commitments mirrored the PHC principles recognized in Canada. Yet our CHC was continually under threat, as political, policy and funding support for this broad-based health care approach was limited, and research and evidence to advance its lobby was lacking. I had been drawn to the CHC by an NP who had an unprecedented appreciation and enthusiasm for community health. In those days she had an advanced diploma in northern nursing, was well integrated into a small urban neighbourhood, and had developed her own niche of expertise and a devoted client following. Her challenges were not in her everyday care of clients, but in having the confidence to practice outside the scope of nursing without legal sanction. The

physicians supported her practice by being available for consultation, signing off prescriptions and charts, and giving her clinical direction. However, they were often unclear about nursing scope and were ever ready to advise on all matters of client care, including that of nursing care. So boundaries of clinical consultation became blurred with nursing supervision, and required daily finesse on her part in order to keep some degree of nursing autonomy; collaboration was often compromised by overzealous physician oversight. Nonetheless, this NP pioneer and mentor taught me much about the art and science of nursing, in that she had genuinely found a balance in caring with, for, and about her clients and community. She moved seamlessly through her day of one-to-one clinical appointments, planning health promotion fairs and events, sharing her health knowledge with small community groups, teaching other practice nurses, advising on housing committees and social welfare lobbies, and collaborating with allied professions in a holistic approach to community health. She weathered ups and downs of the CHC movement, the politics of NPs attaining and losing ground, and many variations of program demands and delivery. Yet, she was able to graciously provide holistic care to prenatal moms and their babies, children as they grew up into adults with their own babies, and aging families as one generation moved into another. She retired after 30 years of being an NP in one small community, having for the most part, seen and been part of it all. As a pioneer NP she truly demonstrated the capacity of the NP role in PHC to improve the health of a local community. My experience of working with this exceptional NP mentor provided me with a vision of how the NP role could have significant effects with respect to the provision of holistic and upstream care, if the role was to be formalized and fully integrated within PHC sites and programs.

Primary Health Care Renewal

PHC renewal is meant to re-vision and re-structure a well-established national primary care system that provides illness-oriented and physician-based medical services (Barnes et al., 1995; CNA, 2005a; Romanow, 2002; Rachlis & Kushner, 1994). The primary care system was formalized as essential first-line medical care, as a result of a series of national commitments: the Hospital Insurance and Diagnostic Services Act of 1957, the Medical Care Act of 1966, the Canada Health and Social Transfer of 1969, and the Canada Health Act of 1984 (Allemang, 2000; Chalmers & Kristjanson, 1992; Storch, 2006). Universal access to medical and hospital services was thus firmly established. However, primary care as a universal health service has not kept up to the needs of a burgeoning aging population with chronic health issues, nor has it addressed the health concerns of marginalized populations caused by an ever-widening gap in socio-economic status (Hutchinson, Abelson & Lavis, 2001; Bloom & Canning, 2000). In addition, an aging workforce, a decline in the number of family physicians in favour of specialization, and an escalating health budget (in excess of 100 Billion nationally) have created additional strain and further compromised primary care access and health system sustainability. PHC renewal is thus intended to shift first line primary care toward a more comprehensive approach signified by principles of universal access and health equity, public participation, health promotion and population health, intersectoral collaboration, and appropriate technology and resources (Calnan & Roger, 2002; CNA, 2000a, c, 2003b; Health Canada, 2006a; WHO, 1978; 2003).

Attaining the promise of PHC is reliant on transforming a medically-oriented primary care system into inclusive and upstream community-based health care services.

The PHC principle of universal access and health equity is underpinned by a social justice agenda, in which social determinants of health, such as conditions of early childhood, education, employment, food security, housing, income distribution, and access to health care services, represent broad contextual factors that influence health status (Nutbeam, 1998; Public Health Agency of Canada, 2002; Raphael, 2003; WHO, 2003). However, addressing social determinants requires financial investment and significant intersectoral collaboration, which has been impeded by incongruent economic and social policies (Labonte, Polanyi, Muhajarine, McIntosh, & Williams, 2005).

Public participation is viewed as an expression of democracy and engaged citizenry and is considered vital to preserving a responsive health system reflective of public values (Abelson & Eyles, 2002; Romanow, 2002). In health care, citizen and community participation is meant to balance power with professionals and policy-makers (Stewart & Langille, 1995). Yet there is an absence of public dialogue and participation about what constitutes PHC, a limited vision as to how it will unfold, and a scarcity of research to inform participatory planning (CIHI, 2006a; Decter & Alvarez, 2003).

Health promotion is defined as “the process of enabling people to increase control over the determinants of health and thereby improve their health” (Nutbeam, 1998, p. 351; WHO, 1986). Health promotion is intended to improve social conditions and the provision of resources in order to reduce inequities and enable health for all. Health promotion is thus intended as a collective effort to improve health with respect to people, place, and policy. Despite Canada’s history and leadership in health promotion, this socio-ecological model of health promotion is readily sidelined by an individual lifestyle

approach that repeatedly gains favour with policy-makers (Hancock, 1996; Labonte & Penfold, 1981; M. MacDonald, 2002; Raphael, 2003; WHO, 1986).

Intersectoral collaboration represents a commitment to interprofessional team development, as well as working across sectors and networks to improve the quality of client-centred care (Barnes et al., 1995; Enhancing Interprofessional Interdisciplinary Collaboration in Primary Health care Initiative [EICP], 2005; Jones & Way, 2004).

However, a dominant medical culture, professional associations caught up in historic and present day power relations, and lack of health organization commitment to collaborative culture hinders intersectoral relations (Hall, 2001; Herbert, 2005; Oandasan, 2008).

Appropriate technology, particularly in the context of community, has been broadly interpreted to encompass all relevant health care resources such as funds, personnel, interpersonal relations, facilities, equipment, tools, techniques, and research (Stewart & Langille, 1995). Thus appropriate technology as a PHC principle includes infrastructure, resources, and service provider utilization to improve team effectiveness and create innovative models of care (Calnan & Rodger, 2002). Yet technology resources remain acute care focused; for instance electronic health record development has yet to produce an effective intersectoral client-centred tool that is relevant to community-based practice. As well, PHC infrastructure funding has been limited to pilot projects and short-term commitments, and has focused predominantly on support to physicians with less attention paid to interprofessional service provider utilization (Decter & Alvarez, 2003; Zelmer & Lewis, 2003).

In order to realize a principle-based transformation of PHC, Canada's health system needs to commit significant attention and resources to its ongoing advancement

(Chaudhuri, Brossart, Lewis, & White, 2005). These interlocking principles constitute a framework for advancing the PHC agenda, yet are largely addressed through separate and disconnected strategies. For instance, a Primary Health Care Transition Fund (PHCTF) of \$800 million over six years was secured by Health Canada in a First Ministers of Health agreement to support PHC renewal of provinces/territories (First Minister's Meeting, 2000; Health Canada, 2005). Federal funding targeted provincial demonstrations, as well as national projects to enhance PHC awareness, technological development, and research and evaluation (Decter & Alvarez, 2003; Health Canada, 2005; Zelmer & Lewis, 2003). As most provincial health services are devolved to regional service structures, demonstration projects were varied and organized within regional and local communities.

With respect to British Columbia, the provincial Ministry of Health oversees one provincial and five regional health authorities. Therefore, these federal funds were distributed to the BC Ministry of Health Services, where provincial health policies, goals, and directions were set, and funding was then dispersed to the six health authorities. The health authorities, in turn, drew up strategic plans and accounted for their respective PHC pilot projects (BC Ministry of Health Services, 2003). Practice models supported by the PHCTF within the health regions ranged from primary care physician practice networks, to shared care between physicians and other specialists and professions. Support to and evaluation of these pilots was limited, and policy change minimal. Despite the concerted efforts at national, provincial, and regional levels, PHC remains at a formative stage of development; the lack of a principle-based approach may have moderated these results.

The PHCTF has now ended, and there is concern as to whether the six-year federally funded demonstration projects created a tipping point to ensure continued

development (Russell, 2006). Some analysts express skepticism about short-term government renewal strategies, and note incremental policy approaches are likely insufficient to achieve transformative system change (Hutchinson, et al., 2001; Rachlis & Kushner, 1994). A 2003 First Ministers Accord, with a \$16 billion Health Reform Fund to target PHC, home care, and catastrophic drug coverage was expected to build upon the PHCTF initiatives; however national political changes have resulted in unconfirmed plans (Detsky & Naylor, 2003; Russell, 2006). Hence, it behoves the provinces and regional health authorities to sustain the momentum of PHC renewal.

Part of the difficulty in sustaining PHC renewal efforts is the lack of consensus about what constitutes PHC, and research to show its effectiveness. Research is needed to conceptualize and clarify PHC as a principle-based vision that will uphold stakeholder investment and foster wide-spread implementation. A Cochrane systematic review to assess the effects of strategies to integrate PHC services and improve health care delivery and health status identified only four studies (Briggs, Capdegelle, & Garner, 2001). Outcomes assessed included health care delivery service, user views of service coherence, and health status indicators, as well as comparative costs. The study concluded that future studies need to do more than describe the service delivery side and focus on measuring aspects of client views and outcomes. Two reports by CIHI (2006a) provide a broader view of PHC, and document 105 PHC indicators and data gaps and options for improving data availability. This indicates the comprehensive nature of PHC service delivery and the complexity in measuring multidimensional care. While Cochrane systematic review is the gold standard for evidence-based research, new research approaches also provide opportunity to develop broad-based knowledge, in which

stakeholder inclusion and consensus help to transform health service delivery.

Specifically, participatory action research and community-based research are noted as relevant to PHC (Hills & Mullett, 2005; Patten, Mitton, & Donaldson, 2006; Reason, 1991; Reason & Bradbury, 2001).

A History of Nurse Practitioner (NP) Progress

The NP role in Canada has suffered from a discontinuous history that dates back, depending upon viewpoint, as long as 300 years ago, with the Grey Nuns in Quebec (deWitt & Ploeg, 2005; Haines, 1993). The Canadian Nurses Association (CNA, 2008a) currently recognizes the NP role as one of two advanced nursing practice (ANP) roles; the other is the clinical nurse specialist (CNS). The CNS role emerged in the 1970s to provide clinical guidance and leadership in the acute sector in response to client complexity; however cutbacks over two decades have eliminated many of these positions. The NP role also got its start by the 1970s, as nurses extended their roles in response to rural and remote PHC needs, and early NP education programs focused primarily on rural and outpost nursing. However, a perceived oversupply of physicians, and lack of formalized legislation, regulation, and remuneration hindered continued progress and most education programs were closed (CNPI, 2005b; Haines, 1993; McIntyre & McDonald, 2006; Pearson & Peels, 2002). Without official sanction, pioneer NPs “flew under the radar” and kept a low public profile. Those who endured over time did so by establishing credibility with patients and partnering with physicians who delegated authority to carry out advanced medical acts (Brown & Draye, 2003; Draye & Brown, 2000; Fairman, 2002; Martin & Hutchinson, 1997, 1999).

The community health centre movement, especially strong in Ontario, was able to retain a number of these pioneer NPs; as well, NPs worked in northern outpost stations (Canadian Alliance of CHC Association, n.d.; Nurse Practitioner Association of Ontario, n.d.). Health reform initiatives in the 1990s, rekindled national interest in NPs, particularly related to PHC. The Council of Ontario University Nursing Programs developed a PHC focused NP program (van Soeren, Andrusyszyn, Laschinger, Goldenberg & DiCenso, 2000). Ontario, along with Newfoundland / Labrador, were first to enact NP legislation, regulation, and education. Over the next ten years all provinces / territories initiated NP roles, although regulatory requirements were inconsistent (CIHI, 2006b; CNPI, 2005a). Ontario's lead in formalizing the NP role has provided extensive knowledge, resources and lessons learned from research and practice leaders, which has helped to advance role development in other provinces (Bryant-Lukosius & DiCenso, 2004; deWitt & Ploeg, 2005; IBM, 2003; Irvine et al. 2000; Sidani, Irvine & DiCenso, 2000; van Soeren et al., 2000; Way, Jones, Baskerville & Busing, 2001; Way, Jones, & Busing, 2000).

Leadership from the CNA has also been a significant factor in fostering and formalizing NP role development. Through a CNA policy approach, delineation of a national NP position statement (2003c), a nursing leadership position statement (2002b), and an ANP framework (first released in 2000 and updated in 2002 and 2008) has helped to fuel and shape the NP role. The updated ANP framework outlines core competencies related to four domains of practice including: clinical, research, leadership, consultation and collaboration (CNA, 2008a). The CNA also sponsored the Canadian Nurse Practitioner Initiative (CNPI), which was funded by the PHC Transition fund in 2004 to

develop a pan-Canadian NP framework for fostering consistency of provincial legislation, regulation, and education (CNA, 2008a; CNPI, 2005a, 2006b). The CNPI (2006b) has provided considerable guidance with respect to NP role development including an updated description of the role:

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 health care 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. (p. iii)

In addition, the CNPI (2006a) designed an implementation and evaluation toolkit to assist provinces in NP role development. All provinces have initiated NP role development by way of legislation and/or regulation, and many have set or are shifting to graduate level education as the minimum requirement for NP entry to practice (CIHI, 2006b). The NP is the only advanced nursing role with additional regulation and title protection currently endorsed by the CNA (2008a).

Literature about Enablers and Barriers of NP Role Development

Despite recent progress, certain lessons can be learned from the literature about historical barriers and potential enablers of NP role development; knowing about past barriers helps to develop enabling strategies and prevent recurrent obstacles (McIntyre & McDonald, 2006). Bryant-Lukosius, DiCenso, Browne, & Pinelli (2004) identified six issues that must be addressed for successful introduction of advanced practice nursing roles: confusion about terminology; failure to clearly define roles and goals; issues of physician replacement and support; underutilization in practice; failure to address structural and policy factors; and limited use of evidence to guide role development and

evaluation. To counter these limiting factors, Bryant-Lukosius and DiCenso (2004) designed a nine-step participatory, evidence-based, patient-focused process (PEPPA) for determining the need for and the development of advanced practice nursing roles. The CNA (2006) identified additional strategies, including, communication and marketing plans, a Pan-Canadian Advanced Nursing Practice implementation plan to influence policy decisions, legislation and regulation, support of collaboration initiatives as an essential component, a focus on employers and human resource planning, and strengthening research and education.

A brief review of barriers and enablers particular to NP role development is presented here. Barriers and enablers are often tied together as opposites, for instance role ambiguity as a barrier responds to strategies of role clarity; inadequate funding mechanisms are countered by improved funding approaches; barriers of legislation, regulation, and education are attended to by structural policy changes; issues with NP reporting relationships are improved with innovative approaches to reporting; lack of evidence to support the NP role is addressed by capturing nurse sensitive outcomes; and problems with collaboration are offset by strategies that improve professional relations and partnerships. These barriers have threatened NP role development and sustainability, while enabling strategies serve to advance the NP role.

Ambiguity about advanced practice nursing roles and titles has been reported as an issue that causes confusion about the NP role (Bryant-Lukosius et al., 2004; El Jardali, 2003; Haines, 1993; Pauly et al., 2004; Pearson & Peels, 2002). The significant role overlap in nursing functions, yet lack of clarity about roles and responsibilities creates tensions among nurses within the profession. External to the nursing profession, allied

disciplines, stakeholders, and decision-makers also lack understanding of the NP role. Inter- and intra-professional strategies have begun to address the issue of role clarity in teamwork by emphasizing the need for practitioner communication and respectful relations; these strategies enhance NP role understanding (Health Canada, 2004a; Jones & Way, 2004). As well, lack of public awareness about the NP role has been noted as a concern (CNPI, 2006b), and is exacerbated by inconsistent access to NPs. Although NPs currently have government support in BC, and the CNPI generated some media attention, there have been few provincial efforts to remedy public awareness, and the general public remains unclear about the NP role. An enabling strategy would be to engage the public through media and education and enhance public understanding of the NP role, as well as increase public access to NP care.

Commitment to funding role development and designing effective remuneration mechanisms have been cited as a barrier (CNA, 2006; CNPI, 2005a; IBM, 2003; MacDonald, et al., 2005; Phillips, Harper, Wakefield, Green & Fryer, 2002). Provincial funding for role development includes infrastructure costs such as funds for policy and practice planning, start-up and ongoing support of roles, and evaluation and research costs. Remuneration mechanisms relate to the direct payment of NP services, and vary within and between provinces. Remuneration mechanisms indirectly influence work processes of client case loads and health interventions, as well as client and community measures and outcomes (Dontje, Corser, Kreulen, & Teitelman, 2004; Fooks, 2004; IBM, 2003; Phillips et al., 2002). For instance, the fee-for-service structures that have historically funded primary care were designed for physicians and a medically-oriented service and are not easily adapted for NP care models that have a socio-humanistic

dimension. Alternatives to fee-for-service, such as blended funding arrangements, block funding specific to NPs, and NP contractual arrangements have instead been trialed. Most NPs in BC are paid as contracted employees of health authorities and funding is dependent upon budget priorities and competing demands. NP advocates and leaders are paying close attention to the implications of funding and remuneration mechanisms.

Lack of legislation and regulatory structure has been noted as a significant historical barrier to NP role development and has received considerable national and provincial attention (CNPI, 2005a; IBM, 2003; El Jardali, 2003; MacDonald, et al., 2005; Schreiber, et al., 2005). Inconsistencies in legislation, regulation, and education across jurisdictions prompted the design of a national framework, in order to overcome past limitations of medical delegation and supervision (CNPI, 2006b). This NP framework provides recommendations for enabling structures and policies such as legislative title protection, regulatory scope of practice, legal / liability clarification, and education competency requirements. In BC, design of NP legislation, regulation, and education was based upon research and extensive stakeholder consultation and contributed to the development of the CNPI framework (BC Ministry of Health, 2005; CRNBC, 2005; MacDonald, et al., 2005; Schreiber, et al., 2005).

NP reporting arrangements are noted to have effects on work satisfaction, retention and role development (Almost & Laschinger, 2002; Reay, Golden-Biddle & Germann, 2003; Schreiber et al., 2003). Reporting relationships are tied to organization structure and culture and influence the degree of autonomy that practitioners have to fully enact their roles and scopes of practice. Healthy workplace environments are noted to foster NP autonomy, professional development, participation in decision-making, flexible

work hours, and career advancement (CNPI, 2006b). NP employment and reporting arrangements can vary. For the most part, NPs are employed by health organizations; however in some jurisdictions NPs are hired and supervised by physicians and remunerated through funds obtained from physician billing practices. In BC, NPs are predominantly under employment agreements with health authorities, in which reporting relations are assigned to site physicians, nurse managers, and/or other health disciplines. In addition, NPs report directly to the chief nursing officer of their respective health authority; this reporting relationship was designed as an enabling and safeguard feature of role development.

There is need for more evidence to show the value-added contributions of NPs, and this has been cited as a limitation of role development (Barton, Baramée, Sowers, & Robertson, 2003; Breslin, Burns & Moores, 2002; Ingersoll, McIntosh & Williams, 2000; Schreiber et al., 2003). Value-added refers to the unique contributions that NPs make to client care and outcomes, separate from other contributing members of the team. Determining the value-added contributions of NPs helps to affirm that NPs are complementary to other professions and roles, and counters the view that NPs are physician replacements. Studies have mostly compared NP and physician care and not focused on the value-added contributions of NPs. For instance, a systematic review by Horrocks, Anderson, and Salisbury (2002) compared NP and physician care, related to patient satisfaction, health status, costs and process of care. The study included 11 randomized controlled trials and 23 prospective observational studies and found patients more satisfied with NP care and the quality of care marginally improved by NPs. NPs provided longer consultations, more investigations, and more information to patients; no

difference was found in prescribing patterns or referrals; however economic analysis was incomplete. The CNPI also cites a number of studies of NP collaborative models showing evidence of improved public access to quality cost-effective care, client satisfaction, and health outcomes equal or superior to physician service (CNPI, 2006b; Jones & Way, 2004). There are a few recent studies related to NP outcomes in acute care, but there remains a need for further research with respect to NP value-added contributions in PHC.

Many of the barriers noted thus far relate to inadequate systemic and structural designs; and some of these barriers are being addressed by enabling strategies. However, the NP role continues to need clarification, as other professions and the public still have misunderstandings. Small numbers of NPs limit public access and professional interactions and this adds to the slow acceptance and understanding of the role. Lack of funding to resource role development and initiate new roles needs to be further addressed; effective remuneration mechanisms will enable development. Legislative and regulatory progress has been significant; although some provinces could benefit from further improvements and all provinces need to continue adjusting regulations to align with the realities of practice. Reporting relations for NPs need to be monitored and adjusted to again support NPs in practice. Finally, there is a need to further develop the NP research base to inform role development and generate practice evidence.

NPs and Collaboration as an Issue

In addition to systemic and structural barriers there are also process barriers that hinder NP role development. Collaboration has been cited as a significant issue in the literature, and studies have particularly focused on the physician – NP relationship (Bailey, Jones, & Way, 2006; DiCenso & Matthews, 2005; El Jardali, 2003; IBM, 2003;

Jones & Way, 2004; Ontario Medical Association [OMA] and Registered Nurses Association of Ontario [RNAO], 2003; Way, et al., 2001; Way, et al., 2000). This attention to physician – NP collaboration reflects the historical tensions that came about as NPs expanded their scope of practice and increased the overlap with medicine. NP clinical advancement led to territorialism by some physicians and their medical associations, resulting in animosity in practice relations (Hallas, Butz, & Gitterman, 2004). The medical profession's reluctance to accept the expanded scope of NPs discouraged physicians from entering into partnership arrangements. This had an impact on NP practice and role development, as NP pioneers depended upon physician teaching, supervision and oversight (Draye & Brown, 2000; Hamric, Spross, & Hanson, 2000; Jones & Way, 2004). Consequently pioneer NPs had to establish individual relationships with physicians to secure practice agreements and arrange practice oversight. In the early goings, authorization and regulation of NP practice was done by practice agreements that allowed NPs to rely on medical supervision, consultation or delegation of medical acts. Although positive relationships developed by way of these partnership agreements, there remains today reluctance by medical associations and physicians to enter into collaborative partnerships.

Progressive legislation and regulation has increased NP autonomy and scope, yet there is still considerable reliance on physicians to support NP role development. In BC for instance, NP students must rely on physicians for practice instruction, because of the inadequate number of NP educators and mentors available to teach in education programs. NP graduates are also reliant on physician mentoring and consultation until they attain practice expertise and the autonomy of full scope. Improved legislative and

regulatory status of NPs has lessened dependency on physician oversight; however, physicians are still very much called upon for NP practice education and role transition, and for collaborative arrangements that support NP practice.

Four Ontario reports and studies are discussed here as they pertain to barriers and enablers of collaboration. I have drawn upon Ontario research, because this province has over ten years of leadership in NP role development. The first report noted is a discussion paper by El Jardali (2003), who was commissioned by the CNA to examine barriers of collaboration between NPs and family physicians. Structural issues were identified including legislative, regulatory, economic, educational and medico-legal barriers. As well, a barrier related to perceptions of independent versus interdependent practice was raised and issues of role misconceptions and varying meanings of collaboration were identified.

The second is a study commissioned by the Ontario Medical Association and Registered Nurses Association of Ontario (2003) and conducted by Goldfarb Intelligence Marketing of the RN extended class-GP relationship. The study consisted of one-to-one and joint interviews with physicians and NPs to assess the nature and extent of collaborative relations and identify best practices to optimize relationships. The study noted involvement of 32 participants but lacked methodological detail about how interviews were carried out. Almost all participants said they had good working relations. NP practice was viewed by some participants as different from physician care, because of the nursing approach to care, and by others as the same as physician care, but with less scope. The need for a clear understanding of roles was identified and four particular models of patient allocation in shared care were described, including: NPs have a

separate client practice and refer to physicians as necessary; NPs take all clients, while physicians restrict practice to complex cases; NPs restrict practice to straightforward care, while physician practice is varied; and NPs and physicians both have varied practices and consult as necessary. The last option was found to be most satisfying to both parties. This study also documented nine themes that enabled collaborative relations including: mutual respect and trust, recognition of unique expertise of NPs, understanding NP scope of practice, good team structure with limited size, understanding of legal responsibility, dealing with hierarchy, NP experience and skills, NP contribution to client access, and shared values. Barriers identified related to NP funding and regulatory limitations. NPs described the relationships as consultative and hoped more collaborative non-hierarchical relations would evolve.

The third is a study conducted by IBM Business Consulting Services (2003) and commissioned by the Province of Ontario to determine how best to integrate NPs into PHC. The IBM study examined barriers and facilitators of NP integration and various models of practice. The study consisted of a four mail-in surveys. The NP survey included demographics, and two scales: the Misener NP job satisfaction scale and the Jones and Way scale for collaboration. The sample consisted of 476 nurses with the designation of RN (extended class), which is the Ontario sanctioned title for the equivalent role of NP, and analysis represented 253 practicing PHC NPs. A survey for physicians working with NPs, was mailed out to 500 and 225 surveys were analyzed. Another survey for physicians not working with NPs was randomized and sent out to 1600 and 492 surveys were included in the analysis. A patient survey was also distributed as part of 27 site visits, in which interviews were conducted with NPs and team members.

For patient surveys, 260 were included in the study. The study did not define the concept of integration; instead the NP role was examined in relation to integration domains that included practice setting, extent of provision of care, decision-making, workplace satisfaction, and collaboration and team dynamics. As the term of role integration seemed to mean factors that facilitated all aspects of NP role development, I report here on the findings specific to collaboration and team dynamics, as these are meaningful to my study. The IBM study found that team dynamics are important to the successful integration of an NP. In organizations in which NPs were found to be successful team members spent time devoted to dealing with team issues. The study concluded that key enablers for successful teams with an integrated NP position included: respect for one another, easy conflict resolution, all team members understand each other's role, team members are willing to help each other, and there is institutional memory of the organization's collaborative culture. Barriers to collaboration were identified as attitudinal issues of physicians, lack of role understanding by all stakeholders, lack of clarity with respect to collaborative relations and practices, and continuity of care issues including limited fraternity with specialty physicians. From my perspective, the study conceptualized collaboration based upon literature and survey questions that related to team dynamics and although the study was sound in methodological design, the findings on collaboration were somewhat limited and incomplete.

The fourth paper I examine was written by Jones and Way (2004) and commissioned by the CNPI and was essentially a literature review to help make recommendations regarding collaborative practice models. The authors employed this definition of collaborative practice:

Collaborative practice is an interprofessional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided. (Way, Jones and Busing, 2000; and used by Health Canada, 2004a)

They examined key components of this definition, as well as collaborative practice determinants including provider, patient, organizational and systemic determinants. Provider determinants included elements of cooperation, assertiveness, responsibility / accountability, autonomy, communication, coordination, and mutual trust and respect. I found it difficult to discern the differences between the terms cooperation, coordination and collaboration. Patient determinants were limited in discussion. Organizational determinants included structure and philosophy, team resources and administrative support, as well as communication and coordination mechanisms, and these were useful to consider. Macro-systemic determinants included social, cultural, educational and professional systems, and this broader view was congruent with my thinking and understanding about collaboration. The authors also reviewed and described 12 interprofessional models or frameworks sourced in the literature over the past decade, and introduced their own design of a collaborative practice model. The Jones and Way review begins to uncover the complexity of collaboration, in that the determinants and models identified show the interrelatedness of micro, meso and macro influences on collaboration, and thus goes beyond the typical internal team dynamics that are discussed in much of the literature.

These studies provide an initial knowledge base about NPs and physician collaboration. However, NP role development in PHC relies on a broader view of teamwork and collaboration. Role development requires collaborative relations with nursing colleagues and the nursing profession, client and community partnerships, and

system and organization leaders (CNPI, 2006b; DiCenso & Matthews, 2005). There is a lack of literature about NPs and inter-professional collaboration that encompasses a broader view of allied health practitioners. As well, there is little research related to NPs and intra-professional collaboration that occurs among practitioners in various nursing roles. Literature is also lacking with respect to NPs in collaboration with health leaders, and with client and community partners. Further NP research is needed to examine a more expansive view of collaboration that takes into account a full team context, not just collaboration between NPs and physicians, as is the case in most studies of NP collaboration. It will also be important to consider organizational and system influences on the nature of collaboration, and the involvement of clients and communities as part of the definition of collaboration.

Understanding the Meaning of Role Integration

In exploring the NP literature, I realized the lack of consistency in the use of terminology with respect to NP role development; numerous terms were used and none were defined well enough to enable me to proceed with my research question. The discourse with respect to NP role development needed clarification. Role integration was the term that I wanted to use for this study, as I conceived role integration to be related to the NP experience within their practice settings. However, there was limited research on this aspect of NP role development and a lack of consistency in how the terms were used in the literature. Nonetheless, there were a few studies and sources to draw upon to help understand dimensions of role integration, although there was inconsistency in the use of the terms within these particular sources.

A study by DiCenso and Matthews (2005) on integration of PHC NPs into the province of Ontario examined barriers, enablers and models that support NP integration into practice settings. The authors essentially applied the “domain” parameters of integration set out by the IBM (2003) study and described these domains as: internal influences on the NP role within the practice setting, external influences impacting NP ability to provide patient care within scope of practice, NP independence and autonomy in decision making, NP workplace satisfaction, and collaboration and team dynamics.

The Canadian Nurse Practitioner Initiative (CNPI, 2006b), sponsored by CNA and funded by the PHC Transition Fund, was established to identify strategies and mechanisms for integrating and sustaining the NP role. The focus of the CNPI was to create a framework that fostered a consistent approach to the NP role development across provincial/territorial jurisdictions. Elements of the framework included information on legislation and regulation; standardized education programs, examination, and credentialing; core competencies and assessment; definition, role description, title protection, and liability; collaborative approach to practice; HHR planning; and strategic communications; as well as an implementation and evaluation tool kit to augment role development planning. This initiative did not clearly define or set parameters of role integration, but certainly discussed many aspects of role development including factors and recommendations for NP integration into practice settings.

In addition, I found a few sources that examined influences of NP role integration and sustainability. A study by Reay et al (2003) reported on research from Alberta, and examined leadership strategies to facilitate NP introduction and sustainability within practice settings; however the authors did not use the specific term of role integration. A

study by Gould, Johnstone and Wasylikiw (2007) reported on a study from New Brunswick, in which they explored NP perceptions of acceptance by patients and resultant professional satisfaction as an indicator of NP integration. Browne and Tarlier's (2008) paper made a case for NPs to take up a critical social justice perspective to foster role sustainability. Main, Dunn and Kendall (2007) examined barriers to NP integration in PHC within a UK context, and identified organization issues of autonomy and funding, and cultural issues and boundary tensions particularly between medicine and nursing. The lack of specificity about the meaning of role integration was problematic for this study. As a result, early in the study, I identified various NP role development terms and differentiated them relative to jurisdictional contexts. I then built into the study design certain questions for the NP inquiry groups that would determine from their perspective the meaning and parameters of NP role integration, and this became part of the findings of the study.

Discourse and NP Role Development in BC

The concept of role development was unduly complicated by the sometimes interchangeable use in the literature of the terms role introduction, implementation, integration, and sustainability. Thus for this study, I differentiated among these terms. To begin with, I have used the term *NP role development* as an umbrella term to encompass the other terms mentioned above. For the terms of introduction, implementation, integration, and sustainability, I have defined these relative to the jurisdictional contexts that have responsibility for specific activities related to each term. The term *NP role introduction* refers to those initiatives and the associated accountability set out by provincial governments, professional regulatory bodies, and educational institutions. The

term *NP role implementation* pertains to the responsibility and strategic actions of health care organizations to create and implement a new health professional role within their jurisdiction. The term *NP role integration* relates to plans and measures to successfully assimilate NPs into diverse health program settings, such that their practice becomes a valued part of day-to-day functioning with the setting and organization. Finally, the term *NP role sustainability* refers to the successful implementation and integration of a broad base of NPs, and the NP role becomes integral to health system performance and efficacy. I have used these terms accordingly to portray and document the BC context of NP role development, as follows:

Provincial introduction of the NP role has now taken place in British Columbia, based upon research and extensive stakeholder consultation (BC Ministry of Health, 2005; CRNBC, 2005; MacDonald, et al., 2005; Schreiber, et al., 2005). Government legislation in 2005 amended the BC Health Professions Act to give the College of Registered Nurses of BC (CRNBC) the mandate to regulate its members, including NP title protection and delineation of the scope of practice (CRNBC, 2005; 2006; 2008c). The Act also introduced “shared scopes of practice” to reflect professional overlap in a team approach to health care (BC Ministry of Health, Services 2007a, c). BC Universities initiated NP graduate level education programs (BC Ministry of Health, 2005; CRNBC, 2008b; MacDonald, et al., 2005; Schreiber, et al., 2003). The Ministry of Health provided policy direction and three-year funding to initiate regional NP expansion (BC Ministry of Health Services, 2008). Nonetheless, other provincial jurisdictions, as well as midwifery in BC, indicate that ongoing provincial commitment and support is needed to ensure NP role development (Jones, & Way, 2004; Kornelsen, Dahinten, & Carty, 2003).

Regional implementation of the NP role is occurring in all six health authorities in BC and varied models and approaches to implementation are being used. Generally, each region has created job descriptions, hired NPs, and developed policies and processes to facilitate and support NP roles. At the time of this study, each health authority region had 10-15 NP positions implemented (CRNBC, 2008a). According to the literature, researchers suggest that successful implementation is contingent upon a systematic evidence-based approach to ascertain health service needs, design relevant NP positions, and assure operative policies, procedures, and resources (Bryant-Lukosius & DiCenso, 2004; Bryant-Lukosius, et al., 2004; DiCenso, Ciliska, & Guyatt, 2005). Lack of role clarity, unprepared team settings, and problems with collaboration are noted to limit NP role effectiveness (El Jardali, 2003; OMA & RNAO, 2003; MacDonald et al., 2005; Pearson & Peels, 2002; Schreiber, et al., 2003). Resultant effects on practitioner job satisfaction and retention, practitioner utilization, and patient outcomes are cited as consequences (Almost & Laschinger, 2002; Bryant-Lukosius, et al., 2004; Hughes, 2005; IBM, 2003; Martin-Misener, McNab, Sketris, & Edwards, 2004; Sidani, et al., 2000). To assure success of NP role implementation, many issues must be addressed, such as organization and program goals clearly defined to facilitate NP roles, medical profession acceptance and patient awareness, ongoing funding and policy endorsement, and operational policies and procedures to assure effective utilization of NP scope and role enactment (Bryant-Lukosius, et al., 2004; de Witt & Ploeg, 2005; Gould, et al., 2007; MacDonald & Katz, 2002; MacDonald et al., 2005).

Program integration of NP roles relies initially on health setting preparation to receive and support new hired NPs (Almost & Laschinger, 2002; Sidani et al., 2000;

Reay, et al., 2003; Stole, Hillier, Esbaugh, Griffiths & Borrie, 2006). This includes clear job descriptions, education of colleagues and clients on varied roles and scopes of team members, planning of care responsibilities and negotiation of overlapping and unique skills, and technology to support NP roles and teamwork. NP integration relies on program leadership to support individual NPs and their extended autonomy, and organizational commitment to assure ongoing funding, policies, and infrastructure for NP integration (DiCenso & Matthews, 2005). As NPs settle into their program settings and roles, gain confidence in their competence and extended autonomy, their presence and modeling of holistic care creates an ambience to reinforce PHC renewal efforts (Gould, et al., 2007; Pogue, 2007). Program integration of the NP role is further advanced by collaborative culture, evidence-based team practice, and strong client and community partnerships (Bailey, et al., 2006; Barr, et al., 2003; Bryant-Lukosius, et al., 2004; El Jardali, 2003; Gould, et al., 2007; Health Canada, 2004a; IBM, 2003; Jones & Way, 2004). Acquiring evidence of the NP role as value-added substantiates NP integration and influences health authority policy and decisions to increase the number and spread of NP positions.

System sustainability of the NP role is contingent upon incremental and secured funding of NPs. As enough NP positions are created and embedded in diverse settings within the health care system, a critical mass will be attained. Yet, in order to reach this tipping point, governments and health organizations must maintain ongoing interest and this continued endorsement is dependent upon the NP role being perceived as integral to system efficacy. Political, policy, and organizational leaders and champions are essential to NP role development (McIntyre & McDonald, 2006; Reay et al., 2003). Maintaining

political allies and endorsement relies on public support of the NP role; yet public support depends upon public awareness of the NP role and its effectiveness. Public image can be enhanced by media and public awareness campaigns, and increased dialogue about the breadth and diversity of NP roles (CNPI, 2006b). Evidence of role effectiveness also contributes to NP sustainability (Gardner, 2004). As NPs become recognized and valued for their unique and effective contributions to health care, the NP role will gain stature. At the same time, positioning the NP role as an essential team member and a champion of team-based care contributes to the expansion of teams and PHC models of care (Dontje et al., 2004). By linking the NP role to PHC sustainability, NP sustainability is advanced.

The Research Question

The NP role represents the first official professional role to be adopted nationally by each province/territory to augment physician primary care practices; therefore the NP role is particularly suited to contribute to PHC renewal efforts (CNA, 2003c; CNPI, 2006b; CRNBC, 2005). With advanced nursing education and advanced clinical competencies, NPs are able to combine socio-humanistic and bio-medical knowledge and skills to provide comprehensive and holistic evidence-based care (CNA, 2003c, 2005b, 2008a; CNPI, 2006b). The NP role creates capacity to extend access to health services and address health inequities, enhance client and community relations, promote health innovation, and advance collaboration with other professions (Bailey, et al., 2006; Jones & Way, 2004; Martin-Misener, et al., 2004). NPs, as advanced practice nursing leaders, are also well positioned to pave the way for integrating other professional roles, such as pharmacists, social workers, midwives, so that PHC teams can be truly realized. Advancement of the NP role is consequently significant to health service improvement.

Given that PHC is reliant on a team approach to care, and effective teamwork depends upon collaboration, a research study about NP role development and IPC was of particular interest to me. Previous studies from other provinces had predominantly focused on NP – physician collaboration, and although these studies provided a sound base, there was little literature about NPs and collaborative relationships with other professional groups, clients or communities. Also, BC had some notable differences, in that legislation and regulation had formalized the NP role to reflect a high degree of autonomy and a broad scope of practice, relative to many of the other provinces. This means that NPs are not reliant on physician oversight or supervision and do not require the delegation of medical acts to diagnose and treat clients. The autonomous nature of NP practice also means there is great potential for NPs to partner more readily with other professions. In addition, it was important to begin to establish a NP research base relevant to the BC context. The research question of “how does *interprofessional collaboration* advance NP role integration” was designed to capture the story of NP collaboration, as well as show the importance of collaborative relations in establishing and securing the NP role within PHC. I also wanted to ensure there was a strong NP voice and direction in this study, so I chose PAR as the approach. I fully expected that NP inquiry discussions would centre on team relations. I understood that team relations were affected by internal and external conditions and so I anticipated the discussions might go beyond team dynamics. However, the NP inquiry groups discussed collaboration in a much broader context than the team; they focused on clients, communities, colleagues, managers, leaders, and even politicians. So, part way through the inquiry process, I shifted the question to reflect this reality, and the question became

“how does *collaboration* advance NP role integration”. Although seemingly a subtle difference, it enabled the inquiry groups to engage in discussion and actions beyond the team realm.

In Conclusion

The NP role is currently in favour in BC health politics, and NPs are striving to gain recognition and substantiate a valued role in PHC. Research can clarify and address issues of NP role development and benefit various stakeholder agendas. Health services research offers a way to examine parameters and effectiveness of new professional roles and new care delivery models, and provides direction for responsive system adaptation. Effective collaboration has been noted as an enabler to NP role development, and alternately, lack of collaboration as a barrier. However, research about collaboration has mostly focused on the NP - physician relationship, and very little is known about how collaboration at the interprofessional, community, leadership, and system levels impact NP role development. In addition, further research is needed to understand and advance NP role integration. The considerable efforts of the CNA and CNPI to catalyze national and provincial NP role introduction, and the work of provinces and health authorities to initiate NP role implementation should be highly credited. It is timely to focus on NP role integration within organizations and programs. I now turn to focus on PAR as an approach to research and draw on literature to ground the theoretical and methodological foundation of the study design.

Chapter 2

Participatory Action Research in a Community of Scholarship: First-Person Perspectives of a Graduate Student

As a doctoral student I had a deep sense of knowing that participatory action research was the right choice. My determination grew stronger with each disdainful comment or question: “PAR is too long and involved for a student. Focus on your question and methodology will follow. Does PAR really teach a student about research methods? How will you defend issues of validity and credibility at a doctoral level?” (Personal reflection)

Participatory action research (PAR) is gaining acceptability in many university circles (Bryant-Lukosius & DiCenso, 2004; Hall, 2001; Herr & Anderson, 2005; Kelly, 2005; Reason & Marshall, 2001). Yet from a graduate student perspective, there are tensions and challenges to reconcile. As an adult learner returning to the academy for doctoral studies, I came up against these tensions, and was compelled to explore the discord. The first tension emerged when I confronted the status hierarchy in the academy. From my practice of community health nursing, I was knowledgeable in the varied ways of community networking, and was considered a leader and innovator. Returning to school as a student shifted my status from community leader to novice scholar. The hierarchies of academia challenged my sense of identity and confidence; matters of “who I was, what was important to me, where I was headed, and how I could hold on to my community roots” were ever present.

The second tension I faced related to my own nursing status. My community of interest for a PAR study was nurse practitioners (NPs). The Health Professions Act was amended in 2005 to accord NPs reserved title and actions specific to their scope of practice. This new formalized advanced practice role created unease for me related to where I fit within the expanding hierarchy of nursing and the variable status accorded to

each 'rank'. Did my many years of experience and expertise as a community health nurse count as advanced practice? Would I have insider status in an inquiry with NPs? These questions about how I would create an equitable research partnership with NPs caused me some concern.

The third challenge surfaced with my commitment to PAR. Graduate study requires the student researcher to demonstrate research proficiency, identify a research question, design a proposal and obtain university ethics approval prior to actively engaging in a community partnership (Gibbon, 2002; Herr & Anderson, 2005; Levin & Greenwood, 2001; Reason & Marshall, 2001; Stoecker, 2003). Contrary to PAR, by taking control of the research process, I risked jeopardizing a defining principle of participatory inquiry; that is, begin with real-life issues that originate in and are identified by the community of interest (Greenwood & Levin, 1998; Hall, 2001; Reason & Bradbury, 2001). Tensions surfaced as to how I could employ PAR, while attending to the methodological demands of a doctoral study. As I explored the PAR literature, the perspective of "first-, second-, and third-person action research" presented an appealing and logical framework that allowed me to address these challenges.

First-, Second-, Third-Person Action Research

A first-, second-, third-person action research framework, formulated by Reason and Torbert (2001), provided a useful guide to develop my own process for integrating the stages of graduate student research. Reason speaks of action research as an emergent process that begins at the "initial moment of inception...and continues well after any formal research is complete" (2006, p. 189). In this sense PAR became feasible for graduate study and I adapted and applied this action framework, and this assisted me to

adjust my process to meet student obligations and limitations. For graduate study, the first-person action stage of self-reflective inquiry paralleled that of the action research framework; however I modified the second and third-person stages to accommodate for the realities of graduate study. Reason and Torbert describe second-person action research as face-to-face engagement with an inquiry group to develop and implement an inquiry plan, and third-person action research as incorporating a wider community of inquiry to awaken and influence policies and practice. Bradbury and Reason (2003) discuss the integration of first-, second-, third-person action research, and the importance of working in at least two of these modes at any given time. The stages of first-, second-, third-person action research are not linear, but overlapping, and thus fluid and adaptable to situational context; this afforded me some authorship leeway to adapt the process for graduate student application. It also provided an organizing framework for writing up the findings of the study in a way that honoured the process.

Thus, in this study the following description of first-, second-, third-person action research was applied, and this shaped a methodological framework for my dissertation. First-person research enables the student, situated within a *community of scholarship*, to develop a knowledge base with respect to a research approach and substantive areas of study. I focused on PAR and engaged in a self-inquiry process to articulate and be transparent about my assumptions and then make sense of my multiple roles and worldviews. As well, I developed my substantive knowledge in NP role development, the context of primary health care (PHC), and interprofessional collaboration (IPC) and collaborative culture (Burgess, 2006; Herr & Anderson, 2005; Marshall & Mead, 2005; Torbert, 2001). Second-person research facilitates the student researcher to situate within

a *community of practice*, and denotes efforts undertaken to gain understanding and expertise with respect to the specific context of the study, and then cultivate community partnerships in preparation for and initiation of a PAR inquiry (Bradbury & Reason, 2003). In this second-person phase, I entered into the NP practice community, formulated my research partnerships, and designed and initiated my study. Third-person research takes form as the researcher and participants engage in a *community of inquiry*, and enter into a combined reflexive endeavour of creating knowledge and engaging in action for wider organizational influence (Friedman, 2001; Reason & Torbert, 2001). In this third-person phase I partnered with two NP inquiry groups to generate knowledge and actions for health care improvements.

Chapter 2 highlights my journey of first-person action research, in which I explored the literature related to PAR and embraced the tensions of personal transformation within the hegemony of academia, and created a path to engage early in my research inquiry, prior to formalizing a research plan. First-person action research within a *community of scholarship* revealed ontological perspectives and fostered reflective practice and participatory understanding, which provided a foundation for a PAR study. I explored my beliefs about a participatory worldview and the formative and generative nature of PAR. I examined my values and assumptions about power and control, and I clarified my professional sense of insider-outsider status. I revealed epistemological understandings of knowing and the nature of evidence, and strengthened my commitment to the PAR process. I subsequently published these first-person understandings and reflections of a graduate student in the *Action Research Journal* (see Appendix A).

Theoretical Underpinnings of Participatory Action Research

Making sense of critical discourse in research terminology is a beginning place for graduate students. PAR as an approach to research falls under the rubric of action research. Credit is first given to Lewin in the 1940's for coining the term "action research" to link cycles of theory, practice, and problem solving (Greenwood & Levin, 1998; McTaggart, 1997; Minkler & Wallerstein, 2003; Reason & Bradbury, 2001). Freire (1970, revised 1993) contributed to this conception of research through advancing critical consciousness (conscientization) and social action (praxis) in his work with oppressed Latin American communities. Reason and Bradbury (2001) offered a working definition, "action research is a participatory, democratic practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview" (p. 1). Specific to participatory action research, Hall (1981, revised 2001) defined PAR "as an integrated three-pronged process of social investigation, education and action designed to support those with less power in their organizational or community settings" (p. 171). Fals Borda (2001) referred to PAR as a philosophy of life, and described it as a "*vivencia* necessary for the achievement of progress and democracy; a complex of attitudes and values that would give meaning to our praxis in the field" (p. 31). McTaggart (1997) also employed the term of PAR to emphasize authentic participation and relevancy of actions. Other variations of action research are described in the literature, and several other terms are used such as cooperative inquiry, emancipatory action research, appreciative inquiry, feminist participatory research, and community-based participatory research (Heron, 1996; Kemmis, 2001; Ludema, Cooperrider & Barrett, 2001; Maguire, 1987; Minkler, & Wallerstein, 2003). Each of these has its own nuances, but there are some common core

elements, including a participatory inquiry process to address real life issues, co-generation of knowledge that incorporates diverse perspectives, construction of meanings that lead to action, and an aim that participants gain more control over their situation (Levin & Greenwood, 2001). These common core elements are reflected in my own process of engaging in PAR.

Ontology: A Participatory Worldview

A participatory worldview places human persons and communities as co-authors and co-constructors of their world (Reason and Bradbury, 2001). Individual participants are viewed as social beings and by a reflexive process of individuation and socialization socially construct meaning (Kemmis & McTaggart, 2005). Through interactive relationships, people formulate and re-formulate meaning, and knowledge is generated and educative processes take place. A participatory worldview is also viewed as emancipatory, in which people engage in critical understanding with each other, and reveal the nature of wider social structures (Kemmis & McTaggart, 2005). Inquiry helps people to uncover power relations, injustices, and oppression, and serves to mobilize collective action. The reflexive participatory process enables people “to investigate reality in order to change it and to change reality in order to investigate it” (Kemmis & McTaggart, 2005, p. 567). Theorizing takes place through a process of exploring individual and social practices, knowledge about these social practices, social structures that shape and constrain social practices, and discourses in which social practices are represented or misrepresented. In this way, participatory research aims to transform both theory and practice.

PAR and Critical Social Theory

PAR has roots in critical social theory. Critical social theory seeks to explore and explain how social, political, cultural, economic, ethnic, and gender values shape the construction of a situated experience (Guba & Lincoln, 2005; Kincheloe & McLaren, 2005). Through PAR the local experience of individuals and groups are interpreted with respect to issues of power, justice, discourses, and social structures to reveal contradictions and distortions (Kincheloe & McLaren, 2005; Schwandt, 2001). This process of critical reflection and analysis brings about critical enlightenment of how social systems control local experiences, fosters emancipation as participants become empowered with knowledge, and generates actions to effect individual and social transformations. In this respect, PAR encourages participants to critically reconsider taken-for-granted assumptions of the social world, re-evaluate cultural, historical, and social conditions, and intervene in ways that disrupt the dominant social order.

For this study, PAR is applied using Hall's (2001) definition, which highlights three dimensions of social investigation, education, and action. Hall's perspective on PAR comes from international and third world work and is rooted in his understanding of social movements and civil society. PAR with respect to this definition is meant to open up communicative space to foster democratic social relationships, learning and theorizing about the world, and engagement in the power and politics of transformative action (Reason, 2006). The first dimension of social investigation is grounded in beliefs of community participation and inclusion. Social inquiry generates a deeper sense of equitable relationship, as authentic collaboration and collective ownership takes hold (Baum, MacDougall, & Smith, 2006; Bradbury & Reason, 2003; McTaggart, 1991;

Reason & Bradbury, 2001). PAR embraces inclusive participation and varying views, in contrast to the conventional research tenets of control and exclusivity (Reason & Bradbury, 2001). PAR, when taken up within the context of university and workplace partnerships, is often concerned with issues of discourse, practice, power, and culture.

The second dimension of education draws attention to the aim of PAR to inspire participant enlightenment and critical consciousness by way of collective engagement (McTaggart, 1991). Participants share their experiences and wisdom, and collaborate to theorize about their practices. Learning about and theorizing the world constructs knowledge to advance theory and practice, empower participants, and affect conditions of culture (Bradbury & Reason, 2003). In this sense, the co-construction of knowledge links practice to politics and reveals the interrelated complexity (Hall, 2001; McTaggart, 1991). PAR in the context of worker knowledge fosters theorizing about work issues and interrelated structures, policies and politics.

The third dimension that shapes PAR is that of action. PAR is viewed as a political process, and involves critical analysis of situations that interface with larger institutional and social structures (McTaggart, 1991). PAR reveals the resistances and conflicts of competing views and practices, and fosters participant engagement in collective strategies to address organizational and professional power relations and overcome inequities. Participants engage in power and politics of transformative action to enhance capacity, and foster organizational and societal improvement (Kemmis & McTaggart, 2005; Reason & Bradbury, 2001).

PAR aims to create a synergy of collaboration, solidarity, and transformation, as participants define a problem or question and design a research plan to improve the

human experience. Accordingly, PAR constructs inquiry as a dynamic process to encourage a high degree of participation with community members as co-researchers, co-learners, and co-activists of a common concern (Reason & Bradbury, 2001). PAR is thus concerned with collective goals of knowledge generation, education of participants, action-oriented outcomes, application of results to the local setting, enduring consequences and wider applicability, as well as sound research methodology (Herr & Anderson, 2005; Reason & Bradbury, 2001). In this study, PAR situates inquiry as participatory and *with* NPs, as educative and *for* NPs, and as action in being *about* NPs.

Self-Reflection: Making Sense of My Worldview of PAR

My formative years were highly influenced by my biologist father and many visits to the university lab, where I examined cats and rats splayed out on tables poked with multiple colored pins. I became a nurse, yet was dissatisfied in my choice of *care over cure*, and particularly in the subjugated status of nursing. I returned to school to obtain a science degree and became the dissector in the lab. Fortunately, other perspectives from my early years drew me back to nursing, such as my mother a war-bride with many children to feed and care for, students of other race and nationality that came home to dinner, and the social movements of feminism and student activism that I took part in. As a young nurse, I was drawn to both the technical aspects of nursing, most dominant in practice settings like the emergency room and operating room, and the human aspects of my profession that were evident in practice settings such as maternal care and mental health. Leslie and McAllister (2002) speak of “nursedness”, a unique character and ability of nurses to be empathic, trusted, and practical. In time, community health nursing won over my passion because of its complexity and challenges. Community health work

is messy and I am an organized kind of person; multiplicity is inherent in its diversity and I am a logical kind of thinker; it calls for participation and action, and I like to be in control of my destiny. These dichotomies stretched me, challenged me to be innovative, and fostered openness to continuous learning and change. My nursing practice has accordingly a community development approach underpinned by a participatory philosophy. This legacy influenced my scholarship decisions, and helped to shape my learning journey of transformation.

PAR inspired my sense of curiosity and satisfied my compulsion to press the edges of innovation. Participatory inquiry aligned with my philosophical values and my commitment to collective capacity building. I appreciated the educative nature of PAR to foster integration of worldviews and open up possibilities, and the action part of PAR offered a way for me to give back to community (Bradbury, 2001). My interest in social and organizational improvements was also congruent with PAR. It was a good fit for nursing, a discipline which has come to span and integrate views of biomedical and humanistic knowledge of health (Brant-Lukosius & DiCenso, 2004; Kelly, 2005; White, Suchowierska, & Campbell, 2004). PAR seemed compatible with my research interests of NP role development, IPC and collaborative culture, and PHC renewal, and promised to draw together varying perspectives to make sense of power relations and complex health care dynamics (Munoz & Jeris, 2005; Nelson, Poland, Murray, & Maticka-Tyndale, 2004).

By taking up first-person reflexivity I explored the shifting of my multiple roles. My role of community health leader moved into the background as my new role of novice learner took precedence, and I opened up to varying theoretical perspectives and

embraced the immense learning ahead. I also had a new role as educator and I was teaching and learning with nursing students about social inequities and ways to influence change. As an advanced practice nurse, I was gaining a broader sense of my nursing profession and strengthening my disciplinary relations. As a researcher, I was developing new associations and constructing networks in preparation for my inquiry. I was also gaining confidence as a scholar. As my knowledge, experience, and confidence grew, I renewed my status as a leader. In these roles of leader, student, educator, nurse, researcher, scholar, and leader again, I came full circle. As this transformation occurred, I integrated these roles into my personal life of being mother, wife, friend, and citizen (Gibbon, 2002; Rowan, 2001). Each role necessitated clarity, and in turn raised my critical consciousness and fostered a sense of wholeness (Heen, 2005). Reflexivity helped to separate and integrate the many parts of me, as I engaged in and explicated my unfolding research process. In so doing, first-person cycles of reflection and action validated the 'stepping into' of graduate level research (Munoz & Jeris, 2005; Reason & Marshall, 2001).

Axiology: Value-based Perspectives of PAR

Axiology is about exposing values, morals and ethics, and with respect to PAR includes exposing participant values through self-inquiry, focusing the study on a worthwhile purpose, and engaging in ethical research practice (Reason, 2006). Bradbury and Reason (2003) note "action research is an inherently value laden activity" (p. 158), and identify such values as inquiry grounded in lived experience, theory and practice as inextricably linked, and action as expression of culture and power. From a moral perspective, PAR is meant to address issues of importance for individuals, for

community, and for a global ecology. From an ethical view, mutuality and equality ground participant discourse and experiences as real life issues of importance (Bradbury & Reason, 2003; Kelly, 2005; Marshall, 2001). By being transparent about underlying values of the study, the research is more clearly situated and validity is strengthened. I found the literature of Wallerstein and Duran, and that of Habermas, to be useful in understanding axiology with respect to my research interests.

Wallerstein and Duran (2003) discuss PAR with respect to a southern and northern tradition. The southern tradition, which parallels Habermas' (1987) term the "life-world", is concerned with emancipation of vulnerable people by sharing power, giving voice, and regenerating citizenship; while the northern tradition, or what Habermas terms the "systems-world", addresses systemic structures, economics, and politics for the purpose of organizational improvement and a rebalancing of the dominant social order. Habermas' (1987) theory of communicative action, which acknowledges the significance of interpersonal communication and relations to learning and liberation, provides an explanation of the tensions that occur when personal, social, and cultural processes of a life-world collide with the outcome orientation of a systems world (Kemmis, 2001). For my master's work I had examined the "life-world" experience of mothers marginalized by the welfare system (Burgess, 1995; McKnight, 1987), and I was now interested in focusing on the "systems-world", but I also recognized the importance of being grounded in the experience of clients and community.

An inquiry with NPs seemed to cross these north-south boundaries. A key aim of the NP role was to improve access and care for underserved communities. Given that the inquiry was to examine how collaborative practice advanced role integration, this was

intended to help secure NP roles, and thus contribute to care of marginalized clients and communities. The bringing together of knowledge of the systems-world in order to impact the life-world reflected the values and ethics of the inquiry. Wallerstein and Duran's (2003) account of "north-south" traditions helped me to make sense of employing PAR for a health services inquiry. In this sense, by targeting PHC with links to the systems-world of policies and politics, focusing on IPC with its reciprocal effects on organizational and professional cultures, and exploring the NP role with respect to processes of client care, I could envision a ripple effect to clients and communities (Herr & Anderson, 2005; Reason, 1998). By improving the systems-world of NPs, the life world of clients and communities would have consequential benefit.

Three particular value-based theoretical perspectives grounded this PAR study and contributed to my understanding of power relations within the systems-world. The first value-based theory relates to the participatory process, whereby sharing power and creating co-ownership of the research, participants embrace diverse ways of knowing and find common ground. The second value-based theory relates to critical feminist theory, and explicates the integral nature of knowledge and power. The third value-based theory is of praxis, in which holistic knowledge is generated from reflexive practice and applied for the purposes of social improvement. Examination of my values and how they related to underlying theories helped to reveal the basis of my research endeavour. I later transformed these theories into PAR principles so as to be explicit about the researcher - NP partnership and used these principles to implicitly guide the unfolding process of collective inquiry (see Appendix B for PAR principles).

On Participation and Power

Reason (1998) identifies dimensions of participation as political, epistemological, ecological, and spiritual imperatives. From a political perspective, participation addresses concerns of human rights and flourishing. Epistemological views emphasize the world as interconnected “relationships, which we co-author” (p. 7). An ecological dimension affirms human persons as part of the natural world and universe. A spiritual imperative of participation assures human inquiry as healing and holistic. Participatory action researchers take into account the wholeness of the inquiry and through reflexive looking, learning, and action co-generate meaningful practical knowledge (Greenwood & Levin, 1998). PAR is thus concerned with the practical and the applied; inquiry entails a participatory process of choosing and framing an issue, creating relational experiences, effecting changes in practice, and actualizing the significance of inquiry outcomes for human flourishing (Reason & Bradbury, 2001). Participation engenders a social democratic process, equity is created between researcher and participants, moral and humanistic concerns emerge, and action takes on a practical nature (Flood 2001; Pasmore, 2001). Participation underpins my belief in research as a collective undertaking with aims to make the ‘doing’ of research accessible to those outside of the academy, empower participants in their social relations, understand the complexity and interrelatedness of structures and processes, and generate ideas and actions to overcome discord and create a sense of flourishing. My commitment to the participatory process was an endeavour to foster an exchange of expertise between community and university, and through joint research efforts share our collective power. In this way NPs as co-researchers would have co-ownership in determining the inquiry process and generating

collective knowledge. NPs would help direct and shape the study, participate in decisions of emergent actions, and together we would translate our learning to share with others.

On Knowledge and Power

Smith (1987) makes known the linkages of gender and power to expose oppression, in which the silencing of voice and the everyday of experience results in construction of knowledge that favors the dominant social order. Knowledge and power are thus inextricably linked to control decision-making, resources, and political agenda (Gaventa & Cornwall, 2001; Hall, 2001; Herr & Anderson, 2005). A feminist lens deconstructs knowledge and power as patriarchal dominance. Action research from a feminist perspective opens up relational and communicative space to engage self-discovery, advance collective knowledge and transform social and cultural contexts (Maguire, 2001). Foucault's (1982) contributions to the study of knowledge and power reveal how relational knowledge serves to identify common concerns and strengthen collective resistance and resilience.

PAR argues for a democracy of participation, explores difference in ways of knowing, recognizes knowledge as socially and culturally constructed, and fosters humanism in the recovery of power (Hall, 2001; Lofman, Pelkonen, & Pietila, 2004; Maguire, 2001; Rowan, 2001). Knowledge and power is important to NP role development because NPs have suffered from a discontinuous history, in which they have been silenced and side-lined by a dominant medical profession that has significantly influenced health care politics. A social investigation was intended to create collective voice, generate alliances, and compel actions to rise against dominance and stabilize the future of the NP role (Gaventa & Cornwall, 2001; Hall, 1981). A PAR partnership would

support NP capacity to engage in self-discovery, share and construct collective knowledge about client and community practice, take up actions to strengthen organizational and professional alliances, with the intention of safeguarding the NP role.

On Praxis and Power

Park (2001) notes participatory research is a form of praxis, in which human and rational views are integrated to actualize potential. Praxis is the combining of knowledge and practice, in which shared understandings and values are connected to life and work for the pursuit of human good (Schwandt, 2001). Borda (2001) underscores the inadequacy of science and reason to make sense of moral and humanistic concerns; bringing head and heart together requires holistic epistemology. Praxis also enables comprehension of complexity. Flood (2001) contends that action research fosters convergence of systemic thinking to balance the mystery and mastery of knowing the unknowable. By this he means coming to know the unlikelihood of fully understanding technological and complex systems. Action research teaches participants to act meaningfully within the unknowable. This systemic thinking reveals the wholeness of existence, the impossible knowing of the whole, and the necessity of relinquishing prediction and control. Thus, as system complexities are uncovered, interpretations reveal points of view, and transformative actions reconcile the mystery and mastery of multilayered systemic culture (Green, Rootman, & Poland, 2000; Wilson, Plotnikoff, & Shore, 2001).

Praxis and power informed my understanding of NP role development in two ways. By conceptualizing praxis as the integration of the *art and science* of nursing theory and practice, I saw the capacity of the NP role to combine relational and clinical

knowledge to enhance client care. By viewing the NP role within complex organizational structures, I saw the importance of explicating the dimensions of the NP role that foster system improvements. Praxis also underpinned my understanding of health system complexity and transformed my thinking of IPC as a practice level issue to a matter of broader collaborative health care culture.

With respect to creating a study of worthwhile and practical purpose, in this PAR study I intended to engage NP participants and support them to gain power through our collective efforts to cultivate broader interpretations of health care culture and politics. I hoped that the knowledge developed from the study would help NPs to inform and shape their role in PHC and their collaborative relations within the health system (Bradbury & Reason, 2003; Gaventa & Cornwall, 2001). Action would elicit application of this knowledge to enrich NP care and health care culture and contribute to integration and sustainability of the NP role (Bradbury & Reason, 2003; Gustavsen, 2001; Park, 2001). These underpinning values and perspectives of power denoted the significance of explicating societal, organizational and system complexities of NP role development.

Self Reflection: Assumptions of power in insider-outsider roles

As a self-inquiry, I engaged in my own look, think, and action cycles to explore being both an insider and outsider to a community inquiry with NPs (Koch, Mann, Kralik, & van Loon, 2005; Lofman, et al., 2004). Being authentic about who I was and what I was bringing to the research was a measure of research validity and helped to safeguard my own assumptions and biases that I brought to the study (Heen, 2005; Heron & Reason, 2001; Park, 2001; Schein, 2001; Whitehead, Taket & Smith, 2003). I first explored my own perspectives about PHC and IPC with respect to the NP role. My

previous work as director of a community health care centre had shaped my understanding of PHC culture and politics, the capacity and barriers of teamwork, and how collaboration eased practitioners' burden of client care, extended the NP role, and enhanced PHC delivery. PAR challenged me to see the world beyond this local PHC model and experience, find new ways to take up leadership, and foster the shifting of power relations through scholarship and research.

In my transition to academia, I was confronted with determining my sense of power in a new role as student researcher. I explored distinctions of insider-outsider perspectives (Minkler, 2004). My inquiry was with NPs, who had a newly constituted health care role bolstered by provincial legislation, regulation, and graduate education and these system changes were intended to more effectively secure the NP role. Yet, as an advanced practice nurse, I stood outside their legislative entitlement. In this sense I was an outsider, as my practice and perspective was not that of an NP. Nonetheless, my knowledge of the NP pioneer role, my talents of nursing leadership and sharing power with others, including community, had equitable value (Gibbon, 2002). Heron (1996) speaks of a "deep kind of participative knowing", where the researcher is grounded in her experience as co-subject (p. 21). As a co-learner and co-researcher, I came to see that my knowledge and experience provided a significant contribution, and this gave me the assurance of insider status for an advanced nursing focused inquiry.

As an insider, I was sensitive to the politics and demands of early role development and wanted to ensure the study design would appeal to NPs and their respective health authorities. I knew there was NP readiness for a participatory approach to research, because I had previously validated this assumption by hosting a pilot focus

group with NPs during earlier course work. Continued informal conversations with NPs indicated increasing interest in a study of this kind. NPs expressed a desire to better understand role and team development and how their individual and collective practices were influencing and shifting PHC (Bryant-Lukosius & DiCenso, 2004). NPs also conveyed interest in learning about the research process, in order to explore their value-added contributions to client care and community practice. As I formulated inquiry questions for NPs, I placed my query within their situated experience. NPs faced the tensions of pioneering a formalized professional role embedded within a milieu of health politics. Not only did they have a steep learning curve related to their clinical skill development, but there were also organizational expectations of NPs to inspire teamwork, improve client care and outcomes, and revitalize PHC renewal efforts. These were high level demands, which I needed to acknowledge and accommodate in order to shape a successful research partnership.

Minkler and Hancock (2003) outline core PAR principles: “start where the people are” (p. 136), “begin with community strengths and assets, rather than problems” (p. 137), and accent “authentic dialogue” (p. 138). This was good counsel and I began to design questions to engage NPs in dialogue about role development and practice patterns, what mattered to them with respect to IPC, what meaning role integration had for them, and how IPC would contribute to their role integration. I also formulated ideas about how I would represent and safeguard the authenticity of participant voices by exploring and asking about points of divergence and convergence. As well, it was important to ensure interpretations and findings were validated by way of a consistent reflexive group process that fostered critical reflection and deepening of understandings.

Epistemology: PAR Dimensions of Knowing and Participation

The nature of knowing in PAR is taken up as ‘many ways of knowing’. The everyday lived experience of tacit knowledge is translated by way of collective inquiry to explicit knowledge. PAR addresses significant issues and problems of everyday life and work life, formulates theory of practical relevance and application, and generates forward thinking and action of future consequence. The participatory nature of inquiry engenders multiple views of critical reflection to address real life problems and the sharing of power (Park, 2001; Torbert, 2001). Theorizing shifts understanding from the micro to macro view, and takes on an ecological and political perspective of knowledge development, while ensuring local and practical relevance (Reason & Bradbury 2001; Reason, 2006)). PAR seeks to integrate past knowledge, with current circumstance, to create vision for an emerging future, and thus inspires confidence for innovative thinking and action (Ludema et al., 2001; Reason & Bradbury, 2001; White, et al., 2004).

PAR also seeks to broaden epistemological views and empower participants by a reflexive process of knowledge construction, consciousness-raising, and actions toward improvement of socio-political circumstances (Creswell, Clark, Gutmann, & Hanson, 2003; Park, 2001). Epistemological frameworks structure the research design, inform the research process, guide the methodological rigor of the inquiry, and help to translate everyday knowledge of participation into organized forms of improvement (Park, 2001). In PAR, participants use their insider knowledge of social conditions, generate new knowledge by means of acquiring and sharing information, carry out systematic analysis, and construct solutions to their problems. I examined the epistemology of PAR by drawing upon knowledge frameworks from the participatory action literature.

Representational, Relational, and Reflexive Knowledge

Park (2001) provides a framework of representational, relational, and reflexive knowledge that fits well with a first-, second-, third person approach to study.

Representational knowledge is functional in correlating variables, and interpretive in making meaning of these connections. In this sense, representational knowledge embodied *community of scholarship*, in which self-inquiry and academic preparation grounded my substantive knowledge of NP role development, and IPC and collaborative culture. Relational knowledge captures the understanding we have for each other as human beings. Relational knowledge represented *community of practice* and ‘getting to know’ the NP context and culture. Reflective knowledge connects the social nature of human life to the problematic, by way of critical reflexivity. Reflective knowledge characterized *community of inquiry*, in which the researcher and NPs came together to determine and mediate dominating influences.

Appreciative Inquiry

The appreciative inquiry framework by Ludema, et al. (2001) was used to modify my approach to this study. In PAR, the intent is to identify an issue or problem and employ critical reflection and analysis to explicate broader understanding. Appreciative inquiry served to complement this intent and enhance ‘generative capacity’. Appreciative inquiry reveals knowing by raising questions about contemporary social life, challenging taken-for-granted assumptions of the culture, and reconsidering new alternatives for social action that serve to nourish the human spirit. In this way, appreciative inquiry generates conversations of passion and innovation to unseat fixed patterns of discourse, and create space for new voices, ideas, and actions. The power of unconditional positive

questioning is the basis for appreciative inquiry. Binary language that causes defensiveness, polarization, and reinforces social hierarchy is replaced by deliberate affirmative assumptions about people, organizations, and relationships. Questions are based upon future qualities and aspirations that nurture enthusiasm and co-create vision. Appreciative inquiry is outlined by four stages: “discovery” by valuing the best of what is, “dream” by envisioning what could be, “design” of the future by dialogue and inclusive interaction, and “destiny” in constructing new cultures by innovation and action. Appreciative inquiry focuses on participant experiences of feeling most engaged and alive and asks questions to generate spirit and effectiveness, such as: what do you value most, what are your best practices, what are your aims, and what is unique about your culture? Appreciative inquiry enhances sensitivity to multiple ways of knowing, and reinforces a positive cycle of long-lasting egalitarian relationships. The authors note: “never have we ever seen a group dream of increased hierarchy, greater power distance between individuals, or more command and control in a system” (Ludema et al., 2001, p. 198). Appreciative inquiry helped me to shape affirmative questions to initiate a dialogue with NPs about what matters in practice with respect to their current situation, and how they could envision their future and in this way influence NP role integration.

Multidimensional forms of knowing are interdependent and reflexive in linking theory and practice in the creation of knowledge (Gaventa & Cornwall, 2001; Schwandt, 2001). Finlay (2002) defines reflexivity as “thoughtful, conscious self-awareness” (p. 532) in constructing interpretations by “moving back and forth in a dialectic between experience and awareness” (p. 533). The practice of self-reflexivity by the researcher, with attention to everyday life, models for others a presence in dialogue (Reason, 1988;

Treleaven, 2001). This in turn inspires reflexive discourse amongst participants, in which motivations, assumptions, various roles, tensions and power imbalances are examined in order to create a congruence and credibility in what and how is researched (Naylor, Wharf-Higgins, Blair, Green & O'Connor, 2002; Rowan, 2001). Reflexivity served to enhance my understanding of past practice through integrating theoretical learning, incorporating participant perceptions, and interpreting and translating new knowledge for future practical application.

Self Reflection: Issues of Evidence and Validity

As a graduate student in the nursing discipline, epistemological discourse often focused on evidence and research validity. First-person reflexivity helped me to identify philosophical conflicts within my discipline, as well as make sense of dichotomous accounts of history that have shaped nursing research. The shift back and forth in nursing history between an illness approach and more humanistic models of care reflects the objective-subjective duality that nurses experience (Nelson, 1997; Playle, 1995). As a student with the Advanced Practice Nursing Chair, there was considerable emphasis on empiricist research, yet my interests were to explore and understand the current practice experiences of NPs and their perceptions of the future. I felt the tension in deviating from clinical quantitative methods to a participatory approach. I thus examined the controversies and sought out more understanding about the nature of evidence as it relates to advanced practice nursing, in order to strengthen my confidence in PAR as an evidence-based epistemology that could be applied to the clinical world of NPs. By exploring the history of nursing research, I came upon varying perspectives about the

nature of evidence as it relates to the human condition. I interpreted these perspectives to formulate my understanding of evidence, as outlined in the following discussion.

Early in the profession, nursing adopted a dominant empiricist approach to research in efforts to gain credibility; methods of the physical or natural sciences were applied to the complex world of human experience and relational practice (Johnson, 1999; Kinn & Curzio, 2005; Playle, 1995). Polarization of the *art and science* of nursing occurred, in which *art*, with a humanistic philosophy of the personal and the subjective, was subjugated by *science* that propagated analytical and legitimate evidence (Playle, 1995; Zurakowski, 2005). As feminism, humanism, and emancipatory aims inspired nursing research, more qualitative approaches were taken up in order to advance holistic health and healing aspects of nurse-client relations. Yet the powerful roots of post-positivism in human research, along with political and economic demands for numeric evidence, continued to create uncertainty and discord about what constitutes valid research and reliable evidence (Playle, 1995; Forbes et al., 1999; Rycroft-Malone, 2003).

Since the early 90s, the term ‘evidence-based’ has consumed the medical and nursing literature and professional discourse (Holmes, Perron, & O’Byrne, 2006; Rycroft-Malone et al., 2004). DiCenso et al. (2005) describe evidence-based practice for nursing as the “integration of best research evidence with clinical expertise and patient values to facilitate clinical decision-making” (p. 4). Yet, Holmes et al. (2006) contend that evidence-based nursing (EBN) “oversimplifies the complexities of clinical nursing...compromising the development of nursing knowledge” (p. 96), and argue that it is paradoxical for the nursing profession to promote reflective and critical practice, while accepting EBN as truth. Nolan (2008) advises nurses to call upon various kinds of

evidence in order to meet the complex needs of clients, as well as draw attention to their effectiveness. Nolan makes the case that if evidence-based nursing focuses mainly on explicit measures and politically charged outcomes, then the implicit and personal nature of nursing care remains invisible. Rycroft-Malone et al. (2004) note the extent to which quantitative research evidence has been highly valued in health services delivery, and many resources have been directed toward the evidence-based practice agenda. The authors discuss the importance of drawing on multiple sources of knowledge, in which evidence is derived from various research approaches, clinical experience, perspectives of clients and carers, and information from the local context and environment.

These debates helped me come to terms with applying a PAR approach to evidence-based practice, in that NPs with their clinical focus could also be served by less conventional approaches and methods. Through PAR, NPs could discover their capacity to combine practice and research in order to strengthen their role in health service delivery. Knowledge derived from examining local practice experiences could be interpreted and theorized for broader dissemination, so that others could reflect upon and apply these new understandings to their own settings and experiences for comparison of similarities and differences (Friedman, 2001). In this way, the findings from a PAR study would be interpreted beyond the local for generalizability to broader contexts.

Purkis and Nelson (2006) also contributed another dimension to this discussion about evidence and interpreting findings. Nurses are expected to delivery quality care and generate evidence about their efficiency and effectiveness, yet the authors note fewer resources are available to support nurses in their work. The nursing profession's move toward competency standards and self-governance has created pressure on nurses to hold

themselves accountable for evidence-based care, despite the lessening socio-political responsibility for assuring economic and material resources (Purkis & Nelson, 2006).

This bifurcation of accountability creates tensions for nurses who strive to uphold nursing standards and performance of best practice. NPs are particularly attuned to this tension, as there are increased expectations on NPs for advanced clinical competency and accountability in care decisions. Yet, infrastructure and resources to support NPs are not necessarily in place. In order for NPs to generate evidence that captures the whole view of their role and the multiple dimensions of their practice, collaborative efforts are needed between NPs and health researchers and leaders to create innovative measurement tools and instruments, as well as ensure adequate infrastructure and resources to communicate and disseminate results. PAR offered a way to engage with NPs about the art and science of practice, to discuss the issue of evidence and the need for measurements, and to reveal tensions of supply and demand, authority and accountability. My decision to use a PAR approach was strengthened by understanding these debates and controversies.

In Conclusion

Hall (2001) speaks of the research process as being genuinely and organically situated. Through an inquiry partnership, participants become co-researchers, share their everyday experiences, and emergence of new understanding and knowledge results. As relations strengthen and learning takes place, the collective reveals a broader perspective and generates ideas and actions to transform the problematic. First-person action research in a community of scholarship enabled me to explore ontological perspectives and address tensions and challenges of a PAR approach to doctoral research. Through self-inquiry I came to see that my many and varied roles cannot be compartmentalized. PAR,

being context-bound (Levin and Greenwood, 2001), and yet open to multiplicity (Maguire, 1987), permitted me to be situated and synergistic in multiple roles and interests. In exploring my underlying values I revealed implications of power and this helped to qualify my outsider status, yet affirm my insider status in the research study. In making known my epistemological views on power, I explored the art and science of nursing practice and revealed the nature of evidence from varying perspectives. Life experiences have taught me that congruence in my beliefs and actions keep me healthy in mind, body, and spirit. Congruence in this study was validated by many moments of synchronicity during my learning path, and this enhanced my self-assurance and countered the power relations of scholarship (Marshall, 2001). Making sense of emotions and explicating assumptions were indications of my growing critical subjectivity and self-awareness (Heen, 2005; Nolan, 2005). First-person research facilitated my learning about PAR as an approach to graduate study and fostered self-inquiry, both of which strengthened my validity as a researcher.

Chapter 3

Participatory Action Research in a Community of Practice: Second-Person Perspectives of a Graduate Student

In my commitment to PAR, there was no doubt. Yet as I moved forward in my doctoral program to that middle uncertain stage, where structured course work ends and realities of solo research take hold, my confidence was again tested. Would busy NPs actually agree to participate? Would their employers support them? Could I facilitate an effective PAR process? Could I deliver on my vision? (Personal reflection)

The essence of PAR is that it is participatory (Reason & Torbert, 2001). The quality of a PAR study depends upon building true partnerships, in which participants and researcher become co-researchers. Yet from a student perspective, there are certain challenges to overcome in order to create true research partnerships (Herr & Anderson, 2005). My first challenge was that I could not enlist NP participation, nor gain their endorsement of a plan, until I had a research proposal accepted by my doctoral committee, and ethics applications approved by multiple board reviews. I managed this tension by engaging informally with a few NPs to ask them about practice issues and their interests in research. My second challenge was that I did not have insider privilege within any health organization, nor did I have the title of NP and was considered an outsider to the NP association. I managed this challenge by attending NP related events and meetings, so that I could create alliances with NPs and their leadership networks, and cultivate authentic partnerships. My intention for the study was to create a collaborative atmosphere, in which I would share my knowledge of research and NPs would share their knowledge of practice and collectively our talents would be complementary and reconcile insider-outsider differences. However, to attain a sense of collaborative and equitable status, a complex progression of relationship development was required. Relationship

building transpired as a process of interpersonal interactions, recognition of talents and allies, finding common interests and goals, taking up mutual positions, and engaging in collective activities. Developing relationships of trust and respect took time and were enhanced by opportunities in which I engaged with NPs and their leaders and ascertained their interest and commitment to the study.

Chapter 3 describes my journey of second-person action research, in which I entered into community of practice, participated in networks and formed partnerships, gained contextual knowledge and expertise, and designed and initiated a research inquiry with NPs. In this way, second-person action research accorded recognition to my efforts of navigating an inquiry plan, while adhering to university standards, limits and conditions (Herr & Anderson, 2005; Reason & Marshall, 2001). During this early stage there was much behind the scenes positioning and conferring, in order to align interests and agendas and create a meaningful and realistic participatory study, all prior to formally engaging with and recruiting participants. Associations with influential leaders and key stakeholders were formed and my expertise became recognized within relevant community networks. Second-person action research thus helped me to establish university – community partnerships, address power differences with stakeholders, and locate myself as a researcher within two NP communities of practice (Bradbury & Reason, 2003; Israel, Schultz, Parker, & Becker, 2001).

Entering into Community of Practice

I have a strong belief in local community, but I also recognize the value of networking within broader contexts. I wanted my research study to be noteworthy and relevant to where I live in BC; but I also hoped the study could influence the Canadian

context of health care, and possibly have broader implications. I thus sought out and developed national and provincial partnerships and this helped me to establish my status as a health service researcher, which in turn fostered opportunities to partner with local communities of practice. At the national level I became a member of two unique but separate learning networks, and at the local level I linked with health leaders, created new contacts, and developed partnerships specific to my study plans. My membership in the Health Canada IECPCP network began as an informal affiliation, where I attended early meetings on behalf of the UVic Dean of Human and Social Development, Dr. Mary Ellen Purkis, and overtime I established a role for myself and gained recognition for my commitment and expertise. My membership in the CHSRF/CIHR Advanced Practice Nursing Research Chair was formalized from the outset by way of an application and specific learning expectations. Local partnership development was less tangible, in which I made contact with past colleagues, seized opportunities to be in contact with identified leaders, and drew upon university connections and occasions to forge new relations.

The Health Canada IECPCP initiative took off in BC under the leadership of Dr. John Gilbert, at that time Principal of the College of Health Disciplines at University of British Columbia. Gilbert formed the Interprofessional Network of BC (In-BC, 2006), as an inclusive structure to engage leaders from education, research, practice, and policy in the development of a BC vision for interprofessional education and practice. I attended early national and provincial meetings, assisted in securing local funding, and was selected as Education Coordinator for the Vancouver Island Interprofessional Education (IPE) Project. This role afforded me many learning and teaching opportunities, and connections to an ever widening network. In the education realm, I was a co-investigator

in a study to examine interprofessional education interventions for student learning; while in the research domain, I was involved in examining interprofessional collaboration and its implications for practice. Thus, I was networking across disciplines and sectors and appreciating a full view of the interprofessional movement. Over a two year period, I presented 14 papers and posters at provincial, national and international academic conferences, along with numerous presentations at Vancouver Island events, thereby significantly advancing my lecture skills. I also co-authored the Final IPE Project Report (Burgess & Purkis, 2008). My interprofessional network extended internationally, and my contributions were recognized. For example, I received the 2008 National Health Sciences Student Association Interprofessional Education Mentorship Award; and I was asked to participate as co-investigator of an Ontario study to survey registered practical nurses, based on the emerging collaborative health care culture framework I developed.

My involvement with the Advanced Practice Nursing Research Chair, Dr. Alba DiCenso, was more specifically tied to doctoral scholarship. As a student of the Chair, requirements included establishing a link with a decision-making partner, completion of research and policy practica, and participation in biweekly student teleconferences. During this three year experience, I met students from across Canada who studied various aspects of advanced practice nursing (APN), and I gained access to a national network of nursing leaders who shape APN development. This form of leadership learning extended my research scholarship beyond the institution to that of the power and politics of nursing practice. The Chair's mentoring of students, by way of integrating the domains of research and practice, was both inspiring and empowering. The value derived from learning about pioneer provinces and practitioners, and linking to current APN expertise

across Canada was immeasurable. These network connections afforded the opportunity to extend my capacity in APN research, and put me in good stead to be accepted for post-doctoral research in 2009, as part of a CHSRF tri-province study, titled “Strengthening Primary Health Care through Primary Care and Public Health Collaboration”.

I also had the benefit of a doctoral supervisor, Dr. Marjorie MacDonald, whose early research established the foundation for NP role development in BC. Her mentorship was integral to my emergent status as a researcher within the provincial and regional NP networks, and her standing helped to secure decision-making partners for my study. NP role development was strategically situated in the BC health authority regions with each of the Chief Nursing Officers and their respective Professional Practice Units. My partnerships therefore needed to extend to at least this level of the health organizations with which I would collaborate. A choice point arose as to which and how many health authority partners I would aim to engage to assure a sound study design. Six partners were surely too many to orchestrate, while one seemed not enough, as each health authority had only 10 to 15 NPs hired by this time. I made a decision to approach two health authorities for the study and engage two separate inquiry groups concurrently. This would assure a large enough NP base for participant recruitment. The study would also benefit from explicating and contrasting varying processes of regional implementation. The two health authority regions of interest shared similarity of an urban-rural population base, and I had connections within each of these regions to the Chief Nursing Officer and their Professional Practice Leads for NP role development. However, by choosing to design a study with two regions, I realized there would be some challenges. Could I actually orchestrate the NP research meetings concurrently? Would I keep the inquiry

processes, confidences, and data collection discrete? Would I carry out data analysis separately? And how would I link the findings from the two inquiry groups? These were a few questions and concerns that arose from an evolving and emergent PAR inquiry. In preparation for an inquiry with NPs, I searched pertinent literature and engaged in conversations with colleagues and consultants. Second-person action research and the entering into community of practice afforded me the resources and expertise to answer the queries and complexities of a PAR study (Reason & Marshall, 2001). Entering into community of practice became a reflexive experience of increasing self-assurance, making sense of ambiguities, managing the tensions of compromise, and gaining confidence in a realistic research plan (Herr & Anderson, 2005).

The Methodological Design of a PAR Inquiry

My decision to employ PAR as an approach to dissertation study originated from my belief in community of practice as a form of empowerment, in which participation counters inequities of knowledge, power, and resources, serves theoretical and practical interests of participants, and creates collective capacity (Reason, 2006). A PAR study with NPs about collaboration had significance and worthwhile purpose, in light of a new legislated role for NPs within PHC team settings. My aim of generating theoretical knowledge about collaboration and NP role integration had importance to NP role development and PHC renewal, and served the need of NPs to generate practical knowledge about their new professional role. And PAR offered a way to develop NP research capacity and address this professional competency expectation.

PAR also promised to explicate tensions related to the study and make sense of certain dichotomies. For instance, new NPs must assimilate advanced clinical practice

with respect to varied client needs, and within team and community settings, while simultaneously re- defining and clarifying a new evidence-based nursing role (DiCenso et al., 2005a; Rycroft-Malone et al., 2004). Delivery of PHC requires integration of clinical and social care within team and community contexts; yet primary care and medical endorsement is uncertain (CNA, 2005a; EICP, 2006). IPC entails re-balancing tasks and processes of care and reframing health care culture; however organizational buy-in is not well established (D'Amour & Oandasan, 2005; Hall, 2005). I envisioned that these complex challenges could be more effectively addressed by taking up a collaborative approach to inquiry. My confidence in collective problem solving and the collaborative process of PAR underpinned the research plan.

Methodology: Uncovering PAR Promises and Perils

PAR is a collective dynamic process that encourages a high degree of participation, as community members become co-researchers, co-learners, and co-activists for a common concern. PAR engenders repeated cycles of reflection, where understanding is deepened and knowledge is generated and validated by the group's authentic collaboration (Heron & Reason, 2001; Reason, 1999). Through collective consensus the group designs and applies actions toward enhancing performance and solving problems (Levin & Greenwood, 2001; Reason, 1988; Whitehead, et al., 2003). The collective nature of PAR thus makes it difficult to precisely design and plan an inquiry. To prepare myself for the possibilities of an emergent methodological process, I drew upon the literature and created a road map of promises and perils that I could refer to as the inquiry process got underway. Identification of the promises and perils of PAR helped to prepare me for the anticipated and the unexpected.

With respect to PAR, early inquiry challenges often arise in determining recruitment of participants for the study and the degree of inclusivity that can be attained (White, et al., 2004). Participants can vary and new members can be included during the inquiry (Israel et al., 2003; Mitton & Patten, 2004; Sullivan et al., 2003). The researcher fosters participation by modeling self-study, and mentors participants in reflective learning and critical subjectivity (Koch, et al., 2005; McTaggart, 1997). Group members gain facilitation skills, meaningful roles, and make it their own (Heron & Reason, 2001; Koch, et al., 2005; Sullivan et al., 2003; Wadsworth, 2001). As real-life issues emerge through collective engagement, participants articulate agreement to discover and create practical knowledge for human flourishing (Israel et al., 2003; Reason & Bradbury, 2001). Friedman (2001) refers to “building theories in practice” by identifying practice puzzles and making sense of them (p. 161). Positive questioning encourages participants to gain hope, excitement, and ownership of their future (Ludema, et al., 2001).

A common identity develops within the group with recognition of each others’ knowing; despite members having varying degrees of expertise and experiences of power. As diversity is explored, the group shares the personal and practical and gains group confidence for shared decision-making (Lawson, Anderson-Butcher, Petersen & Barkdull, 2003). Disclosure creates a sense of trust, cooperation, and mutual obligation. Issues of time and commitment may arise to threaten decision-making and group sense of equality (Whitmore & McKee, 2001). Differences in worldview, multiple perspectives, differing goals, and changing agendas jeopardize solidarity, yet at the same time, enrich construction of new meanings and strengthen group relations (Friedman, 2001; Levin & Greenwood, 2001; Munoz & Jeris, 2005). The “conscious and unconscious, discussable

and undiscussable” surface and interconnect for deeper meaning (Wadsworth, 2001, p. 425). Questions of control emerge and are resolved through dialogue, listening, and learning (Lincoln & Guba, 2000; Martin, 2001). Differences poorly negotiated run the risk of the research agenda superseding the community perspective (Wallerstein & Duran, 2003). Relationship building and attention to a democratic process, as equal to or as more important than the outcomes, consolidates group dynamics (Gustavsen, 2001; Sullivan, et al., 2003). Ideally, the researcher comes to share the same goals and values taken up by group participants (Lincoln, 2001a). Common language and understanding reinforces collaboration and contributes to group empowerment, mutual decision-making, and power sharing (Friedman, 2001; Israel, et al, 2003).

Design planning of PAR accommodates diverse methodology and may draw on qualitative and quantitative methods (Reason and Bradbury, 2001). This versatility may cause undue complexity and unwieldy group process. Starting small and using iterative cycles of action and reflection aids the unfolding research process, and balances agendas of knowledge creation and transformation (Heron & Reason, 2001). Participants record changes in progress of activities, practices, relationships, and expertise (McTaggart, 1997). Again, the limitless boundaries of the inquiry may cause group chaos and time demands (Lawson et al, 2003; Reason, 1988, 1999; Whitehead, et al., 2003). Concerns about long-term commitment can be overcome by the value participants place on the research (Minkler & Hancock, 2003) Collaboration in all aspects of the research process validates a more accurate and authentic dialogue, analysis of social reality, and fostering of findings and solutions (Israel et al., 2003, McTaggart, 1997; Reason, 1988).

The goals of PAR are realized, as willingness for self scrutiny, awareness, and reliance develops, in an individual and joint spiral of learning and change (Martin, 2001). As part of creating change, the researcher shares with the participants' ways of influencing decision-makers and community leaders for relevant policy making (Lincoln, 2001a; Themba & Minkler, 2003). Together, they discover and co-author knowledge, generate innovation, and validate their collective efforts by mobilizing others in transforming systems and social culture (Reason & Bradbury, 2001). As learning and knowledge development take place, issues of knowledge ownership, individual and joint publications, and agreements on dissemination and knowledge translation are sensitively addressed (Hills, 2001; Israel et al., 2003; Reason, 1988). These are particularly important matters to graduate students, who must prove themselves through academic publishing, conference presentations, and dissertation ownership. Closure of this lengthy process is also an essential element that requires attention. PAR, done well, has tangible results, where group participants gain a stronger sense of self, enhanced knowledge of the issue explored, a sustained network to draw upon, a more democratic structure for humanistic policy-making, and an improved status in the lives of the people who are beneficiaries (Greenwood & Levin, 1998; Hall, 2001; McTaggart, 1997).

Issues of Validity: Choice and Quality in PAR

With respect to action research, issues of validity are reframed by Bradbury and Reason (2001) as discussions of choice and quality. Reason (2006) maintains that "action research is characteristically full of choices" (p. 187). Awareness of and transparency about choices made, and their consequences, enhances the quality of inquiry. Bradbury and Reason (2001) identify choice points that contribute to validity and quality in action

research, and these include relational practice, significance of the inquiry, plural ways of knowing, outcomes of practice, and emergent and enduring consequence. Herr and Anderson (2005) discuss five alternate validity criteria: outcome validity, that is the extent to which actions resolved problems; process validity as ongoing reflection and learning; democratic validity, the extent of collaboration; catalytic validity, as the degree participants are reoriented and energized by the inquiry; and dialogic validity, the extent the research is deemed good by peer review and publication.

Heron and Reason (2001) document procedures to enhance validity and these include: balancing repetitive cycles of action and reflection; convergence and divergence in exploring depth and breadth of issues; authentic collaboration reflecting group ownership; contesting consensus to avoid collusion, distortion, and false assumptions; managing group distress; and risking chaos, as it precedes an unfolding sense of order. As well, Heron and Reason note a number of inquiry skills that contribute to validity, including being present and open in a participatory climate; bracketing and reframing, in order to open up to alternative constructs; radical practice and congruence with motives and implications of actions; being fully committed to the purpose, but not overly invested in the action at the expense of one's identity; and having the skill to identify and manage emotional states and counter distortion.

Second-person action research for a graduate student represents the upfront conceptualization and planning of a study, when many choices and decisions are made about the practicality of inquiry, and criteria are established for assessing the quality of the study and the validity of findings and conclusions. By building in critical self-reflection and being transparent about decisions made in constructing and carrying out an

inquiry, the researcher's assumptions and biases are made known and one's presence in the study is acknowledged (Herr & Anderson, 2005). For judging the quality of this study with, for, and about NPs, I identified the following validity criteria as most relevant: the relational and participatory dynamics of the inquiry groups, knowledge development and educative outcomes, the significance of emergent actions taken up by the NP inquiry groups, and the potential enduring consequences of the inquiry for a larger community (Bradbury & Reason, 2003; Reason, 2006).

Regarding participation, this social investigation aimed to enhance the quality of NP relationships, including creating a space and place for voice, strengthening the co-ownership of their collective practice, and reinforcing a caring collaborative culture. Concerning education and knowledge development, the inquiry strived to integrate different ways of knowing, create a collective sense of practical knowledge, and translate learning into theoretical knowledge. With respect to emergent actions, the inquiry endeavored to engage participants in a reflexive process of reflection and action, leave lasting research capacity amongst those involved, strengthen the links between policy and practice, and plant tentative seeds of transformational change (Reason, 2006, p.198). In terms of enduring consequences of the inquiry, this potential can be determined by the extent of professional and policy recognition of the study; dissertation endorsement and success in peer publications and presentations including individual or joint efforts; and the extent that knowledge transfer takes place and findings are applied to other research initiatives and/or practice settings. Credibility of inquiry results are thus measured by advancement of social relations, enhancement of education and knowledge, engagement

in social action to improve conditions of practice, policies, and systems, as well as future success of inquiry dissemination and knowledge transfer and application.

Research Method and Ethics

There is no prescribed method or technique for the practice of PAR. Hall (2001) notes that “the best way to think about working in these ways is to approach participatory research as a political or philosophical phenomena” (p. 173). In determining a particular method for this study, I wanted to engage NPs in a group process so that they could share their new experiences, learn from each other and generate new knowledge, and gain power as a collective. My research plan incorporated the philosophical focus of connecting practice to theory, and also had undercurrents of a political agenda with respect to balancing power differentials. I also wanted to demonstrate for NPs that inquiry was a common way of working together, and since NPs in the two health authorities had been constructed into communities of practice, it seemed a natural extension to shift their communities of practice into communities of inquiry. Friedman (2001) speaks of creating communities of inquiry in communities of practice, and states: “The role of the researcher is to create conditions under which practitioners can build and test ‘theories of practice’ for the purpose of learning” (p. 160). So, I proceeded with a plan to incorporate inquiry into the NP communities of practice. However, the actual method of engaging NPs in group discussion lacked procedural technique, and would emerge and evolve, as is the case with PAR. This created a challenge for me, as research ethics boards require the researcher to submit a proposal application with precise methods outlined. Yet PAR aims to foster an emergent, open-ended inquiry process (Brydon-

Miller & Greenwood, 2006). To reconcile this tension, I chose to explore the possibility of a multiple method design for the inquiry.

Multiple method design and PAR share similar ontology of transformative and emancipatory worldviews (Reason & Bradbury, 2001; Teddlie & Tashakkori, 2003). PAR draws on both qualitative and quantitative methodology, and so mixed data collection procedures can be employed. The utility of adopting a mixed method approach serves to improve inferences, and represent divergent views. A sequential inquiry design occurs by way of a two-stage model that serves the ‘practical’ of exploratory or explanatory aims (Creswell, et al., 2003; Gilbert, 2006). The convergent and divergent inferences generated from the use of mixing methods can extend different voices and perspectives, and foster more credible and robust accounts of social processes. Adopting various methods to generate data sources and analysis reveals more complete understanding of “complex multifaceted institutions or realities” (Teddlie & Tashakkori, 2003, p. 16).

Thus, for the informative stage of the NP study, my plan entailed forming two separate and concurrent NP inquiry groups; one group from each of two health authorities in BC. The method of inquiry was designed as an iterative group discussion, which was clearly an interpretive and exploratory method. In this way, NPs in their collective form would come together to discuss research questions that I prepared and facilitated for them and through this meeting interaction we would generate data; the data would be audio-recorded and later transcribed. An exploratory approach would generate a baseline of information and inform a subsequent transformative stage, in which mixed qualitative and/or quantitative measures could be used. To create flexibility for a later transformative

stage, I built into the research proposal and ethics applications the option to resubmit an ethics amendment to request use of additional methods if necessary. The inquiry was specified as a six month timeframe to accommodate dissertation timelines, and to curtail demands on NP time; this timeframe presented a constraining factor in advancing an inquiry from an informative to fully developed transformative stage, and presented a potential limitation for the study. However, optimism prevailed and I crafted the research plan to allow for the possibility of emergence, innovation, and extended inquiry.

In actuality, the informative stage of the inquiry process unfolded as expected. Two separate and concurrent NP inquiry groups engaged in exploratory group discussion to generate qualitative data, in which we linked theory and practice. For the transformative stage I had anticipated extending the inquiry into particular NP practice settings, and in this way apply either qualitative or quantitative methods. However, true to PAR form, the emergent process took us in a surprising direction. Based upon the informative stage, actions emerged for the transformative stage that were also exploratory by nature and were taken up by each of the inquiry groups. Thus, the exploratory method of group discussion was used in both stages of the inquiry, and it was not necessary to submit ethics amendments.

Specific to the transformative stage of the inquiry, the NP inquiry groups engaged in two noteworthy action strategies. The first was to organize for each group a research action day, in which we collectively explored and designed a model for initiating practice-based inquiry within the NP settings. This action was based upon findings from the inquiry that identified the desperate need of NPs to understand, theorize and measure or account for practice. By formulating a model for practice-based inquiry, the NPs could

initiate their own investigations and not have to wait for or rely on health authority or provincial measurement tools. This action is discussed in further detail in Chapter 7. The second action undertaken was to invite health authority leaders to an inquiry meeting, in which we interviewed the Professional Practice Office (PPO) leaders charged with NP role implementation, and engaged in collective exploration about the NP implementation strategy and the adoption of a “communities of practice” model to aid this process. This particular action was not simply an extension of the NP inquiry discussions, but was in fact a purposeful and planned action, in which the NPs developed questions to interview the PPO leaders and gain insight into the strategic planning process of the organization. As a result of the meetings, the PPO leaders agreed to dedicate more time and attention to mentoring the NPs in strategic capacity building. This action is further discussed in Chapter 5. These actions reaffirmed the political nature of the study. In addition, possibilities for future inquiry actions were discussed toward the end of the six-month inquiry, but are not included as part of this dissertation.

The ethics approval stage of the research planning process required two separate ethics applications. One application served the dual requirements of the University of Victoria and one of the health authorities. However, another complete and different ethics application was required by the other health authority. Each ethics application required signatures and a letter of agreement from health authority sponsors. As well, each ethics board required a copy of the other’s approval certificate. By engaging with two health authorities, there were a number of procedural details to clarify and the ethics approval process was more complicated than expected. This ethics approval process presents a challenge for NP research. As NPs are employed by six health authorities and each has its

own ethics approval process, to do research with NPs province-wide requires multiple ethics applications and an enormous amount of time to prepare for a study. I have not included ethics applications or approval letters in my dissertation appendices, because they specifically name the health authority, and this could compromise participant anonymity, considering the small number of NPs and health authority leaders in BC. The ethics applications and certificates of approval are on file at the University Ethics Research Office and with my dissertation supervisor.

Initiating the NP Inquiry: Participant Recruitment

Recruitment of NPs was done by way of a strategic sampling approach (Mason, 2002), whereby two health authorities (noted here as HAA and HAB) were targeted and all NPs employed by each health authority were invited to participate as co-researchers in the respective inquiry groups. Letters of approval from the Chief of Professional Practice of each region were obtained. This ensured organizational sanction of the study and NP employment release time for their participation in the inquiry meetings. Initial ethics applications to each health authority review board outlined my plan to recruit NPs directly; however both review boards requested a change to the application, so that the direct invitations to NPs would come from the health authority employer. The intent of this change was to distance the researcher from the recruitment process and limit ethical concerns of coercion. However, this did not address the possibility of coercion by the employer, or the NP perception of coercion, as NPs who did not feel supported by their health authority might decline on that basis. Nonetheless, I had no option but to proceed according to the requirements of the ethics review board, and an invitation for the NPs to attend an introductory meeting to outline the research project was provided to each Chief

of Professional Practice. This was subsequently e-mailed by them to their respective NP employees (See Appendix C).

The NP invitation confirmed employer endorsement of the study, and informed potential participants that NP participation would be considered as work time and would be paid by their respective employers. The invitation outlined the agenda of the introductory meeting including: to describe the intent of the study, clarify time commitments, explain issues of confidentiality and anonymity, and review the consent form and request NP participation. Confidentiality and anonymity required some clarification with group participants. Because the inquiry was constructed as a group effort, there was no means to protect anonymity; however to safeguard confidentiality, group participants were asked to refrain from sharing information discussed in the groups with persons outside the group setting. In addition, participants were informed that all written materials and audio-tapes would be coded so that no names would appear in any data materials and information about protecting the security of the data and its storage was provided. The invitation asked the NPs to contact the researcher by e-mail or telephone if they were interested in attending the introductory meeting. An NP from each health authority contacted the researcher and identified herself as having a communications role in their respective health authority regions. This was significant to recruitment success, as these key NPs talked informally to their colleagues and encouraged attendance at the introductory meeting. This reinforced for me the significance of engaging in relational strategies to ensure successful planning and recruitment for a PAR study.

Introductory Meeting and Logistics

The two hour introductory meeting for HAB was held November 28, 2007 at the location that NPs were accustomed to meet as a group. The meeting was attended by five NPs, a doctoral student assistant who had agreed to attend inquiry meetings to write up reflections of observed process, and myself as researcher. The student assistant was planning a subsequent study with NPs and so this arrangement was helpful to her future endeavors, and had been approved by ethics review. Similarly, an introductory meeting for HAA was held December 5, 2007, at a regular location of their NP community of practice meetings; I and 11 NPs attended this meeting; the student assistant was unable to attend this first HAA meeting.

For each introductory meeting of HAA and HAB, I provided a binder of materials to potential participants, which included a meeting agenda, a summary of the research proposal and inquiry questions, a consent form, a demographics form, and a selection of ten journal articles to foster a collective grounding in knowledge about PAR, PHC, IPC, and NP role development (See Appendix D). NPs were told the inquiry meetings would take the form of face-to-face group encounters, and/or teleconference arrangement if travel was problematic. I discussed the consent form, which outlined parameters of participation, and emphasized the voluntary nature of research. Participants were told they must sign the consent form, in order to take part in subsequent audio-taped meetings. I explained the inquiry would consist of 5-6 meetings of about 2-3 hours in length and would informally follow the research question template. The meetings would span a period of six months and dates would be organized according to group participant

availability. Meeting locations, and teleconference as necessary, would be arranged for participant ease of attendance.

Community of Inquiry Principles

To help set the tone of an inquiry based upon collective participation and co-ownership, I developed a one page document of “draft principles for PAR” to share with the groups and adapt according to their feedback (see Appendix B). The draft principles outlined the PAR definition set out by Hall (2001), which had been adopted for this study, as well as a definition of action research from Reason and Bradbury (2001). Ten draft principles were delineated for discussion, and amended to reflect additional input of each group. The final set of principles was a common document accepted by both inquiry groups. The document served as a worthwhile foundation for a value-based inquiry.

Participant Consents and Meeting Dates

At the introductory meeting, the participant consent was outlined, which included the purpose and objectives of the study; a tentative meeting schedule; participant commitment and employer time compensation; the voluntary nature of the study; safeguards for anonymity and confidentiality; intent for dissemination of results; and contact names and numbers for the researcher, academic supervisor, and regional ethics board (see Appendix E). A few NPs were not able to attend the introductory sessions, and consents were reviewed and signed prior to their first data session, and binders of information were provided to them at that time.

For HAA, 11 NPs were recruited out of a possible 12 employed NPs and consents obtained. For HAA, the NPs expressed concern about the meeting schedule, as winter was upon us and travel difficult. We agreed to compress the schedule into longer sessions

and meet less frequently; the first meeting was set and later dates were organized as we progressed. The HAA group suggested we meet at the health authority central office, where their regular communities of practice meetings were held, and one NP took responsibility for organizing space and facilitating communication. For the HAA inquiry, a total of 20 hours of meeting time and 12 hours of data taping plus a research action day⁷ was completed. Four meeting dates were scheduled, and included December 7th for the introduction and first data session, February 7th for two data sessions, April 17th for two data sessions, and April 18th for one data session and the research action meeting. A total of six data collection sessions were held. Two NPs from the original 11 participants withdrew after the first date, due to employment changes. Table 1 outlines these details.

For HAB, 6 of 12 NPs were recruited and consents completed. The NPs agreed on a first meeting date, and suggested that further dates be set as we proceeded, so as to accommodate varying schedules. We agreed to meet at a hospital meeting room, which I booked with assistance from the Professional Practice Office. For HAB, meetings were organized into half day sessions and totalled 18 hours of meeting time and 10 hours of data taping plus the research action day. Five meeting dates and sessions included November 26th for the introduction, January 9th for the first data session, followed by February 11th and April 3rd data sessions, April 7th for a full research action day, and May 26th for the final data session.

⁷ The data taping represented the actual inquiry and feedback discussions; it did not include the social welcoming and closure that often occurred at meetings, nor did it include the research action day, which represented about 6 hours for each group. Data were drawn from the actual data taping, from reflective notes written by the researcher and PhD student assistant, and notes from the research action day.

Table 1: Inquiry Session Details

Table 1: Inquiry Session Details				
HAA	Attendance	Session	Hours	Focus
Dec 7	11	Introductory Session 1	2 2	Confirmation of participants Practice patterns & IPC
Feb 7	8	Session 2 Session 3	3 2	IPC framework NP role integration meaning
April 17	9	Session 4 Session 5	3 2	Action meeting with PPO IPC & role integration
April 18	8	Session 6 Action Session	1 5	Inquiry reflections Research action day
HAB	Attendance	Session	Hours	Focus
Nov 26	6	Introductory	2	Confirmation of participants
Jan 9	5	Session 1	2	Practice patterns & IPC
Feb 11	6	Session 2	2.5	IPC framework
April 3	5	Session 3	2.5	NP role integration & IPC
April 7	5	Action Session	5	Research action day
May 26	6	Session 4 Session 5	2 2	Action meeting with PPO Inquiry reflections

Data Collection

Data collection methods and plans for audio-taping the discussions were shared with the NPs at the introductory meeting to prepare them for the inquiry process. During the actual inquiry, research questions were posed to each group and I facilitated their interaction and reflection about practice. For each inquiry meeting, I prepared research questions to journey us through a discussion that would answer the overall question of “how does collaboration advance NP role integration within PHC”. For each session, I prepared a primary research question and then sub-questions to assist me in facilitating a well rounded discussion. Not all sub-questions were asked explicitly, because the

dialogue often moved along naturally and the NPs spoke to these questions without being prompted. This gave me reassurance that my questions were relevant and sequential.

However, as facilitator, I did prompt discussion and at times specifically asked questions to elicit direct responses. Appendix F outlines the agenda and inquiry questions used for each NP inquiry group and their respective sessions. Each session was audio-taped and these tapes were transcribed by a transcriptionist. I then listened to each tape recording and made any necessary corrections to the transcription prior to beginning analysis.

The first data meetings focused on the primary question of “what is the current status of NP collaborative practice” with additional sub-questions. The second data meetings started with me presenting my written analysis, which I prepared for each group based on their first data meetings. I requested feedback and further discussion. We then carried on with the focus of the meeting about interprofessional collaboration and collaborative culture. By the third meetings, the agendas shifted slightly for each group, because there were differences in numbers of participants and discussions did not have the same timely flow. As well, timelines for the meetings differed and I applied learning from one group to the other and sometimes added or shifted questions slightly. For the third meetings, I used PowerPoint to share my analysis and asked for feedback, and then we shifted to discuss the primary and sub-set questions about NP role integration. By the fourth meetings we had moved into a transformative stage and we interviewed the NP leaders. I prepared the NPs by reviewing the most up-to-date PowerPoint data summary and we discussed and adjusted questions for these interviews. When the NP leaders arrived for each of the NP sessions, we oriented the leaders to our inquiry by sharing the PowerPoint summaries and then proceeded with interview discussions about role

implementation. The fifth meeting for HAA continued with previous questions because we had progressed more slowly than HAB. For the final meetings (for HAA this was a sixth meeting, while for HAB it represented the fifth meeting) the focus was about interests for further action and reflections about the inquiry. As well, each group held a research action day, but this day was not audio-taped; instead summary notes were taken by me and the student assistant. Additional data included reflection notes that both I and the student assistant generated over the course of the inquiry.

Data Analysis

For each inquiry group, participants were asked if they would like to assist in the data analysis process as part of a research learning experience, and also as a way to strengthen data interpretations, and authenticate credible results. Both NP groups expressed concern about time commitments for data analysis, and were noncommittal, although one NP expressed some interest and willingness. Collectively we decided that I would do the analysis of meetings and bring summaries of findings back to subsequent meetings, where we would review, reflect, and make changes and additions. NPs were asked at a later date if they would like to reconsider participating in the analysis. However, both groups agreed they were pleased with this feedback loop, because we had been able to set time at each subsequent meeting to reflect on the data analysis summaries, discuss interpretations, and adjust as necessary. This data analysis format also addressed the concern of NPs in taking too much time away from their practice settings and responsibilities. In addition, NP participants and invited PPO leaders were asked to review my written dissertation work and provide feedback on the accuracy of findings, because this validated the analysis and conclusions drawn for the study.

Data analysis in the informative stage of the research was done by a process of constant comparative analysis, drawn from analytic techniques of grounded theory, to support emergent theories of plausible relationships (Charmaz, 2005; Schwandt, 2001). Applying the technique of constant comparative analysis in this PAR study enabled me to examine interrelationships among codes, categories, sub-themes and themes, yet the intention was not to produce a grounded theory result. QSR NVivo 7 electronic software was used to index data into initial codes (free nodes), create associations (categories), then cross section index into sub-themes (tree nodes), formulate themes, and make thematic and conceptual correlations (Mason, 2002). I made the decision to keep the data sets from each NP inquiry group as separate NVivo projects, so as to compare project results, and then later integrated the two projects to capture common themes and findings. For each separate project, codes (free nodes) were derived and named by way of interpreting participant meaning from the data content, and grouped together into categories and sub-themes (tree nodes) and thematic associations. The data were also explored for repetitions, metaphors, declarations, contradictions, and outliers (Alita, McIlvain, Susman, & Crabtree, 2003). The codes, categories and sub-themes were continually shaped and re-shaped as stronger associations were catalogued. Sub-theme analysis and thematic interpretations were translated into written text and power point presentations and taken back to respective NP inquiry meetings.

Data analysis in the transformative stage of the inquiry was also done by applying the constant comparative analysis process and similar coding procedures were used (Charmaz, 2005; Schwandt, 2001). The Informative stage of the inquiry had revealed the importance of organizational leadership to NP role development; as well

NPs had raised the issue that they lacked measures to capture the value of their practice contributions; transformative actions thus unfolded from these findings. Transformative actions were generated and agreed upon by each inquiry group and three strategies were undertaken. For the first strategy, each inquiry group invited their Chief and NP lead of Professional Practice to a feedback session, at which we shared our respective inquiry and research findings, as well as interviewed these leaders with respect to certain queries that had arisen during the inquiry. These sessions were audio-taped and used as part of a comparative analysis about the NP communities of practice, which is reported in Chapter 5. The HAA group was first to invite their leaders, and from this I made a few process improvements for the HAB session with leaders. The second action strategy was based upon a request by NPs to develop a practice-based inquiry framework that could be applied in varied NP settings. We thus organized a research action day and invited my supervisor Dr. MacDonald to assist with the learning process. The HAB group was first to engage in this research day and a research framework template was designed, which was then applied to the HAA group and a few alterations made. This practical template was later made available to both groups for their application. The third strategy was taken up as a discussion of how to best utilize the inquiry findings and dissertation writing. As researcher, I was keen to share my written work with the inquiry groups, and we agreed that when the dissertation was complete, we would discuss further opportunities for group or joint publications, and the use of the materials for conference presentations. Also, the possibility for a subsequent research study was raised.

Data analysis of the collaborative inquiry process used descriptive and interpretive analysis to uncover and disclose the reflexivity of dialogue, reflection,

learning, and action (Banister, 1999; Finlay, 2002). A reflexive process was used for each meeting, in which time for an intro and closing check-in created discussion of collaborative inquiry experiences; as well, at the final meeting an additional session was devoted to reflecting back on the inquiry process. This data set was used to describe the collaborative inquiry process and is reported in Chapter 7. The findings generated from the inquiry process were analyzed and compared against the identified validity criteria and the definition of PAR employed in this study.

Data Analysis Variations

The NP inquiry generated data to inform three particular knowledge bases. Chapter 4 describes an ecological framework to advance collaborative health care culture. Chapter 5 reports data on how communities of practice have served to support NP role development in the two health authorities and discusses the value of this model for role development. Chapter 6 reports the findings related specifically to the research question about collaboration and NP role integration. Each of these discrete chapters also informed each other and so again, the iterative process of PAR was revealed. However, writing is essentially a linear process so it is difficult to capture and represent the iterative nature of the inquiry in a way that stays true to the process, while also allowing the reader to understand both the process and outcomes of the inquiry.

Although I consistently applied a process of constant comparative analysis to the data generated, certain variations emerged with respect to each of the findings chapters. There were variations as to the manner in which data were generated and thus there was variation in the application of the constant comparative analysis process. According to Greenwood and Levin (2005), data analysis in action research, is influenced by the

context or conditions from which the data are derived or to which it pertains. The following accounts for my process with respect to each findings chapter and the variations that occurred in data collection and analysis.

An Ecological Framework

The collaborative culture framework, as presented in Chapter 4, evolved by way of three forms of knowledge. The first came from an extensive scoping review of the literature, the second from consultations within the IECPCP network, and the third came from the actual NP inquiry. Therefore the framework was quite well conceptualized by the time the inquiry started. At the first inquiry meetings NPs were encouraged to discuss the following questions about collaboration which included: asking about their patterns of practice, what matters to them with respect to IPC, what factors enable or impede collaborative practice, what IPC looks like in practice, and what qualities denoted IPC. For the analysis, the preliminary collaborative culture framework was applied and NP data were coded according to the identified elements of the framework. This initial analysis was returned to the NP groups at the following session. The framework was then introduced and NPs were asked to provide feedback about it, and further questions were asked about elements of the framework that NPs had not addressed. The data generated from the NP inquiry were compared to concepts derived from the literature and the constant comparative analysis took the form of a reflexive process, in which the preliminary framework informed my understanding of the NP inquiry data, and the NP inquiry data shifted the conceptualization of the framework. In this way, concepts generated from literature and then from practice were a form of data triangulation

(Russell, Gregory, Ploeg, DiCenso, & Guyatt, 2005). This iterative process of data analysis generated important changes to the framework, and is discussed in Chapter 4.

Communities of Practice

As the inquiry unfolded, it became clear the communities of practice model was a key feature in supporting NP role development, thus understanding the relevance of communities of practice was useful to the study. Chapter 5 focuses on this aspect of the research. As each health authority had initiated different processes for their communities of practice, and each NP inquiry group showed variation in role development progress, the NP communities of practice are reported on separately. From the informative stage, particular questions elicited responses and data relevant to communities of practice; these included asking NPs about their everyday practice patterns, how they perceived their role developing, what enabled or impeded NP collaborative practice, what comprised the organization's commitment to collaborative culture and to NP role development, and what factors contributed to NP integration. In addition, as part of the transformative stage, an action strategy was adopted by both NP inquiry groups, which included inviting their respective Chief and NP lead of Professional Practice to a data collection meeting. The purpose of these interactive action meetings was to engage PPO leaders in a discussion about organizational strategies employed in NP role implementation, the relevance and value of communities of practice, and ways to enhance collaborative relations between PPO leaders and NPs in order to advance NP integration. A comparative analysis of the two inquiry groups was undertaken to explicate the value of the communities of practice model for NP role development. The comparative analysis

also revealed certain features that cultivate communities of practice and strengthen NP and policy leader collaboration in role development.

Data analysis specific to this chapter on communities of practice was carried out after all NP meetings were concluded. I wrote up the data and findings as a distillation of separate inquiry group discussions, and issues and themes that emerged. In this way, from the actual interactive data, I created stories of NP experiences often using their words, yet my own too, so that their narrative accounts made sense in written form. I also drew upon quotations from group discussions to enrich and authenticate the write up; most quotes are direct passages, although superfluous wording was removed as requested by the participants. The comparative analysis and conclusions represent my interpretation, based upon the inquiry findings. As the study only drew upon data from two health authorities, and the analysis of communities of practice compared the two health authorities, the issue of anonymity and sensitivity to findings meant that health authorities would not be named, nor would demographic profiles be provided. But suffice it to say, the two health authorities shared a number of demographic similarities, including similar population sizes, diverse urban and rural geographic terrain, and analogous health care aims.

Collaboration and Role Integration

The intent of the PAR inquiry was to explicate the overall question of how collaboration advances NP role integration; this is the focus of Chapter 6. Findings from the two NP groups were remarkably similar with respect to questions about practice patterns, the meaning of role integration, and effects of collaboration on role integration. Data from each of the groups were initially analyzed as two separate N-Vivo projects, but

because of similarity in findings, were integrated into one project data set. The data and analysis in this chapter is reported as combined findings of the two NP inquiry groups.

Data were generated from the combined contributions of 17 NP participants and 4 Professional Practice Office leaders, and derived from 11 meetings and 22 hours of taping that extended over a six-month period. Relevant inquiry questions included asking NPs about their everyday practice patterns, what IPC meant to NPs, what enabled or impeded collaboration, and what were qualities of IPC. This provided a base-line of information about who the NPs collaborated with and how they went about it. An interpretation of role integration was also examined by asking questions about the meaning of role integration, what enabled or impeded role integration, and the qualities of role integration. This helped to determine an understanding of the term role integration. I then explored with the inquiry groups how collaboration contributes to NP integration, and applied the collaborative culture framework to analyze this discussion. I did this by listening to the stories of NPs and linking these stories to elements of the framework, and generating further discussion about collaboration and role integration. As well, the inquiry meetings with PPO leaders asked about collaboration and NP role integration, and these specific data were also combined and included in this analysis.

I carried out data analysis after each inquiry meeting and preliminary analysis was taken back to each subsequent meeting for group discussion and feedback. These feedback sessions were also recorded and further analyzed. The first analysis summary was returned in the form of written work; this enabled participants to see the quality of my written analysis, and participants seemed to gain confidence in the inquiry process from seeing the interpretation of their words and discussions. I took subsequent analysis

back to the groups in PowerPoint form, which helped to convey increasing breadth and depth of the analysis and findings. I wrote up the data and findings as a distillation of the combined inquiry groups. Again, I used the interactive data to create narrative stories of NP experiences and drew upon quotations from group discussions to enrich and authenticate these stories and study findings; most quotes used direct passages, although superfluous wording was removed as requested by participants. Participants were also sent out a draft of the dissertation and asked for feedback about these stories and quotes and the quality and validity of findings and interpretations. NP responses to the actual write up of the dissertation findings chapters are included in Chapter 7, where I examine the community of inquiry process and the quality and validity of the study.

In Conclusion

Second-person action research affords recognition to the foundational work required by a graduate student embarking upon PAR, and enables the student to situate within a community of practice, establish grounding in contextual knowledge, and prepare a well laid out plan to engage participants in a research inquiry. For this study, NPs from two health authorities were invited to participate in separate but concurrent inquiry groups over a six month period. Data generated from this PAR inquiry was analyzed and consolidated into three focused chapters that now follow. Third-person action research is taken up in Chapter 7, in which I describe the community of inquiry process and comment on the quality and integrity of the NP inquiry.

Chapter 4

Community of Scholarship: An Ecological Framework to Advance Collaborative Health Care Culture

On the surface there was an ethos of rosy cooperation, yet as a team we were confounded by philosophical differences, internal complexities, and external pressures that interrupted professional relations. Important dialogue of our views and visions was continually undermined by the minutia of performance logistics. (Personal reflection)

Early in my doctoral studies, I made a decision to explore in-depth the matter of interprofessional collaboration (IPC), because I intended to focus on this aspect of practice in my study with primary health care (PHC) nurse practitioners (NPs). My own experience of managing a community health centre and working with a pioneer NP had raised my awareness of the significance of IPC with respect to securing NP role success, and I wanted to explore whether this observation was a common NP experience. My perceptions of IPC had been deeply influenced by this community health experience, because our centre had endured much turmoil in implementing a community-based vision of primary health care, and this had deleterious effects on team relations. My pursuit to gain scholarly knowledge about IPC was driven by my interest to make sense of the internal and external dynamics that influence team practice. Visions of what might be, yet could not be attained, led me to the academy to explore and discover from a new standpoint. My quest to better understand the concept of IPC became a reflexive journey of exploring the literature, entering into networks of learning, and creating a presence with respect to my contributions. By delving into the known, distinguishing the knowers, and identifying the unknown, my clarity increased and further aroused my curiosity, and my passion grew. As synchronicity would have it, I was invited to participate in the Health Canada IECPCP initiative, and was also accepted as a student of the

CHSRF/CIHR Advanced Practice Nursing Research Chair. These two networks provided me opportunities to explore and ground my scholarship in IPC and NP role development.

Chapter 4 begins with a discussion of three reviews relevant to IPC and from this I show the need for further research, and the relevance of my study in adding to this knowledge base. Chapter 4 is thus written as a findings chapter, because it represents the knowledge synthesized from an extensive literature review, consultation with experts in the field, and the actual NP inquiry. Through a reflexive process, I examined the concept of IPC and uncovered multiple dimensions that influence practitioner relations. My understanding of the concept of IPC transformed from that of internal team dynamics to a complex ecological construct, which I named *collaborative health care culture*. I came to see that IPC was embedded within societal, health system, and health organization contexts, all of which significantly influenced the collaborative capacity of practitioners and teams. By drawing upon research and grey literature, I linked IPC to health care outcome targets at the system, organization, team, practitioner, and client levels. I explored each of these sector levels to identify elements associated with IPC. An ecological framework emerged that mapped this broader view of *collaborative health care culture*, and this new conceptualization informed and shifted somewhat the focus of my research question and study. An eco-map depicts these interrelations, and I describe in detail this ecological framework of collaborative health care culture. A discussion section outlines the contributions made by NPs during the inquiry to modify and substantiate this framework. The conclusion of this chapter provides a definition of collaboration with respect to collaborative culture.

Relevance of Interprofessional Collaboration

IPC is increasingly reported to contribute to multiple health care benefits, yet the actual outcomes are not fully substantiated. Three particular knowledge syntheses are reviewed here before I proceed with outlining the collaborative culture framework. The first is a Health Canada (2004a) report titled “Interprofessional Education for Collaborative Patient-Centred Practice” (IECPCP) that was developed by a national expert committee and encompassed a literature review, environmental scan, and ten issue papers. The committee examined interdisciplinary education and collaborative practice models in Canada, the United States and the European Community, developed a conceptual framework and reported findings and recommendations. With respect to effectiveness, some evidence was found that post-licensure collaborative practice improves quality of care and patient outcomes, primarily related to hospital care; however little evidence was available to indicate that pre-licensure interdisciplinary education improves client outcomes. These findings parallel the following review by Reeves et al. (2008). As well, the elements of collaborative practice and interdisciplinary education were examined in the report; however I discuss here only the collaborative practice elements. Collaboration was revealed to be a complex, voluntary and dynamic process involving many skills. Studies identified interactional determinants, however structural and macro determinants related to organizations and systems had largely been ignored in the literature. This had important implications for my research, which conceptualized macro structures of collaboration. The environmental scan included a survey sent to 550 people with 316 responses, of which 91 reported collaborative practice initiatives. Collaborative practice initiatives were found in 41.9% of primary care settings

surveyed, 14.5% of tertiary care settings and 6.5% of rehabilitation setting. The final IECPCP report outlines a conceptual framework, which depicts interprofessional education process and outcomes and collaborative practice process and outcomes, framed within systemic factors and social cultural values. The IECPCP framework and much of the report findings are published in a Journal of Interprofessional Care Supplement issue (May 2005). The collaborative culture framework outlined in this chapter builds upon and adds further detail to the collaborative practice aspects of the Health Canada (2004a) framework.

The second synthesis is a Cochrane systematic review by Reeves et al. (2008) carried out to assess effectiveness of interprofessional interventions on professional practice and health care outcomes. The review found six studies that were either randomized controlled trials, controlled before and after studies, or interrupted time series studies. This built upon a previous review by Zwarenstein et al. (2000), in which no studies were found to meet Cochrane criteria. Of the six studies identified by Reeves et al. (2008), four studies reported that interprofessional education improved how professionals worked together and the care they provided, while two found interprofessional education had little to no effect on any dimensions of care. This two-step cause and effect relationship, in which effects of interprofessional education on collaborative practice, and in turn, effects of collaborative practice on client care and outcomes is studied, has been difficult to satisfy Cochrane review standards that preference randomized control trials. Nonetheless, the authors continue to assert that lack of evidence of effect does not mean there is an absence of effect.

The third is a CHSRF (2007) synthesis of IPC and quality PHC, which focused on evidence and benefits of IPC to patients and providers. This systematic review examined peer-reviewed literature, 65 of 227 articles were included; grey literature, 70 of 161 documents included; findings from Primary Health Care Transition Fund (PHCTF) initiatives, 71 of 147 included; and the review also included a Canadian environmental scan with 46 survey respondents. Inclusion criteria and a grading system were based upon previous frameworks established in the literature; the review determined that 42% of the evidence was moderate-high level, and specific to client outcomes in chronic disease management and some special needs populations, such as the elderly. The remainder was determined to be of low or very low quality evidence. Overall, IPC was related to numerous benefits and positive effects for providers, patients, and the health care system. As well, several research gaps were identified with respect to IPC and PHC, IPC and general population outcomes, IPC and model variations, and related costing implications.

My conclusion from examining these reviews is the need for continued research. There is still little understanding of the complexities of collaboration. Collaborative practice has been primarily studied from the perspective of individual practitioners or team dynamics; the external influences on collaboration have largely gone unaddressed. As well, there is little known about what constitutes health care culture or how health care culture influences collaborative practice. Diverse approaches to research are called for in order to uncover the multidimensional influences on and results of collaboration.

A Reflexive Process

In retrospect, my quest to understand IPC moved back and forth between first-, second-, and third-person forms of inquiry, thus affirming the non-linear nature of PAR.

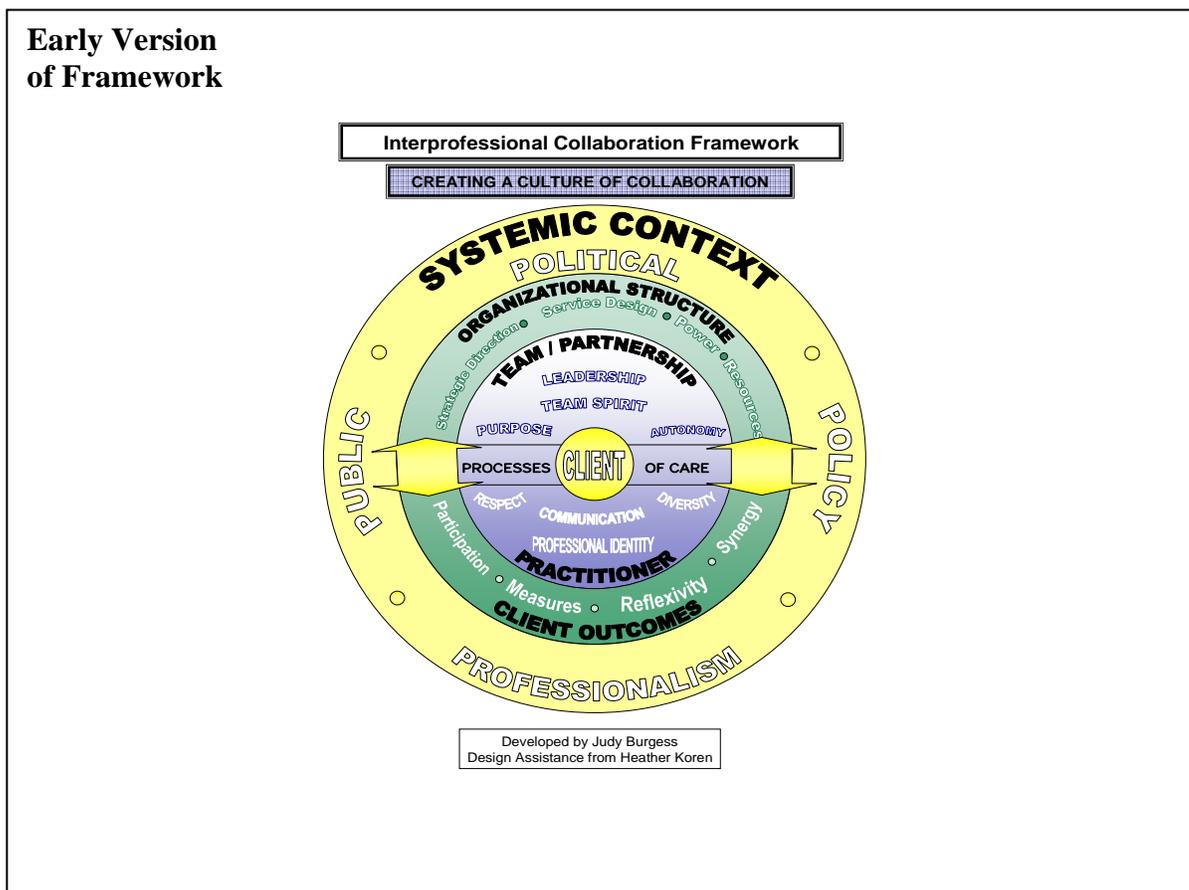
However, this reality also makes it difficult to present because the framework emerged in stages, yet for ease of reading, I have presented it in a single chapter as a final product. First-person action research represented a reflexive process of knowledge development, where knowledge from my past practice and experience in PHC teams merged with new learning from an extensive and continuous literature review. To begin with, I was particularly intrigued by the preoccupation of many leaders in the interprofessional network to identify practitioner competencies of collaboration so that interventions could be designed to improve IPC and teamwork. I found this to be a limited view that put the onus on practitioners to effect change, and my practice experience told me otherwise. In my practice world, our good teamwork intentions had not overcome the challenges of reconciling funding pressures and quality of care issues, nor had they addressed inadequacies in communication systems, organizational and professional policies, and evidence-based measurements. So, I set out to explore the literature and gain new insights about IPC. I used a semi-systematic approach to knowledge synthesis, best described as a drawn out scoping review of the literature. According to Arskey and O'Malley (2005), a scoping design is useful when the study question is undefined, and the aim is to gain a broad view of the literature in order to map key concepts. This scoping review, like PAR, was also not linear, but iterative, as my thinking about IPC evolved from that of concept to conceptual framework. My literature search included databases of CINAHL, Medline (EBSCOHost), and Cochrane Collection (EBSCOHost). I started with the key terms: interprofessional collaboration, interprofessional education, collaborative practice, interdisciplinary, multidisciplinary, teams, and teamwork. Then, I expanded my search to include the terms: primary health care, nurse practitioners, client-centred care, healthy

workplace, and organizational culture. The search also included grey literature from websites of national associations and program initiatives related to these topics, and I also tracked references from seminal sources. Grey literature became significant, because knowledge synthesis of IPC was taken up by a number of research bodies over the course of my studies (Canadian Health Services Research Foundation [CHSRF], 2007; CNPI, 2006a; EICP, 2006; Health Canada, 2004a).

As I uncovered the multifaceted nature of IPC and collaborative culture, I moved into second-person action research, where I consulted and reflected with others in my expanding networks and presented variations of an increasingly complex framework to key stakeholders and at academic conferences. As my study design and analysis evolved, I came to see the complexity of IPC from an ecological perspective of nested and interconnected relationships. I identified health care outcome targets associated with IPC from the literature and categorized them according to stakeholder sectors and levels; these included improved client health outcomes, practitioner client-centred care, team role integration, healthy organization workplaces, and system effectiveness in health human resources. Subsequently within each of these sectors or levels I mapped out elements that were associated with these health care outcomes. These multi-level elements comprised certain values, structures and processes necessary to advance IPC (Davoli & Fine, 2004; C. MacDonald, 2002). The development of an eco-map served to depict how sub-sectors and elements dynamically influence and are influenced by the targeted health care outcomes (Fitzgerald & Teal 2004; Flood & Fennell, 1995). I renamed the evolving ecological framework *collaborative health care culture*. Thus the inherent theoretical premise of the framework was that by shifting prevailing health care

subcultures and cultures toward a collaborative frame, the targeted health care outcomes would more effectively be realized. Figure 1 depicts my early eco-map version, prior to the NP study.

Figure 1: Early Version of Framework



In the stage of third-person action research, this ecological framework was further shaped and reshaped as I applied it to my PAR inquiry with NPs and they provided input to refine it. The PAR inquiry served to create reciprocal effects. By re-conceptualizing IPC as collaborative health care culture, I shifted my assumptions about the NP inquiry. I had initially expected to focus on IPC and NP interactions between colleagues and within teams, and instead opened up the inquiry dialogue to explore the NP experience of collaboration within the broader context of health care culture. In turn, by exploring with

NPs their understanding, experiences, and practice of collaboration, elements of the framework shifted and in-depth understanding within and between the elements was revealed. The modification and substantiation of the eco-map by NPs during the PAR inquiry is discussed at the end of this chapter. Thus in this first-, second-, third-person action research process, I set out to explicate the concept of IPC and through a reflexive progression of past, present, and future inquiry, I morphed and transformed my understanding of IPC into a complex ecological framework, which I termed *collaborative health care culture*. Consequently, for the NP inquiry my initial research question of “how does *IPC* advance NP role integration” was re-framed to “how does *collaboration* advance NP role integration” where collaboration is understood as a much broader concept than interprofessional collaboration and its limited focus on team interactions.

Employing an Ecological Approach to Understand Complexity

There is growing interest in ecological models for understanding complex issues. Ecological models and frameworks characterize an issue with respect to a wide range of environmental influences (McLaren & Hawe, 2005; Sallis et al., 2006). An ecological perspective takes in the more expansive physical, social, cultural, historical and political contexts, including local and global trends, and examines the interrelatedness of these multiple relations (McLaren & Hawe, 2005). Ecological models also presume that interventions will be most effective if applied at multiple levels and engage multiple stakeholder groups (Sallis et al., 2006). Thus, in the examination of IPC, by way of an ecological approach I posit that practitioner and team collaboration is not merely influenced by psychosocial variables, but involves a wide range of influences at multiple levels that affect the ability of practitioners and the capacity of teams to collaborate. As a

guide to action and change, the collaborative culture framework also outlines a range of elements, in which potential interventions could be directed so as to enhance collaboration and shift health care toward a more collaborative culture.

Bronfenbrenner's (1977) ecological typography was adapted and used to organize the factors influencing collaboration at multiple levels, and to explicate the complexities within this broad framework. IPC and its associated potential outcomes were mapped in relation to health care subsystems at micro, meso, endo⁸, exo, and macro levels. Within the framework, at the *micro* level, the client experience and client outcomes were located at the centre of importance; the term of 'client' is used here in both an individual and collective sense. Thus, to the extent that IPC is effective, then the client experience and health outcomes would be realized. The *meso* level denotes the practitioner level with the desired outcome of IPC being improved client-centred care. The *endo* level signifies the team and network level and the outcome of IPC would be enhanced role integration. This is a primary focus for the dissertation study. The *exo* level represents the health organization and the outcome of IPC would be a healthy workplace. Finally, the *macro* level denotes the system level of national and provincial policy decisions to achieve the outcome of sustainable health human resources. Consequently, the concept of IPC shifted from its original focus at the practitioner (*meso*) level to comprise a more complex conceptual framework of collaborative health care culture that integrates the influences and actions of multiple levels.

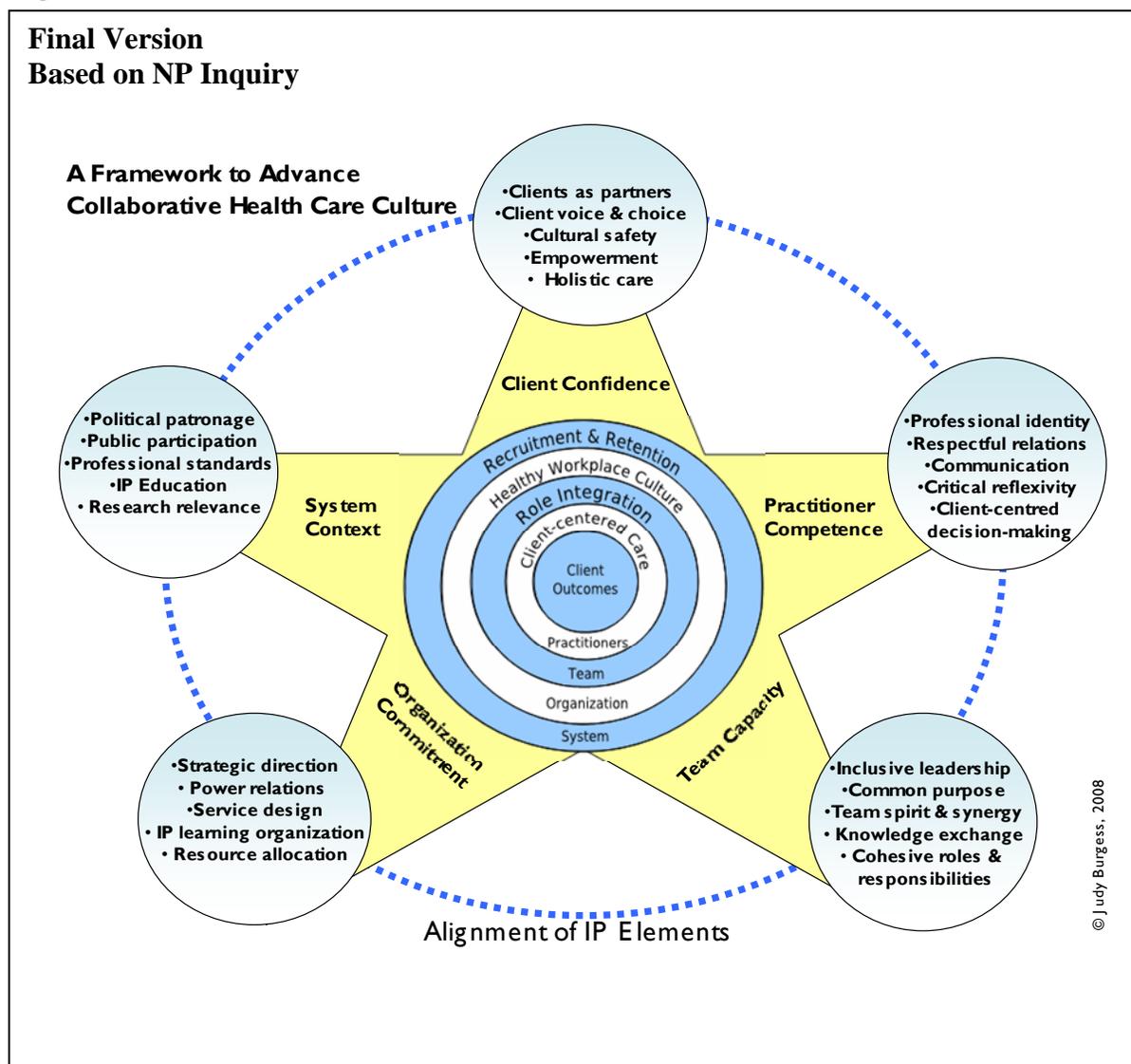
⁸ Bronfenbrenner (1977) ecological system includes micro, meso, exo, and macro subsystems. This model was adapted by the author to include the endo subsystem, which denotes the team level of interaction in the collaborative culture framework.

As the collaborative framework emerged, the implications of effecting health care culture change by influencing multiple levels of system, organization, team, practitioner, and client levels seemed enormous. This meant shifting health care values and beliefs, policy structures, and processes of care (McCormack et al., 2002; Scott, Mannion, Davies & Marshall, 2003a). And with respect to Canada's health system this was a tall order, because health care delivery is primarily provincially or territorially mandated and in most provinces structured as regional health authorities. To shift health care culture in such large service structures seemed an improbable challenge. Nonetheless, if NP role development was reliant on team and collaborative relations and IPC was only part of the picture, then I needed to understand this bigger context and its implications. A literature review by Scott, et al. (2003a) that focused on the nature of organizational culture and culture change was helpful because it identified two broad streams of culture. The first stream explicated culture as one attribute of an organization's many qualities, while the second viewed culture more globally and defined culture as the whole character of organizational life. The authors also explored subcultures that either relate back to the dominant culture or have their own distinct culture as separate from the organization. This analysis raised the possibility that incremental subculture change could take place, and an argument might also be made that subculture improvements could serve to demonstrate and influence transformative change at the larger organization and system levels (Rachlis & Kushner, 1994; Scott et al., 2003a, b). However, from an ecological perspective the best scenario for constructive change is to engage all levels of the health care system in cultivating common vision and purposeful aims.

Accordingly, the premise of this ecological framework is that each of the sectors or stakeholders must shift and align their spheres of influence toward a collaborative philosophy. The collaborative culture framework makes explicit, the implicit elements that need to be addressed by each stakeholder group in order to advance collaborative culture. Advancing collaborative culture entails a philosophical alignment of the interrelated health care values, structures, and processes of care, with the aim of improving health care performance. The combined intent of enhancing system, organization, team, practitioner, and client interactions and performance is expected to improve client care and ultimately client outcomes. However, further research is needed to verify this framework, with respect to certain elements that warrant additional study, and as a whole in how each of these sectors and their respective elements interrelate and influence each other. The collaborative framework continues to evolve, and is currently being applied in the design of a survey to evaluate the interprofessional experience of Ontario registered practical nurses. I envision design of other measurement tools, educational activities, practice strategies, and policies based upon the framework. My intention for the framework is that it offers direction in designing suitable interventions and guiding actions of various stakeholders, such as policy and decision-makers, health care leaders and researchers, teams and practitioners, and clients and communities. For this study, the collaborative framework was employed first as a tool to guide questions and dialogue with the NPs during the inquiry process, and then as an analytic framework to guide the analysis of data related to NP collaboration and role integration. The following accounts for my knowledge about and understanding of IPC and collaborative health care culture. Figure 2 is an eco-map to depict the finalized framework that

emerged from the NP inquiry. I follow this with an overview of the collaborative culture framework, and then provide a detailed explanation of its component levels and elements. I have also included Figure 2 of the final framework as Appendix G, for easier retrieval.

Figure 2: Final Version of Framework



An Overview of the Collaborative Culture Framework

IPC is generating provincial, national, and international attention. With respect to Canada, I found IPC to have relevance to certain health outcome targets. These health outcome targets are depicted in the centre of Figure 2 as concentric circles. From a

systems perspective, IPC is associated with health human resource recruitment and retention, and resultant impact on system efficacy, particularly that of PHC. From a health organization view, IPC is intended to enhance healthy workplaces and quality service improvements. At the team level, IPC is expected to advance role integration and team effectiveness. At the practitioner level, IPC aims to strengthen client-centred care and enhance provider satisfaction. Ultimately, IPC is expected to improve the client experience of care and client outcomes, thereby contributing to system sustainability.

I also explored each of these levels of system, organization, team, practitioner, and client, and explicated specific elements, which are depicted in Figure 2 as a constellation of interconnected spheres. With respect to the health system context, advancing collaborative culture was deemed to be influenced by such sectors and elements as political patronage, public participation, professional standards, interprofessional education, and research agendas. Regarding health organizational structures, influential elements included strategic directions, power relations, service designs, an interprofessional learning organization, and resource allocations. With respect to program design and team capacity, influential elements were noted as inclusive leadership, common purpose, team spirit and synergy, knowledge exchange, and cohesive roles and responsibilities. Concerning practitioner competencies, influential elements were identified as clarity of professional identities, respectful relations, effective interpersonal communication, critical reflexivity, and client-centred decision-making. And finally, with respect to clients and communities, IPC and collaborative culture were influenced by elements of clients as partners in care, client voice and choice, cultural safety, knowledge as empowerment, and holistic care.

In the discussion below I discuss the targeted health care outcomes associated with IPC, and outline each of the system levels and associated elements of the framework and present the literature supporting their inclusion. Thus, the framework represents a hypothesized theoretical representation of collaborative health care culture. My premise is that all levels and stakeholders of the health system must attend to their respective spheres of influence to improve collaboration and thereby advance collaborative health care culture. As noted above, this framework guided the inquiry process with NPs and their input contributed to the refinement of the framework and its final elaboration. The final product will need to be further validated through subsequent research.

IPC Targeted Outcomes

IPC: A Systems Perspective of PHC and HHR Planning

Virtually all major health reports in Canada in recent years highlight PHC as key to health care reform (CIHI, 2006a; Health Canada, 2006a, b; Kirby, 2002; Romanow, 2002). The focus on PHC has been a major incentive to advance a team approach to care and draw attention to the issue of collaboration. The First Ministers meeting of 2000 identified the goal of an integrated and interdisciplinary approach to primary care, and in 2002 the national government established an \$800 million PHC Transition Fund. The 2003 First Ministers Accord on Health Care Renewal and 2004 10-Year Plan committed to work on collaborative strategies for PHC, interprofessional education, as well as health provider recruitment and retention (Health Council of Canada, 2005). The Enhancing Interdisciplinary Collaborative Practice Initiative (2006) received Transition Funding to bring key leaders together to focus on collaboration and PHC teamwork. In addition, a National Expert Committee was commissioned, under the auspices of Health Canada's

Office of Nursing Policy and developed an extensive report titled “Interprofessional Education for Collaborative Patient-Centred Practice” (IECPCP), which along with ten issue papers, outlined a literature review, national and international trends, a developmental framework, and findings and recommendations (Health Canada, 2004a). Subsequently, Health Canada provided funding to initiate provincial / territorial interprofessional project demonstrations, with project reporting now complete (Burgess & Purkis, 2008; Herbert, 2005). The Canadian Interprofessional Health Collaborative (CIHC, 2008) was also funded to create a national network and central repository for IECPCP and related initiatives.

Health Canada’s Health Human Resource (HHR) Strategy has been guided by a threefold effort of HHR planning, recruitment and retention, and IECPCP (Health Canada, 2004a, b; 2006b). HHR planning is also a key priority of many national fora and networks; to name a few, are the Health Council of Canada (2005), the Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources (ACHDHR, 2007), the Canadian Health Services Research Foundation (CHSRF, n.d.), and the Quality Worklife – Quality Health care Collaborative (QWCHC, n.d.). The Health Council of Canada, founded by government on advisement of the Kirby Report (2002) and Romanow Commission (2002), has clearly linked HHR strategies to a focus on teams, and recommends addressing regulatory and scopes of practice issues, IPE and collaborative learning, technology and other incentives, and collaborative planning at local and national levels. The ACHDHR authored a Pan-Canadian framework, which outlines principles of HHR planning in respect to population needs, patient safety, cultural sensitivity, interdisciplinary models of care, and healthy workplaces. The

CHSRF priority research theme of workforces and workplace environment focuses on healthy health care workplaces and has funded and synthesized a number of reports and initiatives that draw attention to the value of effective IPC and teamwork. The QWCHC represents a coalition of national health leaders to address the issue of quality of work life for health providers.

These strategic initiatives highlight the extent to which IPC is associated with PHC and HHR planning, through the work of many influential national bodies. IPC is an integral focus of PHC renewal and its team approach to care. As well, IPC is seen as a response to HHR issues of worker shortages and recruitment and retention; particularly, as the locus of control shifts from employers and agendas of economics and efficiencies to employees and their interests in quality healthy workplaces. By drawing on these national reports that profile the value of IPC, I make the case that IPC is actually embedded in a bigger context of health system renewal, and that by advancing collaborative health care culture, more effective progress can be made with respect to PHC and system efficacy.

IPC: A Health Organization View of Healthy Workplace Innovation

Numerous health care challenges compel health organizations to take up more integrated and interdependent models of service delivery. Health organizations face rising costs of bio-technology, an aging population, issues of inequitable access, human resource shortages, and concerns about evidence-based quality assurance (CHSRF, 2006; CNA, 2005a, 2005b; Health Canada, 2004b; Romanow, 2002; Shamian & El-Jardali, 2007). From a health organization view, the premise of IPC is to support healthy workplaces, increase worker satisfaction, enhance service integration and foster

innovative care delivery models (Curran, Sargeant, & Hollett, 2007; Kinnaman & Bleich, 2004; Sicotte, D'Amour, & Moreault, 2002). However, IPC entails a new way of delivering health services, and this requires adaptation of health system structures and provision of relevant resources, and it also requires practitioners and teams to re-balance work tasks so as to attend to processes of care (Curran, et al., 2007; Hutchinson, 2008; Oandasan & Reeves, 2005b).

At the health organization level, the predicted concerns about health provider recruitment and retention have transpired; many, if not all health organizations have health provider shortages (WHO, 2006). With the nursing profession as the largest professional workforce in health care, efforts to recruit and retain nurses have attuned leaders to healthy nursing workplace conditions (CIHI, 2006b). Shamain and El-Jardali (2007) reviewed healthy workplace initiatives and reported improvements in recruitment and retention, workers' health and well-being, quality care and client safety, organizational performance, and societal outcomes. Healthy workplaces were also linked with innovative service designs and quality improvements. The authors call for continued strategies in this area to ensure policy initiatives bring about effective changes to workplaces. Yet workplace sub-cultures are noted to be influenced by dominant organizational culture and shifting organizational culture is difficult (Fitzgerald & Teal 2004; Flood & Fennell, 1995). Some policy analysts suggest that incremental policy changes are not enough to shift organizational and system culture and transformative measures are needed instead (Hutchinson, 2008; Rachlis & Kushner, 1994; Scott, et al., 2003a; van Soeren, Hurlock-Chorostecki, Pogue, & Sanders, 2008).

This has implications for team collaboration because organizational culture and healthy workplaces are known to influence teamwork (CHSRF, 2006; Jones & Way, 2007; Shamian & El-Jardali, 2007). For instance, in large organizations with significant hierarchy and power inequities there is a tendency toward diminished collaboration (Arford, 2005). Conversely, CHSRF (2006) reports that team collaboration is promoted by a clear and supportive organizational philosophy, with related strategic plans and policies. IPC is also seen as a strategy to advance healthy workplaces and contribute to new care delivery models, evidence-based practice, professional development, and the ethos of a learning organization (Newman & Papadopoulos, 2006; Soklaridis, Oandasan, & Kimpton, 2007). Thus, there seem to be reciprocal effects and benefits by attending to both healthy workplace strategies and interprofessional teamwork (Greco, Laschinger, & Wong, 2007; Jones & Way, 2007; Laschinger, 2007). Jones and Way (2007) note that healthy workplace strategies mirror those of interprofessional teamwork, and require leaders and champions to promote IPC. McCormack et al. (2002) suggest that transformational leaders influence cultural values and behaviours, by employing more participatory and horizontal approaches to decision-making. Koerner and Wesley (2008) report that knowledgeable empowered workers flourish in creative, adaptable and collaborative cultures, as demonstrated by Magnet Hospital research (Aiken, Sloane, & Sochalski, 1998). Thus, by drawing on the literature and initiatives associated with improving healthy workplaces, I contend that healthy workplace and collaborative health care culture have synergistic aims, as each complements and reinforces the other.

IPC: Role Integration Enhances Team Performance

Increasing complexity in client care has driven an interprofessional imperative for teamwork and client-centred practice, yet development of teams has not come easily (D'Amour & Oandasan, 2005; Hall, 2005; Heinemann & Zeiss, 2002; Reeves, et al., 2008; Schmitt, 2001; Shaw, Lusignan, & Rowlands, 2005; Yeager, 2005; Zwarenstein, Reeves, & Perrier, 2005). To understand the challenges of interprofessional teams, it is important to examine how discipline-specific silos developed. A history of gender, social class and race underlie professional distancing of current day teamwork (Hall, 2005; McPherson, 1996). Medicine, as one of the first organized health professions, acquired control over all patient and team matters. New health care roles came about alongside bio-medical and organizational advancements (Barr, 2002). Professionalization transpired as each discipline delineated an exclusive body of knowledge, scope of practice, unique skills and distinct value base (Gilbert, 2005b; Hall, 2005). Silo structured professional schools developed to reinforce learners in disciplinary values and discourse (Oandasan & Reeves, 2005a). Professional colleges and regulatory bodies formed to regulate members in standards of practice (Lahey & Currie, 2005; Purkis & Nelson, 2006). Emphasis on practitioner independence, rather than interdependence, strengthened the status of professions, while at the same time socialized members to distance each other (Henneman, Lee, & Cohen, 1995). Professional cultures, reinforced by their respective prevailing values, came to identify and frame health concerns from an exclusive perspective (Barker, Boscoe, & Oandasan, 2005; Ginsburg & Tregunno, 2005). This historical cultivation of professional roles and cultures has had significant bearing on development of interprofessional teams and teamwork dynamics.

An increase in client and system complexity, expansion of disciplinary sub-specialties, and need for holistic and population approaches to care, has called upon health providers to work collaboratively within and among professions. Yet there is still very little organizational support of teams. A recent literature review by Xyrichis and Lowton (2007) examined studies that focused on team-working processes. The authors found little reference in these studies to organizational responsibility and support for teams, and note that in the absence of organizational leadership, the medical profession has tended to assume control of teamwork in PHC. This is in spite of the fact that nursing is the largest professional group to provide direct client care and the group that primarily serves the coordinating and communicating role. Legislation and regulation that eliminates unnecessary restrictiveness and provides broader flexibility in regulatory frameworks are noted to support interprofessional practice (Lahey & Currie, 2005; Thornhill, Dault, & Clements, 2008). The silo-structured education system is reported to be a significant barrier to IPC (Oandasan & Reeves, 2005a). There is a need for significant changes to system, professional, organizational, and educational approaches to foster integrated professional roles and responsibilities, and ensure teams work cohesively to provide high quality client care. In addition, these larger system contexts must create supportive and coordinated structures and processes to accommodate the increased specialization and role development within and between disciplines.

Role integration and team performance is intended to improve health care efficiencies and effectiveness (CHSRF, 2006). Interprofessional efficiency is linked to such expected health care results as lower readmissions, decreased emergency room visits, more timely referrals, and cost-benefits, and has been described by the adage: “the

right service is provided at the right time, in the right place and by the right provider” (CNA, 2005c). Interprofessional effectiveness is tied to results of improved client self-management and outcomes, delivery of a broader range of services, reduction of health care errors, and improved client and provider satisfaction, and has been described by a common saying: “the whole is greater than the sum of its parts”, hence the connection to teamwork and team synergy (CHSRF, 2007). Yet, despite the significant interest in and promise of team care, the concepts of teamwork and IPC lack clarity. A concept analysis of *teamwork* was undertaken by Xyrischis and Ream (2007) to determine a definition:

“Teamwork is a dynamic process involving two or more health professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physical and mental effort in assessing, planning, or evaluating patient care. This is accomplished through interdependent collaboration, open communication and shared decision-making. This in turn generates value-added patient, organizational and staff outcomes.” (p. 238)

This definition provides a good view of teamwork within a limited internal context. It does not, however, reflect the complexity of teamwork, in which external conditions often influence and affect the capacity of teams. The interrelated structures and policies in health care have significant influence on teamwork. As well the definition uses the term collaboration to describe teamwork, yet collaboration is not well defined in the literature (Henneman, et al., 1995). Currently, there is no specific definition referenced in the literature for IPC. However, Way, Jones and Busing (2000) defined collaborative practice as: “an inter-professional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided” (p.3). Again, this definition lacks a broader health care context, which I find limiting, as quality client care depends upon organizational features of service design, staff mix, and resource availability, as

well as system elements of politics, policies, professional standards, and educational approaches, all of which influence IPC. In exploring the history and development of professional cultures and professionalization, I take the position that IPC and team role integration are significantly affected by organization and system cultures, and that by advancing collaborative health care culture, synergistic enhancement of IPC and integration of team roles would result.

IPC: Client-centred Care and Practitioner Satisfaction

There is still little understanding of what constitutes client-centred care in the context of IPC. The term client-centred is used here, instead of patient-centred or person-centred, in order to broaden the view of client as individual, family, community, or population. Client-centred as a term is noted by Kelleher (2006) to have originated from Karl Rogers' (1951) theory, which advocated a bio-psycho-social model of care. To-date, client-centred literature has focused predominantly on the individual perspective of client. The Health Canada IECPCP initiative commissioned an issue paper by Brown on collaborative patient-centred clinical practice (Health Canada, 2004a). Brown describes a model of six interactive components for physician-patient interactions, including: exploring both the disease and illness experience, understanding the whole person, finding common ground, incorporating prevention and health promotion, enhancing patient-doctor relationship, and being realistic. This model is specific to physicians, yet these are very familiar concerns of the nursing profession, which advocates for client-centred and holistic collaborative practice (CNA, 2003a, 2005b). The nursing synergy model adds to this discussion. The nursing synergy model was derived from critical care nursing, and highlights patient characteristics and competencies that influence the

characteristics and competencies of nurses. The matching of patient and nursing characteristics is said to create synergy in adopting a patient perspective, meeting the ethics and standards of care, and attaining mutual goals (Annis, 2002, Kelleher, 2006). This issue of ethics and standards of care in interprofessional practice raises further complexity to client-centred care, because IPC requires practitioners to openly discuss their diverse moral values and find common ground in providing client-centred care (Clark, Coot, & Drinka, 2007).

The influences of IPC on client-centred care and subsequently on client outcomes are not well substantiated in the literature and require more research to validate the relationship and identify specific outcomes; yet, the limited evidence that is available is compelling (CHSRF, 2007; Reeves et al., 2008; Zwarenstein et al., 2000). As mentioned, Magnet Hospital research provides some links between quality client-centred care and nurse workplace satisfaction (Aiken et al., 1998; Aiken & Patrician, 2000; Scott, Sochalski, & Aiken, 1999). Other studies show nurses are more satisfied with primary nursing, because their autonomy to establish effective client relations and quality of care is increased (Rafferty, Ball, & Akiken, 2001). Research is also needed with respect to dimensions of nurse satisfaction within the context of PHC and community nursing. My contention is that client-centred care and improved client outcomes need to be examined with respect to the broader view of health care culture. High quality client-centred care depends upon many factors that go beyond client-practitioner-team relations, such as client control in health care, practitioner autonomy in care decisions, effective team leadership, and program design and resources. Thus, client-centred care is influenced by

external organizational, professional and system conditions, and is fostered by collaborative health care culture.

In summary, health outcome targets associated with sustainable health human resources, healthy workplaces, integrated team roles, client-centred care and client outcomes have been increasingly linked to IPC as a responsive strategy. Yet the view of IPC remains that of improved practitioner-team interactions. In my opinion this view is too narrow and simplistic, and that a broader conceptual framework is needed to understand the nature of collaboration, and this is reinforced by other scholars in the interprofessional network (Herbert, 2005; Oandasan, 2008). This ecological framework referred to as *collaborative health care culture* identifies levels of influence in the health care system and hypothesizes that all levels and stakeholder groups of the health system need to be onsite, attend to their respective spheres of influence, and align values, structures and processes of care. This commitment to collaborative culture will foster incremental sub-culture efforts at local levels and create transformative change at the organization and system levels. The next section delineates macro to micro stakeholder levels and constituent elements to advance collaborative health care culture.

Alignment of Collaborative Elements

The System Context Influences IPC

Canada's publicly funded *health system context*, compelled by rising costs, quality care issues and impending health worker shortages, has deemed IPC a responsive strategy that will contribute to system sustainability. To shift and shape a health care system toward a collaborative culture, it is critical to align political, professional, public, education, and research sectors toward an interprofessional policy agenda. As policies are

often based in values, goals, and principles, accountability in each of these sectors will be achieved by vetting all policy decisions through an interprofessional lens (Clarke, 2006).

Political patronage of IPC is generated by societal pressure to sustain and extend our publicly funded health care system, and is specifically tied to system priorities of PHC renewal and HHR recruitment and retention (CHSRF, 2007; EICP, 2006; Health Canada 2004a; 2006b, 2006c). Legislation rulings that clarify scopes of practice and extend professional autonomy and latitude for responsive care are needed (Gilbert, 2005b; Lahey & Currie, 2005; Shamian & El-Jardali, 2007). Federally funded PHC and IPC initiatives have generated national knowledge exchange, and laid groundwork for provincial and organizational uptake of innovations. The Ontario government contributed \$15 M over a two year period of 2006-2008 toward interprofessional strategies. Similar commitments must be encouraged by other provinces. Continued national and provincial efforts to further the aims of PHC and IPC are essential, and this involves concomitant attention to collaborative workplace culture (Curran, et al., 2007; Herbert 2005; Hutchison, 2008; Katz, 2008).

Public participation in Canada's health care system represents a symbol of democracy to the citizen electorate (Abelson & Eyles, 2002). Universal funded access to medical and hospital care was attained in the 1950s; publicly funded health care continues to be given priority as an election platform (Kirby, 2002; Rachlis & Kushner, 1994; Romanow, 2002). Yet public participation is largely missing in the discourse about IPC and related policy making, and this must be addressed in order for real progress to take place in cultivating collaborative health care culture. Public participation will ensure

there is a client and community voice in culture change, which in turn, will strengthen collaborative health care partnerships.

Professional standards vary with respect to endorsement of IPC. There is a need for all national and provincial professional associations and regulatory bodies to recognize the merit of IPC and incorporate relevant core indicators into educational benchmarks and practice standards (Gilbert 2005b). Problematic issues of professional liability and regulatory mechanisms continue to compromise provider autonomy and require national and provincial attention (Curran, et al., 2007; Lahey & Currie, 2005). Medico-legal safeguards and appropriate protective liability must be put in place to enable interprofessional practice (CHSRF 2006; IBM 2003; El-Jardali 2003). Integration of IPC into professional norms will foster improved inter-association relations (CNA 2003a, 2005b; Frank, 2005).

Interprofessional Education is not well incorporated into post-secondary curricula, and the prevailing silo-structure and uni-professional education processes of post-secondary schools are a serious concern to the advancement of IPE and IPC (Barr, Freeth, Hammick, Koppel & Reeves, 2006; Gilbert, 2005a, 2005b; Hall, 2005). Overly demanding and slow to adapt curricula, as well as lack of interprofessional faculty development and incentives are barriers (Burgess & Purkis, 2008). Student requests for interprofessional learning opportunities are motivating faculty champions to advocate for IPE curricula development. Academic accreditation that includes parameters of IPE also induces education programs and institutions to incorporate concepts and practice of IPE and IPC into core curricula (Gilbert, 2005b; Oandasan & Reeves, 2005a).

Research Agenda of national research foundations such as CHSRF and CIHR have begun to prioritize collaborative approaches in funding allocations. CHSRF (2007) makes a strong case for rigorous research of IPC in relation to PHC renewal. The interprofessional research community is slowly growing in Canada, as indicated by the extensive Canadian representation at academic conferences (All Together Better Health IV, 2008). An international network has been formed to link worldwide interprofessional initiatives and Canadian leaders are champions of this initiative (InterEd, 2007). However, within academic institutions, individualized and discipline-specific research is still prevalent and there are few incentives to foster collaborative research. Significant restructuring of research recognition and rewards is needed to shift the agenda toward collaborative research.

Organizational Influences of IPC

The philosophy, structure, and size of organizations give rise to workplace culture and subcultures. Healthy workplaces are driven by an agenda of provider recruitment and retention, and are seen to be aligned with IPC (Fitzgerald & Teal, 2003; Jones & Way 2007; Laschinger 2007; Shamian & El-Jardali, 2007). Advancing a culture of collaboration is highly influenced by *health organization commitment* to reframe strategic directions, power relations, service designs, an interprofessional learning focus, and resource allocations (Bishop, 2008; Koerner & Wesley, 2008; Latham, Hogan, & Ringl, 2008).

Strategic directions are set by health care organizations, in response to societal values and political and policy decisions of system reform (D'Amour & Oandasan, 2005; Fitzgerald & Teal, 2004). Clear strategic directions guide philosophical consistency in

service design and delivery. Health organizations that convey an interprofessional philosophy and vision create enabling conditions for leaders and practitioners to partner collaboratively with recipients of care (Ginsburg & Tregunno, 2005; Health Canada 2004a; Jones & Way 2004; San Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005). Decentralized, nonhierarchical and flexible organizations are considered to be most conducive for fostering collaboration (Health Canada, 2004a).

Power relations refer to hierarchical inequities that contribute to internalized silencing of practitioners, and externalized conflict in teams and within the organization; in this situation, tensions and mistrust counter collaboration (Henneman, et al., 1995; Martin & Hutchinson, 1999). Power relations are best addressed at the organization level, where organizational leadership sets the tone of organizational values and health care delivery expectations. Egalitarian leaders explicitly identify power relations, open up dialogue to varying professional and client perspectives, elicit confidence in application of knowledge, and finesse sensitivities to overcome conflicts (Caldwell & Atwal, 2003; Hills & Mullett, 2005; Martin & Hutchinson, 1997). Organizational leaders who believe in a 'democracy of talents' (Billups, 1987), are able to more effectively use the competencies and enable the capabilities of all human resources (Reay, et al., 2003).

Service designs indicate commitment to client-centred team practice, by way of clarity in service mandates and job descriptions, flexible funding mechanisms, and responsive care delivery models (Cashman, Reidy, Cody, & Lemay, 2004; Allan, Bryan, Clawson, & Smith, 2005; Hughes, 2005; IBM, 2003; Jones & Way, 2004). Service designs ensure proportionate interprofessional staffing to meet the challenges of service

delivery. Innovative technologies support efficient and timely team communication, sharing of professional knowledge and coordination of client care (CHSRF 2006).

Interprofessional Learning Organizations create enabling philosophy and structure for teams and professions to engage in knowledge exchange and access professional development and incentives for team flourishing (Allan et al., 2005; Xyrichis & Lowton, 2007). The learning organization as an interprofessional strategy is linked to issues of patient safety, evidence-based practice, knowledge exchange, professional development, and team capacity building (McCormack et al., 2002; Scott et al., 2003a). Interprofessional learning milieus foster knowledge translation within and between research, education, policy and practice sectors.

Resource allocation of team structures and processes is a strong indicator of the organizational commitment to IPC and collaborative culture (CHSRF 2006; Xyrichis & Lowton, 2007). In order to be responsive to client needs, organizations must determine the right professional mix of teams and effectively resource teamwork. Accordingly, space design, administrative supports, electronic communication, and time allocated for team and network interactions promote teamwork (Barker et al., 2005; Jones & Way, 2004; San Martin-Rodriguez et al., 2005). Innovative teams maximize human potential and resources, and network with community partners to generate health care improvements (Barr, 2002; Boswell & Cannon, 2005).

Team Processes Influencing IPC

Collaboration is seen to foster *team capacity* to more effectively manage increasingly complex care and improve evidence-based practice (CHSRF, 2007).

Teamwork is enhanced as team members come together to share and synthesize varying

member perspectives. Team capacity is fostered by inclusive leadership, common purpose, team spirit and synergy, knowledge exchange, and cohesive roles and responsibilities, as well as the alignment of other sectors toward an interprofessional lens (Cashman et al., 2004; Gilbert, 2005a; Hall, 2005; Hall & Weaver, 2001; Jones & Way, 2005; Reay et al., 2003)

Inclusive leadership inspires a commitment of time, energy and talent; nurtures a vision and sustains common purpose, and creates from within a shared leadership of discovery, knowledge, and innovation (Barker et al., 2005; Boswell & Cannon, 2005; Hall & Weaver, 2001; Heinemann & Zeiss, 2002; Mickan & Rodger, 2005).

Collaborative leaders are trusted as organization stewards, have personal credibility to foster team member talents, and advocate for and create a flexible inclusive workplace (Henneman, et al., 1995; Hughes, 2005; Reay et al., 2003; Ontario Ministry of Health, 2005; Sicotte et al., 2002; Yeager, 2005). Inclusive and collaborative leadership enables improved communication links and feedback mechanisms between direct service providers and organization decision-makers.

Common purpose brings teams and partners together in planning and action to elicit synergistic results (Annis, 2002; Gilbert, 2005a; Grumbach & Bodenheimer, 2004; Mickan & Rodger, 2005; Ontario Ministry of Health, 2005). A client-centred focus is central to achieving and maintaining clear and consensual common purpose (Gilbert, 2005a). A team purpose, “well-defined and forward looking” (Mickan & Rodger, 2005, p. 365), generates shared ownership of vision, goals and principles to guide innovation and sustain collaboration (Boswell & Canon, 2005). Effective teams regularly re-visit and refine their sense of common purpose.

Team Spirit and Synergy take into account the cooperative nature of teamwork and the importance of team building strategies (Heineman & Zeiss, 2002; Way et al., 2000). Teamwork depends on the willingness of members to engage in empowering, inclusive and interdependent relationships (Davoli & Fine, 2004; Harmon, Brallier, & Brown, 2002; McWilliams et al., 2003). Strategies for fostering team spirit include structured interpersonal events, sharing food, social activities, valuing of humor, and working in close proximity (Cashman et al., 2004; Charles, Bainbridge, Copeman-Stewart, Art, & Kassam, 2006; Oandasan, Barker, Kwan, Moaveni, & Sinclair, 2007). Synergy is a “defining feature of interprofessional teams”, in which practitioners engage in creative decision-making and achieve quality outcomes (Jones & Way, 2004, p. 10).

Knowledge Exchange requires a climate of openness to share disciplinary knowledge and perspectives and foster team development and role integration. Appreciating diversity and other ‘ways of knowing and being’ (Henneman, et al., 1995) supports teams to embrace a multiplicity of views, clarify tensions, and address conflicts. Opportunities for formal structured learning and everyday informal exchanges enhance client-centred care (Cashman et al., 2004). Time set aside for team meetings and inquiry is noted by Burgess & Purkis (2008) as an issue, in light of increasing health care and staffing demands. Communities of practice show promise as a structure and process to enable knowledge exchange and promote strategic endeavours; the agendas of top-down leaders and ground-up practitioner are brought closer through this practice model (Wenger, McDermott, & Snyder, 2002).

Cohesive Roles and Responsibilities foster provision of seamless team-based care that is responsive and context specific to client decision-making. Teams that discuss

professional identities, disciplinary philosophies, and scopes of practice are more able to negotiate work roles and functions, and thus have resultant improvements to continuity and comprehensiveness of care (Almost & Laschinger, 2002; Clark, et al., 2007).

Professional awareness promotes sharing of unique and overlapping knowledge, competencies, skills, and responsibilities of client-centred care (Hall, 2005; Jones & Way, 2004; Munoz & Jeris, 2005). Negotiation of roles and responsibilities counters conflicts related to professional role confusion and fosters professional autonomy.

Practitioners with enhanced professional autonomy are more able to fully enact their roles and scopes, draw upon the talents of other disciplines and collaborate in collective efforts with respect to complex client care.

Practitioner Processes Influencing IPC

Practitioner competencies for collaborative practice are also required for successful delivery of complex client-centred care. Competencies for effective IPC include clarity of professional identities, respect and trust of one another, effective interpersonal communication, critical reflexivity, and client-centred decision-making. These elements represent the knowledge, attitudes, skills, reflexive-learning, and performance that come together as praxis.

Professional identity refers to practitioner knowledge of their disciplinary philosophy, role in the organization, and scope of practice (Davoli & Fine, 2004; Gardner, 2005; Hills & Mullett, 2005). IPC relies on the confidence and integrity of professionals to articulate their role and scope, as well as understand the roles and scopes of other team members (Henneman et al., 1995; Oandasan & Reeves, 2005a). As professions specialize and develop internal hierarchies of practice, this ability to describe

roles, scopes and functions is important to effective intra-professional collaboration (Colyer, 2004).

Respectful relations are fostered by practitioners who have an innate attitude of respect for their clients and other professions (Hallas, et al., 2004; Ontario Ministry of Health, 2005) Respect is a precursor to relationship building and the foundation for developing trust in the knowledge, skills and decision-making of other team members. Trust is generated by confidence in self, develops over time with others through positive and empowering interactions, and is enhanced by an allegiance to the workplace (Gilbert, 2005; Henneman et al., 1995; McWilliam et al., 2003).

Communication is both content and relationship specific, and relies on interpersonal skills of information sharing, empathy, listening, humor and conflict resolution (Collins, 2005; Drinka, 1994; Gardner, 2005; Health Canada, 2004a; Henneman et al., 1995; Jones & Way, 2004; Mickan & Rodgers, 2005; Vazirani, Hays, Shapiro & Cowan, 2005). Team and client relations are enhanced by formal communication methods, such as electronic health records and regular structured meetings; and by informal modes of time and space for day-to-day interactions within a flexible social climate of learning and inquiry (Ontario Ministry of Health, 2005).

Critical Reflexivity integrates practitioner understanding of theory and practice in the provision of client-centred care. Critical reflection enables practitioners to consider multiple perspectives and complexities, while reflexivity fosters ongoing and iterative assimilation of learning and practice experiences (McWilliam et al., 2003). Practitioners reflect on performance, assess health care complexity, employ quality improvement strategies, and engage as active participants of program and system renewal (Mickan &

Rogers, 2005; Niemeier & Kosseff, 2003). Reflexivity leads to praxis and integration of the art and science of professional practice (Clark, 2006; Kilpatrick, 2008).

Client-centred decision-making locates the practitioner in service with clients, in which the practitioner and client combine their respective knowledge and experience, along with available evidence, to make decisions that best serve the needs and wishes of the client (de Witte, Schoot, & Proot, 2006). The client's experience of 'client-centredness' is described by Schoot, Proot, ter Meulen, & de Witte (2005) as self-determination, continuity of life, uniqueness, comprehensiveness, and fairness. The practitioner's view of client-centredness is characterized by relationship building, sharing of power and negotiating best solutions, with respect to the participant's context and the situation at hand (Dalton, 2002; Gallant, Beaulieu, & Carnevale, 2002). Further research of client-centredness is needed, particularly with a broader view of client as family, community, and population.

Client Confidence in IPC

Client confidence refers to the client's experience of health care in receiving quality services of a clinical, social, and interpersonal nature. Client confidence develops by way of client participation, exchange of knowledge and information, and shared decision-making in health concerns. Client confidence in interprofessional teams is fostered by the elements of clients as partners in health care, client voice and choice within the team, attention to cultural safety, knowledge as empowerment, and being recipients of holistic care.

Clients as Partners validates clients as equal members in teamwork, as experts within the context of their life, and as active recipients of health information (Jones &

Way, 2004). Clients as partners, represents a philosophy of care and requires organization, team, and practitioner commitments in order to shift structures and processes and enable authentic partnership. Clients, practitioners, and teams thus create partnerships to find common purpose and process, in order to achieve best possible care and outcomes (EICP, 2006; Gallant et al., 2002).

Client voice and choice conveys an importance in creating space for client perspectives within health care dialogues and interprofessional discourse. Client is again considered here from both an individual and collective stance. Client voice is enabled by assurances of security and trust so that clients can disclose their true beliefs and views, not simply what is expected of them. Client choice is fostered by a flexible climate, in which clients engage in shared decision-making to the extent of their comfort, willingness, and capability (Dalton, 2003; McWilliam et al., 2003).

Cultural safety refers to client confidence in practitioners, teams and systems to provide service that is sensitive to the unique and diverse cultural views of health and healing, including those of racial, ethnic, cultural, and linguistic difference (Purden, 2005). Cultural safety entails practitioner willingness to listen, to address language and literacy barriers, and to acquire cultural knowledge, particularly in relation to health beliefs and understanding. A focus on Aboriginal health in Canada is generating a better understanding of cultural safety and holistic healing practices (Hunter, Barton, & Goulet, 2004; Rootman & Gordon-El-Bihbety, 2008).

Knowledge as empowerment denotes the value of objective and subjective evidence about client illness and health. Best evidence, in a collaborative climate, integrates quantitative, qualitative and participatory knowledge to inform the art and

science of holistic care (Caramanica, Cousino, & Petersen, 2003; DiCenso et al., 2005a; Heinemann & Zeiss, 2002). For practitioners, empowerment represents a way of 'being with' clients to enable mutual building of trust and caring, and mutual sharing of knowledge and understanding (Gallant et al., 2002; McWilliam et al., 2003). Practitioners in this sense share their disciplinary power and status with clients to redress inequities and gain services and resources for effective care.

Holistic care entails attending to the physical, emotional, social and spiritual needs of clients. IPC is based on the premise that most client health concerns are beyond the capacity of any one practitioner or profession (Freeth, 2001). For example, chronic disease management initiatives highlight the value of a comprehensive and collective approach to care delivery (Barr et al., 2003). Holistic care requires a trusting ongoing relationship with clients, balances the health and illness concerns of care, fosters client self-care, addresses social determinants of health, and brings the talents of all together for best health care results.

In summary, the collaborative culture framework identifies targeted outcomes that are expected to result from IPC, and outlines sub-sector elements that serve to advance collaborative culture. The premise of this ecological framework is that health care sectors must align and initiate improvements with respect to the identified elements in order to effectively advance collaborative health care culture. This seems a tall order; nonetheless by delineating the sectors and identifying the relevant elements, the ecological framework provides direction to stakeholders for moving forward. This framework evolved by way of a reflexive process integrating a literature review, professional engagement in the Canadian interprofessional network, and a collaborative inquiry with NPs. The following

reflective discussion documents how the NP inquiry modified and substantiated the collaborative culture framework.

Inquiry Discussion

The PAR inquiry with NPs provided further opportunity to modify and validate the collaborative framework. Construction of the framework had evolved by way of a comprehensive scoping literature review informed by past practice and scholarship knowledge, consultation with an interprofessional network of colleagues, feedback from numerous academic conference presentations, and my added involvement in a Health Canada research project on interprofessional education. A complex ecological framework emerged from this process and was named *collaborative health care culture*. The collaborative framework was altered again during the PAR inquiry, to reflect the perspective of NPs and their experience of PHC practice.

During the PAR inquiry, NPs were asked to reflect on what matters to them with respect to IPC, what facilitators enable collaborative practice and what barriers impede it, and finally what qualities or characteristics represented IPC; that is, what does IPC actually look like on an everyday basis? Many accounts of collaborative practice were presented during this recursive questioning. The preliminary collaborative framework was not shared with the NPs until after these conversations took place and data from the NPs' perspectives had been analyzed. I coded their data with respect to the emerging framework and then returned to the NP inquiry groups to ask about a few elements that had not been talked about in their initial discussions. It was at this point that I shared the emerging framework with the groups and asked for their further thoughts, ideas and feedback. I highlight here the areas of NP discussion and feedback that relate to the

shifting and re-shaping of the collaborative health care culture framework. Additional findings about NP collaborative practice are discussed in Chapter 6.

The most significant change to the framework came from extensive discussion by NPs about collaboration with their clients, be they individuals, families, groups, populations, or communities. The preliminary framework had depicted health system, organization, team, and practitioner components, all in relation to achieving client outcomes. NP discussions brought forward the understanding that clients were significant stakeholders and participants in collaboration and this resulted in the addition of client as a separate sector. Clients were not simply recipients of care, but noteworthy participants in health care culture. Alongside this was the realization that IPC was linked to many health care targets, which had not been adequately represented in the early version. An ‘aha’ moment occurred for me while attending a nursing conference, in which a poster presentation helped me to visualize the collaborative framework as turned ‘inside out or outside in’. The aspect of client outcomes shifted to locate the client at the centre of health care targets. Consequently, each successive outcome level of practitioner, team, organization, and system interrelated, all for the common and central purpose of improved client outcomes. Health care outcomes were thus depicted as a nested arrangement of interrelated targets, and located as the core of the collaborative framework. The sectors or stakeholder groups of system, organization, team, practitioner, and client were depicted as separate yet linked clusters, with constituted sub-sector elements that fostered IPC and collaborative health care culture. Depiction of the framework shifted to a star constellation with outcomes as the core, surrounded by interrelated stakeholder spheres and elements that influence and shape health care culture.

Figure 1 (p. 106) and Figure 2 (p. 111) display how the conceptualization of the framework shifted through input from the NP inquiry.

As the new eco-map took shape, I went back to the literature to explore health care outcomes associated with IPC. The grey sources were of particular interest, as there were increasingly more reports about IPC as a strategy for addressing health care outcomes, and these were incorporated into my review. From the system context, the significance of IPC was tied to a health human resource alarm and concerns of worker shortages and the impact on system efficacy. From the health organization perspective, interest in IPC was linked to healthy workplace improvements and patient safety. At the team level, IPC was associated with improved role integration and team performance. IPC was also meant to enhance practitioner competence in the delivery of complex client-centred care as well as relieve the burden on individual practitioners and increase worker satisfaction. Finally, IPC was linked to improved client experience and client outcomes.

The NP inquiry also shifted some of the sub-sector elements that are now depicted as a constellation of spheres. As noted above, the addition of the client as one of the spheres created five in the constellation. Data analysis and a further search of the literature characterized certain client elements of collaboration, which were described as clients as partners, client voice and choice, cultural safety, knowledge as empowerment, and holistic care. Lack of research about the client role in collaboration indicates need for further validation of these elements. Through data analysis of the NP meetings, I was able to corroborate most of the elements of the spheres by way of their stories and narratives of collaboration; however, a few elements were added or changed. In particular, NPs repeatedly spoke of the need for interprofessional education and collaborative learning at

all levels of the health system as part of advancing collaborative culture; this element was thus added to each sphere and substantiated with relevant literature. For the system context, the element of interprofessional education was added; in the organization sphere the interprofessional learning organization was included; in the team sphere knowledge exchange was added; for practitioner competence critical reflexivity was included; and in the client sphere the term of knowledge as empowerment was identified.

One particular NP discussion is introduced here, in terms of how it shifted the collaborative framework, and is taken up again in Chapter 5. Within the team sphere in the early framework, the element of negotiated autonomy had been included. NP autonomy has been clearly identified in the literature as a factor in collaborative practice, particularly with respect to physician – nurse relations. However, the NP’s discussions of autonomy re-framed autonomy as a legislated professional entitlement in BC. Thus, autonomy was not so much an issue here in BC as it has been during role implementation in many other jurisdictions that do not have such a broad scope of practice. The Health Professions Act with respect to the Nurses Act was amended in 2005 to include introduction of NPs, and legislated scope of practice with reserved actions for NPs, in accordance with standards, limits and conditions of the CRNBC. The Health Professions Act also delineates scopes of practice for RNs and other professions. The inquiry revealed that autonomy is not negotiable; NPs are responsible for their scope of practice and autonomous actions, and this pertains to RNs as well. Autonomy was described as the ‘what of care’, that is, the substance of their scope and practice. One of the NPs asked that negotiated autonomy be taken “off the table”, and removed from the framework. We instead renamed this element as cohesive roles and responsibilities, which better

described the capacity of teams to deliver seamless care with the aim of improved continuity of care.

A Description of Collaboration with respect to Collaborative Culture

The Health Canada (2004a) Interprofessional Education for Collaborative Patient Centred Practice (IECPCP) Initiative adopted the Way, Jones and Busing (2000) definition of collaborative practice, as outlined previously in this chapter, and reiterated again here: “Collaborative practice is an inter-professional process for communication and decision-making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided” (p. 3). Although this definition provides a sound conception of collaborative interactions between providers, my assertion here is that a more comprehensive definition is needed to describe the necessary structure and process conditions that complement and foster collaborative practice at provider and client levels. Collaboration is thus viewed as both a philosophy and a practice. As a philosophy, collaboration denotes leadership vision and values that shape the culture of the health organization, in which egalitarian power relations are cultivated and responsive structures, policies, and resources are provided to enable providers to deliver quality client-centred care. As a practice, collaboration signifies the dynamic and combined efforts of stakeholders to share knowledge, decision-making, and mutual responsibility for the common purpose of quality client-centred care and thus actualize the organization’s vision. The interrelatedness of philosophy and practice and alignment of structures and processes generates synergistic commitment and capacity of all stakeholders to develop and sustain collaborative culture.

In Conclusion

IPC entails a new way of delivering health services. There is a need to understand the complexities of collaboration and develop a systematic approach for advancing collaborative health care culture. This ecological framework illuminates the multi-level interplay of health system, organizations, teams, practitioners, and clients in shaping collaborative health care culture, and adds to Health Canada's conceptualization of IECPCP. This framework maps parameters for policy and decision-makers, health care leaders and researchers, and teams and practitioners to assess the current status of collaboration and design relevant interventions and evaluative tools. Alignment of the multifaceted influences and elements identified in this ecological framework holds promise for advancement of collaborative health care culture and the improvement of client care and outcomes, practitioner satisfaction, team performance, healthy workplace innovations, and HHR issues of recruitment and retention.

Chapter 5

Communities of Practice: A Means to NP Role Development

I actually don't think this is about NPs, it's about people in our communities who require care and access in perhaps a different way...this group is made up of individuals who can actually be strategic...yet few NPs have had experience at the strategic level of an organization, so, how can we expect NPs to be thinking strategically at an organizational level when they've never had that experience? (NP Administrator)

Nurse practitioner (NP) role development has been historically fraught with barriers, including inadequate legislative and regulatory sanction, deficient remuneration mechanisms, medical profession resistance, nurses' limited autonomy, hold ups in primary health care (PHC) renewal, and lack of attention to collaborative structures and processes to foster role advancement. In BC, some NP role development issues have been addressed by way of formalized provincial introduction of legislation, regulation, and education, albeit improvements continue with respect to these efforts. Current challenges now lie with NP role implementation at the health authority level and with NP role integration at the program and practice level. In each of the health authorities, the Chief of Professional Practice has the mandate for NP role development, and a lead designate from each Professional Practice Office (PPO) has been assigned implementation responsibility. In this PAR study, I involved two BC health authorities and sought and received approval from each of the Chiefs of Professional Practice to engage NPs in a participatory action research (PAR) inquiry.

As a way to support NP implementation, both health authorities employed *communities of practice* as a model to bring NPs together to mentor each other as new practitioners, and foster role development within the regions. Communities of practice

are a relatively new strategy in health care and there are few examples in the health and nursing literature to draw upon. Consequently, each of the NP communities of practice evolved their own process, and loosely adapted the work of Wenger (1998), a leading proponent of communities of practice, to guide their planning. The communities of practice provided collective interaction among the NPs and PPO leaders within the two health authorities, although most NPs had individual exchanges with PPO leaders as well. The PAR study recruited NPs from each region as an extension of their communities of practice; the voluntary nature of participation was assured, because the inquiry did not preclude the communities of practice from carrying on with their regular meetings.

Chapter 5 is written as a findings chapter and reports on communities of practice as a means for NP role development. The decision to dedicate a whole chapter to communities of practice resulted from my observations and curiosity about the two NP inquiry groups and their noteworthy differences in group collaboration and role development progress. As each NP community of practice was at a different developmental stage, I was interested in understanding the developmental processes and variations with respect to collaboration and role development. As well, each of the NP inquiry groups was constructed as an extension of their community of practice, and I was interested in how the added component of research could support communities of practice as a role development strategy. I begin this chapter by drawing upon relevant literature to gain a base understanding of communities of practice. Related data and analysis from the NP inquiry are then reported. Through the inquiry we (the NP inquiry group including myself as researcher) reveal new understanding about the political dimension of

communities of practice. Also discussed are qualities of and principles for cultivating a collaborative model of communities of practice.

Communities of Practice as a Social Construct

Communities of practice are distinguished by, and described as the coming together of groups of people who share a common concern or passion about an issue or topic, and interact regularly to enrich their knowledge and expertise (Wenger, 1998; Wenger, et al., 2002). As a leading author and proponent of communities of practice Wenger (1998) notes their historical existence as social constructs in both recognized and unrecognized forms for the intention of learning. According to Wenger (1998), communities of practice have three key characteristics, which he refers to as domain, community, and practice. 'Domain' represents the connection between people of joint interests and competence, and the sharing of their collective expertise. 'Community' signifies a building of relationships, in which members mutually engage in discussion and activities, exchange knowledge, and learn from one another. 'Practice' denotes practitioners sharing meaningful knowledge and developing a repertoire of resources, such as experiences, stories, tools, and ways of addressing recurring problems. Wenger (1998) has also constructed a social theory of learning to conceptualize communities of practice. This social theory of learning is multidimensional and according to Wenger is underpinned by primary theories of social structure, situated experience, social practice, and identity, and further stratified by intermediary theories of collectivity, subjectivity, meaning and power.

'Theories of social structure' emphasize institutional and cultural systems, discourses, and history that influence social patterns. 'Theories of situated experience'

highlight the dynamics of every-day interactions and occurrences, in which individual agency, intentions, and local construction of experiences take form. 'Theories of social practice' are concerned with production and actions, in which mutual relations, coordinated activities and use of resources generate a specific way of engaging in the particular setting. 'Theories of identity' address issues of gender, class, ethnicity, age and other forms of association and differentiation to establish markers of membership. Intermediary theories transverse these primary theories, in which theories of collectivity relate to formation of social configurations and cohesion, theories of subjectivity address the nature of individuality and agency with respect to engagement in the social world, theories of power strive to go beyond conflict (malevolent) or consensual (benevolent) models to that of shared collective power, and theories of meaning account for making and owning meanings through social participation.

Wenger (1998) also describes the concept of practice within social communities and defines various practice components including practice as meaning, as community, as learning, as bridging boundaries, as scope of local engagement, and as knowing from experience and competency. 'Practice as meaning' is about negotiating meaning and by participating with each other members reify the abstract to something more concrete and applicable. "Practice as community" refers to mutual engagement, joint enterprise and a shared repertoire made up of discourse, history, stories, tools, and actions. 'Practice as learning' refers to the bringing forward of continuities and discontinuities of history to generate emergent learning. 'Bridging boundaries' is about negotiating the landscape of difference between the organic roots and institutional structures that make up communities of practice. 'Scope of local engagement' refers to communities of practice

at mid-level engagement and their tie to micro perspectives and macro or more global views. 'Practice as knowing' refers to the reflexive nature of sharing experience and competence and the combining of local and global knowledge.

Communities of practice have a certain appeal, because they have design flexibility and can be adapted in different settings and for varied purposes. Hence, communities of practice are taken up in various forms and are known by many names. Communities of practice can be informally constituted, as groups of people engaged in regular interactions of learning; they can also be constructed as formalized groups to address strategic innovation, specialization, and collaboration (Wenger et al., 2002). The adaptive and varied nature of communities of practice means that some are small with a core group of members, while others are large and include peripheral associations; they can be structured and unstructured, open and closed in membership, recognized and also invisible; include top-down and/or ground-up participation, and engage within and across disciplines and organizations. According to Wenger (1998), the key identifier of communities of practice is their dynamic engagement of all involved for the purpose and value of sharing knowledge and practical learning. Communities of practice have been recognized as a favourable model in various institutional settings, and have been taken up in public organizations, business, education, government, professional associations, civic interests, and project specific activities. Communities of practice provide a structure and process to advance both corporate governance and workforce engagement.

Communities of Practice in Health Care

Health organizations are endorsing and cultivating communities of practice as a vehicle to improve knowledge translation and dissemination and to develop strategic

commitment and capability. Communities of practice enable practitioner members to learn together and enhance performance, manage an ever-increasing amount and complexity of knowledge, and share explicit and tacit knowledge for practical application and innovation (Wenger et al, 2002). However, success in cultivating communities of practice requires balancing the varying agendas of the health organization and the practitioner participants (Garcia & Dorohovich, 2005; Wenger 1998). Wenger (1998) speaks of this tension in balancing the dual elements of design and emergence. He views design as institutional structures, such as vision statements, strategic plans, charters, policies and procedures, which are typically imposed from the top-down. He describes emergence as everyday processes generated by practitioners from the ground-up that create relations and meanings relevant to practice. Top-down design of communities of practice are effective for negotiating alignments, mobilizing resources, diminishing power issues, and generating global links and credibility; yet too much top-down results in unyielding protocols, and immobilizes practice, engenders alienation, reifies domination, and minimizes the value of locality. On the other hand, the strength of ground-up emergence promotes group members in mutual engagement to identify key issues and concepts, build community process, and generate practical meaning and innovation; yet without organizational sanction and resources, ground-up communities of practice often flounder. Wenger (1998) claims practice is not a result of design, but more importantly a response to design, therefore organizations are called upon to be in the service of practice, and balance the design structures of the institution with the emergent processes of practice. Communities of practice are fostered by practitioner autonomy, informality, flexibility, equity, boundary crossing, and adaptive resources; yet these

characteristics also challenge traditional hierarchical organizations (Wenger et al., 2002). Thus, cultivating communities of practice is not a simple matter of structure but also requires attention to systematic process on the part of the organization and participants to successfully develop, maintain, and sustain the collective endeavour.

Communities of practice have particular relevance to professional and interprofessional development, in that collective participation for the purpose of knowledge sharing, situated learning, contextual meaning, and practical application can be effective for improving practice performance (Lave & Wenger, 1991; Tolson, Irene, Kelly, & James, 2006; White, Suter, Parboosingh, & Taylor, 2008). Professional practice combines explicit knowledge gained from textbooks and structured education, with tacit knowing derived from practitioner experience and reflective learning, and can be advanced by way of communities of practice (Wenger et al., 2002). Communities of practice also draw upon collective knowledge and knowing as historic and emergent, to shape and extend practitioner expertise. In this sense, communities of practice contribute to praxis, and the assimilation and application of theoretical, contextual, experiential and practical knowledge (Kilpatrick, 2008; Newman, 1990; Upton, 1999). The integration of these multidimensional forms of knowledge and knowing engenders practitioner identity and competence, and fosters attainment of evidence-based practice, which in turn produces accountability and credibility for the health organization (Tolson, et al., 2006). Health leaders and practitioners, who come together to exchange ideas and share expertise, create collective professional and interprofessional capacity, and thus extend collaborative structures and processes that advance the aims of the organization. This

literature on communities of practice serves to provide a theoretical grounding for a comparative analysis of the NP communities of practice.

Comparing the Data and Findings

A comparative analysis of the two health authority NP inquiry groups was undertaken as a way to explicate the value of the communities of practice model for NP role development. Through the data analysis process, I examined the data from each NP inquiry group separately and also reported here on them separately. See Chapter 3 for further details about the analysis process. The following is a description of interactive discussions and stories that were shared that are relevant to role development and communities of practice. The stories are a distillation of the interactive group data, made up of the NP words and augmented by my words to describe and interpret the intent and meaning of the discussions. Quotations are also included to enrich the text and add depth through participant perceptions. I begin with the perspective of NPs from HAA about role development tensions and triumphs and then report on the data from the action meeting with the NPs and PPO leaders of HAA. I then repeat this process with the focus on HAB. The data presented here about NP role development experiences is important because it provides contextual relevance to enable comparative analysis of the two health authorities and determine the value of communities of practice for fostering role development. The data from the action meetings with PPO leaders is also important, in that it highlights their perspective of NP role development, the collaborative relations of organizational leaders and NPs, and the processes used with respect to communities of practice. I complete the chapter with a discussion and conclusions that represent my interpretation, based upon these inquiry findings.

*HAA: The NP Perspective of Triumphs and Tensions of Role Development**HAA: Novice to Expert*

NPs in HAA saw themselves as pioneers in a new professional role, constructing unique health care positions. As they started off in this new advanced clinical role, many NPs were not yet registered for full scope practice. NPs in BC are given temporary registration on completion of their education program, but also must pass a written exam and a practical OSCE exam (Objective Structured Clinical Examination), which are scheduled twice annually. The time lapse between graduate and full registration means that NPs are restricted in their scope and require oversight from a physician or another fully licensed NP, to carry out NP reserved actions. Reserved actions are defined by the Health Professions Act, and regulated by the CRNBC; NPs must practice in accordance with these standards, limits, and conditions. NPs discussed the tensions between coming into a new role with high expectations held by themselves and others, yet not being fully sanctioned to practice. The different levels and amounts of experience that NP graduates brought to their new role added complexity, because some were very experienced in community nursing and others relatively new to a PHC style of practice. One NP noted:

there's also that piece about novice to expert...your role is evolving as you grow...you want to do a really good job because you know people are watching, and you feel such a huge responsibility, not just to your clients, but to the community as a whole, to the community of practice that you work with, it's huge.

From my perspective, this comment reflected the tremendous amount of pressure NPs experienced in taking up a new role, which involved a shift in their status from RN to NP; being a novice to this new role did not relieve the pressures of responsibility that were tied to having advanced clinical knowledge. There was a lot riding on these NP pioneers

to not make mistakes, to get it right, to build a positive reputation with clients and communities, and to not disappoint employers and colleagues, especially their own peers.

HAA: Autonomy to Practice

For the most part NPs expressed satisfaction with their autonomy to organize day-to-day practice so as to address client situations and demands. Despite the pressures of responsibility, most NPs felt supported in their practice settings by physician partners and some NPs reported mutual mentoring relationships, as reflected in asking each other for advice, or requesting an assessment from a different professional perspective, or gaining a second opinion. NPs also saw their community partners, such as pharmacists and public health nurses as mentors. However, discussions about ‘time’ emerged as a tension, with some NPs having control of their time and schedules, while others felt time pressures that conflicted with providing quality care. Surprisingly, these tensions were not related to remuneration mechanisms; I had expected primary care fee-for-service practice to tightly schedule time to maximize numbers of client visits, while in community health centres that have program-related budgets, I thought that time schedules would be flexible to foster comprehensive quality visits. Yet NPs in primary care fee-for-service pilot projects expressed that they had the autonomy to structure their time for client needs and practice satisfaction; while some NPs in PHC settings complained of overly scheduled time demands, and worried about their roles being constructed as physician replacement roles.

So 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...sometimes we need to step back and say, “how is that meeting my goals and objectives for my client population?” And certainly there are going to be busier days, and there’s going to be demands, but I think we have to be really careful that we don’t become assimilated into the existing [primary care] system (NP participant).

NPs linked the day-to-day scheduling of time to their autonomy and the extent to which they could make decisions about their practice schedules. NPs in fee-for-service practices reported having more autonomy in managing their schedules, which paralleled that of physician independence; while NPs in managed settings had to mediate employer-employee relations and did not necessarily have autonomy in deciding their schedules. NPs perceived autonomy as the authority to make decisions about care with respect to their scope of practice and responsibilities of care. As well, NP autonomy was tied to the flexibility that NPs had to determine and construct their roles as unique and different from physician roles and as responsive to community needs and gaps.

HAA: Establishing Professional Identity and Role Clarity

NP inquiry discussions revealed the importance of establishing their professional identity, differentiating their roles as different from physicians, and educating collaborative partners about their unique role and scope. NPs also noted how meaningful it was to have their new roles recognized, and this recognition often came in small doses, such as getting a consult letter back from a specialist, who actually addressed it directly to the NP, or a patient commenting they had not ever disclosed a particular incident to another practitioner, or a physician colleague thanking them for a job well done.

A number of collaborative partners were identified in the conversations with NPs. Medical office assistants were identified as integral to NP practice, because their function was to triage and schedule and assign day-to-day client requests to the most effective provider. NPs worked closely with the office staff to educate them about their role and mentor them in this triage responsibility. As well, clarifying the overlap and unique aspects of their roles with those of nursing colleagues was seen by the NPs as important

to their success. NPs noted the significance of having collaborative relations with physician associates, because the NPs relied on physician consultation and support, and strived to attain a balance in sharing and exchanging knowledge about client care with their physician colleagues. And NPs also commented on the importance of collaboration with their clients and community partners:

My day does have a lot of consultation and collaboration with physicians, but equally so with the respiratory technologist, with mental health, with public health...mentorship that we get from interprofessional partners, I think that's one of the reasons I chose where I am now, it wasn't just the physicians, it was the whole community that was interested in what the NP did (NP comment).

From my perspective, this comment speaks about the NP's foundational philosophy of being part of a community and collaborating with all manner of stakeholders. NPs were constructing their practices with whole communities, not just with individual clients. This signifies a significant shift in health care, from an individual focus to a community and population focus, and this is a characteristic that differentiates primary care from primary health care (CNA, 2005a; Haggerty et al., 2007; WHO, 2003).

NPs described their roles as holistic and aligned with the people, in which assessment and care extended beyond client to include community and population health. Many NP initiatives were underway and NPs talked of how they were demonstrating their nursing leadership in community and program development, such as starting a women's wellness clinic, facilitating group client visits, fostering open access and drop-in appointments, and providing outreach to marginalized populations. Many stories were shared by NPs over the course of the inquiry that illustrated their commitment to effective visits and approaches to care, such as education to alleviate patient stress and increase treatment compliance, clinical nursing assessments that uncovered the real reason behind

a repeat visit, outreach to make a difference in care outcomes, and mixing western and traditional cultures so as to extend aboriginal ownership in health care. Here are three stories recounted by three different NPs that related to holistic care:

It was just a quick repeat pap test. She said “I have to get it done every 6 months, because I had cancer a while back and now they check all the time”. So I look through the chart and see she had cryotherapy many years ago. I explained levelling on a pap screening, and which is cancerous cells and pre-cancerous changes. With tears rolling down her face she said “all this time I thought I just had cancer, you’re the first person that explained to me and I’m so relieved”. You know, there’s the value added.

Some patients had been waiting more than a year to be seen, so I spent a couple of weeks and saw about 32 patients, and that helped the pressure on the [specialty] clinic a lot. Some of the patients had been worrying for a year about their condition, and on repeat testing were normal, so they lost probably a lot of sleep worrying.

There is something about what we do, it’s the heart of NPs that we’re meeting patients’ needs, and that’s why patients are so happy...One of my physicians has a patient that he’s had for 15 years...she came to me twice, and all of a sudden has divulged information that she’s never told the physician in 15 years. Things like that are happening, and I think it’s because we have a different approach, and it’s just that basis of we’re touching something that medicine isn’t, and because of the core of who we are.

These descriptions of holistic care reflected doing primary care in a different way. NPs facilitated the provision of best care at the individual level; client’s physical concerns, as well as their social, emotional, and spiritual concerns were being addressed. If a population or program gap was identified, then NPs responded by developing a program, or initiating an action to ameliorate the issue from a population approach. NPs were establishing their roles by effectively providing holistic care to clients and constructing sound collaborative relations with clients and communities.

The HAA Approach to NP Role Implementation

A Systematic Evidence-based Approach

HAA, under the auspices of the Chief of Professional Practice, began planning for NP role development in anticipation of provincial NP legislation and regulation. A leader from the Professional Practice Office (PPO) with expertise and interest in NP role development was designated early on, and initiated links to national leaders with experience in NP role development, in order to gain understanding of enablers and barriers. HAA adopted the PEPPA framework for their planning of NP roles; this framework outlines an evidence-based approach to role implementation and describes systematic steps (Byrant-Lukosius & DiCenso, 2004). The NP inquiry discussion with PPO leaders from HAA revealed a number of strategic tactics taken in planning for NPs.

A significant strategy of the Chief of Professional Practice was to intentionally retain decision-making control, in regard to where and what NP positions would be initiated. The PPO leaders noted that the evidence-based approach of the PEPPA framework provided a certain confidence in planning for and locating NP positions. The leaders were wary of including too many decision-makers with differing levels of knowledge about the NP role in the actual planning, because it could complicate the process even further. The PPO consulted with organization leaders as needed, but said they did not fully engage in a collaborative decision-making process with these leaders. Instead, the community level, where NP positions would be located, was identified as a more important locus for collaboration. A formal application, based on the PEPPA framework, was designed, and any primary health program or site within the health authority that wanted to establish an NP position was required to complete an application. PPO leaders then negotiated and collaborated with these potential sites to determine the

local community needs, their readiness for a NP position, and what type of setting

preparations would be required to welcome a new NP. One of the PPO leaders noted:

There was substantial involvement of different strategic groups in providing input and information exchange, but, where there was substantial collaboration was at the community level...what was critical to me is where the positions were placed and there was a receptive team and environment, there was a population health need, and that matched with our ability to attract a NP to the area.

I found this decision of the PPO leaders to consult with organization leaders, yet collaborate with community leaders to be an interesting discovery. What I take from this decision is that the PPO leaders needed to demonstrate the success of these NP roles within their clinic and community settings, to ensure continued organization endorsement and possibly funding support, and thus the most important place to put their time and energy was at the community level, where the efforts of collaboration would have the most effect and potential for success. In this way, by collaborating with community, the PPO leaders perceived they would have more influence and control of the NP role development initiative.

HAA: Adopting the Communities of Practice Model

By participating in national initiatives, PPO leaders were introduced to the concept of 'communities of practice', including a presentation by Wenger. They thought that communities of practice provided an appealing model to address NP role transition challenges. Even though NPs were experienced RNs with master's education, they were coming into a brand new role at a beginner level of NP practice; added to this many NPs would be located in local and rural communities without NP peers or mentors, because there were no experienced NPs in the field. One of the PPO leaders said that after the first

NPs were hired in HAA, they brought them together to talk about what might be valuable as a community, and they flourished as a collective. The PPO leader remarked:

So, it would have been a perfect storm, if you like, for an alone, new NP not all that clear on her role, trying to integrate that role. And so we thought “wow”, the community of practice would be a great model to link all these new professionals so they had a peer network, some support...So, again, this was very strategic and very intentional and became a really important strategy for success.

The PPO leaders arranged for NPs to have full day meetings on a regular basis, monthly over the first year or so, and then at least bimonthly; this also meant travel by most NPs to attend face-to-face gatherings. Meetings were initially small and facilitated by PPO leaders, but as the NPs grew in number, the leadership shifted to the NP members to organize meeting logistics, set agendas, structure in-services, coordinate communication, and facilitate meetings. Clinical practice and in-services were a particular focus. In addition, the communities of practice served to engage NPs in discussions about enacting their new role, clarifying scope issues, the ups and downs of collaboration, challenges of managing documentation and site logistics, as well as collectively sharing their practice passions and successes. Thus, the PPO’s initial vision for using a community of practice model was validated, although as one PPO leader observed and noted, it wasn’t always easy to explain this to others:

When Etienne Wenger presented, honestly, some people in the room were just shaking their heads... he had colors, and balloons, and was eccentric, but of course I loved it! But that’s the difficulty in seeing the value of community of practice, people who feel this is time away from your patient population, and why is this so important? So, trying to explain it’s critically important for success in broad integration of NP roles is a challenge (PPO leader).

The PPO of HAA reported that they now support a number of communities of practice, and see them as important venues for clinicians to talk about practice, with the aims of enhancing performance and providing leadership to the organization. The PPO

leaders said that their PPO unit was somewhat counter-culture in the health authority, and noted their philosophy was underpinned by the Ottawa Charter for Health Promotion, in that the PPO leaders took a ground-up community development approach to day-to-day work, and they saw this as a natural fit with communities of practice. As leaders, they were well aware of the potential paradox in providing organizational support and direction, yet not controlling the ground up process of communities of practice. Thus, the leaders had an openness to what the communities of practice could focus on, what the clinician members needed to evolve as iterative and emergent, and how communities of practice provided direction to the organization. One of the PPO leaders remarked that “communities of practice grow based on the needs of the participants and of the organization”. The other leader noted how participants collaborate instead of compete, and “help one another be successful.” Consequently, over time the organization benefits from practitioner insights and guidance.

And what’s very interesting is virtually all of our communities of practice that we’ve initiated have taken on roles that have provided strategic direction to the health authority, but it’s usually taken a couple of years of maturity to have that happen. (PPO leader comment)

From my perspective, this comment and discussion raised the notion that communities of practice not only focus on the internal interests of the members, but also serve the external interests of the organization; in this sense, communities of practice can have a strategic policy or political function. However, the PPO leaders were also aware that communities of practice require up-front time and effort that is internally focused to address the concerns of members first before the external interests of the group develop. The literature has little reference to the strategic function of communities of practice, so this is a significant finding and is taken up later in this chapter discussion.

HAA: A PHC Focus

PPO leaders noted that because HAA is predominantly a rural health service organization an important decision was made early on to develop the NP role for PHC and to make this absolutely clear and unequivocal, despite pressure from stakeholders who wanted to implement the role in non-PHC settings. PPO leaders viewed requests to locate NPs in emergency departments, in acute care, and in specialist offices without a distinct PHC focus, as risking confusion between the role of NPs and the role of clinical nurse specialists (CNS). Thus, PPO leaders were cautious and clear about the purpose of planning and negotiating NP role development. NPs were initially located in community-based PHC settings; however, these settings were limited in number because most primary care in HAA is still provided in fee-for-service physician practices that are not controlled or funded by the HA. Thus, the PPO made a decision to implement a pilot project and locate a few NPs in certain fee-for-service settings. This entailed strategic negotiations between the PPO and HAA decision-makers, to have base budget funding for NPs allocated to fee-for-service practices that were already funded centrally by the Ministry of Health. Yet a case was made that the NP role was a way to shift the culture of physician practices, possibly that of the health organization itself, thereby making a real contribution to PHC and chronic disease management. A PPO leader commented:

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.

The PPO leaders clearly articulated the value of NPs with respect to moving the rural PHC agenda forward. NPs were seen to have the autonomy, knowledge and skill base to

fill the health care gaps in rural communities; while at the same time making a huge difference to the re-conceptualization of PHC as embodying a population approach, rather than reflecting an individual service delivery model. However, following the discussion with PPO leaders, some NPs expressed concern about being pigeon-holed into rural and even remote health settings, at expense of personal interests or lifestyle choices.

HAA: NP Role Implementation Progress

NP role development has taken considerable effort on the part of provincial and regional leaders to ensure progress, and there was concern amongst HAA leaders that this effort is disproportionately high relative to the effort devoted to other practitioners, particularly in light of the number of employees represented. At the same time, there was awareness that NP role development is highly political and really about transformative health care change. PPO leaders noted that HAA administration is conscious of NP role contributions, as are provincial ministers, and there is increasing clarity about the NP role, as not a physician replacement, but as a new professional role in its own right. One of the PPO leaders commented:

I actually don't think any of this is about NPs. It's about people in our communities who require care and access in a different way...I would honestly say that no one group of health professionals has taken the work, the time, and energy, and the demands, more than the NPs...I would say the most challenging political issues I face are related to NPs.

The PPO leaders acknowledged the stewarding role of NPs in advancing the PHC agenda. They remarked on how NPs were doing care differently and making a difference to the health of their local communities. However, substantiating this benefit within the greater system was challenging, yet necessary in order to shift funding priorities and expand the base of NPs. They noted that demonstrating the added value of NPs would

require more than simply reporting on hospital utilization data; instead, capturing evidence of long term health outcomes and quality of life years was needed. In the interim, however, until appropriate evaluation tools were developed and implemented, the NP community of practice was used as a forum to collectively share stories of NP successes and document evidence about the success of NP practice in collaboration with the organization, colleagues, communities, and clients.

A PPO leader commented:

The most important thing I've heard in my experience around IPC, occurred at that meeting, when the physician said, "I'm looking at my patients differently now, with a different orientation, because of my experience of working with a NP."

The other PPO leader responded:

I wrote his follow-up to that 'I think my practice is becoming more holistic', he used those words. I wrote it because I had to capture it...that's just the most recent example, you've all got those examples...This NP group has been able to provide amazing examples of collaborative practice, not only are patients benefiting, but NPs are very satisfied with practice, and so are other key members of the system, including physicians.

In summary, HAA inquiry discussions confirmed the value that NPs place on their community of practice as a forum to build direct links with organizational leadership, and create relationships for collective support and endeavours. The structured and supportive association with the PPO gave the NPs assurance of the organization's commitment to NP role development. As mediators of NP politics, the PPO leaders were in the forefront negotiating with policy decision-makers, and affording power sharing between NPs and their organization. As well, the PPO leaders were in the background nurturing NPs in practice and modeling constructive and collective relations. The NPs considered the PPO leaders as their champions and noted they were only a phone call or e-mail away in accessibility. One of the NPs noted:

It would never have gotten off the ground in those early days if we hadn't had PPO support. Basically the mandate to say these NPs will have this opportunity to support each other on a very regular basis. As we've grown larger and become more diversified, it hasn't been as directive as those first few months – that half a year or so of nurturing by the PPO, really, was absolutely necessary, or we could have easily been swallowed up in each of our own little environments.

The communities of practice model created a network of support in HAA for the NPs, as they were hired one-by-one into dispersed settings. Mentorship was a significant part of the collective in validating practice experiences, working through role challenges, and sharing clinical knowledge and expertise in ongoing learning. The PPO leader's intentional collaborative and nurturing approach assured that the NP community of practice was a safe and secure place for relationship building, and helped to create a collective vision. NPs overtime have taken ownership of their community of practice, and extended their leadership confidence into their own practice settings. Through collective exchange they have gained clarity in their practice roles and professional identity, and are now striving to articulate this message to patients, to media, to decision-makers, and to speak with one collective voice. One NP commented:

What I'm hearing around the table is people are doing what they want, in what they want their practice to look like, or they've made changes to make it work. So, I think we have ownership, and we have vision. Some of that's been collectively done because of discussions we've had here to reinforce that piece... I think that's huge.

The community of practice also helped to extend the collective vision of NPs and PPO leaders so their future planning and goals could transpire. PPO leaders and NPs saw the value of collective strategic thinking and planning to ensure NP role progression. There was recognition of the importance of keeping policy and decision-makers well apprised of NP role developments. To justify expansion of NP funding envelopes, the value of NPs as change agents of PHC renewal, and as beneficial and responsive to health

care gaps, needed to be articulated and made apparent. The communities of practice model provided a forum to explore the tensions of NP role development, share varying perspectives, plan and secure evidence, and strategize about the future. One of the PPO leaders remarked:

In the next five years, I'd actually like to see quadruple your numbers. I mean there's no two ways about it. I am absolutely, positively convinced that the role can make a major contribution to health of communities in our province, yet it's really challenging to think how we're going to get there...I would appreciate being at these meetings more regularly...it's around two way communication, understanding some of my challenges, understanding some of your challenges, working together on this implementation.

The HAA NPs generated an action idea during the inquiry to bring the PPO leaders to the table to hear their perspective about role development and the purpose and value of the community of practice. This discussion revealed the political nature of the NP role and the political value of their community of practice; consequently the need to mentor the NPs and develop their strategic capacity was raised. The inquiry also brought to light the importance of maintaining ongoing and regular communication between the NPs and PPO leaders, so as to continue to understand each others' challenges, and to work together toward achieving NP integration and sustainability, as well as enhancing PHC as a community and population-based approach to care delivery.

HAB: The NP Perspective of Triumphs and Tensions of Role Development

HAB: Unprepared Settings

NPs in HAB talked about how they had struggled in the start-up of their roles. Settings were unprepared for the NPs, and many logistics, such as telephones, desks, and equipment were not in place. Registered NPs did not have the authorization to order lab tests and x-rays, or link to practitioner resources such as teleplan, medinet, and pathnet

and they had to make numerous phone calls to arrange these. NPs discussed how to improve role start-up and recommended a flexible framework be developed for role implementation to support orientation of NPs; one that would accommodate individual settings and needs, because tasks and functions of immediate importance to one NP may not be useful or necessary to another. In this discussion of role start-up, there seemed to be a disconnect between the good intentions of the health authority to implement NP roles and the lack of adequate infrastructure to support NP practice efficiencies. NPs were confounded by the lack of preparedness in their settings and they reported that this took a toll on their confidence, compromised accountability in their work, and extended their learning curve in reaching practice competence.

One NP reported:

When I got there I realized they had not said anything to the physicians about me coming, they had no idea, so I had to present to the physicians and it took a while to get on their agenda.

A second NP commented:

It's taken me months to figure out, just getting my labs and x-rays and stuff like that...It was a big deal to finally get an electronic lab report back, even though it showed up to 'unknown practitioner'.

A third NP stated:

For me, to have a computer in the room, and an exam table is more important right now, than talking about teamwork!

These comments indicate the struggle that NPs had in settling in to their new sites. The learning curve for the new NPs was particularly steep, because they needed to focus on consolidating their clinical practice while providing care to clients, with every interaction new. As well, they had to adjust to their new communities, develop relations with a new team and network, and design and implement their role with its many dimensions. The lack of infrastructure was a blow to confidence building.

HAB: NPs Align with Clients and Communities

The NPs offset their role development tensions by aligning with their clients and communities. They talked about dedicating time to educate colleagues and client groups about their roles, and they gained comfort in client and community partners coming to know and rely on them as primary health care practitioners. They saw this work of educating others as essential to their effective utilization by clients and colleagues, and to their ability to enact their role to its full potential. Clients needed to learn about and receive care from NPs before they could understand the difference between the NP role and that of RNs and physicians. NPs noted that having flexible time was an element of difference that helped clients to separate the NP and physician roles. NP schedules were more accommodating for patients with complex issues, such as elderly clients with chronic health concerns, or families with sick babies, or people with mental health and addiction problems. Prescriptive authority, on the other hand, seemed to differentiate for clients the NP role from that of the RN. One NP remarked about her clients:

That prescription pad! Ooh, the light goes on, ‘oh you are doing something different’, and it’s amazing how that becomes this one little thing that represents more independence.

However, this notion that NP prescriptive authority set them apart from other nurses and professionals yet aligned them with physicians was somewhat problematic for the NPs.

The prescription pad was a symbol of advanced clinical care, but the NP role offered much more than clinical care. NPs saw the importance of establishing their roles as separate from physicians, so as to not be seen as physician replacements; however, it was also important to be recognized for having more independence, scope, and autonomy than RNs. How clients came to perceive the NP role was important, because NPs wanted to

foster client confidence, yet clients also needed to develop a more sophisticated understanding of the NP role than just the added prescription pad.

NPs talked about the constant demands and changes in practice settings; it was not just about NP role start-up, there were other priority issues, such as changes to physician schedules for open and rapid access initiatives, and electronic developments for shared care. The NPs saw themselves as helping to move PHC forward in an upstream approach; and they noted that having flexible time was a necessity to invest in health promotion, prevention and harm reduction initiatives, and innovations in care. NPs discussed the importance of keeping their practices fluid and open to change, and to supporting the capacity of other colleagues and a team approach. One of the registered NPs noted:

I really thought going into this that the physicians were going to be my key partnerships, I mean, they've been really supportive, but I'm finding the key players now are the people in the community, they are the ones facilitating my being in the community clinics, and welcoming me...I'm always connecting with social workers, nutritionists, other nurses, I'm connecting with all sorts of team members and agencies.

NPs in HAB were developing strong and varied collaborative relations with colleagues and community. One of the NPs noted that being less reliant on physicians was a real indication of the increased autonomy she had gained from her transition from temporary status to full registration, and this came from having sound legislative and regulatory authority. At the same time, NP autonomy did not preclude their ability to be champions of collaboration. One NP commented:

I find interprofessional collaboration is integral to the NP role...I don't know what it's like to not work that way.

The NP group engaged in an interesting discussion, and came to the realization that autonomy and collaboration are not mutually exclusive, but are in actuality complementary.

HAB: Autonomy – Consultation - Collaboration

An NP noted that the leap between temporary and full registration was a much bigger shift in autonomy than expected; she no longer needed to consult with physicians about labs, x-rays, prescriptions, and often a full day would go by without a consultation. The NPs from HAB engaged in a rich discussion about distinctions between autonomy, consultation, and collaboration. They spoke of autonomy from the perspective of NP - patient relationships, and their extended authority for and responsibility to their patients in what care they provided. With respect to consultation, NPs saw this as more relevant to NP – physician relations, in which consults were requested when care was beyond scope, had a certain complexity, and required a deeper understanding of why a particular kind of care was needed. Collaboration, on the other hand, was applicable to NP partnerships with colleagues, clients, and communities in how care was provided; and this was perceived as integral to nursing practice. Thus autonomy was constructed as determining the “what of care”, consultation was identified as answering questions about the “why of care”, and collaboration was described as the “how of care”.

One NP noted:

Our practice with our patients is individualized, you may have basic guidelines, but what you provide for the patient is your own, I think that’s autonomy.

A second NP commented:

Consultation is an official way of getting input about complexity, and it’s going to be documented...and collaboration means that there’s a good working relationship and we’re on equal footing...

While a third NP stated:

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're going to make the decisions.

From my perspective, this discussion had tremendous significance, because this language is frequently debated by NPs, and this differentiation in terminology was an important contribution. The debate centers on the concern that if NPs gain too much autonomy, this will compromise their ability to collaborate; and at the same time the literature on collaboration indicates that autonomy is a required element for successful and effective collaboration (Jones & Way, 2004; Health Canada, 2004a). With professional legislative changes taking place, there is increased recognition by policy-makers and professional organizations that autonomy is an important feature of increased scope of practice. Thus, NPs with their extended scope of practice have increased autonomy. Collaboration, on the other hand, signifies a different matter and is separate from autonomy and scope of practice. This discussion and differentiation is taken up further in Chapter 6.

HAB: Measuring the Value-Added

NPs worried about demonstrating their 'value added', so as to secure their roles. In team settings with physicians, other RNs, other disciplines, and overlapping scopes of practice, the NPs were concerned about how they would generate evidence to highlight the value-added of their unique roles. Improved access and timeliness were identified by the NPs as quantitative indicators of value-added. They also recognized the importance of measuring the quality of their advanced nursing work and the value-added of health promotion, education and teaching, and client and community partnerships. They stressed that measurement needed to include more than one-to-one encounters and ICD9 codes, based on the physician model of care; NPs needed to also demonstrate how they were

making a difference, fillings gaps in care, and addressing population and priority health issues. However, the NPs also revealed and reflected on a particular tension related to measurement. If PHC practice was meant to be responsive and fluid and the goal was to build a robust team, by focusing only on NP outcomes, they questioned whether this would be detrimental to team relations. One of the NPs commented:

I worry about how I can measure the value-added, that's unique to NPs. We talk about being holistic, but I work with a physician who's pretty holistic; it's a bit insulting to other practitioners who think they are holistic. We need to be smarter about how we're thinking about the value-added... I'm not sure we're asking the right questions, we need to start thinking more outside the box.

Nonetheless, they were not naïve, and strategically concluded that because the NP role was new, they needed value-added evidence that aligned with organizational goals, and attested to the improvement of client outcomes and advancement of PHC. Discussion shifted to the need for evaluation and research expertise, and the importance of a community-university partnership that would match their competence as clinicians with the capability of academic researchers; the untapped resource of graduate students was considered a real asset. The inquiry group generated the idea of an action strategy to explore and develop a research model that would assist NPs to secure value-added evidence from their everyday practices. This inquiry action is reported on in Chapter 7.

We need measurements that are different than what have been traditionally used in clinical settings. I think getting someone with some expertise to come in and talk about that – what type of research is being done, what type of tools are out there. (NP comment)

The HAB Approach to NP Role Implementation

The PPO leaders reported that at the time NP legislation was brought in, HAB was in the process of recruiting a new Chief of Professional Practice, and so a PPO lead was designated for NP role development. As well, a large cross-sectoral steering

committee was brought together to advise on NP planning, and over time was condensed to a core group. The steering committee provided a range of expertise in clinical, program, finance, and employment services, and included senior management and physician leadership; this facilitated decision-making on various aspects of NP role implementation. There was an explicit commitment by the steering committee that the NP roles would be prioritized for PHC and underserved populations, and criteria were developed to inform decisions about NP program and site readiness. Negotiations with program directors and site managers were described as initially collaborative because the number of NP positions was small, but as NP numbers expanded, the steering committee adopted structured guidelines and feedback so as to assure planning and start-up issues were addressed in a timely and equitable manner. One of the PPO leaders commented:

When things have gone off the rails – and they have – it has been very good to have a steering committee...It has created a committed group of people beyond PPO, and an ownership within the organization for NP success and sustainability.

HAB: Adopting the Communities of Practice Model

The NP community of practice model was adopted and started up in HAB about 18 months into NP role development. PPO leaders stated that they had waited to see if practitioners would initiate their own network, and in time started the community of practice when there were enough NPs hired to build a sense of community. PPO leaders saw the communities of practice model was a way to legitimize NP networking and collaboration, encourage sharing of experiences in how to navigate new roles, and foster mentoring of clinical knowledge and practice amongst NPs. The community of practice meetings began as monthly half-day sessions, and recently since the agenda content has expanded, full day scheduled meetings have been adopted. PPO leaders facilitated the

first meetings, and at the time of the inquiry were in discussions with NPs to encourage them take more control of and responsibility for their community of practice. The inquiry action meeting with PPO leaders and NP participants opened up discussions about the community of practice as a strategic collective.

HAB: A PHC focus

PPO leaders of HAB articulated very clearly that NP role development was tied to PHC renewal. As with HAA, this region similarly had a limited number of PHC settings to place NPs, and a pilot project was also underway in a few fee-for-service physician practices. The importance of the NP voice in PHC renewal was emphasized by PPO leaders. NPs as a group were encouraged to participate in the retooling of the provincial PHC charter, and to be strategic and prepared for an upcoming scheduled presentation to the HAB Board meeting (BC Ministry of Health Services, 2007b). This Board meeting was viewed as a huge opportunity for NPs to educate HA administrators about their role development and gain organizational recognition. In the discussion meeting with PPO leaders, there was general agreement that developing individual NP practices was an essential and valuable strategy; however PPO leaders also placed considerable emphasis on NPs developing capacity to influence population health and systems change. This is not surprising given that influencing system change is an important characteristic of advanced nursing practice. NPs were encouraged to develop their leadership in both opportunistic and strategic ways. In this sense opportunistic was seen by the PPO leaders as the proactive work of individual NPs to network locally, design practice innovations, and enhance population health; while strategic was viewed as the collective endeavour of NPs to be political at health authority and provincial levels, to identify and align their

goals and targets with those of the health organization, and to intentionally shape and effect systems change. One of the PPO leaders commented:

NPs as a group need to be put on the HAB map, individual NPs are absolutely on the map, but the group is not...NPs need to carve out a niche, be strategic in what they do, in what their goals are as a group, as a whole. I need a go-to group, that I can take the PHC issues to and be strategic about it.

The PPO leaders emphasized the importance of the NP collective becoming strategic in order to secure their roles, and were keen to develop a collaborative relationship to further this agenda. However, the NP community of practice was still very new and internally focused, and to the NPs this seemed like a tall order.

HAB: NP Role Implementation Progress

As in HAA, PPO leaders in HAB also reported NP role planning and implementation as taking an enormous amount of time, and that each and every NP position initiated in PHC had unexpected complexities. The NP role, from their view, was seen as fundamentally different from any new role that had been initiated in the past several years, if not ever, and the health authority had clearly underestimated the complexity of implementation. They remarked that NP role development was not a site-specific initiative, but instead a provincial initiative that involved whole systems and significant policy negotiations. One PPO leader commented that NP role development was a “go big, or stay home” approach! This meant that NP role implementation was tied to extensive system change, and did not simply involve modifications that the health authority or programs could make; thus a longer term strategic commitment from PPO was warranted. This discussion had implications for NP role integration at the program level, because further NP role integration was contingent on strategic initiatives of the

provincial ministry and health authority to expand funding for NPs and further develop PHC sites. A PPO leader remarked:

I think the strategy going forward, at least for the next year or so, is for PPO to spend more time so we'll spend less time [later]...investing more up-front time, and more structured check-ins, and making it more explicit with NPs in how to be proactive...then I think it will take maybe three more years until we have enough of a NP base.

My interpretation of this statement is that the PPO leaders realized the significance of the NP role with respect to PHC renewal and system change and had come to terms with devoting enough time to ensure role development and foster strategic capacity in NPs, at least until a sound base of NPs was established in which they could sustain their own strategic efforts. Later, the NPs expressed concerns about cultivating a community of practice for the purpose of strategic endeavours. NPs stated that their education programs had not prepared them to be political. They expressed worries, not of being practice-competent, but about how they would become politically savvy as a group so as to be responsive to health organization politics. Their community of practice was still young and needed internal nurturing and maturity before it could become an external force. NPs perceived that the PPO largely retained control of their community of practice, and the NP collective had yet to take ownership; tensions surfaced as to who would or should determine the vision and agenda of the community of practice. NPs discussed the importance of trust in cultivating a resilient and compelling community of practice; and trust was just developing amongst the NP collective, and also needed to be extended to include PPO leaders.

You don't pull fourteen people together who really actually don't know each other, who lack understanding about the context of HAB, and what they can and cannot do. And expect that you're going to, bang, have trust there, because trust is something that you gain over time when you start to have relationships with

people, and we're right at the very beginning...part of me says we are expecting superheroes or something. If we're going to be really good at clinical, can we really be good at all these other areas too? (NP comment)

In summary, the inquiry action meeting with HAB PPO leaders helped NPs to renew a vision of their community of practice and its possible purposes. NPs came to see that their community of practice could have multiple aims. As a group, NPs could support one another, know they were not alone in practice, and discuss worries and tensions within a milieu of trust and safety. The community of practice could facilitate the sharing of clinical knowledge and create a structure for continuing education. As a collective, they could be explicit about their vision of the NP role and articulate what and how NPs added value and effectiveness. The NP community of practice could also be part of the feedback loop to the NP steering committee to advise on policies and decision-making; they could actually be strategic and name health care issues and devise action plans accordingly. Yet, to have strategic influence as a collective, they would need to increase their awareness and understanding of current health care priorities, learn about how systems worked, and develop capacity to influence policy and political decisions. Some NP members expressed strategic readiness, while others were quite new to this thinking. A suggestion was raised to have PPO leaders provide mentoring in strategic planning to the collective. One of the NPs 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, then we can probably do a heck of a lot. So, I think the community of practice is a really important place for us to start strategizing as a group.

By the close of inquiry meetings, a critical consciousness was emerging within the NP group with respect to power sharing with PPO leaders and creating capacity as a

strategic collective. NPs asked themselves if they were ready to step up and take control of their process, and begin to steer their course. Strategies were generated, such as recording minutes of community of practice meetings for distribution to managers and leaders, so as to be more public as a collective; requesting mentoring and resources for their community of practice to advance strategic and political skills of members; creating partnerships with local communities and marginalized populations as part of advancing PHC practice; and examining ways to measure NP value-added in care delivery and contribute to research agendas. One NP spoke in reference to their previous community of practice meeting:

I also felt that we had some power, that finally we were coming together as a professional group, I don't mean that I felt powerful, but I felt I had a little bit more clout ...I was feeling optimistic at the end of the [community of practice] day as we set ourselves when the next meeting was going to be, where it was going to be, and what the agenda was going to be. And I left feeling like okay, we're all coming together now.

The inquiry meeting between HAB PPO leaders and NPs seemed a timely and useful action as it opened up discussion and generated awareness of many issues and tensions yet to be addressed by their community of practice. From the NP perspective, NPs were mostly settled into their practice settings with logistic issues addressed, and were now learning to trust each other and develop internal capacity as a collective. While from the PPO perspective, leaders were waiting for and willing to mentor the NP group so as to engage in external dialogue and strategic planning. The NP group expressed assurance they would get beyond their internal focus, and the PPO provided reassurance of support to the NP community of practice for extending their professional development, evidence-based practice, and strategic capacity. One NP commented following the meeting with PPO leaders:

So I'm really glad this meeting happened, it was similar to when you presented the preliminary findings and I thought "wow, we said all that!" And I'm quite proud of this, and being able to participate in it. And I think there weren't any surprises in what they said, that we are expected to take a leadership role... there was reassurance that okay, I don't have to get everything done this week, that I'm being supported in taking my time to develop this role, and doing it right, that there is a lot of support from above.

Discussion: Comparative Analysis

NP Role Implementation

The PAR inquiry engaged with two comparable health authorities in BC. The health authorities had similar population size, were diverse in geographic terrain, had analogous health care aims, and a similar NP employee base from which to draw. The Chief of Professional Practice in each health authority was responsible for NP role development, and at the time of the inquiry, an equivalent number of NPs had been hired in each region. The research inquiry employed a consistent process for recruitment of NP participants; 11 out of 12 NPs were recruited from HAA, and 6 out of 12 NPs were recruited from HAB. I attribute the recruitment success with HAA NPs to a well established community of practice with a commitment to extending collective experience. Recruitment was less successful in HAB and likely due to the fact that it had a less mature community of practice; the group had only begun to come together and still had to develop trust amongst each other. Discussion of the community of inquiry relational process is taken up in detail in Chapter 7.

Both health authorities had hired their NPs in stages, a few positions each year. NPs from HAA reported being settled in their health care settings and supported by PPO leaders. Nevertheless, challenges in HAA practice settings were still occurring, although NPs said they had a collegial network to discuss their concerns and explore solutions. On

the other hand, HAB NPs who participated in the inquiry were relatively new to their positions, many were under temporary registration, site readiness issues were still being attended to, and NPs had only recently become a community of practice. At the beginning of the inquiry, HAB NPs were apprehensive to engage with each other and it took a couple of inquiry meetings for participants to warm up and discussions to open up.

Both NP groups directed their dialogue to issues of role enactment and discussed enablers and barriers. NPs spoke about establishing and clarifying their roles and this required considerable education of clients, colleagues and community, to have their roles and expertise used effectively. Time utilization was significant to both NP groups, in constructing their roles as holistic and in differentiating their roles as being other than a physician replacement role. Time flexibility was an indicator of autonomous practice, and meant NPs could shape their practice to be more accessible and responsive to varied client needs, extend care to communities and populations, and develop innovative and upstream PHC initiatives. Time spent with patients was identified by Williams and Jones (2006) as a factor in patient satisfaction with NP style of care.

Discourse in both groups helped to differentiate the meaning and conceptual understanding of the terms autonomy, consultation, and collaboration. The groups raised the question as to whether NPs needed autonomy to be able to collaborate, or if autonomy was an element of collaboration. It was HAB that entered into a rich dialogue about these conceptual terms and concluded that autonomy was the “what of care”, consultation was the “why of care”, and collaboration was the “how of care”. The HAB group requested that autonomy be removed as an element of the collaborative framework because they did not see it as an issue or factor in NP role integration. This delineation of these terms and

concepts was validated by the HAA group, and was also presented to the PPO leaders at the action meetings. The PPO leaders of HAB reaffirmed that this differentiation made a significant contribution to the understanding of interprofessional relationships, in that the preoccupation with NP autonomy seemed to put other professions on the defensive and complicated NP role development. Autonomy, reconstructed as the “what of care”, allowed for conceptualizing scope of practice as being within the power and control of NPs, as set out by regulatory standards. This meant NPs did not have to negotiate their autonomy with other professions. Consultation, as the “why of care”, was about managing care that was beyond scope, by drawing upon the expertise of other professions and resources, and this paralleled how physicians consulted. Collaboration, as the “how of care” was inherent to how NPs practiced, and was particularly relevant to complex care in multifaceted clinical and social matters. In light of this translation of concepts, the collaborative framework was adjusted.

This discussion of autonomy builds on C. MacDonald’s (2002) view, in which autonomy was linked to profession-based scope and professional-based discretion. Profession-based autonomy refers to external factors such as legislation to enable self-governing professions to grant self-regulation. Professional-based autonomy means professionals have and take substantial control over their practice and related decision-making. The parameters of legislation, regulation, and education are cited as significant factors in constructing and influencing the clinical autonomy of NP practice (Marsden, Dolan, & Holt, 2003; Turner, Keyzer, & Rudge, 2007). This was affirmed by the NP inquiry, in which BC legislation and regulation have afforded NPs increased autonomy, and according to the NPs this autonomy has enhanced their ability to collaborate.

Both inquiry groups spoke of concerns about how to measure the value-added contributions of NPs within the context of team settings. Numerous stories had been shared about NPs making a real difference to clients and populations; but worries arose as to how anecdotal stories would translate into data to capture NP efficiencies and effectiveness. Some HAB NPs were tracking ICD9 encounters, however expressed unease in only collecting client encounter data, as this did not sufficiently reflect their multidimensional practice and risked constructing their roles as analogous to physicians. Just as important to NPs was to portray their advanced nursing work of health promotion, prevention, harm reduction, and community partnerships. NPs questioned whether qualitative data would be valued by health managers and leaders, as much as hard statistics seemed to be. The methodological challenges of designing outcome research to attain nurse-sensitive evidence and value-added contributions is noted to require strategic consideration (Barton, et al., 2003; et al., 2002; Litaker, et al., 2003). In the action inquiry with HAA PPO leaders, they praised NP achievements many times during the meeting, reaffirmed the value of their advanced practice nursing work, and committed to a collaborative approach to taking up the challenge of measurement. The PPO leaders of HAB offered less commendation to NPs during the inquiry meeting and discussions were more directive; yet there was an openness and willingness by PPO leaders to assist NPs in developing their community of practice and strategic capacity.

Clearly, HAA PPO leaders were proactive in NP role implementation, as indicated by employing a systematic approach to initiate roles, and researching and commencing the communities of practice model very early into NP hiring. The decision by the HAA Chief Nursing Officer to retain control, consult with organization leaders as

needed, and collaborate with communities so as to ensure their preparedness, denoted the PPO Chief's authority and autonomy within the organization to enact decision-making in line with responsibilities for role development. As well, the decision to focus time and energy toward collaborating with community partners indicated an understanding of the complexity and significance of NP role implementation to system change. The HAB circumstances were quite different at commencement of NP role implementation; a new Chief Nursing Officer was being recruited, there had been less groundwork, and a large steering committee had been formed. The steering committee took collective responsibility for decision-making, and much of the negotiations and effort was focused at this level to learn about and address the complexities of NP role implementation. HAB committed to a collaborative approach with organization leaders, which resulted in less time and attention to prepare community partners and sites to receive an NP.

The commitment by both health authorities to align NP role implementation with PHC renewal efforts was strongly articulated. In both regions, PPO leaders saw NP role implementation as highly political, and conveyed the importance to NPs of asserting their strategic influence within the realm of their own practice settings and collectively at the systems level. However, HAA leaders were more experienced with communities of practice and recognized the time and attention it takes to nurture collectives, to create collaborative relations, and to mentor leadership, so as to move beyond internal performance issues and contribute to the strategic goals of the organization. In this sense, the model of communities of practice was seen to have dual purposes of effecting improved performance and enhanced leadership. Both health authority PPO leaders had a future vision for NP role development, which involved keeping NPs on the radar screen

of health authority administrators, and increasing the number of NP positions in PHC, so as to create a tipping point that would foster NP role integration and secure sustainability. The importance of the collaborative relations between PPO leaders and NP communities of practice became a salient finding of the inquiry. The inquiry as informative and transformative raised the critical consciousness of NP participants and PPO leaders, as to the importance of extending their collaborative relations, and by so doing this would enhance NP role implementation, advance NP integration, and assure NP sustainability. The collaborative culture framework reported in Chapter 4 provides some direction for determining the strengths and challenges of these strategic relations and offers guidance for future improvements.

New Learning about Communities of Practice

This inquiry revealed that communities of practice have multiple benefits. Communities of practice provide a social structure to engage practitioners in processes that involve practice learning and knowledge exchange, inquiry and knowledge development, and policy leadership (Wenger et al., 2002). As a social network, communities of practice promote collegial and collaborative relations. Communities of practice are a forum for practice learning and knowledge exchange, in which individual and collective historic and emergent expertise is shared and, in this way, practice proficiency is enhanced. Interactive dialogue occurs within the collective to generate queries, inquiry, and discovery of new knowledge, and foster the pursuit of professional advancement and innovation. Communities of practice are also a leadership tool for stewarding knowledge, where knowledge as power shapes and transforms organization policy and politics.

Research about communities of practice is limited; Wenger is frequently cited and considered the reputed expert. Yet, there is some debate in the literature as to the limitations of Wenger's social theory of learning and its restrictive focus of communities of practice for the purpose of intrinsic learning (Andrew, Tolson, & Ferguson, 2007). Other research has raised concerns about the quality of learning in communities of practice, because groups focus on sharing tacit experience rather than on evidence-based knowledge exchange (Gabbay et al., 2003). However, this health care inquiry with NPs revealed that communities of practice contribute to multiple domains of practice, education, research and leadership. The NP communities of practice demonstrated capacity to create social support networks; provide forums for sharing and exchanging evidence-based knowledge; engage participants in collective knowledge development, and contribute to strategic leadership of the health organizations.

In this study, PPO leaders of both health authorities were very clear that NP communities of practice had an important strategic role to play in organization policy and politics. This finding adds new knowledge about the functioning and benefits of communities of practice, because the existing literature highlights the purposes of practice, education, and research; while the purpose of strategic policy leadership is essentially absent in the literature. Yet, there is some suggestion in the literature about the importance of having both organization and practitioner commitments for forming and sustaining communities of practice (Addicott, McGiven, & Ferlie, 2006; Andrew et al., 2007; Garcia & Dorohovich, 2005).

My interpretation from the inquiry is that organizational and leadership support is engendered by communities of practice having tangible relevance and value to

management operations and goals. Thus, the issue revealed in this inquiry was not whether strategic endeavour was a vital feature, but instead how to balance the cultivation of communities of practice to serve both practitioner needs and organization demands. Finding this balance and maintaining this equilibrium called on the importance of having a collaborative culture that fosters the combined and shared efforts of policy leaders from higher administrative levels engaged with well-grounded practitioners. The collaborative framework derived from this PAR study provides a road map for advancing collaborative health care culture and aligns well with communities of practice as a strategy. The collaborative framework can be used to guide the cultivation of communities of practice based upon a collaborative philosophy, including attention to values, structures, and processes for engagement.

Cultivating Communities of Practice in Health Care

Cultivating communities of practice requires being purposeful and perceptive to address the interests of practitioners and the agendas of policy leaders (Garcia & Dorohovich, 2005). A top-down management approach, referred to by Tolson et al. (2006) as a technical model, includes guidelines, policies and structured control, yet there is a need for practitioner buy-in for changes to be adopted. Overly managed communities of practice tend to focus on performance targets, policy issues, and strategic goals of the organization, which often alienate practitioners with their primary interests of client care (Addicott, et al., 2006). A ground-up organic approach, termed by Tolson et al. (2006) as an emancipatory model, aspires to elicit practitioner reflective practice, empowerment, and autonomy; yet organizational sanction is an essential precursor to success. Communities of practice that are organically spawned and focus primarily on practitioner

networking and knowledge exchange may not attract the participation and interests of policy leaders.

Wenger et al. (2002) outline seven principles for cultivating communities of practice that are 'alive'. First, the authors note to use a design structure that catalyzes evolution, not an imposed structure; second, open dialogue between inside and outside perspectives, as well as extend up and down relations; third, invite different levels of participation, and encourage leadership to be shared or shifted to readied members; fourth, develop both public and private community spaces, so individuals and the collective are nurtured, and work is carried out between meetings; fifth, focus on value through practical relevance, appreciative inquiry, and aligning to organization targets; sixth, combine familiarity and excitement in creating a neutral place and space for engagement away from everyday pressures of the workplace; and finally, seventh, create a rhythm for the community, in regularity and dependability, and in the celebration of success.

The experience of HAA in cultivating the NP community of practice, in many ways demonstrated these principles. Design was formulated by early discussion between the PPO leaders and NP participants and was revisited as new NPs joined. Dialogue was opened up between PPO leaders and NPs and extended outside to participation in academic conferences, interaction with other professional groups, and attending organization meetings. The research inquiry represented an outside resource coming into the community of practice. Collaborative participation was fostered by sharing leadership and designating member roles for communication, education, facilitation, meeting logistics, and ad-hoc interests. The PPO leaders committed significant time and energy to

nurturing NP members individually and collectively; the mentoring of strategic thinking and engagement was inherent to NP role implementation in HAA. Community of practice meetings were diversified to capture varied interests, and participants valued a social component, structured education and clinical in-services, and attention to policy and strategic endeavours. NPs were afforded time away from practice to travel to a central gathering place, and meet together for one or two day regular scheduled meetings; they welcomed each other including new members with friendship and ease and created a buzz of interaction in the room. Achievements by the community of practice were recognized and celebrated; this came in the form of NPs valuing each others' contributions and celebrating successes, the PPO providing feedback and praise, organization leaders interacting with NPs, ample attendance and presentations at academic conferences, initiation of a provincial NP conference that has become an annual event, retention of NPs in the region and a good reputation for recruitment, and research and evaluation initiatives underway. The inquiry revealed a collaborative approach to cultivating and sustaining communities of practice, and this informed certain features that were drawn from the literature and from the inquiry findings.

In Conclusion: A Collaborative Approach to Communities of Practice

A collaborative model for communities of practice fosters a negotiated structure and process to attain equitable leadership and address matters of importance to both practice and policy stakeholders. This PAR inquiry found that a collaborative approach to communities of practice relies on four particular features: structured collective identity, a relational approach to knowledge exchange, valuing of knowledge development, and power sharing between practitioner and policy leaders. A structured collective identity

means the community of practice is sanctioned and resourced by the organization, and mentored or nurtured as a social unit to develop cohesive and intentional aims (Wenger et al., 2002). A relational process for knowledge exchange fosters sensitivity and flexibility, so that members can be active or passive participants depending on their degree of engagement yet retain collective commitment (Andrew, et al., 2007). Valuing of knowledge development engenders in the collective a sense of discovery to examine and generate evidence, and extend professional / interprofessional contribution and commitment (McDonald & Viehbeck, 2007; White et al., 2008). Power sharing between practitioner and policy leaders recognizes the interactive and proactive nature of communities of practice to address common concerns and strategic and political interests of stakeholder perspectives.

PAR as a methodological approach is a resource to enhance a collaborative model of communities of practice. PAR is delineated by qualities of social inquiry, education, knowledge development, and transformative action (Hall, 2001) and is closely aligned with a collaborative model of communities of practice. Four features of a collaborative approach to communities of practice were identified in this study: structured collective identity, a relational approach to knowledge exchange, valuing in knowledge development, and power-sharing between practitioner-policy leaders. PAR can contribute in two specific ways to the cultivation of communities of practice. PAR, as an informative methodology, extended our understanding about the values, structure, process, and outcomes of communities of practice in this inquiry, and enhanced evidence-based knowledge development. PAR as transformative methodology shifted the ideology and culture of communities of practice toward a collaborative approach to better serve the

varied needs of practitioner and policy leadership in health organizations. These findings about the value of PAR to foster collaborative workplace conditions are in keeping with a study by Munn-Giddings, Hart, & Ramon (2005) about promotion of workplace well-being. This PAR inquiry confirmed that strategic collaboration between health policy leaders and NP collectives is an essential element of NP role implementation, integration, and sustainability.

Chapter 6

Community of Inquiry: The Relevance of Collaboration to NP Role Integration

When I think about being a new NP I think about how do I work with other people? What does that fluidity look like? 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...So, to me it's about how do I begin to build relationships and partnerships that are going to help me enact this role. (NP participant)

A number of reports and studies have examined NP role development in Canada, and utilized a variety of language to describe this matter (Bailey, et al., 2006; Bryant-Lukosius, et al., 2004; CNPI, 2006b; DiCenso & Matthews, 2005; IBM, 2003; OMA & RNAO, 2003; MacDonald et al., 2005; Way, et al., 2001; Way, Jones, & Busing, 2000). In Chapter 1, I described NP role development as an umbrella term that encompasses the formalized stages of role introduction, implementation, integration, and sustainability and I differentiated each of these stages with respect to particular health care contexts. Thus, in this study NP role introduction refers to the BC provincial initiatives set out by government, by the CRNBC as the professional regulatory body, and by designated educational institutions. Role implementation pertains to the health authorities' responsibility and strategic actions to establish the role in specific program settings. Role integration relates to program plans and processes to assimilate NPs into the day-to-day functioning of sites and settings. And role sustainability refers to the elements of system redesign to ensure the NP role flourishes over time and becomes integral to health authority and health system performance and efficacy.

Specific to BC, NP role development was built upon lessons learned from other provinces; as well there was extensive provincial consultation and systematic research to

inform the design of legislation, regulation, and graduate level education (MacDonald et al., 2005; Pauly et al., 2004; Registered Nurses Association of BC, n.d., 2003; Schreiber et al., 2003). The Ministry of Health and the CRNBC partnered to introduce NPs into the province (CRNBC, 2005). The Ministry broadly framed legislative regulations and scope of practice, and funded educational programs, start-up costs, and interim funding to initiate hiring of NPs into regional health authorities. CRNBC was given regulatory authority to determine NP competencies, set registration requirements and process, and provide oversight of the standards, limits and conditions to practice.

The Ministry and CRNBC partners agreed on eight principles to guide introduction and implementation, summarized as follows: prioritize best interests of the public, support a sustainable health system, improve health care access and provider utilization, situate NPs in a broad variety of settings, parallel the legislative governance of other professions, create flexible regulation to accommodate varied practice environments, establish the CRNBC as regulatory body, and regulate NPs according to a competency-based framework (CRNBC, 2005). This political and policy context helped to shape and formalize NP role development. At the health authority level, where NP role implementation is now taking place, the responsibilities include incremental increase in the number of NP positions, policy and infrastructure re-design to accommodate this new role, and provision of responsive leadership, performance measures, and adequate support and resources, so that NPs are integrated into various program settings. Since 2005, and to the date of study completion, over 120 NPs have received full registration status in BC and most are employed in health authority positions (CRNBC, 2008a).

Research to assess the stages and effectiveness of NP role development is an important contribution to advancing the role in the BC context. This community of inquiry focused primarily on NP role integration and a forward looking examination of role development. A collaborative PAR approach seemed an effective way to promote NP awareness of and interest in the value of research and to foster stakeholder investment. PAR facilitated NPs to come together to be reflective, learn from one another, look beyond everyday practice, envision their future, and be strategic about their intentions. The inquiry looked into the current status of NP role development in two health authorities to explicate NP role integration at the program level and the effects of collaboration on this process.

In Chapter 6, I begin by discussing NP competencies, the underpinnings of collaborative practice, and certain tensions related to NP role development and collaboration; these tensions are taken up later in the chapter with respect to study findings. This chapter particularly focuses on the research question of “how does *collaboration* advance NP role integration within PHC”? This overriding question was studied by way of three queries. The first query explored and revealed current practice patterns of NPs and demonstrated that NP practice is aligned with advancing the PHC principles. The second query explicated the meaning of NP role integration from the perspective of NPs and their Professional Practice Office (PPO) leaders. The third query applied the collaborative health care culture framework (as outlined in Chapter 4) to an analysis of NP discussions about the matter of advancing NP integration. The analysis revealed that NPs are leaders of holistic client and community care, stewards of PHC renewal, and champions of collaborative culture.

NP Competencies and Collaborative Practice

Fundamental to NP practice is attainment of advanced clinical competencies with diagnostic and prescriptive authority, in addition to other advanced nursing competencies.

There are several documents that delineate NP competencies, and also reference advanced nursing practice competencies (CNA, 2005b, 2008; RNABC, 2003).

Competencies are defined by the CNA (2005b) “as the integrated knowledge, skills, judgment, and attributes required of a NP to practice safely and ethically in a designated role and setting” (p. 4). The CNA core competencies for NPs include: health care assessment and diagnosis, health care management and therapeutic intervention, health promotion and prevention of illness, injury and complications, and professional role responsibility (2005b). The CNA core competency framework drew upon the BC framework and thus the core competencies are similar; however the BC document also acknowledged the CNA advanced nursing practice competencies and included these as additional expectations for NP practice (CNA, 2002a, 2005b; RNABC, 2003). The CNA 2002 Advanced Nursing Practice National Framework competencies delineated clinical, research, leadership, collaboration and change agent competencies. The CNA 2002 framework was updated in 2008 and the competency of change agent was deleted, although this function was embedded within the other identified competencies.

Particular to NPs and their advanced clinical competencies is that NPs and physicians now have more overlap in scopes of practice, and this has intensified the debate about whether NPs are replacing the physician role. However, this debate is countered by the assertion that the NP role is grounded in the theoretical underpinnings of the nursing discipline and profession. Relevant to NP practice is theory supporting the

‘art and science’ of nursing that originated with pioneer nurse theorists, such as Florence Nightingale (Thomas, 2003b; Zurakowshi, 2005). The ‘art’ of nursing represents a socio-humanistic caring dimension of practice, in which caring is seen as central to fostering health and healing (Thomas, 2003a; McPherson, 1996). The art of nursing with a socio-humanistic dimension recognizes the broader socio-economic differences that shape the health of individuals, groups, and communities (Sheilds & Lindsey, 1998; WHO, 1986). On the other hand, the ‘science’ of nursing, derived from bio-medical roots, represents the clinical dimension of practice and addresses concerns of illness and healing. The science of nursing informs clinical judgement in practice and fosters evidence-based practice and inquiry. By combining socio-humanistic and bio-medical dimensions, nurses are recognized for their provision of holistic care. Thus, for this study holistic care is described as the combination of the ‘art and science’ of nursing; in which the ‘doing of nursing’ and the ‘knowing of nursing’ generates a synergy of client empowerment and healing (Barton et al., 2003; Curley, 1998).

The NP role is designed to extend the capacity of nurses to provide holistic care and facilitate holistic health. Through advanced practice competencies NPs increase access to clinical and social care, facilitate client empowerment and community relations, foster collaborative practice with other professions, and contribute leadership to health innovation (CNA, 2003c, 2005b, 2008a). Although the advanced clinical skills of NPs are often profiled in order to set them apart from other nursing roles, new NPs need to be cautious to maintain a balance in their art and science, and be wary of surrendering to a physician style of practice and a role of physician replacement (Brown & Olshansky, 1997; Kelly & Matthews, 2001). Instead, NPs must develop their own way of knowing

and doing, enriched by nursing theory and practice, and thereby develop and strengthen their autonomy. Practice autonomy enables NPs to utilize their full range of competencies, discover and adapt their new roles, yet draw upon the skills and resources of others, in order to be responsive to clients and community. In this way NPs demonstrate the provision of a different kind of PHC.

Collaboration is an important feature of the NP role, and is incorporated into the core competency functions and highlighted as one of the advanced practice nursing competencies. NPs are expected to be proficient in collaboration and this is reinforced by a number of position and policy statements of the CNA (2003a, b, c; 2005a, b, 2008a), and the CRNBC (2005; RNABC, 2003). NPs in PHC are thus well situated to champion collaborative client care efforts and provide leadership with respect to interprofessional teamwork. Alternately, collaborative relations can benefit NPs and serve to advance role integration. Collaboration between NPs and various stakeholders, including team members, clients, and communities, other professions, and health leaders can generate synergistic effects for client care, which in turn can secure the NP role as an essential member of the PHC team and advance role integration.

Tensions Related to NP Role Development

Particular tensions were identified in the literature that were useful to have in mind as I began this inquiry with NPs. I highlight three issues here, which are relevant to role development: NP multidimensional competencies, role clarity, and professional autonomy. For each issue, I draw upon literature to explain the tensions and formulate a particular view point with respect to collaboration. Concerning the first issue of multidimensional competencies, there is tension with respect to the preoccupation with

NP clinical competence. This preoccupation starts with education programs that aim for due diligence in preparing NP students with advanced clinical education, and then reinforced by regulatory bodies that focus on clinical competence through examinations and standards. As well, NP graduates enter practice consumed with the need to further develop their clinical skills (Brown & Olshansky, 1997). This clinical focus is nonetheless very important because it prepares NPs to provide high quality safe clinical care. However, a tension arises with the perceived lack of NP preparation in other aspects of their advanced role, such as health promotion, illness and injury prevention, leadership, research, and change agent work, despite these components being included in current NP curricula in BC (CNA, 2008a; RNABC, 2003). It may be that the NP's concerns about becoming clinically competent overshadows and minimizes their learning in these other areas, or NP curricula need to enhance these areas of learning.

Browne and Tarlier (2008) make the case for NPs to employ a social justice mandate and reach beyond the physician replacement function. This discussion raises the importance of NPs staying close to their nursing roots, remaining grounded in the theoretical underpinnings of nursing, and preserving strong disciplinary relations in order to safeguard the NP role as one that provides holistic care. To frame the NP role as holistic means all facets of the role are recognized including advanced clinical competence, health promotion and social justice, community partnership and development, professional leadership and collaboration, change agent work, and practice inquiry research (Browne & Tarlier, 2008; CNA, 2005b; 2008a; Pogue, 2007; Way, Jones, Baskerville & Busing, 2001). The NP role, viewed as multidimensional,

differentiates NPs from primary care physicians, and also strengthens their collaborative relations with clients and community.

The second issue of role clarity raises the concern about the lack of understanding of the NP role and this includes misunderstandings among nurses within the profession, as well as confusion among allied disciplines and with the public (Bryant-Lukosius, et al., 2004; El Jardali, 2003; Haines, 1993; Pauly et al., 2004; Pearson & Peels, 2002). This lack of NP role clarity causes tensions for NPs in practice, in that NPs can be underutilized in terms of their competencies and capacities and thus are not able to fully enact their role (Bailey et al., 2006; Way et al., 2001); or they can be over utilized and relied upon as physician replacements, and consequently do not carry out the full dimensions of the NP role (Bryant-Lukosius et al., 2004). It is therefore important to delineate the NP role from other nursing and allied professional roles. A key feature that differentiates the NP from other nurses, including other advanced practice nurses, is their advanced clinical diagnostic and prescriptive authority, yet this is a feature that reinforces the perception that NPs are physician replacements (Sidani et al., 2000; Bailey et al., 2006). To have the NP role clearly articulated and recognized, there is a need to differentiate their unique scope and capability, as well as acknowledge the overlap in scope of practice with other practitioners, such as RNs and physicians. This is particularly important in PHC with the increased focus on interprofessional teamwork. To successfully integrate NP roles in PHC, role clarity is essential. In addition, it is important to provide the public with clear information and understanding about the NP role. Clarifying the NP role will serve to increase understanding of professional identities, roles and responsibilities and cultivate effective collaboration amongst practitioners.

The third issue is about professional autonomy; this issue is often raised in the literature with respect to NP and physician collaboration (El Jardali, 2003; Jones & Way, 2004, 2007; Marsden, et al., 2003; Phillips, et al., 2002; Way, et al., 2000). The concern is whether professional autonomy and collaboration are mutually exclusive. Because NP roles and scopes of practice vary in accordance with legislative and/or regulatory parameters, some provinces require physician oversight of NPs, while others, such as BC, have designated professional autonomy of NPs under the legislation (CRNBC, 2008c; Jones & Way, 2004; Martin-Misener, et al., 2004). Nonetheless, NPs generally require some physician oversight during the period of temporary registration, and until they gain clinical confidence in practice decisions.

Historically, NPs have negotiated nurse-physician power relations and managed their relationships with physicians by emphasizing collaboration, and downplaying autonomy (Martin & Hutchinson, 1997). Yet this strategy compromised NPs in attaining full competence, gaining credibility, and making timely client care decisions (Almost & Laschinger, 2002; Draye & Brown, 2000; Hughes, 2005; Way, et al., 2000). Improved legislation and regulation has increased professional autonomy; NPs in BC are responsible and accountable for their decision-making, and less reliant on physicians. This suggests that professional autonomy is contingent upon systemic and structural mechanisms, not on collaborative processes. Autonomous practitioners are able to negotiate unique and overlapping scopes with confidence, and determine team roles and responsibilities for quality client-centred care. From this perspective, professional autonomy does not preclude collaboration, but actually enhances collaborative practice. I return to discuss these issues later in the chapter, based upon the study findings.

The NP Inquiry: Current Status of NP Collaborative Practice

In the first meeting with each NP inquiry group, we began by exploring the NPs' practice patterns and discussing what an average practice day looks like. Themes that emerged from this discussion of practice patterns included: role diversity, clients as partners, holistic care, collaborative practice, and agents of change. As these themes were more closely analyzed, we came to see NP practice patterns as the application of PHC principles of equitable access, public participation, health promotion and population health, intersectoral collaboration, and appropriate skills and technology. I introduced and discussed these PHC principles previously in Chapter 1.

Role Diversity

As the NPs described their everyday work, the diversity of practice patterns, client populations, and settings were noticeably varied amongst the NPs. Every NP role looked different, and the notion of a uniform NP role or typical practice day seemed a paradoxical idea. 'Role diversity' therefore emerged as a theme. One NP noted:

I think this is one of the positions that I've had that has required a lot of flexibility, and I think also because it's a work in progress...So each day is different. I have some days that are set aside strictly for clinical...so yesterday I was with the aboriginal centre and had a full day of clinical. Then another day its paperwork, meetings, still meeting with people that I'm going to be working with in the community, and then I might have another day where I'm traveling somewhere to do a clinic, and then coming back into town to do another clinic later on in the day. So each day is different.

NPs provided health care to all manner of age groups and populations. One version of care described was in a mixed family practice; while other accounts were of NPs providing care to specific populations, such as seniors, women, youth, homeless and First Nations people. Still other NPs provided care to specific local and rural communities. As

well, some NPs focused their practice on particular client health conditions, such as diabetes, renal care, seniors care, or mental health and addictions.

I'm working with the homeless, marginalized population...so I go to the place where a lot of the clients get their meals, and also at the women's center...I have very short times to target and see who I can (NP participant).

NPs also described varied work settings. A few NPs went to the same office, had scheduled appointments, and had some predictability to the flow of their day; this was particularly apparent for NPs working in physician practices. On the other hand NPs practicing in community health centres modified their days so as to manage a blend of client appointments, walk-in clinics, health promotion and education, and specialty programs, such as women's health and chronic disease. One NP noted:

I have a very small family practice. I think there's probably now between 150 and 200 patients in my family practice. I usually book 4 or 5 of those patients a day for general follow-up appointments or physicals, [while] the majority of my day is spent seeing urgent or emergent patients and ambulatory care in our clinic.

A few NP roles had great variability to each day, in which settings changed, and outreach to clients involved flexibility and unanticipated contacts. An NP spoke about her aboriginal outreach focus, "Everyday is different...Where do I do my work? Everywhere!" An NP with a practice in senior's health noted that on any given day her schedule was open to respond to long term care referrals, rapid response phone calls, follow-up to emergency admissions, and home visits to frail elderly. NPs worked in interprofessional team settings, in partnership with physicians, and as independent community practitioners. One NP with a more independent practice commented:

So basically what my day looks like is I work quite independently, I don't have a team per se that I work with, I don't have a clerk so I do my own bookings, my own filing.

Yet what I saw as the commonality among these different practice patterns was the NP's ability to be accessible, flexible, and fluid, in order to provide care to underserved populations and to address health care gaps in service. The versatility of roles required professional autonomy to schedule and practice according to client and community needs, and to fully enact the diversity of their roles. One NP commented:

I might have a day that I have lots of patients. I do a phone-call follow-up with them. It's different with each family, some families I'm calling... you know I have a couple of moms at the methadone clinic who are trying to stay clean, so I'm offering them frequent support. I might call some of those every day, "how's it going, how's the baby, how're you feeling?" Others I've backed off and I'm calling them, you know, once every several weeks, or a month or so. So I do have a lot of phone contact with my patients.

The NPs suggested that their autonomy came about from the endorsement and support of managers and health leaders who encouraged them to construct their roles in accordance with the needs of their client base. The NP pattern of role diversity revealed the extent to which NPs explored new ways to be responsive to clients, communities and populations, and this reflected the principle of equitable access to PHC.

Clients as Partners

NPs repeatedly discussed their relationships with clients and their alignment with 'clients as partners' in care emerged as a theme. The importance of fostering collaborative client relations, addressing complexity of client care, and developing community and population approaches to practice were noted as salient features of this theme of clients as partners. One NP commented:

My worry is that a lot of the value-added of an NP is around health promotion, is around teaching, is around patient partnerships and those kinds of things, that others don't do, but we have a real desire to maintain that, and we have a desire to create the role to protect that, which I don't think has always been possible in physician practices in a fee-for-service model. (NP participant)

NPs described collaborative client relationships as reciprocal, in which interactions took into account the perspective of both the client and the practitioner. One NP noted that whether she was seeing a client for the first or tenth time, what was important was to discern the client's agenda, and support client decision-making in how to address their concerns. Another NP commented:

Or you know they come in and they have this little list and I've looked at their lab work and I have a little list, and I say "so what are we here to do today?" and out comes the list, and I say "before we get started can I just say that you have some things, and there are some things that I see here in the chart that we need to deal with. Let's get them all out and then let's see what we need to do first".

NPs spoke about clients that required complex care. This entailed drawing upon their advanced clinical knowledge and nursing care skills, consulting with other practitioners, making use of evidence-based guidelines, and developing responsive programs for particular populations or health conditions. They noted the importance of having flexible schedules to carry out comprehensive assessment and education, apply intervention strategies for clinical and social concerns, and accommodate client limitations, such as home visits to frail seniors or spending more time with people who have mental and physical challenges.

I have a lady coming who really needs all her cognitive assessments repeated so we've scheduled a longer time to do all those things because it will take more than a half an hour and I don't want to feel rushed, nor do I want her, so the gift that I have to give to patients is time (NP participant).

The NPs in both inquiry groups spoke about time as a gift or a luxury. Yet, on further reflection, they came to the conclusion that the gift of time was not a luxury; time was actually an essential feature of integrating clinical and social care. NPs, as autonomous practitioners and employees of Health Authorities, had, for the most part, the discretion to design their schedules to meet client needs and concerns. NP time translated into being

‘in relationship with clients’ and ‘in partnership with communities’, so as to provide responsive, relevant and effective care. Nonetheless, a few NPs described a subtle undercurrent of tension in being compared to physician practices, and this was manifested in the way managers and colleagues focused on such things as the number of client visits per day. NPs thus felt undermined in taking the time to develop programs to meet an identified population need. One NP discussed the struggle her predecessor had in the NP role and how this affected her new position too.

They were watching the previous NP and were concerned about the number of patients she was seeing, and I’m... there’s been no number mentioned, but the directors look at how many patients are you putting through.

Another NP commented about this underlying tension with respect to time:

One thing I struggle with is that because NP work looks different. I feel I’ve been afforded a bit of a luxury, I suppose, in that I have longer appointment times. I hope to hold on to that...I don’t know what that’s going to look like over time. Like, I don’t know how that’s going to be seen, because I’m working with physicians who are booked half that time, they have 15 minute appointments, which is already longer than many GP practices.

An NP reported at the next analysis feedback session:

I think the time piece for me was the thing that jumped out... I mean it’s the thing that I wrote I don’t know how many sentences on...a measure of success is how many clients can you serve in a day, because that’s the mindset of a clinic, you know, we have all these numbers of people who need to be seen and we as NPs get locked into that, rather than which select group should we work with today?

NPs wondered why physician-type schedules, which were driven by a fee-for-service system, would be applied to their practices, because NPs were employees and worked under a different funding structure; yet some NPs seriously felt the pressure to practice in accordance with a physician practice style, and this was seen as a barrier to establishing client partnerships.

NPs also explored the view of 'community as client'. An NP working with on-reserve and off-reserve First Nations people spoke of 'OCAP' principles, of ownership, control, access and possession, as central to forming trusting relationships and assuring cultural safety. The OCAP principles shape the self-determination position that has long been advocated for by First Nations in Canada, and was coined by the Steering Committee of the First Nations Regional Longitudinal Health Survey (Schnarch, 2004). It was interesting to hear how an NP was applying a research framework to practice, and this provided an example of evidence-informed relational practice.

Another NP talked about a particular client population and the need to educate the client group so that they would change their habits of using walk-in clinics and draw on the NP services more effectively. NPs discussed how they employed their competencies and scope of practice to shift how care was delivered, and their client populations also needed to change how they accessed care. NPs described a full service role as one that spanned a range of services and engaged with both clients and communities. For instance, an NP told of assessing mental health clients, prescribing, counseling, providing cognitive behaviour therapy, and consulting psychiatrists as needed, and then participating in a community housing initiative; while another NP noted:

I think the beauty of the role is we can step up to the plate when it comes to clinical...when it's busy in the clinic, you just roll up your sleeves, help out, and then we also have that opportunity to step back and to look at what's happening with this community, what are the health challenges and the gaps.

My analysis was that the theme of clients as partners underpinned NP determination to share power and engage clients as active participants and decision-makers in their own health care. Also, by bringing clients together around common concerns and interests for social support, health education, and group clinical care, NPs

fostered client and community empowerment. This approach of sharing power and fostering empowerment enhanced role clarity and public awareness of the NP role. The NP practice pattern of forming client and community partnerships contributed to fostering public trust and reflected the principle of public participation in PHC.

Client-centred Holistic Care

NPs described their care as 'client-centred and holistic'. A nursing philosophy underpinned a client-centred approach, while advanced clinical education extended the ability of NPs to provide holistic PHC. 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. Another NP similarly noted the comprehensive nature of her client interactions related to a chronic health service.

I spend about an hour doing a history and physical exam and I start doing some one-to-one education...make sure people have had their vaccinations, and health screening...I decide what type of lab work we need for a good baseline, if they possibly need an ultrasound...and when they come back we can talk about their initial questions and concerns, review their lab work and then decide on a schedule for monitoring.

NPs also spoke about their approach to care as more systematic and stressed the surveillance function of their role. An NP commented on this aspect of her care.

I think you have that opportunity as a NP to set up that follow-up in different ways. To support the patient when they are feeling a little bit unsure, when they need more than 10 minutes to absorb the facts, we have that ability to set up follow-up in a different way than traditional medicine sets it up. You know, not to create dependency, but to build that relationship in a more meaningful way, and recognizing that there are some resources for the patient, and to be able to work with those things...it's really about setting up a system of care that supports patients and their choices, but also gives them more opportunity for follow-up.

NPs shared their various innovations in program development, such as outreach clinics, group client visits for chronic care, a women's wellness clinic and screening services, and a community assessment that resulted in a 24-hour blood pressure monitoring program. Other NPs reported more conventional approaches of urgent, emergent, and ambulatory care with appointment times scheduled to address specific client concerns. Nonetheless, all NPs 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.

NPs discussed how doing upstream prevention and health promotion extended their social justice work, better addressed chronic conditions, and improved proactive health decisions and client compliance. An NP noted:

We keep hearing about the under-served, and that's our goal is to increase access. We need to identify marginalized populations.

NPs discussed their aims of providing comprehensive health care to clients with complex health concerns, and identifying marginalized and underserved populations, so as to increase health care accessibility and redress health gaps. These aims were viewed as important value-added contributions of the NP role. One NP noted:

I think we look at our vision of the patient that exists from the patient out into the community, a lot more than perhaps the physician who's looking really only at that particular disease process...So it's being able to look at this issue with this patient as being more than just the disease at hand. You know, it has to do with their relationships, or the environment. It has to deal with a lot more with the population health component.

Another NP commented:

I think part of the value-added is really about the time for teaching. The time for that holistic work that you do...to practice the way I want to practice, the way that makes a benefit to the patients...it's hard to measure, that is a concern for me.

NPs expressed how they appreciated being able to draw upon aspects of both the medical and nursing role to provide a much more well-rounded provision of care for clients and communities, especially for clients who previously had lacked access to care. NPs also reported that a client-centred approach strengthened client participation and was useful in engaging hard to reach clients. Client-centred holistic care was underpinned by the NP's commitment to social justice and empowerment and reflected the PHC principle of health promotion.

Interprofessional Collaboration

Collaboration was described by NPs as being foundational to their everyday practice as a nurse. They discussed how they utilized a full range of people and resources in the provision of complex client care. NPs were taught to be collaborative as part of their undergraduate and graduate education programs, and so this came very naturally for them. One NP commented:

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.

Collaborative practice has typically been taken up in NP research literature with respect to NP-physician relationships; this may be due to past limited autonomy and regulatory scope. However, the NPs in this inquiry revealed a much wider circle of collaboration. One NP discussed the importance of collaboration with community care, and this to some extent compensated for lack of access to a geriatrician, as the community resources joined together to create collective expertise.

In senior's health...without, if you will, a system in place for specialized geriatrics. We looked for mentorship, we looked for a geriatrician, which we do not have, so basically I work with community care, and we definitely work collaboratively, whether it be the community care pharmacists, myself, we have various case reviews, the nurses of course, and not undermining the role of the home support workers who are my front line eyes and daily reporters of changes in health status.

A NP spoke about the medical office assistant (MOA) who was noted as a key team member, and how the MOA's understanding of interprofessional scopes of practice and skills was integral to booking clients appropriately. An NP mentioned taking time over lunch to mentor the MOA to assist with chronic care visits, such as preparing patients for examinations, measuring weights and waist circumference. NPs discussed various professions they drew upon for complex client care.

It's not just physicians that we're always collaborating with...but equally so with the respiratory technologist, with mental health, with public health, with tobacco reduction...a speech pathologist...So I really try to make use of [everyone] in the office.

In discussions of engaging a full range of resources, the notion of team was viewed as broader than a fixed group of people. Teams in close proximity, as in an office or centre, with regular face to face contact, fostered everyday informal opportunities to collaborate. NPs also facilitated formal collaboration with a fluid network of professions in order to plan and coordinate complex care, thus the notion of team was expanded. One NP reported:

He was diabetic and was definitely out of control and I just called all members of the team...and they just said sure "when do you want it?" and they all just came – physicians, nutritionist, our diabetes nurse, the pharmacist, the physician, and the patient...to me that was a measure of collaboration, you know when it works.

The NPs' stories of their practice patterns clearly indicated their underlying nursing values of collaborative practice. One NP said, "Certainly on my part we continue, we don't stop, we're always trying to collaborate". Another NP responded:

Collaboration means that we're all, ideally, on a level playing field. That there's respect for the skills, talents, values, that each individual brings to the table, and that its process, that building that relationship as part of a bigger process so that I learn from them and they learn from me, and we share.

Although NPs conveyed a natural comfort in collaborating, attaining effective collaboration required persistent education of colleagues about their capabilities. An NP described feeling hurt and uncertain when colleagues did not engage or utilize her as a resource, "It feels like grade 9 all over again when you were the girl that no one wanted to hang out with". Being a pioneer in this new role had its downside and at times eroded self-confidence; NPs questioned whether this feeling of being the underdog was part of a past nursing ethos that they needed to leave behind; or due to the start-up demands of the job, where NPs were expected to bridge the gap of team and client relations, in order to truly advance PHC. An NP commented:

Scope of practice is very very important, I find that now I'm bringing it into any kind of health-related conversation that I have, so either I say something like "treatment of this headache is within my scope...or "you know I saw your patient and I just wanted to let you know that this is what I think is going on but I can not diagnose that in my scope of practice so I've referred him back to you".

Collaboration, described earlier as the "how of care" meant NPs needed to model new ways of doing care and generate awareness in colleagues about how care could be transformed. One NP described the sense of equity she felt, as a collaborative bond developed with a physician partner; however, she also noted that this kind of collaboration was not apparent between the physician partners. In her view, the competitive nature of physicians got in their way of forming collaborative relations.

A physician said “can you come down and have a chat with us about something”...a patient who has diabetes – poorly controlled, hypertension...At lunch time the physician came up to me, and says “that was so good...that makes my day, like everything else could go wrong today, but that interaction that we had with that patient is good” (NP participant).

NPs were particularly adept at exploring community resources and drawing upon the support and resources of other sectors, such as social services, antipoverty programs, housing initiatives, and community programs, as well as connecting and utilizing a full range of practitioner expertise. One NP discussed her collaborative planning with public health for a school intervention initiative:

I also have another meeting coming up with public health nurses later on this month, we’re going to confirm it for another high school where they have a high pregnancy rate, and high aboriginal population, so talk about going in there and supporting public health nurses with doing a clinic now and again.

From this standpoint, NPs facilitated collaborative partnerships and their practice reflected the PHC principle of intersectoral collaboration, in this way NPs collaborated across health care professional boundaries and extended collaboration to other sectors such as education, housing, and social welfare.

NPs as Agents of Change

By doing PHC differently, NPs were catalyzing change in how others practiced. Their commitment to advancing a PHC vision was enabled by extending collaborative interactions and relations. NPs reported facilitating physician practice changes by their innovations of group client appointments and participation in regional and professional initiatives, such as the chronic disease collaboratives, mental health projects, and the BC Medical Association practice support program. One NP noted:

Our clinic is used now as a template for the practice support programs as far as group appointments...vascular appointments, as well as chronic pain, we also use advanced access principles.

NPs spoke about demonstrating a vision of PHC, and moving past the rhetoric to make it work in practice. They recognized their contributions as something quite different from medicine. One NP said, “NPs are nurses, we’re not physicians...it’s different, we’re doing something different than a physician. Another NP noted:

It’s sort of like the physician role has been so used to treating that patient as a body, and with a disease in that body. And the NP is looking at all those different, various components, looking at mind, body, and relationships within the community, and trying to connect and interlink all of that together for the benefit of the patient.

Their attention to the client as a composite of “mind, body, and spirit” within a community context was seen as complementary to the physician role, whose expertise was in treating patient illness and disease. And their focus on ‘community as client’ and building community health capacity was noted as supplemental to the medical role. NPs also recognized their role overlap with physicians, and noted that both professions could provide best clinical practice, yet provide it differently. One NP noted:

Best practice is best practice, whether it’s physician-driven, or it’s NP-driven. You know, the guidelines are the same for providing care. But the care and relationship may look different in how it’s provided, but the best practice should still be the same.

NPs discussed their collaborative relations with the MOAs in problem solving and shifting clinic cultures. The MOA role, which is to mediate the needs and requests of clients with the schedules and practice scopes of practitioners, was seen by NPs to be very demanding, and done well often went unnoticed. The NP bond with MOAs fostered a consultative process to create solutions, finesse overly complex health system protocols, and address client concerns effectively. As agents of change, NPs spoke about the complexities of shifting practice culture, and this was not simply related to fostering

collegial relations and practice innovations. Shifting practice culture also relied on effective infrastructure to foster teamwork. One NP said, “Part of our role as NPs is to really understand what exists in the here and now and how to build better relationships, or leverage resources, or develop partnerships”.

Sharing of information was viewed by some NPs as problematic; tensions related to client charting and electronic health records were of particular concern. Some NPs spoke of being pressured to record client notes similar to their physician partners; yet were uneasy with charting a physician style of “pertinent positives”, and not reporting the full client picture. This discussion also had bearing on issues of client confidentiality and client ownership of records. Charts that only recorded client problems did not represent the client well, and resulted in clients being hesitant about sharing their files with a team of practitioners; yet holistic care relied on shared information. One NP noted:

I like to think of peoples’ strengths, because I sometimes look at these lists of patient problems...and think, oh my goodness they won’t be able to get in the door, and then they walk in and say, “oh I just came from tennis”, you know? They look like a train wreck [on paper].

Yet, other NPs reported their comprehensive charting had influenced and modified how physicians recorded client data, so that the chart became more than a client record, it was a shared client plan. Nonetheless, the electronic health record that many of the NPs used was problematic, because it did not effectively capture the breadth of NP practice and thus was not useful for assessing NP role effectiveness. One NP commented:

It would be really nice to have some input in how these electronic records will look, if it’s really designed for more than just physicians...the PHC components are missing from billing...if you’re going to work in the full scope of NP practice and you can’t even track social determinants of health in a meaningful way then it really doesn’t suit my needs.

The inquiry enabled NPs to explore their ideas of how PHC team practice could be constructed. The idea of NP led clinics was raised as a way to collaborate with NP colleagues who were “on the same page and thought the same way”; yet this did not address the benefits of an interprofessional team. The discussion on NP-led clinics was reframed to talking instead about enacting their leadership, so as to influence the right mix of practitioners, foster holistic models of care, and address client and community health issues. The responsibility to reflect on their own change processes as individuals and as a nursing profession was raised by an NP:

We’re change agents, but...because we’re expecting others around us to change, but I also think we have to. We have to remember that we may have to change as nurses a little bit as well, and if that means that our professional association needs to re-look at policy and things like that, so be it.

The NP as a strategic agent of change emerged out of the discussions. At the practice level, NPs were building partnerships with others and shifting the practice politics of PHC. The commitment by the Minister of Health at their provincial conference, which took place during the inquiry timeframe, was viewed by NPs as a vote of confidence, and furthered their interests in being politically strategic. An NP noted:

That [commitment] is a tool for me to use for change within the organization to ensure NPs are being incorporated into the language...that NPs are part of the health care system in the same line as the physicians; therefore they are part of the mandate.

In my analysis, the PHC principle of appropriate skills and technology was reframed to include NPs as agents of change. In this way, NPs were demonstrating a new role, and applying knowledge, skills and values in a new way, with intentions of extending PHC renewal efforts. This notion of NPs as agents of change is reflected in the literature in references to NPs as ‘disruptive technology’ or ‘disruptive innovation’ (Phillips et al.,

2002; Pogue, 2007). The idea of NPs as disruptive or catalytic technology relates to NPs demonstrating their flexibility in filling health care gaps and thus catalyzing a shift in the behaviour of other practitioners. For this study, I have used the phrase of ‘agents of change’, because this provides a more positive representation and is consistent with the APN framework that refers to the change agent responsibility of NPs, and is included in the BC core competency framework (CNA, 2002a; RNABC, 2003).

In summary, by exploring NP practice patterns, the NP role gained clarity and was seen to be aligned closely with PHC functions, as outlined in Table 2. NP practice reflected the diversity with which PHC models can be actualized. The range of NP practice settings included community health centers, extended primary care physician practices, community outreach programs, specialized services, and ambulatory care settings. NP practice patterns aligned with a principle-based conception of PHC, in which their delivery of first line comprehensive and holistic care was underpinned by PHC principles of universal access and health equity, public participation, health promotion and population health, intersectoral collaboration, and appropriate technology (Calnan & Roger, 2002; CNA, 2000a, 2003b; Health Canada, 2006a; WHO, 1978; 2003).

NP role diversity signified the NP commitment to improve health access to marginalized and underserved populations and thus address a social justice agenda and accompanying social determinants of health (Nutbeam, 1998; Public Health Agency of Canada, 2002; Raphael, 2003; WHO, 2003). NPs encouraged clients to be partners in care and the term clients refers to both individuals and communities, thus NPs fostered public participation in PHC (Abelson & Eyles, 2002; Romanow, 2002). NP practice patterns illuminated their commitment to holistic care and this included health promotion,

prevention, and harm reduction strategies that exemplify a PHC approach (Nutbeam, 1998, p. 351; WHO, 1986). Collaborative practice was foundational to how NPs provided care, and this included drawing upon resources of other sectors and from community, as well as sharing their expertise with others to improve the quality of client-centred care (Barnes et al., 1995; EICP, 2005; Jones & Way, 2004). Finally, NPs reported on their growing capacity to be agents of change and model and advocate for a different way of providing PHC, and in this way they exemplified a resource technology (Calnan & Rodger, 2002).

Table 2: NP Practice Patterns Linked to PHC Principles

Table 2: NP Practice Patterns Linked to PHC Principles		
NP Practice Patterns	Characteristics	PHC Principles
Role Diversity	Different settings & populations Social justice approach Variability in everyday schedules Flexible, fluid, responsive Practice Autonomy	Equitable access
Client as Partner	Reciprocal relations Accommodating complex care Power sharing and empowerment Client as community Public trust	Public Participation
Holistic Care	Client-centred care Comprehensive service Upstream prevention and health promotion Population-based programs Focus on underserved and health gaps	Health Promotion & Population Health
Collaborative Practice	Intra-professional nursing philosophy Interprofessional teamwork Collaborative networking The “how of care” Utilize full range of resources	Intersectoral Collaboration
Agents of Change	Change catalyst PHC vision Practice innovations Shifting practice cultures Strategic collective	Appropriate Methods and Technology

Explicating a Meaning of NP Role Integration

To generate collectively a meaning for NP role integration was an intriguing and challenging exercise for the inquiry groups. NPs were so new to their role and very much focused in the here and now. As individual practitioners, their attentions were directed at sorting out day-to-day complexities and as NP communities of practice they were discovering and learning about their collective capacity. So, asking inquiry groups to envision five years into the future and identify characteristics or qualities of NP role integration was not really in their purview. Yet, with continued probing and discussions, analysis revealed that the NPs understood role integration to mean: NPs would have autonomy to fully enact their role, their role would have public recognition, their value-added contributions to PHC would be demonstrated and measured, their collaborative relations would help NPs to become viewed as essential PHC team members, and NPs as individuals and collectives would secure strategic capacity and alliances to foster role sustainability. From the NP perspective, these five characteristics delineated the concept of role integration. NP practice examples served to further classify these characteristics as early, intermediate and longer-term indicators of NP role integration. In this way, I saw these characteristics as potential outcome markers that could be used or adapted to design evaluation of NP role integration, and inform and guide further research endeavours.

Autonomy to Fully Enact NP Roles

Through analysis, NP autonomy to fully enact their role was identified as a characteristic of role integration. NPs with autonomy collaborated with clients in decision-making and relied much less on physicians. Clinical decision-making now

rested within the realm of NP responsibility and set NPs apart from RNs and this autonomy contributed to their sense of role integration. An NP noted:

I guess it depends how we define autonomous, because autonomous to me means that I have some control, that I have some power. Because I think that's one of the biggest complaints of RNs is that we have so much responsibility with so little power, and I find that as an NP I have a bit more, like I can decide things because ultimately, I have someone in the room and I'm deciding, okay this is where we're going to head today.

NPs discussed the importance of having sound relations with and support from managers and policy leaders; this endorsement supported NPs in their autonomy to fully enact their roles and scope. An NP described a collaborative leader as:

A leader who's actually willing to draw on expertise within the group...if you're going to want me to work to my utmost in capacity, then allow me to have some input, and allow me to be as autonomous as possible.

However, NPs in clinic-style settings noted how easy it was to get caught up by appointment schedules that left no time for their other work of health promotion, prevention, and innovative program development. One NP described her persistent resolve to control her schedule to ensure that time was protected for program planning, despite the constant requests to see more patients. Another NP worked with MOAs to triage clients with less complicated needs to a nearby walk-in clinic, so that some time could be protected for other than patient appointments. By preserving roles as flexible and fluid, NPs safeguarded their capacity to provide holistic care, be responsive to underserved populations, and address health care gaps. NP autonomy to schedule and design every-day practice, employ a variety of practice methods and approaches, and fully enact their role was an early indicator of NP integration.

NPs reported that role enactment was also fostered by regional and provincial policy and procedural changes. Absence of supportive infrastructure caused limitations to

NPs functioning within their team settings. For instance, NPs were hindered by nursing referral forms that still read “most responsible physician”, practice guidelines that referenced only the role of physicians, electronic health records made by and for physicians, and ICD9 billing codes that did not sufficiently reflect NP practice. As well, a concern was raised that other practitioners, such as public health nurses, did not have access to client charts or information and this meant that valuable information was missing from client records and raised the possibility that care could be compromised. An NP noted that changes need to recognize the contributions of all practitioners, and that even subtle differences are important to fostering collaboration:

Everywhere in [practice guidelines] the physician will ‘this’, the physician will ‘that’, and I’m thinking yeah, but NPs use these, physiotherapists use these, nurses working in chronic disease management use these. What’s wrong with changing the language to ‘the primary care provider will’ ...and just those little language things can really go a long way.

Infrastructure modifications for effective client information exchange were an intermediate indicator of role integration. The NPs also discussed replacement of NPs when they are away on vacation or extended leave as an intermediate indicator of role integration. If NPs are considered essential staffing of a clinic, and not supernumerary, a locum replacement to offset work load would show that the role had been well integrated.

NPs believed that if they were able to fully enact their roles and be recognized for their unique contributions, then this would reinforce continued expansion of NP roles. And as NP numbers increased in the province, this “power in numbers” was viewed as a long term indicator of NP role integration. A commitment by the province and/or health authorities to maintain incremental funding was needed to assure continued NP role

expansion and effective utilization of new graduates. Without this commitment, the impetus for NP role development and full enactment of roles would diminish.

When issues come up...we can say our community of practice has put a statement out, certainly adding validity to our role, substantiating the role...When we actually had one of our community practice meetings...with ten NPs here at the clinic, all of a sudden, there was, wow, there's lots of you, like, now you're [considered] important. (NP participant)

This comment reflects that individual NPs in their separate settings are not recognized by their teams as being part of a bigger NP community or health authority initiative. By having a community of practice meeting at the NP clinic with ten NPs in attendance, this served to create a collective presence. An increase in the number of NPs would also support the flourishing of the community of practice, as there would be additional members to share the organizing work, extend the pool of NP talents and strengthen the collective image.

NP Role Clarity

NP role clarity was identified as a characteristic of role integration. NPs discussed the significance of developing relationships with clients and building partnerships with communities, because relational practice helped to strengthen and clarify their role. Through respectful and informative interactions, clients learned about the breadth of the NP role, gained trust in NPs to provide quality care, and discovered advantages of a team approach to shared care. Successful interactions brought about new client contacts. One NP said, "You see a patient, and then pretty soon over the next month you see their whole family because you did the right thing". Client understanding of and satisfaction with the NP role was seen as an early indicator of NP role integration; clients able to determine which health provider best suited their health needs was also an early marker.

Everyday it's about educating and empowering people to think that NPs are a good thing...you're in the exam room with that patient for the first time and they don't have a clue what an NP is, how do you get that right, so that they want to come back and see you again? (NP participant)

NPs identified empowered and educated clients as an important sign of their role success; an example was educating clients about their hemoglobin A1C and their A1C levels consequently improving. Tracking and surveillance of client progress would be an important indicator of role success that contributed to role integration.

I do chronic disease, I think that the relative spin-off of that is that you can support people's quality of life in a slightly different way and potentially keep them out of hospital – that revolving ER door – or keep them out of long hospital stays, because you can follow them in a systematic way.

Thus, practice success as indicated by improved client health results was considered an intermediate indicator of NP integration; although shifting client population outcomes, such as decreased smoking rates, or increased screening rates was considered a longer range sign of NP role success.

When [patients] actually come to see me to say "oh look I'm 40, let's do my cholesterol", I see that's my patient as a partner, and the teaching that I've done they're following the preventative guidelines...I see that as an indicator when people are coming in and saying, you know, this is what I'm due for.

At the community level, the capacity to develop effective programs and report on program successes was also considered an intermediate indicator of role integration. This included NPs carrying out community assessment, developing responsive programs, and designing tracking systems of client use and progress. Examples, in which NPs were already initiating programs, included the women's wellness clinic, a 24 hour blood pressure clinic, a walking program, group appointment clinics, and outreach to First Nations reserves, and the NPs noted the importance of documenting program and client progress. Programs that were well used by clients and effectively improved client care

and outcomes were viewed as a sign that the NP role was being assimilated into community and thus an indicator of role integration.

NPs also discussed the importance of creating public awareness of the NP role. This required knowing key people in the community, presenting to influential groups such as the health advisory councils or rotary clubs, networking with community programs, such as daycares or recreation centres, or linking to established resources, such as universities and colleges. NPs noted this meant “actually having to carve out some time every week to get out there...to create some space for people that ask for your time”. Creating opportunities for public participation and providing ways to give the public a better voice in health care, was seen to benefit both PHC renewal efforts and NP role integration. People knowing about and understanding the NP role was seen as an important indicator of integration, as the following quotation suggests:

I think it would be nice in five years if everybody had at least heard of an NP, and understood the role...It would just be common place, we would not be an anomaly. NPs would be a part of the common discussion of health care providers.

Thus, public awareness and recognition of the NP as a key PHC team member was determined to be a long term indicator of NP integration, and one that would take time and effort to attain. NPs talked about the importance of their health authorities and the provincial ministry assisting with this effort through public awareness campaigns.

Value-added Measures of the NP Role

Development and application of value-added measures that would assess and substantiate the NP role was identified as a characteristic of role integration. NPs saw participation in this inquiry, and their growing enthusiasm for evaluation and research, as an important first step in determining measures of their contributions to PHC, as well as

assessing NP role development progress. Evaluating the “value-added” of NP roles meant identifying and qualifying the unique contributions they were making to PHC and specifically to client care. However, measuring their value-added work seemed very challenging. An NP reported fewer ER visits and hospital admissions from their clinic and this was attributed to the NP role, but was anecdotal evidence and needed to be systematically tracked, yet no processes were in place to do so. A second NP reported:

The project that we’re working on, one of the things we wanted to show was that we’re meeting targets. Specifically in chronic disease populations, when people have two or more morbidities. I would like to show others that the value added of the NP role is that we can get patients to targets more quickly, and in a more satisfying way for both the client and the caregiver within the family practice setting, without sending them to siloed programs here and there.

Another NP noted that the women’s health program they had initiated was based upon screening rate evidence and although they were keeping service delivery records, they had not actually realized the significance of these records for evaluation purposes. This meant that they already had data and now needed to do analysis and see if there was a way to show the value-added contributions of the NP role.

So one of the things that we did here...and again this is something that we’ve already done, yet I don’t think we’ve really actually realized that we’re doing it. Our pap screening rate was, like, 52, and a group of us got together and decided, you know, this is just not good, so what are we going to do to improve it? We also had women in the community that were not able to access pap screening services. So what we’re looking for is the data...I think that’s the type of thing that we’ve already doing.

NPs talked about their roles within teams and the difficulty in singling out their contributions. This created some ethical discussion about profiling their roles over and above other practitioners, but at the same time, they also realized the importance of securing evidence to substantiate the NP role, which would then foster role integration. The inquiry piqued NP interest to further collaborate with research partners, to increase

attendance and presentations at academic conferences, and to initiate joint publications, and these actions of reporting on their progress of role development were considered early indicators of NP integration. Involvement in research inquiry and dissemination of findings was seen to be very important to NP role success and a professional responsibility of advanced practice nurses.

It's nice that PPO leaders go to different conferences and spread the good word about us, but they can't always share the passion that we have for the role, so to give opportunities for different practitioners to actually be out there on the front lines answering questions about what goes on day-to-day, and how we implemented the role, what the struggles were, and what the journey's been like.

NPs expressed their concerns about the lack of direction and tools to track and measure NP practice. Outside of recording ICD9 codes, there was no established framework to map NP efforts and outcomes with respect to relational practice, health promotion, harm reduction and prevention, community engagement, community development, and collaborative partnerships. A joint effort by health authorities, the Ministry of Health, and NPs to develop instruments and tools to measure their value-added contributions was seen as an intermediate indicator of NP integration. One NP commented on long range need for measurements:

What I do in practice, how is it changing the service provided to clients, how is it changing outcomes... You're not going to see what I do tomorrow or the next day, but hopefully you'll be able to see in 10-20 years when people are healthier – not smoking, exercising, doing all of our health screening maneuvers. I think that's one of the big contributions of NPs is that we are doing the screening that maybe in medicine sometimes isn't done.

NPs also identified that measures to evaluate and report on successful collaborative partnerships would indicate the acceptance of the role and be an important indicator of integration. To be able to measure teamwork and the progress being made

toward more effective collaborative culture would advance NP integration, and would be a significant measure for PHC advancement. One NP commented:

Well, I'm just thinking that if we're looking at collaboration as being an important aspect towards NP integration, then being able to look at and measure that within a practice would be helpful.

NPs also suggested that measures of effective teamwork with NPs that are linked to cost savings would strengthen the resolve of health systems to sustain NP roles and PHC efforts, and this was considered as a longer term indicator.

Intra- and Interprofessional Collaboration

NPs saw enhanced intra- and interprofessional collaboration as an indicator of role integration, as collaboration with colleagues fostered client-centred care and client-centred care was the essence of good NP practice. NPs noted that creating strong collaborative relations within their own nursing discipline, with physician partners, and across professions was critical to NP role integration. NPs reported the importance of having discussions with their own nursing colleagues about role differences, and working collaboratively to establish practice efficiencies. One NP said,

We forgot about our actual nursing colleagues and that's probably the place that I've had some of the greatest difficulty is with other nurses, but I think that will all work out.

Most NPs had close ties to physician colleagues and good teamwork was noted to depend upon the quality of this collaboration. An NP shared how a physician colleague had told a patient that by receiving the added value care of the NP, she was getting a "better kind of care". Another NP reported the physician partner said that by having had the experience of partnering with an NP, he could no longer go back to the old uni-professional style of practice. One by one, physicians were getting on board with shared care. NPs also

reported that their commitment to developing collegial relations between and across professions, such as with pharmacists, physiotherapists, and nutritionists, was critical to delivery of holistic health care.

I think you make a list of all your collaborative partners and go through them in your communities, like pharmacists, seniors programs etc., because if you miss people they feel left out, and maybe it's not up to me to do it all, but I think it helps.

Stories about collaboration and the extent to which teams were seen to be flourishing were considered early indicators of NP role integration.

Recognition of the time and effort necessary for effective teamwork was a significant factor in team development. Commitment to team building enhanced collaborative practice cultures. Informal interactions allowed colleagues to share their knowledge, expertise and perspectives about client concerns, as the practice day unfolded. For instance, one NP talked about these informal collaborative interactions that occurred on a daily basis:

It [informal collaboration] offers many opportunities for me to walk down the hallway and tap on a physician's door and ask a question, or ask them to come and see something that I'm not entirely sure about...And likewise, that happens to me sometimes from them – they come down and say "I'd like you to meet a patient that I'm going to ask to see you" and so that's great because then they can see the physician values what I have to offer in the upcoming visit.

As well, formal time set aside by the team for collaborative planning, client case reviews, and program development, and structured mentoring and learning opportunities were important. Team building and collaboration were considered intermediate signs of NP role integration.

NPs suggested that their recognition as an essential member of the team would lead to other professional roles, such as social workers, public health nurses, pharmacists,

and community development workers being added to PHC settings, so additional team roles would mean that the NPs had been successful in paving the way to true interprofessional teams. This would be considered a long term indicator of NP integration. Broad based acceptance of and collaboration with the BC Nurse Practitioner Association (BCNPA) by other professional associations was also viewed as a longer term indicator; particularly important was to establish direct links with the medical profession, and set up regular processes to engage in joint initiatives.

NP Strategic Alliances

NP development of individual and collective strategic capacity was necessary in order to cultivate strategic alliances and advance the NP role, promote PHC renewal efforts, and foster improved client care; strategic alliance was also a characteristic of role integration. NPs within their practice settings engaged in strategic opportunities to establish community partnerships and advance practice innovations. Demonstrating their strategic capacity at the local level of practice meant that NPs were included in, or possibly even leading, community planning initiatives, and this was an early indicator of NP integration. One NP reported on an opportunity to participate in mental health planning:

We got invited to Mental Health and Addictions big crisis meeting to talk about our community and now we're sitting on the steering committee that's actually going to look at planning.

Also as part of NP strategic actions, NPs noted the importance of engaging in regular feedback to the CRNBC and advocating for adjustments to the scope of practice document. This document outlined standards, limits and conditions of practice and as the NP role unfolded this informed input would assure congruence with the realities of

practice. By modifying the regulatory standards to better meet the conditions of practice, NPs were fostering role integration.

We were looking at the [scope of practice document] under plastics – referrals to plastic surgeons...I've encountered a lot of women looking for breast reduction surgery, and that's not one of the things for me to refer them on. So I think those things need to be looked at...broaden the scope, or tighten things up so that there aren't so many uncertainties about what we can and can't do.

NPs could envision a stronger collective presence, in which they had representation at various committees and levels of their health authorities. However, to attain this strategic representation, they needed to strengthen their communities of practice and become more political in their collective. This would require mentorship from policy leaders and some coordination of NP talents so that they could be well represented at various strategic meetings. One NP said she did not have interest in organizational politics, but realized the importance of contributing to role integration, and felt her talents could be better used by participating in discussions about a common health record that would interface between local PHC and emergency room staff. This was a good example of how NPs could see the value in sharing their talent pool to advance role integration. Participation within health authority structures, such as sitting on NP implementation steering committees and professional practice advisory bodies was seen as an intermediate indicator of NP integration. One NP commented:

We're in our infancy, there are only 64 bodies, it's hard to spread all that work out amongst only 64 people. So I think we'll get there, and those people will step up who have a stronger political interest, because some of us aren't really interested in the politics, right? We just want to go to work, and do our jobs and see the patients, and maybe make a political statement from time to time, but to actually sit in on meetings and do the real nitty-gritty work, that doesn't fit for all of us.

The continued development and support of the BCNPA was an important part of gaining strategic alliances and capacity at provincial and national levels. Gaining NP status as a

“go to” group that has political power, where NP expertise was sought after, and their collective was included in strategic policy initiatives, was viewed as a long term indicator of NP integration.

In summary, despite the difficulty that NPs had in characterizing role integration so early into their role development process, the NP inquiry generated discussions about what was needed to secure NP roles. This led to visioning about their future, and helped us as a community of inquiry to understand the concept of role integration. The meaning of role integration was produced from the collective stories and perspectives of NPs and PPO leaders, as well as my interpretive contributions, and is described here by five characteristics. As well, the stories provided some examples of early, intermediate, and long term indicators of role integration. Table 3 provides a summary of these findings.

The first characteristic of role enactment meant that NPs would employ their autonomy and scope of practice to fully perform the competencies of their role, although the caveat here was that NPs were also reliant upon organizational infrastructure to facilitate role enactment. The NP competencies include clinical care, health promotion, illness and injury prevention, leadership, research, collaboration and change agent work (CNA, 2002a, 2008a; RNABC, 2003). The second characteristic of role clarity meant that clients, communities, and colleagues would have a good understanding of the NP role and its holistic approach to care, and would thus utilize the role effectively. The third characteristic of value-added measures meant that evaluative tools and instruments would be developed through joint efforts, and utilized to explicate NP contributions and evidence of NP effectiveness, with respect to client and community care and advancement of PHC. The fourth characteristic of intra- and interprofessional

collaboration meant NPs and their teams and networks, supported by organization leaders, would provide cohesive client-centred care. The fifth characteristic of strategic alliance meant that NPs would effectively partner with their local communities in innovative endeavours to enhance population health, and also NPs as collectives would engage in political and policy strategies to further integrate and sustain their roles, and contribute to health care policy and improvements. These five characteristics created a frame of reference for the concept of role integration.

Table 3: Meaning of NP Role Integration

Table 3: Meaning of NP Role Integration			
Characteristics	Early Indicator Examples	Intermediate Indicator Examples	Long-term Indicator Examples
Role Enactment	NP autonomy to design and enact practice	Infrastructure modifications to recognize NP role	Incremental funding to increase number of NP roles
Role Clarity	Client understanding of & satisfaction with NP role	Positive client health results; responsive program development	Public awareness & recognition of NP role as essential team member
Value-added Evidence	NP collaboration with research partners and joint initiatives	Instruments and tools to track and measure NP functions & quality	Measurements of collaboration & teamwork linked to cost savings
Interprofessional Collaboration	Stories of collaboration and teams flourishing	Commitment to team building of informal and structured formats	New professions added to teams; BCNPA & other associations collaborate
Strategic Alliances	NPs engage in practice partnerships and innovations	Strategic mentorship, participation, & representation in health authorities	Consultation, & participation in provincial, national strategic initiatives

These characteristics and indicators reveal that NP integration, from the perspective of NPs, is reliant on NPs attaining proficiency in clinical competencies,

engaging in community initiatives, advocating for change to infrastructure, collaborating with clients, communities, colleagues, and networks, developing innovative programs and approaches, participating in research, being strategic at local and provincial levels, and contributing to policy and political strategies. If NPs can attain these accomplishments, their role could be said to be fully integrated into the practice setting and the organization.

The NPs in this study exemplified a different kind of health care with their commitment to holistic care and comprehensive approaches. From this perspective, the NP role is different than and complementary to the physician's role. NPs came to see that their role was integral to PHC renewal efforts and that they were very much part of a political agenda. However, NP integration is contingent on political and organizational commitments to extend the vision of PHC, strengthen teams and intersectoral networks, adopt various care delivery models, and make PHC mainstream. In this sense NP integration is closely tied to the realization of a principle based approach to PHC and relies on collaboration with all manner of stakeholders.

Collaboration and NP Role Integration Findings

NP practice patterns revealed NPs were constructing flexible and diverse roles, partnering with clients and community, and collaborating with colleagues and leaders, to provide holistic client-centred care, respond to community and population needs, and shift the vision and effects of PHC. The meaning of role integration was understood by characteristics that included: full role enactment, role clarity, evidence of role effectiveness, effective collaboration and teamwork, and strategic alliances. The stories of NPs illuminated NP collaboration as far reaching and included PPO policy leaders, site

managers, clients and communities, other professionals and professions, regulatory bodies, researchers and educators, and provincial and national leaders.

The NP stories created a dilemma for me with respect to my original study question of “How does *IPC* advance NP role integration?”. I had expected that in examining *IPC* I would be learning about NP interactions in their teams and in their professional relations. However, NPs spoke about client and community partnerships and political alliances as being central to NP role integration, and *IPC* did not reflect these additional relations. The term of *IPC* was too constrictive to accurately reflect the study findings. The iterative nature of PAR inquiry guided the redesign of the study question, so as to acknowledge and address the extensive collaboration expected of and required by NPs at various system levels. The research question was thus reframed to, “How does *collaboration* advance NP role integration?” This new study question incorporated a broader range of collaborative relations, including those of interprofessional collaboration. This new study question now more effectively addressed NP role integration from the perspective of collaborative culture, and NP stories of collaboration were then analyzed in relation to the many sectors and elements of the collaborative framework.

NPs portrayed themselves as being a nurse first and practitioner second. As nurses, NPs were grounded in nursing values, theories and knowledge. As practitioners they integrated multidimensional competencies into their everyday practice. Collaboration was viewed as a key feature of NP practice and is recognized by the CNA Advanced Nursing Practice Framework (2008a) and included in the CRNBC core competencies (RNABC, 2003). NPs discussed collaboration as foundational to their

practice. Collaboration was viewed by NPs as a philosophy, underpinned by nursing theory and values, and as a practice, informed by nursing knowledge and skills. As a philosophy, collaboration denoted equitable relational status, where each partner was seen to have significant contributions to make to decision-making. As a practice, collaboration signified the enactment of this philosophy, by way of fostering and modeling the sharing of expertise and power. The NP commitment to collaboration was seen by the inquiry groups to be central to advancing NP integration.

NP Collaborative Practice Fosters Autonomy to Enact Diverse Roles

In applying the collaborative culture framework to NP discussions, I examined NP stories of their collaborative practice and the associated practitioner elements of the framework, which include professional identity, communication, respectful relations, critical reflexivity, and client-centred decision-making. I came to see how collaborative practice fostered their autonomy to enact such diverse roles and positions. Autonomy to enact diverse roles, I contend here is a precursor to full role enactment, and NP role enactment was identified as an indicator of role integration. Legislation and regulation in BC aimed to establish NP autonomy and allow flexibility for NPs to provide safe and responsive health care (CRNBC, 2005). Yet this intent was reliant on policy and program leaders at the health authority level to understand and endorse NP autonomy. Autonomy enabled NPs, located in various PHC settings and positions, to design diverse roles in accordance with their assessment of client and community need. As well, autonomy facilitated NPs to fully enact their roles and self-manage everyday practice.

Professional identity of NPs was very much tied to their increased autonomy. NPs noted they had been constrained by flow sheets and checklists as RNs, and now as

NPs they had the autonomy to apply evidence-based guidelines, carry out complex assessments, and engage in advanced practice. The role of NPs combined and integrated their advanced clinical knowledge and skills from their NP education with their nursing knowledge and skills attained from past RN practice. One NP noted her new found sense of autonomy:

I know in the fee for service setting 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].

Critical reflexivity was described as self-reflective practice, in which NPs needed to clarify and articulate their new professional role with clients, colleagues and managers, and be clear about their unique contributions. Self-reflection also assisted them to shift from the RN role and re-establish themselves as advanced practice nurses. This was particularly challenging during temporary registration, when their official NP(t) status was similar to that of an RN. NPs noted how authority to write prescriptions, once fully registered, had significance for colleagues, yet this was not how they wanted to be differentiated. NPs commented on how clarifying this new professional role as different from the RN and clinical nurse specialist roles required a certain amount of diplomacy, so as not to alienate their nursing colleagues or be perceived as more aligned with medicine than with nursing. By navigating the hierarchy of professional and interprofessional relations, NPs increased their autonomy and strengthened their collaborative relations, which helped them to more fully enact their roles. One NP commented:

I've been working in an environment where I was working as an RN, so redefining myself has really helped, but I find that sometimes people still expect me to do what I was doing before, but that's not really utilizing me to the capacity that I can be working now.

Communication strategies helped to extend NP autonomy and role enactment, and this included both informal interactions, and formalized processes. NPs noted that informal communication meant sharpening their receptive listening and speaking skills. By being sensitive to the backdrop of power relations within their sites and settings, NPs were able to navigate role tensions and finesse role development. By being confident and articulate, NPs shared information about their unique differences, negotiated role overlaps, and clarified their vision of NP practice with team members, site managers and PPO leaders. NPs noted that they engaged in open and honest communication with patients, colleagues, and health leaders, to manage everyday tensions and sensitivities as part of settling into health care sites. The challenges of formal communication systems, such as employing electronic health records constructed by and for physicians, were viewed by NPs as problematic and were ineffective for tracking much of the NP work. This was a concern and was noted as a barrier to NP role integration. NPs emphasized the need for new record keeping designs that would enable effective exchange of information from varied professional perspectives, and foster client ownership of files. Data and communication infrastructures to document comprehensive client care and to track NP contributions to PHC progress were very much needed, and would likely require their collective advocacy to ensure an effective system response.

Respectful relations cultivated acceptance of NPs and facilitated role enactment. To NPs, respectful relations meant they were recognized for their knowledge, skills, and values and they in turn respected, commended, and made use of their colleagues' capabilities. The effective utilization of team member talents relied on this trusting and respectful milieu. The subtleties of respectful relations meant to NPs that they were being

appreciated and recognized for their contributions, such subtleties included physicians no longer referring to the clinic as “my practice, and my patients”, or the NP name added to letterhead and forms. The small but important nuances that no longer went unnoticed were signs to the NPs of emerging collaborative culture and NP role integration. One NP shared this understanding of small nuances by her story:

The physician in our practice said “have you noticed that your name on the door is smaller than ours?”...“we need to change that, you’re a practitioner just like I am...it’s something as simple as that then you realize that they do feel we’re on an equal plane.

Client-centered decision making was the aim of collaborative practice. NPs were very much aligned with clients and communities and engaged in sharing empowering information, advocating for improved care, linking clients to community resources, and helping clients gain power in decision-making about their health and care. One NP noted:

It’s up to us, I feel, as the leader in my visit and as client-centered that I’m always going back to the client and affirming with them – is this what’s going to work for you? Does this work for you? And that’s how I involve them and make it client-centered. I don’t necessarily have to explain to them that that’s what our vision is all about. 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 enactment enabled NPs to engage in client-centred and community-based approaches. NPs collaborated with various resource people, such as community leaders, mental health practitioners, teachers, and income assistance workers, in order to effectively make a difference in complex clinical and social care. An NP noted the proactive approach of securing shelter and food for marginalized clients with chronic health conditions, before being able to address their specific health issues. NPs were changing the way PHC was being provided, and these changes required ongoing support of managers and policy leaders.

One NP noted “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’re going to make the decisions, like sometimes you have to do some things and make sure that the needs are met because it really comes down to good patient care.

However, NPs also realized that in order to truly make a difference and influence health care delivery, more NPs would be needed throughout the system. The tall order to secure role integration, advance PHC, and champion collaborative culture, would require a critical mass of NPs in the province. During the inquiry there was considerable angst from NPs about the political commitment for ongoing and incremental funding of new NP positions. Role enactment was tied to this commitment, as NPs contended that without continued growth in numbers, their roles would overtime be weakened and devalued, and this would compromise their ability to fully enact the NP role.

NP Collaboration with Clients Cultivates Role Clarity

Application of the collaborative culture framework to the inquiry discussions illuminated NP - client relations. NPs in collaboration with clients helped to cultivate role clarity, and role clarity was identified as an indicator of role integration. The client as a stakeholder group within the collaborative culture framework was not well conceptualized at the start of the inquiry, but through NP stories, new elements emerged including clients as partners, client voice and choice, cultural safety, empowerment, and holistic care. NPs offset their worries about the politics of role development by developing strong collaborative partnerships with their clients and communities. At the practice level, this was a strategy within their control and supported their role integration.

Clients as partners were a fundamental belief in how NPs constructed their practice patterns. NP role clarity transpired as NPs strengthened their collaborative

relations with clients and communities and role clarity had been identified by NPs as an indicator of integration. Clients as partners signified the dual expertise of clients and NPs combining their respective knowledge, in which NPs as professionals applied theory and practice to client care, and clients contributed the personal lived experience of managing their day-to-day health condition. Yet, NPs reported that supporting clients to be experts in their own health meant constant assessment and sensitivity to the varied capacity of clients to self-manage their care. If an NP provided too many choices to a client with inadequate information, the client was confused or distanced; whereas if the NP took too much decision-making control with a client who was educated and empowered, the client felt disrespected and the relationship suffered. One NP noted:

I think that the relationship is critical. I mean just because we're going to support self-management and empowerment, patients do it within a collaborative relationship with us...if we get the relationship piece right then they come back and see us, and that's the whole point.

Client voice and choice emerged from the discussions, in which NPs questioned the focus on self-management. NPs expressed a caution about the self-management model of care, in which turning over responsibility of care to a patient with very little authority was a set-up for failure. One NP said, "Sometimes we think we're empowering patients, especially with the population I'm working with, sometimes I think it's just one more thing that they have to do in terms of all that they're trying to manage". NPs noted that some clients were quite powerless in the health system, so their role was to be an advocate and share their power, educate clients about choice, and foster client empowerment. An NP commented:

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.

Empowerment was derived from the client - NP partnership, in which a step-by-step process of exchanging respective expert knowledge, addressing holistic health concerns, and generating consensus decision-making occurred. One NP noted that relational practice had more worth to her than a prescription, because clients expressed how thankful and grateful they were for attention; “it shows how, almost hungry the patients are for somebody to spend some time with them and explain some things to them”. Another NP reported:

I feel like I’m trying to tell my patients that they have more power than they have. I’m trying to say “you’ve got choices, you can ask for more”. I feel like I’m trying to empower them.

Cultural safety was raised by one of the NPs working in an aboriginal community. She described how being sensitive to cultural and local differences fostered trust and respect between NPs and community partners, and cultivated confidence in health care.

They may not tell you why they can’t come to your appointment. You set a time and they just don’t show up...They come from a culture where grandpa is more important, or uncle came to visit, or it didn’t work for me because of this, but they won’t say “I can’t make that appointment time”. So you need to figure out how to include the cultural aspect of what they do, and how they do things...but also because where some of them have come from they won’t speak up and say “this doesn’t work for me, can I come later in the day?”

NPs articulated the value of creating meaningful and robust collaborative relations with both clients and communities.

Holistic care was discussed and NPs talked about encouraging the client to become part of the team. Synergy resulted, in which NPs provided holistic care and in turn clients appreciated the full NP care approach and participated more in care decisions. NPs talked about the importance of collaboration to providing holistic care. One NP said:

And in my interactions I feel like the scale is much more balanced. I think there are a couple of telling comments. One is the question of “now when am I supposed to come back and see you?”, and I say “well when do you think we should have another appointment together?”, and they’re kind of like shocked and alarmed, and then they get used to it and they think it through, and they say “Well I’m not sure I’m feeling all that much better, I’d like to come in a couple of days”.

A second NP noted:

It is meeting the needs of the patient...And I think when a patient leaves and they say “thank you” and you know, “you’ve helped me so much”. I get so much of that “you’ve explained it to me”, and “thank you”.

A third NP responded:

But it’s because on various levels you’ve met their need. So they feel, it’s sort of like whether they say it or they don’t say it, but you have met that need. It’s that service I talked about that you have provided for them. And that’s collaboration.

The NPs also noted that clients knowledgeable, empowered, and confident in their health care were able to identify and choose when the NP was the right practitioner to address their health concerns. Clients gained clarity about the NP role by participating in their care. One NP reported her clients discussed the NP role amongst themselves and this word of mouth was an effective way to increase public awareness.

The community is really important...I see a lot of frail seniors...the long-term case manager said to me “so how did this client get your name? She’s not even a senior at risk yet?” I said “they share my name and number”...But that’s good PR, they’re citizens that have lived in the community their whole life, and they’re in their 80’s and 90’s, and they’re saying “you know, I don’t remember her name, but I got her number, and she’s a NP. Have you heard of one of those?”

However, NPs also realized that a more systematic public awareness campaign by health authorities and provincial leaders was really required to establish widespread role clarity, and this would likely take some advocacy work on their part to lobby government and health authority officials in order to actualize this strategy.

NP Collaboration Enhances Team Capacity

The collaborative culture framework was used to assess NP discussions and stories about interprofessional team and network relations. Effective interprofessional collaboration was identified as an indicator of role integration. The framework elements that guided this analysis included inclusive leadership, common purpose, team spirit and synergy, knowledge exchange, and cohesive roles and responsibilities. NPs declared teams do not just develop naturally; teams take intentional hard work, “that’s why it is called teamwork!” They noted that practitioners with knowledge, skills, and abilities of how to collaborate helped to mentor other team members who were not quite so inclined.

Common purpose in care was raised as an important element of teamwork. All the NPs reported either being in a team, or part of an extended team or network. Some NPs described teams as effective and satisfying and noted that by being clear and purposeful about goals for client-centred care, teamwork seemed to fare better. A clear team vision resulted in members sharing leadership and keeping the client population front and centre in day to day operations; holding on to a collective vision required the team to structure and prioritize time for team building. On the other hand, some NPs reported difficulties within their teams, and attributed struggles to lack of consensus in vision and values, and lack of clarity in the purpose and principles of practice.

I think where we are having problems right now is that two, three years ago we didn’t address the bottom line of how to make this work, and we just got all piled in here...public health has their own hallway, their own space, their own program, so they’re very different from us. And I think at the very beginning we thought that somehow we could all be a team, but no one did anything about it.

Team leadership was deemed very important. NPs saw the value in having a leader who managed administrative tasks, lobbied and ensured resources were available,

addressed power issues and tensions within the team, and made tough decisions. Yet they also wanted a collaborative leader who was altruistic, did not see themselves as the expert, drew on team member expertise, and fostered practitioner autonomy. These divergent characteristics revealed the demanding nature of team leadership. NPs also noted that hiring well was important; leaders who hired people with a natural willingness and propensity for teamwork created team synergy. One NP commented:

So I think that's a sign of good management, and also of a good team – people were all willing to participate and say yes, this is a priority, and we're going to make sure that we're coming, and actively participate...So, I think that comes at all levels. From the top saying this is a priority and from the bottom saying this is a priority, it becomes part of the structure, and the structure has to support that.

Team spirit and synergy were discussed in terms of teamwork. NPs noted how team members pitched in on a busy day this overlapped practice scopes more than usual; fluid and flexible roles enabled capacity in others and generated team synergy. NPs said that social relations helped to break down barriers, and foster familiarity of non-verbal cues. The social aspect of collaboration both inside and outside of work had a positive effect on team dynamics. And for teams without this social aspect, tensions and innuendos were noted to erupt into conflicts and relationship breakdown. A team full of life was described as one that shared food, humor, laughter and noise, “there's lots of noise in our clinic”. Laughter was noted as important to de-compress sometimes stressful and tragic situations. Colleagues knowing each other socially and spending informal time together cultivated positive interactions, acceptance of differences and resilient relationships. One 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, it isn't done through retreats it just works. And it's a safe environment; its climate, its culture.

This notion that “it just works” came from a discussion about why some teams work and others do not. This NP attempted to describe the culture of a team where there is a deep sense of emotional connection. The team culture was really a composite of so many facets and elements and represented the whole of the team.

Knowledge exchange was raised a number of times as inquiry concerns related to client record keeping, electronic charts, and differences in practitioner reporting of care. This was discussed earlier in the chapter, in which some NPs reported being pressured to change the way they charted client care, while others were mentoring physicians in charting more comprehensively. Informal sharing of knowledge was noted to be occurring in teams in the form of “hallway interactions”; however challenges in finding time for formal exchanges and the importance of having structured meetings and in-services was also discussed.

Cohesive roles and responsibilities were the aim of collaborative teams. NPs noted they used negotiating and finessing as approaches to help establish clear roles and responsibilities. One NP commented about her approach of engaging others in collaboration to ensure best assessment and care were provided:

I think the other part of it – the collaborative part of it – is you going to that physician, health counsellor, or whoever, and saying “my expertise, or my assessment of the situation is this, what do you think. How can we work together on this?” or “this is how I see this patient. Is that the same perspective you have?”

Also, NPs noted how it was important to be fluid and flexible in sorting out collaborative and overlapping scopes. One NP said:

When you think about people you work with, it has to be more fluid than that. We wanted to compartmentalize things so quickly, you know, like okay you’ve got this person with this disease, and this person will do this, and this person will

do that, to have role clarity, and it doesn't work in practice like that. It's much more fluid...you want to be respectful; because that's the relationship you have with everyone on your team about supporting their capacity, for them to work to their full interest and scope.

Generating interprofessional collaboration and team capacity was reliant on many factors of leadership, common aims and commitments, a sense of team spirit, sharing of knowledge and expertise, and ensuring team roles and responsibilities overlapped so that clients received safe quality care. When teams functioned well, there was energy, laughter, noise, and a general sense of well-being and satisfaction. Teams that were in struggle were described as quiet, sullen, private and tense. The "dance of teamwork" was somewhat elusive to describe, but at the same time very tangible to experience.

NP Collaboration Furthers Strategic Alliance

The collaborative culture framework was applied to NP discussions and stories to examine how collaborative relations between NPs and health authority leaders were fostering strategic alliances. Strategic alliances were identified as an indicator of role integration. The elements that guided this analysis were strategic direction, power relations, service design, interprofessional learning organization, and resource allocation. The health authority support for NP role development was clearly championed by leaders of the Professional Practice Office. These policy leaders had absolute commitment to NP implementation. PPO leaders moved forward with role development even before the details had been worked out, but were soundly in support of NP implementation and determined to resolve the problems and barriers and see it through. One NP commented:

It [PPO] is their motto, ready, shoot, aim! It means let's go, we'll check it out later. So as much work as PPO did to build this [role] there's still structural and system things that weren't put into place to make sure that it would be seamless and streamlined.

Strategic direction was discussed by PPO leaders during the action inquiry meeting as they stressed the importance of collaborative alliances to advance the NP role and to further the PHC agenda. Each partner group relied on the other to foster visibility of their alliance; NPs needed PPO leaders to negotiate with organization decision-makers and remedy system problems, and the PPO needed NPs to steward the cause well, and be strategic in how they presented this alliance to political leaders and to the public.

However, NPs noted there was still much work to be done to educate officials so they really understood the role, scope, and practice of NPs and the various PHC positions.

An NP commented:

As we integrate new roles and in different settings we discover problems, things that we never thought would be a problem, let alone [many] pieces of legislation that need to change to actually become an autonomous practitioner.

NPs worried about inadequacies of legislation and regulation, about continued funding for NP expansion, and about policy misunderstandings. The NPs said that their approach to these structural problems was to work harder at building client partnerships and at fostering collegial relationships; yet, sheer determination was not enough to secure their roles or make teamwork effective. For instance co-locating with public health was seen as a good first step, which allowed practitioners to interact informally. But co-location did not generate the extent of collaboration that NPs had hoped for, and they felt strategic direction and support from a higher level was required to improve collaboration.

Service design and the appropriate location of the NP role were discussed.

Despite support from PPO leaders to reinforce the NP role as PHC focused, there was pressure from various sectors to extend the NP role to secondary and tertiary acute care, to specialist services, and to long term care. NPs noted this as a significant tension, and

worried that by diversifying the NP role beyond PHC there would be further confusion about the NP role. One NP commented:

If you let the community administrator loose on it they would have a total view or use for the NP, and without really understanding what it is we do. Like they just want help with everything. You know, stick an NP in the emergency department, stick one on medicine, stick one in orthopedics, and then we get further and further away from that PHC place, which is why I went in to this in the first place.

The service design of PHC was viewed as a good fit for NP practice, and PPO leaders and NPs saw the benefits of focusing NP role implementation in PHC, so as to clearly delineate and safeguard the NP scope and practice as a PHC function. PPO leaders envisioned that once NPs roles were firmly established as PHC-based, positions could be created in acute and ambulatory settings, such as cardiac services or emergency rooms to carry out PHC functions.

We do have to find a way to situate NPs in small rural hospitals...we have to define that role...as part of the rural health care team...so we re-frame what rural emergency looks like, we make it look like PHC that has a little emergency on the side...but we're still true to the model of meeting population needs, and we're true to the practice of NPs.

Power relations were also a worry of NPs, with respect to the medical profession and to health authority governance. Although NPs were aligned with PPO leaders, this did not ensure a direct link to the physician power structure within health authorities. Despite the valiant job of PPO leaders to locate NPs one by one into settings with physician support, the professional structures remained siloed. The success of NP-physician relationships within practice settings was making inroads to new physician interests, yet this incremental strategy was not addressing the power relations and medical dominance in primary care, nor influencing the traditional and political leanings of the BCMA. NPs also expressed concerns about health authority cultures. Although

some teams were progressing well, NPs saw these as isolated examples. Organization commitment to inclusive leadership and power sharing was inconsistent, and this variability had impact on NP integration in local settings, and within the larger health authority. An NP commented:

I don't think that there's a high tolerance in this organization for actually going against the flow. For saying "you know what, I know that's what you really believe but I have a problem with that".

Although NPs heard from their PPO leaders that they wanted the NPs to become strategically active in the organization, there was also the sense that this meant NPs needed to be in agreement with the positions and decisions of the organization and leaders, so NPs remained cautious about this strategic commitment. This comment reflects the sense of power inequity felt by some NPs.

Interprofessional learning was discussed by NPs and this was seen to be important to begin early in education programs and then be extended into health authority culture through in-services and practice workshops. As well resources were needed and additional time allotted to enable collaborative learning: One NP noted:

I think you need some financial support to develop a culture of collaboration, because although in the end the outcome is a less expensive individual client for the health care system, over the course of learning how to do [collaboration] it's a time-consuming process, and many health care providers individually are assessed by the numbers of patients they can see, or how much time they put in at a job. And so there needs to be that financial support that allows that culture to grow.

Resource allocation was discussed in terms of the lack of resources that many NPs experienced in setting up their practice, as well as the difference in resources that physicians had compared to what NPs could access. This was as basic for some NPs as having desks, phones and computers at start-up, to that of more sophisticated resources,

such as decision-making tools for diagnostic conditions and prescribing practices. One

NP noted:

Right now physicians have more resources than what NPs have, and if they're providing a similar type of care...then we should be able to have access to that knowledge base no matter where, or who has that information, if it allows us to provide better care for our patients.

The discussion about organization commitment and the importance of strategic alliances to NP role integration was significant, and an increased awareness emerged as to the essential alliance of NPs and PPO leaders.

NP Collaboration Promotes System Change

The collaborative culture framework was also applied to NP discussions about the need for system change. Elements that guided this analysis included political patronage, public participation, professional standards, interprofessional education and research.

Political patronage as an issue was revealed through the significant impact made by the Minister of Health attending and speaking at the BCNPA conference. A huge impression was made by when he addressed their concerns about role sustainability. NPs became cognizant of the importance of developing collaborative relations with system leaders and officials, in order to influence strategic policy decisions.

Coming from the [Minister] himself, the reassurance that we are a part of what is happening in PHC, that took a big weight off my shoulders, that's one piece now that I'm feeling confident in...once I was reassured I realized what a big part that was of how I perceive what I'm doing. And so now I feel like I can relax a bit.

NP confidence was reinforced by hearing their roles were provincially mandated as part of the health system plan and this strengthened their resolve to be strategic and more engaged in health politics. NPs could see the need for the Ministry to better understand the realities of teamwork in PHC, so that relevant policy and resource decisions would be

made that would break down barriers, rather than create further complexities. Ideas were generated about how to influence system politics, such as educating politicians so they could be public ambassadors for the NP role, and lobbying government to initiate a public education campaign about the NP role in PHC. The NP collective felt more assurance that they could make their needs known and that their requests would be taken seriously and not be detrimental to their status. One of the PPO leaders recommended to the NPs, “You have your key messages...if you’re in the elevator with the Minister, what are the three things you want to tell him?”

Professional standards as part of system change also were discussed. The NPs as a strategic policy resource for health authorities, and the BCNPA as a political advisory group to the CRNBC and Ministry, would mean having increased input into legislation and regulatory improvements, accreditation, legal barriers to role enactment, and PHC policy development. The NPs saw this as having significant impact on NP role integration, as well as on teamwork and PHC efforts. One NP commented on the amount of detail she needed to understand to ensure she was practicing within her reserved actions and within legal parameters:

A lot of the barriers relate to system barriers. I mean I get frustrated most days on physician signature required, for instance pre-op histories...I asked my manager and she said, “well the previous NP did it”, she said “so, it should be okay”, I said “that’s not good enough, I need to know if this is a legally okay document and that the system will accept it” so I emailed a few people and no, it’s not okay. So I have a conference call to talk with CRNBC at noon today.

Another NP reported

The BCNPA is now just in the last couple of months been invited to the implementation committee to sit as part of the others in implementation and integration process. So, I think we are moving in that direction and I agree that that’s a vision that we have. We need to be a recognized, both politically and with the provider body.

Research and evaluation was revealed as a significant issue for NPs, as they repeatedly raised concerns about lack of measurements to delineate the value-added of the NP role. As well, they noted stakeholders had varying perspectives as to which measures were more important to prioritize. The NPs clearly wanted to know the effectiveness of their practice, to foster practice improvement. Site managers seemed to focus on how NP roles were improving program efficiencies and service access. PPO leaders focused their discussion with NPs about how the NP role was influencing PHC design and innovation. Health organizations wanted data on how NPs were making a difference to client care outcomes. The CRNBC focus seemed to be about NP provision of safe care to the public and scope of practice issues. And the provincial Ministry wanted facts and figures about how NPs were contributing to system efficiencies. The issue of evaluation was still at an early stage of planning and deliberation by these various stakeholders; nonetheless NPs felt the burden of producing and documenting results. The opportunity to learn more about evaluation and inquiry was introduced and NPs were keen. A research action day was planned to discuss their questions and concerns. NP interest in evaluation was compelled by their desire to safeguard the parts of their role that were unique to PHC, and be able to set their practice apart from medically-oriented primary care; this included tracking and evaluating the value-added work of health promotion, prevention, harm reduction, and patient and population partnerships. An NP commented:

Somehow [we need] to show that we are filling in gaps...Do we need to look at the demographics of the people that we're seeing, versus just the one-on-one? What are the trends of the population that we're seeing?...The measurements have to fit with the organization's goals.

Interprofessional education was discussed by NPs within university programs and in continuing education within practice; they said that workshops and opportunities to learn about teamwork and collaboration were sorely needed. One NP said that she had been introduced to interprofessional education at a conference and came to see the importance of having university professional programs integrated, so that health professions learned alongside each other; she felt this would enable students to “learn with, from, and about one another”, so that when they actually headed into clinical practice, barriers would be fewer, and providers would understand each other’s scope and education. Another NP noted:

If one takes a look at how the seeds are grown in the first place, our education system, is growing doctors, nurses, pharmacists, nutritionists...at the basic university level, having some of our courses together, if we’re learning together, then we’ll be novices together, we’ll all be partners together in health care. It would be really good to start there.

This NP raised the issue of interprofessional education and linked it as a precursor to collaborative practice. As previously noted in Chapter 4, there is still sparse research evidence to show IPE improves collaborative practice (Reeves et al., 2008), yet there is considerable interest in establishing this connection and research is currently underway.

Discussion and Analysis

Taken-for-Granted Assumptions Create Role Development Tensions

The inquiry revealed certain tensions and barriers to NP role development. From these tensions raised, I identified certain assumptions that were made at and by different levels of the health system about role development. These assumptions have created difficulties for NP practice, and have consequential effects on role integration. McIntyre

and McDonald (2006) note that by identifying barriers, the “taken-for-granted assumptions that often sustain an issue and obstruct its resolution” are uncovered (p. 23).

At the provincial health system level there seemed to be an assumption that by the time provincial legislation was complete, and regulation, education, and funding support were underway, health authorities would be ready to begin NP role implementation. This was not necessarily the case; the health authorities had begun their preparations, and still had many uncertainties and issues to resolve. Yet the health authority leaders were committed to the initiative and presumed they could manage the challenges and the unexpected, and for the most part they have done so. However some of the fallout of this lack of preparedness has created practice difficulties, tensions and stress for NPs.

The next assumption at the health authority level was that leaders expected NP role development to be similar to that of other new roles that have previously been established. Because of this assumption the complexity of locating the NP role in PHC was underestimated. The PPO leaders raised this issue when they discussed the tremendous amount of time and effort they had so far dedicated to role development. I think to some extent this difficulty arises because PHC reform has also not progressed smoothly and has many barriers and challenges. Thus, aligning NP roles with PHC, a program which has its own political tensions and is underdeveloped in BC, creates double the complexity, and again this has put extra pressure on NP practice. Limited PHC sites under the jurisdiction of the health authority has also resulted in fewer choices for placing NPs and this may become problematic as larger numbers of NPs are added to health authority regions.

An assumption made by health authority and PPO leaders was that sites, settings, and teams would be readied and prepared for NP arrival, or at least the process would be well underway. Setting readiness meant infrastructure would be in place, such as phones, desks, computers, client record and coding systems, prescription and referral protocols, and teams ready to welcome the newcomer. The NPs heading into their new sites certainly held the assumption that settings would be welcoming and readied, but this was not how it unfolded for some NPs. Some settings were quite prepared, while others not at all. Inherent in the assumption that sites would be ready also meant that program leaders and colleagues would accept and endorse NP autonomy and scope of practice. However, for some NPs, autonomy and scope of practice were problematic. There was a lack of clarity about the NP role and this was complicated by the diverse ways that the NPs were constructing their positions; every role looked different. This diversity was viewed by NPs and PPO leaders as important, because it meant NPs were being responsive to clients and filling gaps in care. However, role diversity made the issue of role clarity more complex and NPs thus needed to expend much time and effort in educating others about the nature of their role so that they could fully enact them.

Finally, a last assumption I note here is related to the NP graduates who came into PHC practice with their predominant focus on providing direct client care. Many NPs discussed their surprise at the political nature of the NP role and for the most part said they were unprepared for the strategic policy, political and leadership components of the role. NPs talked about their education programs being clinically focused and how they did not feel they received the formal preparation necessary for these additional complexities of role development. As well, they realized that their communities of

practice and the BCNPA required organization, coordination, and leadership skills, and this was also a learning process for which they were somewhat unprepared.

Inquiry Findings Reveal Understandings and Solutions

At the beginning of this chapter, I discussed the tensions related to role clarity, multidimensional competencies, and professional autonomy. With respect to role clarity, the inquiry findings solidified the inquiry group's understanding about the NP role as a leader of holistic client and community care. In terms of clinical competencies, NPs discussed many aspects to their role and revealed their multidimensional competencies and their commitment to PHC; this showed NPs as not merely physician replacements, but as stewards of PHC. In relation to professional autonomy, the inquiry revealed that NPs in BC have professional autonomy and this autonomy fosters their capacity to champion collaborative relations at all levels of the health system and these collaborative relations advance role integration.

NPs as Leaders of Holistic Client and Community Care

For BC, a conceptual framework was developed by the Registered Nurses Association of BC (RNABC, 2003) that outlines competencies required for NPs. This document builds upon the CNA (2002a) advanced nursing practice framework and identifies four specific NP core competencies. The CRNBC competencies framework is the only policy document to provide a well rounded outline of the NP role. In this study, we uncovered many parts to the NP role and affirmed that NPs are called upon to practice all required competencies (RNABC, 2003). NP stories referred to clinical and social care; client and community engagement; health promotion, prevention and harm reduction; program and community development, team and intersectoral collaboration, research and

practice inquiry, professional accountability and leadership, and strategic agents of change. This description of the NP role ‘from the ground up’ exemplified holistic care.

Through the inquiry, we came to realize the high expectations placed on NPs to provide holistic health care, especially for new graduates. Yet, the inquiry also raised a number of challenges for NPs, including pressures from managers and colleagues to emulate a physician style of practice, lack of public awareness of the NP role, insufficient autonomy to direct practice decisions and innovations, intra- and inter-professional misconceptions about the role, inadequate electronic health records for information sharing, and the lack of political savvy on the part of NPs to be effective agents of change. In addition, NPs had dual reporting structures to the PPO leaders and direct program managers, and although it was an advantage to report to the PPO level of the organization, there was not always consistency in the messaging and communication between PPO leaders and program managers.

This discussion reveals the disjuncture between NP role responsibilities and the lack of advocacy support to address role development challenges. This lack of advocacy support is linked to both provincial and health authority levels. At the provincial level, through legislative changes to the Health Professions Act, the RNABC was restructured in 2005 and the CRNBC became the regulatory body for RNs and NPs (CRNBC, 2006). This official legislative status provided CRNBC with a direct link to government; however this status also reinforced the CRNBC duty to serve and protect the public and this became its primary mandate. The previous professional association functions, and local chapter representation provided by the RNABC were eliminated, which consequently reduced the CRNBC advocacy function for its registrant members. The

replacement of this advocacy function by some other mechanisms in BC has yet to be fully addressed. At the health authority level, a disconnect is revealed, because NPs were hired as excluded contract positions; this meant they did not have the representation or advocacy of the BC Nurses Union. The advantage of being excluded contract positions is that NPs, despite their small numbers, could take up their leadership and change agent competency functions and represent themselves directly to the highest decision-makers and leaders. However, the BCNPA, as a fledgling association, still had limited capacity as a strategic collective and NPs were discouraged by managers and PPO leaders from being political at an individual level. Consequently, NPs new and sometimes struggling in their roles had little to draw upon for advocacy representation and to address issues of role development at the practice level. The point being made here is that NPs require adequate infrastructure, resources, and leadership support to fully enact their roles, and until they have strategic capacity to advocate on their own behalf, they are reliant on the good will of health leaders to assist them in solving role development issues and challenges.

NPs as Stewards of PHC Renewal

Recent efforts have been undertaken to qualify and improve public and system understanding of PHC, because PHC continues to be misinterpreted as primary care physician services (Broemeling, Watson, Black, & Reid, 2006; CHSRF, 2007; Haggerty, et al., 2007; Hutchinson, 2008; van Soeren, et al., 2008). The PHC principles serve to make this differentiation and highlight the essential PHC features of equitable access and responsive care; client and public participation, health promotion and population health, interprofessional and intersectoral collaboration, and information and resource

technologies. This research inquiry revealed NP practice patterns and further clarified the NP role with respect to PHC. NP practice patterns demonstrated the application of PHC principles and brought to light the NP commitment to advance a vision of PHC. NP practice patterns showed how NPs designed their roles as diverse and flexible to reach out to marginalized and underserved populations, engaged in relational practice with client and community partners, provided holistic care and a broad range of health services, developed collaborative collegial relations, and practiced strategically to shift and change PHC culture. The inquiry revealed the commitment of PPO leaders to NP role development with the specific aim of advancing PHC renewal efforts. NPs were directed by PPO leaders to develop their individual and collective strategic capacity in order to steward the PHC cause. Both NPs and PPO leaders expressed determination to protect the NP role as a PHC function.

The inquiry also uncovered that NPs were striving to articulate their role as separate and different from that of primary care physicians. NPs were clear that they were not physician replacements, yet they expressed concerns about being compared to physicians and measured according to physician parameters, because they lacked their own measurements. Redressing the interprofessional imbalances is important to assure role development as different from that of physician replacement and to advance NP role integration. NPs are noted to be burdened with high expectations and limited resources (Browne & Tarlier, 2008). This was found to be true; the inquiry uncovered NP role responsibilities and expectations to improve health access, provide advanced clinical and complex care, address social issues of clients and communities, carry out community assessment and design responsive approaches and programs, extend public and

community engagement, champion teamwork and intersectoral collaboration, steward the cause of PHC, and be a strategic agent for health care policy change. These expectations conflicted with NP experiences of limited role autonomy and clarity, variable levels of understanding and support from program managers, lack of public awareness about the NP role, inadequate preparations for role start up, deficient quality improvement resources and infrastructure to guide and measure NP work, and organization power relations that hinder collaboration. The disjuncture between NP role expectations and NP experiences of practice is exacerbated by the fact that NPs with increased clinical decision-making autonomy practice in diverse settings and may not have ready access to consultation. At this time in BC role development, NPs have only elementary tools, measures, and infrastructure to draw upon and support them in providing quality client and community care. As well NPs have only a young association to advocate on their behalf. On the other hand, physicians are well resourced by provincial funding, have access to numerous quality assurance initiatives, and are supported by a strong association and infrastructure. This study identified that NPs require significant resources and endorsement from system and organization leaders to address the current inequities and strengthen their capacity to meet the obligations of this broad PHC based role. By proceeding with a collaborative strategic approach, NPs and health care leaders can determine and shape the fundamentals needed to secure NP practice and advance role integration.

NPs as Champions of Collaborative Culture

Legislation and regulation in BC aimed to enable NPs to practice with autonomy and flexibility for the public good (CNPI, 2005; CRNBC, 2005; Keith & Askin, 2008). C.

MacDonald (2002) discusses two forms of autonomy as profession-based and professional-based. Profession-based autonomy is determined by external factors such as legislation to enable self-governing professions to grant self-regulation. Professional-based autonomy means professionals have and take substantial control over their practice and related decision-making. In this study, autonomy as profession-based was seen to be contingent upon sufficient legislative and regulatory structures to enable NPs to have increased independence of decision-making; as well, health organization endorsement was needed to allow practitioner discretion. Autonomy as professional-based was reliant on NPs as individuals and collectives to effectively employ their granted power of autonomy. NP autonomy in BC has a sound structural base of legislation and regulation, and now requires consistent endorsement by health authority leaders and site managers. As well, NPs individually and collectively need to recognize and make use of their autonomy to fully enact their roles. This inquiry revealed that autonomy means that NPs are accountable for their decisions and care. Autonomy also complements collaboration, because NP relational skills and values promote shared decision making in the best interests of client care. Professional autonomy thus strengthens collaborative partnerships.

The inquiry reinforced that NPs must strike up collaborative partnerships with system officials and policy leaders. NP integration is reliant on Ministry support for sustained and incremental funding, development of infrastructure and measurements to track data on role effectiveness, and public education campaigns that will enhance client and community awareness and support. Development of the BCNPA is important to ensure strategic capacity as a collective. Collaborative partnerships between NPs and the

CRNBC will support the modification of scopes of practice in accordance with the evolving realities of practice. NP collaboration with educational leaders will help to modify educational programs so that graduates can be adequately prepared for the multidimensional demands of this role. NPs also need to collaborate with researchers in order to assemble relevant research designs, secure evidence, and benefit from the study and evaluation of role development progress.

In particular, NPs need to partner with health authority leaders to shift collaborative culture and PHC renewal efforts. This partnership will encourage health leaders to reinforce or redesign strategic direction and programs to support NP practice; address power relations within the organization and mediate interprofessional tensions; and provide team building education, strategies, and resources. Health leaders can also mentor NPs to be effective stewards of PHC. Mentoring of NPs and their communities of practice will foster their strategic capacity. NP collaboration with site leaders, colleagues and community partners are essential to the success of NP practice. Site leaders need to understand the multiple demands on new NPs, prepare sites and teams for NP arrival, and mediate team dynamics, to enhance NP role autonomy, flexibility, and role utilization. Leaders also need to facilitate their teams to articulate collective vision of client-centred care, delineate purpose and principles of practice, and negotiate respective roles and responsibilities. This will foster collegial relations, full enactment of team roles, and effective and efficient care.

NPs need to settle into their roles and settings, gain confidence in their autonomy and scope of practice, contribute energy and time to the development of their communities of practice, and embrace their multidimensional role. NPs and their

communities of practice need to strengthen commitment to collaborative partnerships with the many and varied stakeholders, at the practice level with clients, colleagues and communities; in the health authorities with site and policy leaders; in their own profession and across sectors; and with strategic system leaders. Collaboration is foundational to how NPs carry out their everyday practice. NPs as champions of collaboration contribute to the advancement of collaborative culture. Collaboration is also strategic and integral to advancing role integration.

In Conclusion

Health care challenges and changes in the last decade have generated a political and economic climate amenable to, if not reliant on, PHC renewal, interprofessional team development, public and population health, social justice and cultural diversity, and community-based endeavours. NPs are well positioned to champion many of these causes and determine a new health care (Browne & Tarlier, 2008; Gould, et al., 2007; Pogue, 2007). However, for NPs to be leaders of holistic health care, stewards of PHC for clients and communities, and champions of collaborative health care culture, they must draw upon foundational nursing skills to generate collaborative partnerships. Enacting the many parts of the NP role, those of clinical and social care; client and community engagement; health promotion, prevention and harm reduction; program and community development, team and intersectoral collaboration, research and practice inquiry, professional accountability and leadership, and strategic agents of change, requires NPs, as individuals and collectives, to balance attainable goals, effective approaches and strategic partnerships.

Provincial commitment to NP role development was reiterated by the Minister of Health at the 2008 annual BCNPA conference. Assurances from PPO leaders of the two health authorities involved in this study also emphasized this promise, and clearly tied NP role development to PHC renewal. PPO leaders expressed willingness to invest extra time and effort to NP role development, because NPs were seen as important catalysts for actualizing PHC. This governance endorsement has significant meaning for NPs. The time is now for NPs to create a visible presence. NPs need to reframe their aims and intentions as a collective and strategic influence in health care policy and politics. NPs must be engaged in fully enacting all aspects of their role, and become an indispensable part of the health system. The inquiry revealed NP integration means achieving role enactment, role clarity, value-added evidence, collaborative partnerships, and strategic alliances. NPs in collaboration with stakeholders and allies will advance role integration and at the same time further the agenda of PHC. The extent to which health care systems, organizations, and leaders cultivate collaborative health care culture will influence this progress.

Chapter 7

Participatory Action Research in a Community of Inquiry: Third-Person Perspectives of a Graduate Student

Overall for me it has been a really positive experience...I have much more clarity around what some of the issues are now...So, I really have gained an understanding of the [inquiry] process, and how it can actually help us as a community of practice identify our problems as a group, rather than just those individual things, where it's all about me. (NP participant)

This PAR study entailed creating communities of inquiry within communities of practice (Bradbury & Reason, 2008; Friedman, 2001). My role as researcher fostered the participatory conditions for NPs to come together in social investigation, share experiences to generate theories about practice, and adopt actions for NP integration and health care improvement (Hall, 2001). My confidence as a researcher grew as my understanding of PAR developed, and as I increased my knowledge in substantive areas of NP role development, IPC and collaborative culture, and PHC renewal. By coming to understand complexities and tensions within these areas of learning, I was able to identify choice points and make good decisions to enhance the quality and integrity of the inquiry (Bradbury & Reason, 2001). The framework of first-, second-, third-person action research was adapted for graduate study, and the emergent process of self-inquiry, cultivating research partnerships, and creating capacity in communities of inquiry was realized. Third-person action research denoted the actual community of inquiry, in which researcher and participants applied their combined talents with the aims of enhancing reflective relational learning, constructing knowledge and theories, and generating actions, in order to shape practice, shift policy, and regenerate workplace culture (Friedman, 2001; McTaggart, 1991).

Third-person action research aims to connect participants to a wider community, beyond that of typical everyday experiences; interpret practice findings within policy and political contexts; and leverage improvements across organizations and communities (Bradbury & Reason, 2003; Reason & Torbert, 2001). My decision to engage two concurrent inquiry groups promoted the crossing over of learning, translated knowledge beyond the local, and raised actions to a systems level. My role in the process was to facilitate constructive dynamics within each inquiry group, including interactions amongst NPs from various settings and communities, and as part of an action strategy between NPs and PPO leaders (Wadsworth, 2001). I adapted and employed a data analysis process from grounded theory, known as constant comparative analysis, to develop and extend knowledge development across the two health authorities and communities of practice (Charmaz, 2005; Coghlan, 2002; Eaves, 2001; Strauss and Corbin, 1998). By drawing on and applying the collaborative culture framework, outlined in Chapter 4, to NP discussions and data analysis, the complexity of inter-level and transverse relations were revealed. PAR served to engage participants as co-researchers in informative and transformative inquiry to strengthen relationships, develop knowledge and associations, and generate actions for improvement and flourishing. The integrity of the study was reinforced through constant assessment of group process, applying systematic analysis procedures, and substantiating analysis with NPs at each subsequent meeting, as well as reporting to the PPO leaders about our learning and findings (Bradbury & Reason, 2001; White et al., 2004).

In Chapter 5, I identify the validity criteria used to evaluate the quality and integrity of the process and product of this community of inquiry. I describe the inquiry

process including the relational and participatory dynamics that enhanced depth and breadth of discussion; I interpret and analyze participant data for knowledge development and educative outcomes, and discuss the significance of emergent actions taken up by the NP groups. Unexpected occurrences and limitations of the inquiry are disclosed. I also provide my researcher reflections of the inquiry process and make conclusions about third-person perspectives of action research.

Reflective Analysis of the Community of Inquiry Process

The quality of a PAR study is reflected by the measures of validity and choice points made by the researcher to ensure research rigor (Reason, 2006). The validity criteria that I used to judge the quality of this study were threefold and include the relational and participatory process, knowledge development and educative outcomes, and the significance of emergent actions (Bradbury & Reason, 2001; Heron & Reason, 2001; Herr & Anderson, 2005). These criteria parallel the PAR definition used for this study, which was taken up as a three-pronged process of social investigation, education, and action (Hall, 2001). The additional criterion of enduring consequences, which is noted by Bradbury and Reason (2001), is not discussed in any depth here, because the community of inquiry was bounded by graduate research timelines; thus the three validity criteria that I chose to evaluate the study reflect this reality. Enduring consequences of the study are difficult to assess at this early juncture of time and require a more complete dissemination phase by the researcher and participants before an accurate assessment can be made. However, for dissertation purposes, this criterion of enduring consequences is taken up by the researcher as a prospective discussion in the final chapter.

Relational and Participatory Dynamics of Collaborative Inquiry

I fostered participant recruitment by employing strategies to ground the inquiry, such as orienting members to PAR and the scope of the study, collectively determining principles of inquiry, and clarifying roles and responsibilities within the group; these actions were carried out at the introductory meeting before NPs completed participant consents, and were outlined in Chapter 3. I promoted and nurtured participant engagement through informal interactions, sharing of food, cultivating trusting, respectful, and equitable relationships, and celebrating achievements (Burgess, 2006; White et al., 2004). I facilitated a genuine and safe participatory experience, and was sensitive and flexible to time and travel demands; this helped to maintain participant presence at consecutive meetings. I began inquiry discussions with participant experiences and used an appreciative inquiry approach to discover ‘what is’; this helped to engage the group in authentic dialogue about current practice (Ludema et al., 2001; Minkler & Hancock, 2003).

Recruitment of NPs was very successful in HAA, with 11 out of 12 NPs employed in the region agreeing to participate; for HAB 6 of 12 NPs were recruited. HAA interest in the inquiry was apparent from the start by the quick and certain response of 8 NPs to the research invitation, while recruitment of NPs from HAB was slower and required three repeated requests for participation. I attribute this difference in response rate to HAA having an already established community of practice, in which NPs were accustomed to monthly meetings and collective engagement. On the other hand, HAB had only just initiated their community of practice and NPs did not yet have this collective commitment. Each inquiry group identified a communications person to

organize meeting rooms and equipment, and send out e-mail reminders of meetings. This was an established role for HAA; while for HAB, I assisted with some of these logistical tasks.

The HAA NP community of practice engaged in spirited interactions. Each inquiry meeting started with lively greetings and laughter, and quickly settled into interactive dialogue. Regular encounters with HAA NPs had been facilitated and nurtured by PPO leaders over a previous two year timeframe, and development of mutual trust and respect had opened up communication among participants. The spirit generated within this community of practice and the NP enthusiasm to include PPO leaders in the inquiry reflected the efforts of HAA leaders to model collaborative culture. On the other hand, the NPs from HAB were initially tentative about engaging in discussion, and tensions surfaced between some participants; yet by the third inquiry session the NPs were more willing to explore issues in depth and disclose their values and perspectives. For HAB, the community of practice had not yet developed a sense of collective trust and respect, so NPs needed to ground their relations before they could fully engage in the inquiry process. The PhD student assistant attended most inquiry sessions and took notes about meeting content and wrote up short reflections of group process. The content information from these notes was used for analysis purposes as a quick check to review meeting discussions, and the reflections of group process were used in this chapter as part of examining and analyzing the inquiry process. The student assistant and I debriefed after each session to share our thoughts about group dynamics and ideas about emerging next steps. The following is taken from the HAB notes of the student-assistant and was discussed in a debriefing session.

The group opened up more and talked more as the morning progressed, the antagonism remained throughout the meeting... There are clearly issues that are creating problems for these NPs to get their roles implemented and they did not seem to see that administrative help would address these issues.

I found my facilitation of group process to be a multi-tasking exercise. Although my facilitation skills were strong, the inquiry served to strengthen them further. I began each meeting with a welcome and a personal check-in and this helped to settle the group and centre the group dynamics. I fostered relational interactions and reflective learning, by reflecting back individual positions and recapping collective viewpoints, and this served to generate breadth and depth of knowledge production. I participated as a member in knowledge development by providing intermittent opinions, but I also held back so group ideas could emerge. I provided an agenda for each session and this set the stage for focused discussion. I prepared well with overriding key questions and versions of questions, which helped to elicit collective engagement (see Appendix F for meeting agendas and key questions and variations). I tried to keep the discussion focused on the salient questions, and redirected the group when participants strayed too far from topic. The early meetings required more of my intervention, especially for the HAB group who were still developing a collective identity; however, as meetings progressed a rhythm was established and my facilitation became less directive. The student assistant wrote in one of the early HAB meeting notes:

The discussion seemed disjointed and from my notes does not seem to flow in any specific direction that day. It had to be led strongly by the researcher and that shows in the notes. There did not seem to be any cohesion within the group.

Participants were encouraged to build upon each others stories and experiences, and identify disagreements. A few times tensions surfaced and I tried to support the participants in understanding and resolving differences. Sometimes it was necessary to

mediate multiple interactions to ensure that audio taping was discernable. Facilitation also involved shifting discussion away from participants who spoke a lot and encouraging quieter participants to contribute more. Yet, creating an inclusive atmosphere meant respecting individual communication styles. Initially in the groups I identified issues and practice puzzles as they surfaced, and this modeling encouraged other participants to also query comments and delve deeper into issues. At the conclusion of each session, I summarized key ideas and complexities that had been revealed, and I asked group participants to reflect on their experiences. PAR required good facilitation to strengthen group dynamics, create confidence in social investigation, enrich quality of discussion, and situate the action stage of the inquiry.

The decision to focus the first session on everyday practice patterns of NPs stimulated dialogue and awareness of their diverse settings and roles. Much of the discussion centred on their commitment to client care and stories of client interactions. Issues and challenges emerged about NP role start-up problems that impacted their ability to be responsive to clients. Both groups quickly recognized the benefits of having this time to reflect on their progress and examine the NP role from a bigger context than their own local practice settings. One NP participant stated:

I think it's nice just to have a space to talk about this stuff, and to air it, and I think some frustrations have come out, but also it's good to communicate and hear what other people are experiencing and going through. So I appreciate the fact that there is this time and space to do that.

NPs from HAA noted the inquiry process was quite different than that of their typical community of practice meetings, and in recording their discussions they were correlating individual experiences to reveal common concerns. One NP said:

If our managers were to hear some of this, I think it would be good to know what our challenges are, what we think is good and, what's not working quite so well. That it's not just in our clinic, the same challenges are happening everywhere.

The design of the study and my knowledge and facilitation skills helped to cultivate a relational and participatory collaborative inquiry process. I validated and reinforced the participatory process by modeling relational practice, creating transparency in both my views and those of the participants, being open to varying views, managing group tensions and distress, documenting the inquiry process and the knowledge and theories we generated, and reframing our local experiences into broader contexts (Bradbury & Reason, 2001; Heron & Reason, 2001). Participants thus engaged in a collective experience and developed a sense of ownership in the research inquiry.

Knowledge Development and Educative Outcomes

In PAR, participants aim to develop knowledge by way of a social investigation. In this study, we focused on the worthwhile practical purpose of NP role development (Reason & Bradbury, 2001; Bradbury & Reason, 2008). We engaged in dialogue about present day experiences of practice, and NPs revealed many ways of knowing and being (Reason, 2006). Because our group sessions reflected an educative atmosphere, this engendered the shifting of perspectives, raised participant consciousness, and helped participants to translate the local experience into a broader context (Park, 2001; Rowan, 2001). Through a participatory process, we collectively recognized the value of combining NP knowledge and researcher knowledge to make sense of and integrate theory and practice (Gustavsen, 2001). The significance of our educative process and knowledge outcomes was reinforced by translating my data analysis into written reports or power point presentations and returning them to participants for verification. As well,

we shared our new learning with the PPO leaders, and have future plans to make known our final results and outcomes to a wider audience through dissemination strategies (Senge & Scharmer, 2001).

The process of interpretive analysis was surprisingly time-consuming. Between NP meeting sessions, a transcriptionist converted audio-recordings to written form, and as researcher, I reviewed each transcript by listening to the tape and then made necessary corrections. I was able to recognize voices and code most data to individual cases, and then I proceeded to group codes into higher level categories. From these descriptive categories I identified associations among them into sub-themes and formulated emergent themes. I offer here an example related to this particular section on educative outcomes. I formed the category “somebody’s listening” from individual statements made during feedback discussions about the inquiry process. One NP said:

I mean there’s tape recorders’ running, somebody’s listening, and this is a conversation that we have a lot and now it’s moving ahead, and that’s really good.

Another NP stated:

I’m just happy to see that what we’re doing is being put out there, you know...coming from bottom-up, and being able to show leaders and other providers, and you know we can then use at conferences to show that we are having something of value to contribute.

This category of ‘somebody’s listening’ was then incorporated into a sub-theme about the ‘value of the inquiry’, and included under the theme of *educative outcomes* and discussed here as part of the validity criteria.

Here is another example with respect to coding NP practice patterns and the themes that emerged. The theme of *holistic care* as a practice pattern came from HAA sub-themes of ‘comprehensive care, doing an assessment, and upstream care’; and from

similar HAB sub-themes that included ‘holistic work, upstream care, and best-practice’. The sub-themes were named using “N-Vivo” codes, that is, actual wording used by the NPs, but I reflected on what the conversations were really about and from there determined that *holistic care* captured the sub-thematic coding. For the practice pattern of *agents of change*, the HAA sub-themes were ‘catalyst for change, the PHC vision, and doing health care differently’; while the HAB sub-themes included ‘changing PHC practice, NPs are nurses not physicians, and mentoring and educating about PHC’. I thus grouped these sub-themes together under the theme of *agents of change*. These NP practice patterns were later analyzed as paralleling the PHC principles.

For each inquiry session, I conducted a preliminary analysis, which I returned back to the group in written form. My original intent was to hold monthly group data sessions; timeline plans had been included in the participant consent forms, but in actuality these timelines were unrealistic. To my favor, NP schedules were also tight and we compressed the dates and extended the time between meetings. After returning the first analysis to each group at our second round of sessions, we began by reading the preliminary analysis documents I had prepared, and then we discussed feedback and reflections that either affirmed or shifted the analysis. In the quotation below, one NP describes her reaction to reading my preliminary analysis summary:

Well, two things that stood out for me as I read it...I’m like “oh yeah, we talked about that”, and I think the section on time...really isn’t a luxury, it’s necessary to distinguish our role from other care providers’ role. And I love your last sentence that the tension of autonomy and collaboration requires further understanding...when I drove home I thought a lot about that, and continue to think about that, and look at things differently in the office now.

This quote demonstrates that the research analysis and reporting back at each successive session fostered participant awareness and consciousness-raising. For HAA,

this process generated more in-depth discussion and new data were incorporated into the next iterations of analysis. For HAB, the analysis uncovered role development issues and tensions within the NP group, which caused concern for the NPs, and they discussed the analysis further. The student assistant observed and noted that “tension and unhappiness was evident in the room, only one NP smiled when reading the [analysis] document, everyone else seemed uncomfortable”. A couple of the NPs took issue with the analysis and a dialogue ensued.

I don't know if I would call it discord within the group, I mean, I don't know...
Yeah I am a bit taken aback by that word as well...
I think the discord is within the system, not necessarily within the group.

A brief debate about the nature of the tensions and renaming the discord as conflict dynamics between people at different levels in the hierarchy of the organization helped to ease the concern. Discussion eventually moved on to how the HAB NP roles were exemplifying PHC, and the participants began to relax and discuss positive associations in the analysis document, as reflected in the following quotation by an NP:

PHC is entirely within the health authority so anything that we're doing to contribute to that and [write] that down I think will help us, it will advance PHC, and it fits with the agency's goals...And it moves the NP role forward for others as well.

By the end of this second session, HAB NPs were envisioning how the research could be applied to benefit role development and health authority agendas. Common ground, consensus and convergence about ideas and experiences were bringing the group together as a collective. By the third session, the dynamics shifted and the group was fully engaged and invested in the reflective inquiry process. The social investigation was now well underway for both groups and learning and knowledge development was

progressing; NPs looked forward to the analysis and feedback of each subsequent session. One NP described what this process meant to her:

I think it's been a really good exercise to make me stop and look at the bigger picture and to hear from other people. And then to have this given back to me, that I'm saying things and I could read some of my words.

The inquiry process facilitated a reframing of practice into broader theoretical constructs thereby creating an educative atmosphere (Bradbury & Reason, 2008). Both groups were excited to see evidence of their everyday work reconstituted as PHC renewal, and their convictions and commitment to the inquiry grew stronger. This excitement was described by an NP as follows:

The way you tied it in with PHC...I thought that was great. I mean it's like what a great sell for NPs, you know, that this is going to advance other things. There's a good marriage between how we think it will work and some of the big time goals for the Ministry and the local health authorities.

Yet despite linking their practice so closely to PHC principles, NPs also realized the value of clearly articulating their roles as different from physicians. They expressed their commitment to collaborative partnerships and collaboration as foundational to their practice, and emphasized the importance of championing teamwork to advance PHC. As they came to see the significance of their role with respect to other professions, they articulated these differences, called attention to these findings and outcomes, and provided direction to the analysis and what I should emphasize in the findings. For instance, one NP said:

This piece around 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. So I think it really should be made more evident.

As I introduced questions about the meaning of NP integration, participants began to reflect on how far they had come in their roles and where they were headed in their futures. Appreciative inquiry was again useful in constructing visioning questions about ‘what could be’ (Ludema et al., 2001). For HAB, the NPs could see role development was moving forward and their new community of practice had great potential if members invested in participatory leadership. An NP commented on the inquiry benefits:

This whole research and process has been really good in helping us articulate, helping us organize what we’re going through, giving us some basis to see that we are moving beyond the phone and the desk issues.

Conversely HAA NPs recognized that they had achieved real gains in participatory leadership from their community of practice, and this meant they had a unique contribution to make to others about how to establish and sustain this collective model. For both groups, knowledge development from the local perspective was being translated into a more expanded context and the significance of sharing their learning with a wider audience shifted NP understanding about how knowledge and power are so closely linked. An NP stated:

What I’d like to hope is that as we move forward evolving and integrating the role, that this is a useful piece of work that we can present in other places, to the province, to our practices, or our communities, or whatever... so that it just doesn’t become a piece of research that nobody pays any attention to.

This comment reflects the educative process that occurred by way of the inquiry, in which NPs began the study with uncertainty about the PAR process and about what they could offer others, and by the end of the inquiry came to see the value of PAR in generating collective knowledge, and this collective process positioned them as having expertise, and able to influence a wider audience and contribute to NP role development in other communities and provinces.

Significance of Emergent Actions

The process of action research cannot be predicted or defined in advance, because it “emerges overtime in an evolutionary and developmental process” (Reason, 2006, p. 197). The collective educational process that occurred within each of the communities of inquiry deepened the understanding of issues. Common experiences and concerns were redefined by the groups and linked to system complexities. The iterative cycles of learning, action and reflection, extended the consciousness of participants and connected the personal in practice to the political in policy (Heron & Reason, 2001). As the interconnectedness became more apparent to the inquiry groups, we began to articulate the co-construction of ‘what should be’ and designed actions to transform both practice and policy (Ludema et al., 2001)

The transformative expectations associated with PAR seemed rather daunting to me at the beginning of the inquiry. The idea that the inquiry groups would move through an informative stage and we would actually get to transformative actions seemed a lot to expect for a short six month timeframe. Yet I knew action plans necessitated reflexivity to disclose the emerging path, and this required my patience and confidence in group process. By keeping an active imagination and alertness to opportunities, I opened up possibilities for actions. I encouraged NPs to reflect upon their learning and how the inquiry was shifting their perceptions of practice. One NP reported at a feedback session:

When I drove home I thought a lot about that, and continue to think about, and look at things differently in the office now. I mean I don’t run around and tell them what my scope of practice is all day long, or say ‘no, I can’t do that’, or ‘no that’s not my thing’, but, you know, there is sometimes a tension when people don’t understand what it is that I do. And probably that’s reciprocated when I don’t understand what they do, so it’s probably on both sides.

I also introduced discussions about action strategies early in the study and at each session. In each group we discussed actions as typical as reporting to health leaders, publishing findings, and presenting at conferences, but we also contemplated and determined significant actions to transform the current NP circumstances. Participants expressed the importance of increasing public awareness about the NP role, and generated ideas such as promoting NPs during the annual nurses' week, making presentations to local community groups, requesting support from health authority leaders, and finally lobbying government to coordinate a provincial public awareness campaign about NPs. As NPs made these suggestions, I reflected back to them that these could be taken up as action strategies in the inquiry. The action ideas advanced from the local and personal purview to that of political action. Both groups expressed interest in exploring evidence to strengthen role development. Substantiating the value-added contributions of NPs in the health system was viewed by both groups as a priority. NPs discussed rudimentary statistics and data that they were tracking, and wanted to learn more about program and practice evaluation as reflected in the following quotation:

We need measurements that are different than what have been traditionally used in clinical settings. So, I think getting someone with expertise to come in and talk about that – what type of research is being done, what type of tools are out there, what's some of the research that's come out so far, and then adapt it, as each practice is so individual.

NPs also identified the need for research that was appropriate and relevant in their own circumstances. Thus, I introduced the idea of a research action day, which was quickly agreed to by each inquiry group. I invited my dissertation supervisor who has expertise in evaluation design, to participate in these action sessions. The research action day was titled "Burning to Know and Burning to Show" and was planned and carried out

first with HAB, and then findings were presented to HAA and modified again for their purposes. The agenda for these two sessions included reviewing current record keeping and sharing goals and issues of NP practice. A discussion of theories underlying practice was facilitated and a logic model inquiry design was developed. The inquiry tool was then applied to a few NP settings and situations to generate site-specific analysis and develop evaluation measures for NPs to use in practice.

A case example, for instance, was presented by a participant who expressed dissatisfaction with NP workload and functions within a team-based clinic. The team mix in the site had originally included a number of physicians, an NP, and a few other professions. The role and goal of the NP was to complement physician and team practice. However, some of the physicians had left the clinic and demands on the NP had shifted, so that the role became more like that of a physician replacement. The theory behind this discussion led us to articulate the NP role as different from physician practice. NP work was viewed by the participants as holistic and multidimensional, and yet they felt that site management did not fully understand the comprehensive nature of the NP role. They concluded that in order to solve this issue it would require strategic support from PPO leadership, education of site management, and possibly human resource involvement from the organization to recruit new physicians or additional NPs. The implications of a clinic with one physician and a number of NPs were discussed. Participants believed this new mix of practitioners (less physicians and more NPs) would shift the focus from a clinical-focused primary care model to a PHC model that offered a spectrum of services. Yet this first required assessment of client and community needs to determine the right team mix before restructuring a new model. As well, evidence needed to be collected

about NP practices to ensure their functions were balanced and the NP role was kept on track. The long and short of this example is that the NP's dissatisfaction uncovered a complex situation and many implications. By applying the inquiry tool that was designed by the group, a bigger context was demonstrated and practice concerns were interconnected to policy and political issues. Table 4 summarizes another example generated by one of the groups, with relevance to role integration, and outlines the preliminary steps taken in a logic model inquiry so that NPs can carry out inquiry and analysis of their own practices.

Table 4: NP Inquiry Model for Quality Practice

NP Research Logic Model for Inquiry of Quality Practice Example: Role Development		
1. Goal: What is the goal or vision?	→	Role integration within the team
2. Issue: What is the practice issue, problem or focus of inquiry?	→	Lack of clarity about roles & responsibilities. Question: Am I being utilized effectively?
3. Theory: Why is this an issue; why is it important to understand?	→	Lack of NP role understanding, & lack of time for team to discuss, educate, & explore unique & overlapping roles
4. Indicators: What will it look like if solved or resolved?	→	Indicators for effective role and team function are identified
5. Actions: What strategies can I do or influence to impact issue?	→	Identify stakeholders, sphere of influence, and actions within my control.
6. Evaluate: What measures can I use or evidence can I document?	→	Before & after indicators of change; measurement tools or descriptive evidence.
7. Analysis: What impact has been achieved?	→	Analysis of question: Am I now being utilized more effectively?

The second significant action plan taken up by both NP groups was to invite PPO leaders to an inquiry session to gain their perspective on NP role development progress, the NP community of practice model, and their future vision for NP role integration in

each health authority. This action was discussed in Chapter 5 in relation to explicating the value and dynamics of communities of practice. HAA was first to engage PPO leaders and this provided insights to facilitate the HAB session with PPO leaders. I prepared a power point presentation specific to each NP inquiry group, and reviewed it with the NPs prior to the PPO leaders joining our meeting. Each of the sessions with PPO leaders began with this power point presentation, in which I highlighted the findings to-date and used NP data quotes specific to that health authority. We asked for feedback from the PPO leaders about these results, and then proceeded with our query. Also prior to this session with PPO leaders, the NPs and I collectively developed a list of questions to frame the interview meeting. An NP from each group was designated to facilitate the question and answer discussion. We had agreed as a group to primarily be listeners in order to hear the messages of PPO leaders; a short discussion was encouraged at the end of each group's session to clarify understandings. At the end of each of these combined meetings, the NPs debriefed about the session and reflected on their learning. One NP observed that despite the "behind the scene efforts" of the PPO, she still felt there was "misalignment" between the NP vision of practice and that of the PPO leaders; while another NP from the same inquiry group shared a more confident view and noted:

It was really positive because I'm always happy to get a little bit inside their heads and figure out where they're coming from, so I'm REALLY glad this happened...when you presented the preliminary findings and I thought wow, we said all that and there are some really great things. And I'm quite proud of this, and being able to participate in it.

However, overall the NPs discussed how they gained awareness about the political complexities of NP role development. They realized that implementing successful NP roles was not simply the responsibility of individual NPs to exert extra

efforts in practice; it also required the collective presence of NPs in strategic alliance with health care leaders for deliberate planning and action of NP role integration.

One NP noted:

Suddenly the lights going on about the level of responsibility...they are asking us to be strategic in all of our interactions and it's a strange new environment that I've never really been part of.

Another NP conveyed how important it was to be mutually informed, so NPs and PPO leaders spoke the same language, and worked toward a shared vision.

There are absolutely tensions, and I think the busier we get and the more demand there is on our time the more difficult it will become. I was glad to hear the PPO commitment to the community of practice, because that is going to be a huge point of tension in our sites very soon.

NPs discussed the value of having dual reporting to program or site-specific managers and to PPO leaders; advantages and disadvantages were raised. The decision to have all NPs report to their Chief of Professional Practice was seen to safeguard the NP role in many ways. Within each health authority there was a consistent approach to role implementation, resolution of issues arising at individual sites were shared across sites, and there was an advocacy voice for NPs at a higher systems level. As well, the decision to have NPs report to their site-specific managers meant they had supervision and support in their everyday on the ground work. However, the issue was raised that PPO leaders and site-specific managers did not necessarily have similar views about the NP role, and at times, NPs were caught in the middle with these differing expectations.

NPs Reflecting Back

At the final session for each inquiry group, NPs were asked to reflect back on their experience and comment on the outcomes of social investigation, education and knowledge, and action strategies. From a social investigation perspective, NPs learned

they could draw on each others talents. The inquiry substantiated their value as autonomous practitioners with expertise to contribute to others through conferences and publications. By comparing and highlighting their communities of practice, NPs noted the importance of a collective approach; for HAB the inquiry fostered a commitment to move forward and for HAA the inquiry reinforced the strength of their developmental progress and created a vision for future directions. One NP reflected on her experience:

Well, I have to say that it's been much more enjoyable and less difficult than I thought it would be. I expected that it might feel like it was very hard, it hasn't felt easy, but it's been enjoyable. Definitely. And I think that it gave me some insight into the real process that we've gone through, the longer process.

Another NP commented on how the inquiry was shifting her practice:

I think it was also a good place for reflecting on our practices, how we're all different, how we're all the same, and being able to then go back and think, okay so what do I need to do to change the environment I'm in to make it more mine, or more reflective of the practice I'd like to have. I think that's been really good.

With respect to education and learning, NPs gained insights about differences among their practice settings, and how a "cookie-cutter" NP role description would be detrimental to clients and communities. On the other hand NPs learned how they could share practice approaches and solve common issues and problems together. NPs also learned how to connect theory and practice. By linking the many parts of practice and conceptualizing complexities, NPs came to better understand praxis as the 'art and science' of practice, in addition to clarifying the multidimensional aspects of their role. The collaborative culture framework had meaning for their current situations and provided understanding and direction for the future. One NP reflected on the framework:

The other thing that worked for me is the conceptualization of a model graphically, and showing that on a power point slide...so I can actually visualize something represented graphically that means so much more... I can actually see where the linkages are, or where they're not.

From an action perspective, NPs also learned more about the interconnectedness of practice and policy. NPs engaged PPO leaders and both parties gained significant understanding of the importance of this alliance to NP role development and PHC renewal efforts. An NP commented on her vision for the future of PHC:

PHC should be everywhere, it should be pervasive, it should be systemic. It should not be the exception, which right now I think it still is, and continues to be and probably will for some time. I believe that NPs will play a big role in helping to move that agenda forward.

Commitments were made in both health authorities to engage in regular discussions about each other's views and experiences. As well, PPO leaders committed to mentoring NPs in strategic capacity building. NPs also realized the importance of broadening their competencies to extend to leadership, research and change agent functions. Finally, both NP groups expressed their appreciation for the opportunity to participate in a community of inquiry, which enticed their interests and commitment to further research endeavours. The research experience shifted their reluctance to take time away from practice and generated enthusiasm to participate in next research opportunities (Eastbrooks, 2003).

One NP reflected on her experience and future interests:

Well, I must say that a couple of different sessions ago I thought "where's this going?" The part of it that is really interesting is, you know, to be able to do some more of this kind of research where you can participate in the analysis of the data...for me that's actually the value of it, the process and how it all fits together, and then you get a little bit less anxious about where it's going or not going.

Another NP commented in the final session:

I think I learned a lot about the participatory research process, I am just thrilled with it, it is just fabulous and I did not expect to feel that way.

NP interests also translated into continued involvement in the inquiry. The NP groups agreed to read and vet dissertation chapters for accuracy and validation of results.

One NP e-mailed back a comment about the draft chapter on communities of practice:

Great work!! As I read through, it became clear to me that a community of practice is about relationships, it's a "process" and not a "thing"...this process evolves over time, growing and changing as people come and go. It's also clear to me that the community of practice was an essential element for grounding myself in my new role, and dealing with the growing pains of being a novice again and trying to break down resistance to the role. I was really captured by what you had to say and think you have done a great job!

At a recent meeting of the HAA community of practice, the NPs discussed the findings' chapters that had been shared and one of the NPs e-mailed back the following comment:

I am just back from our NP CoP meeting. My comment to our group was that you have captured in words, much of what we try to communicate but have not been able to state verbally. This comment is directly linked to pages 192, starting with "NPs to stay close to their nursing roots, remain grounded in theoretical underpinnings and preserve strong disciplinary relations in order to safeguard the NP role as one that provides holistic care". BRAVO to you...Some of my favourite publications are Browne & Tarlier 2008 and Pogue 2007. You have captured the essence of these papers.

The NP inquiry generated considerable interest in joint publications, so I committed to send out a call of interest to NPs when it was time to re-write chapters for publication. A collaborative approach to conference presentations was also discussed and it was agreed that opportunities would be shared amongst participants as they arise. The next BC Nurse Practitioner Association (BCNPA) conference was determined to be an excellent time to showcase the study and collectively present findings. The HAB inquiry group also requested a presentation be made to their full community of practice group, so that NPs who did not participate could learn about the process and be apprised of the results. Further ideas are expected to be generated with regards to translating the inquiry to a broader community, as the emergent unfolding of the inquiry continues.

Managing the Unexpected: Limitations of the Study

All research has ideological assumptions that need to be identified and reflected upon to counter misinterpretations, enhance the quality of the study, and assess results for translating and applying to broader contexts (Bradbury & Reason, 2008; Reason, 2006; Rowan, 2001). Credibility is enhanced by being transparent about managing the unexpected and weighing in the limitations of the study. Indeed, there were a few unexpected occurrences over the course of this inquiry, which had implications and may have affected the quality of the study.

Despite my diligence in self-inquiry and careful preparation of the study, the realities of PAR at times generated unexpected process and results (Burgess, 2006). I anticipated that I would directly recruit NPs because I know participant engagement benefits from relational contact. Ethics review by both health authorities required me to maintain distance from the recruitment process to minimize the possibility of researcher coercion; however this did not address the other possibility that participants might perceive employer coercion or intimidation. The PPO leaders of HAA helped to facilitate NP participation, while for HAB the recruitment was done by written invitation only and was less successful. As a result the inquiry groups were not equally represented. The HAA group represented the NP employment base well, while the HAB group represented only half the NPs. This was a limitation for the study and may have compromised the quality of comparative analysis (Brydon-Miller & Greenwood, 2006).

The rigor of PAR is in some ways measured by consistency of participation throughout the entire inquiry process and this includes identifying the research issue, clarifying the question, and designing the study (Hall, 2001; Reason & Bradbury, 2001).

This was not possible in this inquiry because the restrictions of the ethics review process required that so much of the front end planning be done without direct participant involvement. Also, for most of the NPs this was their first experience as co-researchers and their curiosity was offset by skepticism. They expressed concern about taking time away from practice and whether site managers really understood and supported their involvement, 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 the study.

The extent to which NPs described their collaborative interactions and partnerships with clients and communities shifted my understanding of the study. My assumption about NPs relatively new to practice was that NP-physician relationships would be the focus of their discussions. This was certainly the impression given by Canadian NP research studies on collaboration. I also anticipated actions would be related to team dynamics. Yet, NPs explicitly talked about their roles with respect to client relations and care; as well, they discussed role development complexities and the importance of relations with health authority leaders. This was an unexpected turn of events that re-shaped my thinking, and reinforced the iterative nature of PAR and the complexity of health services research (Coghlan, 2002). Consequently, part way into the study, I shifted the research question that had initially focused on *interprofessional collaboration* to a more general view of *collaboration*, and so I may have missed opportunities earlier in the inquiry to explore this broader view of collaboration and thus limited the study findings.

When the inquiry began, a number of NPs were still practicing under temporary registration, preparing for final written and oral exams, and preoccupied with this important undertaking. This was often the topic of informal discussions at the beginning of each session and permeated the inquiry process. The NP focus on the ‘here and now’ was an important survival strategy to obtain registration and even have a future role. So asking the groups to explore role integration five years ahead or to examine the bigger context of politics was rather challenging. The NPs as a collective had very little experience in discussing the politics of NP role integration, and were somewhat unprepared for this dialogue; consequently the depth of discussion was limited.

The study was relevant to the NP role in PHC and specific to BC health care 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 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. The study was informative and qualitative by nature and therefore 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 the purpose of evaluating similarities and differences, and in this way can be translated for broader application. Many of the findings of this study were congruent with the current literature and reinforced or added to the existing knowledge base, and this is discussed further in Chapter 8.

Timelines in PAR are typically a challenge, and this is especially true for graduate student research. Conducting data collection for two inquiry groups in a six month period is likely ample for the informative stage of an inquiry, but barely sufficient for completing a transformative stage. Hence, I agreed to continue with inquiry groups beyond my dissertation timeframe to explore further opportunities for actions, to translate findings for a broader audience, and to disseminate results. This continued involvement will enhance the significance and enduring consequences of the study, however the depth and extent of reporting on enduring consequences within the dissertation is limited. Instead, I have taken up the matter of enduring consequences as prospective reflections in the final chapter. The absence of the NP voice related to the enduring consequence of the study represents a limitation to the dissertation write up.

Discussion: Researcher Reflections on the Community of Inquiry

Congruence in ontology, axiology, epistemology, and methodology underpinned the quality of the PAR study. Throughout the inquiry process and in writing up the findings, I stayed true to the PAR definition that was adopted for the study: PAR is “an integrated three-pronged process of social investigation, education and action to support those with less power in their organizational or community setting” (Hall, 2001, p. 171). The participatory inquiry opened up communicative space for NPs to explore experiences and tensions, and foster democratic relations between NPs and PPO leaders (Munn-Giddings et al., 2005). NP stories of practice were applied to the collaborative culture framework, and the framework guided NP discussions with the result that the framework was modified and substantiated. The dialogue and analysis that made sense of participant experiences and created collective learning helped to theorize the NP world, and

reconstitute understanding from micro to macro views. Discussions of power relations were translated to policy and political action, and NPs came to realize the significance of strategic capacity and creating new alliances. The focus for NP role development shifted from that of local practice to regional and provincial politics, as the integral link between NP role integration and PHC renewal efforts came to light. The ontological perspective of a participatory worldview was integral to the PAR inquiry, in that NPs became co-researchers and co-authors of knowledge and actions generated.

The PAR study was also firmly grounded in the lived experiences and values of NPs in their practice. By sharing stories of their unique settings and roles, and dialoguing about mutual and collective understandings, the inquiry interpreted and theorized practice. Choice decisions were made by the groups to engage in actions to address theories of culture and power (Reason, 2006). These actions included exploring a logic model for inquiry which could be applied to their individual practice settings, as well as engaging with PPO leaders about communities of practice and strategic alliance. Communities of practice as a collective identity for NPs held promise for influencing local practice settings and organizational conditions to benefit NP role development (Coghlan, 2002). NPs committed to developing collective capacity through their professional organization of BCNPA, for the purpose of creating strategic presence within the politics of BC. The axiological tenet of structuring and situating inquiry for worthwhile practical purposes was actualized.

NP inquiry groups uncovered tacit knowledge and many ways of knowing to make explicit some of the issues and problems of everyday work-life (Reason, 2006). The historical challenges of NP role development informed NPs' current circumstances

and helped to guide and envision their future. NPs had been so caught up in making practice work, and the inquiry served to open up participants to prospective thinking about future goals and aspirations. By designing a meaning for role integration, NPs articulated steps forward, and gained confidence in actions to co-construct their sustainability. Epistemology denoted as representational, relational and reflexive knowledge came together as theoretical groundings, collective engagement, and critical reflexivity to characterize the problematic, inspire constructive ideas, and generate forward thinking plans (Park 2001).

The validity of findings was reinforced by being transparent about choice points in the inquiry process. A question could be raised as to whether my own assumptions and beliefs could bias the results of the study. However, by employing the process of constant comparative analysis and then returning the analysis for verification to each subsequent inquiry group session served to safeguard the inquiry results. By continually evaluating and comparing data, I shifted coding and themes accordingly, and then returned my analysis to authenticate my interpretations with each inquiry group. As a collective undertaking, we discussed and reflected upon the analysis at the beginning of each session and at times there were disagreements, debate, and modification to analysis findings. The NP inquiry groups were very much involved in a co-construction of knowledge and action.

The NP community of inquiry formalized a commitment to research by engaging NPs in informal and iterative cycles of learning, reflection, and action (Heron, & Reason, 2001). Reluctance and uncertainty transformed during the inquiry to confidence and enthusiasm for continued engagement. The informative stage of the inquiry generated

evidence of the NP role advancing PHC, and formulated strategies and recommendations for NP role integration. The informative stage also guided the transformative stage of the inquiry, in which dialogue was opened up about the value-added role of NPs and the collectives were aligned to a political context. The inquiry fostered participants to gain a stronger sense of self, strengthen networks and connections, re-construct collaboration as multidimensional and relevant to client and community partnerships, and cultivate democratic collaborative process between NP leaders of practice and health authority leaders and policy-makers.

In Conclusion

Third-person action research situated my participation in a community of inquiry and made real the years of preparation to become an authentic researcher. My commitment to align university and community was actualized by taking up the challenge of PAR. Many choice points were made along the way, and the quality of the research was measured by the extent to which we, the researcher and NP participants, became socially linked in an investigation, reconstructed understanding and generated new learning and knowledge, and employed actions to foster professional autonomy, strengthen collaborative partnerships, and envision political status.

Chapter 8

NPs Contribute to a Vision for a Better Health Care: Final Thoughts and Recommendations

For Canadian nursing, the days of giving and taking orders should be relegated to the 19th century where they started. Public trust in nurses is huge, and Canadians are pushing nurses to step up our practice, move forward and lead health systems and health services toward something new. (CNA, 2008c)

The Canadian Nurses Association celebrated its centennial on October 8th, 2008, with one hundred years of leadership. I joined a web-cast on that day and listened to five questions asked by nurses from across Canada that were answered by an expert panel. The issues raised included health access and inequities, infrastructure and funding for NP positions, national regulatory standards, healthy workplace and leadership, and faculty recruitment and need for interprofessional preparation. I also reviewed two related documents: The “CNA’s Preferred Future 2020” (2008b) and “Signposts for Nursing” (2008c). The Preferred Future document reports that in order to move forward and actualize a better health care, collaborative efforts are required by nurses, other professionals, policy-makers, and the public (2008b). The Signposts document declares that “access to timely, appropriate, safe, quality, publicly funded health-care services” is still the fundamental issue for Canadian nursing (2008c). The Signposts document highlights that health care demands are increasing, and have already exceeded resources, particularly those of human resources; and with this scenario concerns for patient safety and quality of care are amplified. WHO’s (2006) prediction of a 4.3 million shortage of health workers, coincides with an aging population, and increasing health disparities in indigenous and marginalized populations, and in rural and remote communities, all of which are creating significant health care challenges. Global politics and economics also

complicate the picture. Strategies to increase the number of nursing school seats, formalize new advanced nursing practice roles, and attend to faculty development are underway in most Canadian provinces. Also, changes to scopes of practice are occurring with respect to all nursing and professional roles. The CNA reports that survival of the health system is reliant on implementing new delivery models, multiple access sites, and team approaches to care, along with appropriate funding levels to support these strategies (2008c). PHC is viewed as a significant feature of this future vision, and attention is being called to collaborative interprofessional education and practice to foster health professionals to work in teams. NPs are noted to be playing an increasingly important role in the delivery of PHC. Findings from this dissertation study have much relevance to the current health care picture and the pressures outlined by the CNA.

In this final chapter I look back at the study findings in order to bring forward the contributions the study makes in adding to the knowledge base and providing guidance to this future nursing vision. I begin this discussion by taking up the position that the NP role is a political role. I follow this by discussing three particular aspects of the study and examine my findings in relation to the larger body of existing literature, and correlate how my study findings support, contradict, and add to the knowledge base. I also bring forward the study title of “Finding a Balance” and review its relevance to the findings of the inquiry. The importance of the collaborative health care culture framework is discussed with respect to adding to the Health Canada knowledge on interprofessional initiatives and its value in providing direction to policy and practice leaders for improvements in health care collaboration and culture; this was highlighted in Chapter 4. With respect to NP role development in PHC, I draw attention to certain knowledge that

was generated from the inquiry about advancing NP role development and discuss how this contributes to PHC renewal efforts; these findings were discussed in chapters 5 and 6. I also translate these findings into recommendations for advancing NP role development. The first-, second-, third-person action framework is revisited to emphasize the value of adapting this framework for graduate education and dissertation research; chapters 2, 3, and 7 focused specifically on the action research framework. Finally, I speculate about possibilities for disseminating study findings and creating enduring consequence, as part of validity criteria that I adopted for the study.

The Political Nature of the NP Role

The CNA (2000b) issue paper highlighted nursing as a political act, and emphasized the political nature of nursing to uncover client stories and voice, and influence decision-makers to improve the lives of clients, communities, and populations. The CNA states: “It is not difficult to see how acting on a political level is a natural extension of the essence of nursing – of caring” (2000b, p. 4). This perspective is particularly relevant to the formalization of NP roles within PHC (Clarke, 2006; McIntyre & McDonald, 2006). NP role development is integrally linked to the advancement of PHC, and both have suffered from a discontinuous history, in which barriers have constrained progress. PHC is now a political imperative in Canada, at all levels of government (First Ministers Meetings, 2000, 2003; Health Canada, 2006a Kirby, 2002; Romanow, 2002). WHO (2008) on the 30th anniversary of the Declaration of Alma Ata (1978) is calling attention to the need for further clarification of PHC, in which PHC delivery emphasizes social justice, equity, and solidarity, and is designed as a

community-based full service approach to care. The NP role is particularly suited to advance PHC and its associated principles, and demonstrate a full-service care approach.

Gould, Johnstone, and Wasyliw (2007) report on a study that investigated the NP role one year after formally being introduced into the province of New Brunswick. Three themes were identified. The first was about the holistic patient care philosophy of NPs, in which 'time' was emphasized as important to establish nurse-client relations, carry out full assessments, identify and respond to client issues and provide client education. The second theme related to barriers perceived by NPs. These included a general lack of understanding by the public about the NP role, inconsistent acceptance by physicians and other professions, and particular system issues that created practice barriers. The third theme was about the pioneering outlook of NPs to engender excitement and pride. NPs expressed optimism in eventually being accepted, forming strong team relations and associating with their nursing profession. The Gould et al. findings are consistent with the findings from this NP inquiry. However, the NP inquiry goes beyond the Gould et al. study to document that NPs are uniquely situated to be leaders of holistic client and community care. I make the case here that there is a political nature to the NP role, and practicing a full service approach will set NPs apart from being physician replacements and at the same time advance the PHC agenda.

Browne and Talier's (2008) paper discusses the NP role from a critical social justice perspective and the authors argue that NPs must demonstrate practice that reaches beyond physician functions of illness care to mitigate health care inequities. They argue that increasing health inequities are the result of neoliberal political agendas that emphasize individual responsibility and self-reliance, and create neoliberal policies, such

as increased privatization, outsourcing of public services, public-private partnerships, and reduced social welfare and safety net benefits and cutbacks. The authors note that NPs are being marketed by political and professional leaders as a way to improve public access to high quality care at a cost saving to the system. This political-economic climate, which has created opportunities for NPs, also causes dilemmas for how NPs approach practice. There is pressure for the NP role to be a less expensive physician replacement, yet this conflicts with NP capacity to address health inequities and social justice. Browne and Talier recommend NPs emphasize greater social responsiveness and take up a political voice in social justice leadership. The NP inquiry reinforced Browne and Talier's argument about the social justice role of NPs. The inquiry revealed that NPs construct diverse and responsive roles to address underserved and marginalized communities, and their practice patterns emulate the PHC principles. The inquiry uncovered the importance of the NP role to steward the cause of PHC. I make the argument here that to steward PHC, NPs must extend the political nature of their role, develop collective strategic capacity, and become a strong voice in PHC renewal efforts.

Keith and Askin's (2008) paper examines the benefits of effective team collaboration and the role of NPs within teams. Collaboration is reported to optimize the NP role and improve PHC delivery. The authors note the complex and multifaceted nature of collaboration. Collaboration elements identified by Way et al (2000) are cited in the article, which include responsibility and accountability, coordination, communication, cooperation, assertiveness, autonomy, mutual respect and trust. However, the authors also discuss several other factors to affect NP collaborative practice, including government support, collaborative practice agreements, professional leadership, interprofessional

education, power relations between NPs and physicians, funding and liability issues, and lack of understanding about scopes of practice. Keith and Askin raise many issues that I identified and documented in the ecological framework on collaborative culture; however the Keith and Askin paper lacks a framework to show the interrelated complexity of collaboration. The NP inquiry brought to light that collaboration is foundational to NP practice and that NPs are champions of collaboration. The inquiry also revealed that collaboration is influenced by and cultivated through a broader context of health care culture. The ecological framework on collaborative culture goes beyond current literature to denote multidimensional influences on and dynamics of collaboration. I make the case here that NPs, as champions of collaboration, must exercise the political nature of their role to influence collaborative culture change in health care.

The NP role in PHC is decidedly political and I believe this aspect of the role has gone underestimated and undervalued. In education, NP curricula have not addressed this well enough to prepare NPs for their change agent responsibilities. In practice, NPs have not been mentored enough nor allotted the time to develop their strategic capacity. In professional and policy circles, NPs have not been offered the collaborative opportunities to participate and influence from the ground up the policy changes that are needed for them to fully enact their role. And in research, the political nature of the NP role has yet to be examined to the extent that we understand this important influence. NPs have an important role to play in providing holistic care, stewarding PHC, and championing collaboration, yet this is a tall order that needs to be adequately resourced and supported. NP integration and sustainability depends upon all stakeholders stepping up to collaborate in this important opportunity. The CNA 2020 vision could advance NP role

development by linking the NP role to political action. I follow this discussion by documenting specific contributions the NP inquiry study makes to the field of research.

Study Contributions to Understanding the Complexity of Collaboration

There is very little literature that discusses theoretical perspectives or underpinnings of interprofessional collaboration (IPC). A few authors have suggested related theories, but have only superficially discussed them (Barr, 2002; Clark, 2006; D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005). This NP study served to explicate the complexity of IPC. By carrying out a scoping review of the literature, I examined various system levels and identified health outcome targets associated with IPC. I also explored each of these levels of system, organization, team, practitioner, and client, and explicated specific elements that can be modified to improve IPC. I make the case that IPC entails envisioning a new way of delivering health services, and this involves all sectors and levels of the health system in the form of culture change. The ecological framework on collaborative culture, outlined in Chapter 4, makes an important contribution to the health care field, and especially to PHC, in which effective teamwork is an identified principle and essential feature. The framework illuminates the multi-level interplay of stakeholders to shape collaborative health care culture, and adds to Health Canada's knowledge of IECPCP (2004a).

Discussions of IPC with respect to complexity and transforming health culture are relatively new in the literature. Herbert (2005) raised the matter of health culture, and Oandasan (2008) discussed catalyzing an interprofessional culture shift at a recent international conference. The development of this collaborative culture framework is a hypothesis that begins to theorize the complexity and multifaceted nature of

collaboration. However, the framework needs to be further researched and the elements substantiated. Nonetheless, the framework serves to map parameters of IPC that can be very useful to policy and decision-makers, health care leaders and researchers, and teams and practitioners to assess the current status of collaboration and design relevant interventions and evaluative tools. Alignment of the multifaceted influences identified in this framework is intended to improve client care and outcomes, practitioner competency and satisfaction, team performance, healthy workplace, HHR issues of recruitment and retention, and ultimately advance collaborative health care culture. This study opens up the dialogue about these complexities, and makes it everyone's responsibility to engage in collaboration, and not simply that of practitioners and teams. The study provides a beginning understanding and direction for further research.

In reflecting on the meaning of "finding a balance", I realize I created this title and image of the "balance scales" to reflect the importance of re-balancing practitioner 'tasks and processes'. Health care wasn't just about 'doing to' but it was also about 'being with'. Yet, as my understanding of IPC evolved to become collaborative health care culture, "finding a balance" took on a new connotation. In this ecological picture, the alignment of sectors and stakeholders toward a common vision meant that as each sector shifted toward this collaborative frame, a balance in the system would be achieved.

Study Contributions to NP Role Development in PHC

Role development terminology

NP role integration was the particular focus of this study. I began this inquiry by first undertaking the challenge of making sense of varying terminology, as outlined in chapter 1. I described the term 'role development' as an umbrella term and differentiated

the terms of introduction, implementation, integration, and sustainability with respect to different health care contexts. Thus NP role introduction refers to the provincial mandate to introduce the role in BC, role implementation refers to health authority directives to establish the role within particular settings in the organization, role integration refers to NP role assimilation into programs and settings within health authorities, and role sustainability refers to the elements of system redesign to ensure the NP role flourishes over time. This clarification of terminology is a significant contribution, as the literature is quite confusing in the use of these terms. Research studies related to NP role development have not defined the various terms used, and thus there is inconsistent understanding of study results (Bryant-Lukosius & DiCenso, 2004; CNPI, 2006b; DiCenso & Matthews, 2005; MacDonald, et al., 2005). Further research is needed to more fully explicate terms to describe role development stages; as well, the terms used may need differing interpretations depending upon provincial contexts.

The Language of Autonomy, Consultation, and Collaboration

The language of autonomy, consultation, and collaboration was also clarified with respect to findings from the study, and was discussed in Chapter 5. Autonomy was constructed as the “what of care”, consultation was identified as the “why of care”, and collaboration was described as the “how of care”. In this sense, autonomy, as the “what of care”, conceptualized scope and practice within the power and control of NPs, as set out by regulatory standards. This meant NPs did not have to negotiate their autonomy with other professions. Consultation, as the “why of care”, was about managing care that was beyond scope, by drawing upon the expertise of other professions and resources, and this aligned with how physicians consulted. Collaboration, as the “how of care” was

inherent to how NPs practiced, and was particularly relevant to complex care in multifaceted clinical and social matters. Thus, professional autonomy was not seen to preclude collaboration, but to actually enhance collaborative practice. Clarification of autonomy as complementary to collaboration is an important contribution. For instance, NPs in BC benefit from legislation and regulation that provides for increased latitude in scope of practice, and this is meant to increase autonomy. A recent article by Keith and Askin (2008) emphasizes legislative and regulatory aspects in enabling NP autonomy, and collaboration was also noted to help clarify scopes and thus enhance autonomy. However, the NP inquiry takes this understanding further and notes the reciprocal effects of autonomy and collaboration.

NP Role Clarity Tied to PHC Principles

The NP inquiry also added to understanding about role clarity. In Chapter 6, I reported our collective learning about early practice patterns of NPs in two BC health authorities. The inquiry brought to light the NP commitment to advance a vision of PHC. NP practice patterns demonstrated the extent to which NPs designed their roles as diverse and flexible to reach out to marginalized and underserved populations, engage in relational practice with client and community partners, provide holistic care and a broad range of health service, strive for collaborative collegial relations, and practice strategically to shift and change PHC culture. By exploring NP practice patterns, the NP role gained clarity and was seen to be aligned with PHC principles of universal access and health equity, public participation, health promotion and population health, intersectoral collaboration, and appropriate technology (Calnan & Roger, 2002; CNA, 2000a, 2003b; Health Canada, 2006a; WHO, 1978; 2003). NPs developed their roles in

unique ways and in diverse settings so as to improve health access to marginalized and underserved populations, and this signified their commitment to a social justice agenda and improvement of social determinants of health. This finding is consistent with a recent paper by Browne and Tarlier (2008). NPs encouraged clients to be partners of care and clients meant both individuals and communities, thus NPs fostered public participation in PHC. Contributing to public participation seems to be a relatively new finding compared to the literature, although NP-client relations are addressed in a number of studies (Browne & Tarlier, 2008; Dontje et al., 2004; Gould et al., 2007; McWilliam et al., 2006). NP practice patterns illuminated their commitment to holistic care and this included health promotion, and prevention and harm reduction strategies that exemplify a PHC approach. This is consistent with study findings by Gould et al. (2007).

Collaborative practice was foundational to how NPs provided care, and this included drawing upon resources of other sectors and from community, as well as sharing their expertise with others to improve the quality of client-centred care. This is consistent with other NP research (Bailey et al., 2006; Jones & Way, 2004; Keith & Askin, 2008). In addition, NPs demonstrated their willingness to be agents of change and model and advocate for a different way of providing PHC, and in this way they exemplified themselves as a resource technology. Pogue (2007) similarly raised the catalyst transformational role of NPs. Despite these recent studies and papers that exemplify NP practice, role clarity continues to be reported in the literature as an issue, and this is particularly noted between physicians and NPs (Bailey, et al., 2006; Brown & Tarlier, 2008; Keith & Askin, 2008; Reeves, Nelson & Zwarenstein, 2008). The NP inquiry also found leaders, managers, policy-makers, and the public lacked understanding of the NP

role. The inquiry served to further clarify the multidimensional role of NPs, and revealed the significant contributions NPs are making to PHC renewal efforts.

The Meaning of Role Integration

Through the NP inquiry we also created a meaning for the concept of NP role integration. We identified five characteristics of role integration, including: NPs would have autonomy to fully enact their role, their role would have public recognition, their value-added contributions to PHC would be demonstrated and measured, their collaborative team relations and joint professional initiatives would help NPs become viewed as essential PHC team members, and as individuals and collectives NPs would secure strategic capacity and alliances to foster role sustainability. The first characteristic of role enactment meant that NPs would employ their autonomy and scope of practice to fully perform the competencies of their role, and these included clinical care, health promotion, illness and injury prevention, leadership, research, collaboration, and change agent work, as outlined by the CNA (2005b, 2008a) and the RNABC (2003). The second characteristic of role clarity meant that clients, communities, and colleagues would have a good understanding of the NP role and its holistic approach to care, and would thus utilize the role effectively. The third characteristic of value-added measures meant that evaluative tools and instruments would be developed through joint efforts, and used to explicate NP contributions and evidence of NP effectiveness, with respect to client and community care and advancement of PHC. The fourth characteristic of intra- and interprofessional collaboration meant NPs and their teams and networks, supported by organization leaders, would provide cohesive client-centred care. The fifth characteristic of strategic alliance meant that NPs would effectively partner with their local

communities in innovative endeavours to enhance population health, and also NPs as collectives would engage in political and policy strategies to further integrate and sustain their roles, and contribute to health care policy and improvements. These five characteristics created a frame of reference for the concept of role integration. The issue of role integration has been studied in Ontario by DiCenso and Matthews (2005), however, the term of integration was delineated by influences and barriers affecting role progress. This NP inquiry moves the agenda forward and provides further understanding about characteristics of role integration, which could be applied to evaluation designs as outcome markers, although further substantiation is likely required.

Collaboration and Role Integration

My aim in the NP inquiry was particularly to focus on the research question, “How does *collaboration* advance NP role integration?” I did this by applying the collaborative culture framework to NP discussions, and analyzed and interpreted NP stories with respect to spheres and elements of the framework. I affirmed that NP collaborative practice supported autonomy and diversity in their roles and this fostered role enactment. Stories of NP-client relations revealed that collaboration with clients helped to cultivate NP role clarity. Concern for needed value-added evidence translated into strengthening collaboration with research partners. Discussions of NP collaboration within their interprofessional teams and networks revealed their commitment to cohesive client-centred care. The inquiry brought to light the interactions and relations between NPs and organizational leaders and uncovered the importance of strategic alliances and effective infrastructure for role integration. I also examined NP discussions with respect to the need for system change in terms of role integration. The collaborative culture

framework served to explicate more fully the issues of role integration. This NP inquiry has particular relevance to BC, although findings and conclusions can also inform other provinces and jurisdictions. Leaders in BC were particularly attentive to the process of role introduction in applying lessons from other provinces, carrying out extensive consultation with stakeholders, and incorporating recommendations from provincial researchers (MacDonald et al., 2005; Schreiber et al., 2003). This was clearly a collaborative process. However, the implementation stage at the health authority level was less organized and was dependent upon champions to move the NP agenda along. The NP inquiry revealed difficulties with implementation, which are exacerbating problems with role integration. Collaborative efforts are needed, in which more systematic and organized approaches to implementation and integration are employed. The collaborative culture framework provides some guidance to these endeavours.

The community of inquiry revealed that NP integration is closely tied to the realization of a principle-based approach to PHC and relies on collaboration with all manner of stakeholders. The NP role, viewed as multidimensional, differentiates NPs from primary care physicians, and strengthens their collaborative relations with clients and community. NP stories referred to their multidimensional work of clinical and social care; client and community engagement; health promotion, prevention and harm reduction; program and community development; team and intersectoral collaboration; research and practice inquiry; professional accountability and leadership; and strategic agents of change.

With respect to NP role development and the title of “finding a balance”, the inquiry revealed NPs must balance multidimensional demands of the role, and integrate

the ‘art of nursing’ and the ‘science of nursing’, in order to align with clients and communities, and foster empowerment and holistic health. The inquiry also raised the issue that PPO leaders and health officials need to re-balance the demands put upon NPs and ensure the responsibilities expected of NPs have congruence with the resources and supports provided.

Communities of Practice

The model of communities of practice to facilitate and foster NP role development was highlighted in Chapter 5. The two NP inquiry groups discussed their experiences of being employed by a health authority and the respective use of communities of practice in role implementation and integration. As well, in each of the groups we interviewed health authority PPO leaders responsible for NP role development. The data provided rich information about the similarities and differences of the two health authority experiences and approaches, and thus a comparative analysis was undertaken to explicate the qualities and features of communities of practice. We came to see that cultivating communities of practice was a valuable strategy to advance the NP role, because the model provided a collective forum for NPs to address the internal interests and needs of the members, and also the external concerns of the organization. Communities of practice facilitated relationship-building between practitioners and organizational leaders, and provided a forum to explore tensions of NP role development, share varying perspectives, plan and secure evidence, and strategize about the future. Thus, communities of practice served varied purposes, including practitioner education and knowledge exchange, practice issues and problem solving, research inquiry and discovery of new knowledge, and strategic policy discussions and planning. We found in

the study that communities of practice required up-front time and effort to mature internally, and this was a prerequisite to addressing external interests and concerns of the organization. We also heard that support and mentorship from organizational leaders would serve to accelerate strategic capacity of the NP collectives.

These findings are for the most part congruent with the limited literature on communities of practice that highlight purposes of professional learning and knowledge exchange, practice improvements, and inquiry and innovations (Wenger 1998; Wenger et al., 2002). However, the purpose of strategic policy leadership and planning is not well documented and the NP inquiry emphasized the value of communities of practice for facilitating collaborative leadership in managing the changing face of health care. The NP inquiry contributes to health care knowledge by highlighting the value of communities of practice for not only practice, education, and research purposes, but also strategic endeavours of the organization. With respect to the title “finding a balance”, the dual interests and agendas of practitioners and policy leaders were noted to be equally important to successfully cultivate and sustain communities of practice. A collaborative model for communities of practice was proposed that will foster this balance of dual agendas; features identified included structured collective identity, a relational approach to knowledge exchange, valuing of knowledge development, and power-sharing between practitioners and policy leaders.

Recommendations Derived from the NP Inquiry

A number of tensions were revealed by the inquiry, which provides some direction for stakeholders to improve NP role development. The following recommendations are directed at certain levels of the health system and provide

suggestions to advance NP role integration and sustainability. These recommendations are not written in order of significance, because all are considered to be important:

For System Officials and Policy Leaders

- Translate and make clear the legislative and regulatory intent with respect to NP autonomy, so that this can be reinforced with and by NP leaders and managers
- Fund infrastructure mechanisms for NPs, including space and equipment, mentoring and continuing education, electronic communications, and measurement tools
- Sustain incremental funding of NP positions to ensure role expansion
- Implement provincial public education campaign about the NP role to foster effective utilization by clients, communities, and other practitioners
- Modify NP education programs to ensure NPs are prepared in all aspects of their multidimensional role
- Re-visit the CRNBC NP competency framework to ensure the multidimensional role of NPs is fully recognized
- Continue to modify scope of practice standards based on NP feedback to reflect realities of everyday work
- Promote research partnerships that design studies to assess and advise on role development progress
- Support the development of the BC Nurse Practitioner Association and provide for avenues in which the Association can partner with policy and decision-makers

For Health Authority Leaders and Site Managers

- Endorse NP autonomy to fully enact their role and scope of practice appropriate to the particular setting and population
- Mentor NPs in developing strategic capacity, and partner in the development of communities of practice for NPs and for PHC teams
- Establish clarity about the NP role and articulate the NP role as PHC focused, before translating into other health care services, such as ambulatory, rehabilitation, and acute care
- Encourage the diversity of NP roles to meet the needs of clients and communities, and continue to utilize the NP role for developing various PHC models

- Endorse NP practice as different from physician services, and foster the multidimensional aspects of the role
- Attend to and address power relations and tensions within the organization, especially between NPs and physicians and within teams
- Prepare sites and ensure adequate infrastructure is in place prior to commencement of new NP roles
- Encourage program and site leaders to foster and mediate team dynamics
- Facilitate and resource interprofessional team-building strategies
- Implement and adjust electronic health records for relevance to NP and interprofessional team practice
- Provide replacement costs for NPs for vacation and leave

For NPs and Communities of Practice

- Articulate the NP role and professional autonomy to health leaders, colleagues, clients and community partners
- Practice from a sound nursing foundation and strengthen partnerships with nursing colleagues and the profession
- Align NP practice with PHC principles and continue to advance the PHC renewal agenda
- Highlight client and community partnerships and strengthen collaborative relations with a range of partners
- Commit to develop collaborative models of communities of practice to advance the NP collective and to foster teams and networks
- Commit to and participate in research and practice inquiry for development of NP evidence and value-added practice contributions to PHC
- Commit to development of the BCNPA as a strategic provincial NP body
- Develop strategic capacity and individually participate in local strategic opportunities, and as an NP collective engage in strategic policy leadership

Study Contributions to Graduate Research: First-, Second-, Third-Person

The first-person action research stage of my study was initiated early in graduate work, when I began to explore PAR as a methodological approach for my dissertation work. I adapted Reason and Torbert's (2001) first-, second-, third-person action framework to write a first-person self-inquiry and conceptualize a process for PAR. I was fortunate to publish this self-inquiry in the *Action Research Journal*, which gave me confidence that I could apply this adapted framework to an actual PAR study and write up a different kind of dissertation. I subsequently re-wrote this publication into Chapter 2 of my dissertation, and related it to *community of scholarship*. As I explored research perspectives of ontology, axiology, and epistemology, I made my assumptions and values transparent and located myself as both an outsider and insider of a PAR study involving NPs. First-person action research helped me to reframe my perspectives of practice and situate myself into the world of scholarship, in which I developed knowledge in my interest areas of IPC and collaborative culture, and NP role development in PHC.

The second-person stage of my study took place as I prepared for a PAR inquiry and formed linkages with academic and practice experts, and made connections with the NP community. As part of preparing for an inquiry, I established my credibility as a researcher and interpreted the significance of the study to health leaders and participants. Planning the PAR inquiry entailed considerable negotiation, particularly as organizational endorsement was required for NP participation. I was surprised at how much time and effort this 'entering into process' took, and acknowledged this as second-person action research in Chapter 3, and related it to *community of practice*. Second-person action research enabled me to situate within a community of practice, ground my contextual

knowledge, and prepare a well laid out plan to engage participants in a research inquiry.

This stage of the inquiry expanded on Herr and Anderson's (2005) discussion of the dissertation process in their guide for students and faculty.

The third-person action research stage of my study involved the actual *community of inquiry*, in which NPs from two health authorities participated in concurrent but separate inquiry groups over a six month period. This stage involved organizing the logistics of setting consecutive meetings, being sensitive to the time and travel demands of participants, and preparing for each meeting with progressive questions that created breadth and depth to the inquiry, and kept the inquiry focused on the overall research question and intent of the study. In the informative stage of the inquiry we focused on questions and data collected from group discussions about NP practice patterns, collaborative practice, and the meaning of NP integration. In the transformative stage of the inquiry, meetings were organized between NP inquiry groups and their respective PPO leaders, and each NP inquiry group also held a research action day, in which we designed a template for NPs to assess and improve the quality of their own practices. Data analysis involved a constant comparative approach of emerging data, and preliminary analysis was returned to the NPs at the next meeting. I identified certain validity criteria to judge the quality of the inquiry, which included the relational and participatory dynamics of the inquiry groups, knowledge development and educative outcomes, the significance of emergent actions taken up by the NP inquiry groups, and the potential enduring consequences of the inquiry for a larger community (Bradbury & Reason, 2003; Reason, 2006). By using these criteria, I evaluated the quality of the study, and reported on this in Chapter 7. Third-person action research fostered our collective

reflexivity, where we talked, listened, observed, participated, reflected, conceptualized, re-conceptualized, and acted so as to advance social relations, enhance education and knowledge, and improve NP conditions of practice and policies, always with the best interests of clients and communities in mind. This stage also involved preparing a dissertation that was shared with NPs to verify findings and discuss next steps for dissemination.

There is little written in the literature from the student perspective (Burgess, 2006; Gibbon, 2002; Heen 2005). A few authors address the importance of transforming university teaching and research cultures to enable students to employ PAR approaches (Hall, 2001; Levin & Greenwood, 2001; Reason & Marshall, 2001). Herr and Anderson (2005) address some of the pragmatics of student research, but I think there is much more to be shared. The first-, second-, third-person action framework, which I adapted and outlined from my perspective, provides a useful example and guide for other students. I received reinforcing feedback from students from around the world (China, India, the US and Canada), soon after my first-person publication. My hope is to publish the second and third instalments of my process on completion of my dissertation. In reflecting on the meaning of “finding a balance”, I employed a PAR approach, which enabled me to balance my interests of academic scholarship and research, yet stay grounded in my roots of community. PAR allowed me to bridge the university – community divide. My story of PAR discusses the strengths and challenges of PAR, yet creates confidence for students to engage in their local settings and make a difference to broader contexts. First-, second, third-person action research framework adapted for student use makes real the possibilities of doing PAR, and thus makes a significant contribution to the academy.

Reflections about the Enduring Consequences of the Inquiry

The next step in the community of inquiry is to discuss the dissertation chapters with the NP participants and determine dissemination strategies. I expect dissemination strategies to include the release of the dissertation report, re-writing of certain chapters or parts of the study with NP participants for publication, and presenting findings to conferences and key leaders. I have already developed a poster that outlines the full PAR study and presented this at two conferences (see Appendix H). However, it would be useful to profile specific parts of the study in poster form and do this in a collective process. I also envision that certain aspects of the study will be used, including application of the collaborative culture framework for practice and research, adopting the collaborative communities of practice model, employing the meaning of role integration in future NP research, and using specific findings from the NP inquiry to inform current and future role development. I am excited about the next steps; it is time to resurface from the analysis and writing stage and initiate new collective actions. The iterative and reflexive nature of PAR means that we have more opportunities yet to explore and many potential actions to engage in for continued collective learning and sharing. The post-doctorate study that I am about to embark upon provides further research opportunity for NPs to participate in, so that we can translate the collaborative culture framework into psychometric measurement tools and apply to NP practice and PHC settings, thereby continuing the research - community partnership.

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Appendix A: PAR Publication

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ARTICLE

Participatory action research

First-person perspectives of a graduate student

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ABSTRACT

This article examines the tensions and challenges of a graduate student maneuvering the institutional hierarchies in her journey of participatory action research (PAR). By using a first-person action research framework, the researcher moves back and forth exploring the prose of others, and revealing her reflexive self-inquiry of underlying assumptions and beliefs. Iterations of insider-outsider positionality, drawing on and integrating paradigms, reconciling multiple roles and perspectives, exploring the complexity of power relations, and uncovering the promises and perils of PAR, moves the researcher toward a partnership with her community of inquiry. First-person action research unfolds a process of self-transformation.

KEY WORDS

- first-person action research
- graduate student self-inquiry
- participatory action research

As a doctoral student with a deep sense of knowing in my commitment to participatory action research, my rebellious determination rises with each disdainful comment or question: PAR is too long and involved for a student. Focus on your question and methodology will follow. What does PAR really teach a student about research methods? How will you defend issues of validity and credibility at a doctoral level?

Participatory action research (PAR) is gaining acceptability in many university circles (Bryant-Lukosius & DiCenso, 2004; Hall, 2001; Kelly, 2005; Nelson, Poland, Murray & Maticka-Tyndale, 2004). Yet from a graduate student perspective, there are tensions and challenges to reconcile. As I return to the academy for advanced learning, I recognize these tensions as disjuncture and therefore important to explore and understand.

The first tension emerges as role hierarchy. As a nurse knowledgeable in the community with its many and varied ways, my visionary leadership contributed to the possibilities of community health care. Yet, I return to school as a student scholar. This shifting between the worlds of community leader and novice scholarship, and maneuvering between hierarchies of health and now academia, confronts my sense of identity and confidence. Matters of who am I, where am I going, and how to hold on to my community roots are ever present.

The second challenge soon surfaces with my commitment to PAR. Graduate program protocol have requirements and limitations (Gibbon, 2002; Levin & Greenwood, 2001; Stoecker, 2003). As a student researcher, I must develop research competencies, identify a research query, design a proposal, and gain university ethics approval, prior to actively engaging in partnership with a community of interest (Gibbon, 2002; Nelson et al., 2004; Reason & Bradbury, 2001). Yet, contrary to participatory action principles, by taking control of the research process, I jeopardize the defining partnership of PAR.

The notion of 'first, second, and third person' action research presents an appealing framework to address these challenges (Torbert, 2001). As a doctoral student at the University of Victoria, I am using first-person action research to engage early in my learning journey, before formalizing a research plan. First-person action research constructs an iterative process, where I can address the student tensions of role hierarchy and transition, and the contradictions of community engagement. By drawing on the PAR literature to inform my reflections of knowledge and experience, examine roles I have and will take, gain awareness of the principles, promises, and perils of PAR, and reveal my underlying assumptions and beliefs, I am able to mitigate or advance these parts of me for the cooperative inquiry process. This article will highlight reflexivity with PAR literature and self-reflections, in order to embrace these tensions of personal transformation and community partnership.

Participatory action research as a worldview

Discourse in research terminology is a beginning place for graduate students. Reason and Bradbury's (2001) working definition for action research is 'a participatory, democratic practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview' (p. 1). In documenting progression of this philosophy, credit is first given to Lewin in the 1940s for coining the term 'action research' to link the cycles of theory, practice, and problem-solving (Greenwood & Levin, 1998; McTaggart, 1997; Minkler & Wallerstein, 2003; Reason & Bradbury, 2001). Freire (1970, revised 1993), eminent for advancing critical consciousness (conscientization) and social action (praxis), shared the collective power gained by oppressed Latin American communities. Hall is recognized for describing PAR 'as an integrated activity that combines social investigation, educational work and action' (1981, p. 7), 'designed to support those with less power in their organization or community settings' (2001, p. 171). Through international and Third World work, he highlights the value of social movements to educate and effect social action. Tandon (1988) noted the rhetoric of community 'involvement with risk of co-optation', and compared this to 'authentic participation', where communities control the research process. McTaggart (1997) used the full-term 'participatory action research' to emphasize both authentic participation and relevancy of actions. Still other variations exist, such as cooperative inquiry, emancipatory action research, appreciative inquiry, feminist participatory research, and community-based participatory research (Heron, 1996; Kemmis, 2001; Ludema, Cooperrider & Barrett, 2001; Maguire, 1987; Minkler & Wallerstein, 2003).

Wallerstein and Duran (2003) delineate two historic traditions, a northern tradition that accounts for systemic improvements, and a southern tradition of emancipatory developments. Habermas (1987) is credited for calling emancipatory practice, the 'life world' (Kemmis, 2001; Wallerstein & Duran, 2003), where sharing power with poor and oppressed people gives voice to their decision-making and control to regenerate citizenship (Burgess, 1995; McKnight, 1987). Alternatively, the northern tradition, as Habermas terms the 'systems-world', consists of structures, economics, and politics. Whitehead, Taket and Smith (2003) make a case for PAR in health promotion and organizational change, and cite innovation, practitioner learning, and user participation as elements of transformative practice. Bryant-Lukosius and DiCesno (2004) outline a participatory framework (PEPPA) to develop, implement, and evaluate advanced practice nursing. The northern tradition of PAR is also evident in public health, heart health, osteoporosis, street youth, and other health areas (Israel et al., 2003; Naylor, Wharf-Higgins, Blair, Green & O'Connor, 2002; Whitehead, Keast, Montgomery & Hayman, 2004; Whitmore & McKee, 2001); and in disciplines with social workers, midwives, nursing, child welfare, and holistic medical prac-

tioners (Baldwin, 2001; Barrett, 2001; Hills, 2001; Lawson, Anderson-Butcher, Petersen & Barkdull, 2003; Reason, 1988, 1991).

Self-reflection: making sense of my worldview of PAR

Reading the literature has led me to choose the term 'participatory action research' to describe my worldview. Like McTaggart (1997), I see importance in emphasizing 'real' participation and 'worthy' action. Hall's (1981) definition combining social investigation, educational work, and action is salient to my inquiry. My research is a social investigation with primary health care nurse practitioners and their respective teams engaging in interprofessional collaboration. Working collectively to uncover and advance knowledge and practice is an educational process. Using this knowledge within a team context to create innovation, and transformation is collective action. However, I have been troubled with the 'systems think' of my research interest and its relevance to PAR.

From my experience in community health, I came to know the southern tradition of PAR. Learning of critical consciousness, emancipation, and social justice is the basis for my understanding of transformative community work, and my past nurse-client relational practice. As my community health work evolved, I became passionate in envisioning and demonstrating the local possibilities for health promotion and primary health care. Within this health context, I was challenged to rethink the individual lifestyle approach to health, and instead create capacity in community to transform social policies and organizational structures, and thereby improve such health determinants as early childhood and education, food security, employment and working conditions, health care services, housing, income and its distribution, and a social safety net (Nelson et al., 2004; Public Health Agency of Canada, 2002; Raphael, 2003; World Health Organization, 2003). Located now in academia, PAR seems integral to my soul. Yet, I have worried that my interest in systems improvement distorts the emancipatory intentions of PAR. Learning about north-south traditions reframes my view, and enables me to make sense of system reforms and health service research, as part of a northern tradition and applicable to a worldview of PAR. With this renewed insight, my commitment to PAR remains sound.

First-, second-, third-person research

Participatory action research falls under the rubric of a philosophy or approach to research. Reason and Bradbury (2001) have named this approach and its practices as an 'action research family' (p. xxiv). In recognition of diversity within this lineage, Reason and Torbert (2001) formulated a three-person framework. These

three separate, yet integrated pathways are described as first-, second-, and third-person action research. First-person action research fosters self-inquiry and increasing awareness of the researcher's own everyday life as the process unfolds. Second-person action research focuses on interpersonal encounters, and the researcher's ability to collaborate with others in their community of inquiry. Third-person research activities extend the inquiry within a wider community with intent to transform the politics of the issue.

In exploring transformational change of institutional systems, Bradbury and Reason (2001) differentiated first-person practice as 'work for oneself', second-person as 'work for partners', and third-person as 'work for people in the wider context' (p. 449). Torbert (2001) explains action inquiry begins in the personal with 'meditative inner work' (p. 252), which enhances second-person relational practice, in being truthful and congruent of intended meaning and dialogue with others; these self-study and interpersonal skills reinforce qualities of third-person leadership, necessary for creating organizational conditions of transformation. Heen (2005) interprets first-person action research as a focus on the single person, second-person for people coming together in cooperative inquiry, and third-person extended to larger collectives or community. Kemmis (2001) speaks of opening 'communicative space' for progressive mutual understanding, authentic engagement, and consensus on and about action (p. 100).

This discussion is not intended to describe first-, second- and third-person action research as a linear experience. All parts of the unfolding inquiry process have iterative cycles of self-learning, reflection, and action (Heen, 2005; Koch, Mann, Kralik & van Loon, 2005; Levin & Greenwood, 2001). Nonetheless, the novice researcher has permission, if not expectation, to begin with self-discovery, in order to locate themselves in their inquiry (Reason & Marshall, 2001; Rowan, 2001). Marshall and Mead (2005), in a special journal issue devoted to first-person action research, summarize first-person qualities as: 'living in the inquiry, practicing new behaviors, reflecting-in-action, conceptualizing new learning about one's identity, staying present to a range of emotional responses, and cultivating a quality of critical humility' (p. 241). For a graduate student embarking on PAR, first-person research offers a practical approach for stepping lightly into research through self-inquiry, second-person research is a means for contextualizing a relationship with a community of interest, and third-person research is the unfolding reality of researcher and community becoming both the data and data collectors in a combined reflexive journey to make sense of and transform that which is not.

Self-reflection: first-person action research explicates my role as insider

A self-inquiry begins with my own look, think, and action cycles, where I bring forward my knowledge and practice experience for new learning and discovery, and explore being both an insider and outsider in my community inquiry (Koch et al., 2005). Being authentic about who I am and what I bring to the research is a measure of research validity (Heen, 2005; Heron & Reason, 2001; Schein, 2001; Whitehead et al., 2003). My profession is nursing, and my interests lay within health care design, in particular, how practitioners collaborate and how communities participate in collaboration. In order to qualify for graduate scholarship, it was necessary that I develop a research query early in my program; only to worry I had breached a central principle of PAR, which is, begin with real-life issues that originate in and are identified by the community of interest (Greenwood & Levin, 1998; Hall, 2001; Reason & Bradbury, 2001). Yet, my query is not without insider significance.

As director of a community health care centre for many years, I came to appreciate the possibilities and challenges of local health care design, the capacities and barriers of practitioners in collaboration, and the burden of illness relieved by the power of participation. However, I now live in the academic world, where I am reinventing myself from community leader to academic scholar. I am learning to see the world beyond local experience, opening up to broader perspectives, and finding new ways to take up leadership. In this role transition, I am confronted with the distinction of insider-outsider (Minkler, 2004). My query begins with nurse practitioners (NPs), who have a newly constituted health role, along with implementation of legislation, regulation, and education. Yet, as an advanced practice nurse, I stand outside their clinical entitlement. Nonetheless, I have knowledge of nursing leadership and know what it means to be influential (Gibbon, 2002). I have experience of interprofessional collaboration, teamwork, and sharing power with others, including community. Heron (1996) speaks of a 'deep kind of participative knowing', where the researcher is grounded in their experience as co-subject (p. 21). As a co-learner and co-researcher within this health care context, drawing on my experience assures me that I am both an insider to this nursing perspective and to this inquiry.

My research question, congruent with PAR and important to my profession, begins by asking what matters to NPs in this team setting of primary health care and how can they contribute to the advancement of interprofessional collaboration. As an insider with knowledge and experience, I appreciate the value of interprofessional collaboration to practitioner satisfaction and improved outcomes for clients. My insider assumptions about NP readiness to engage in team actions and strategies have significance, and I can therefore look ahead to

the possibilities within the research process. Minkler and Hancock (2003) outline core PAR principles: 'start where the people are' (p. 136), 'begin with community strengths and assets, rather than problems' (p. 137), and accent 'authentic dialogue' (p. 138). Fitting with these principles, my inquiry validates the capacity of NPs and their teams to transform practice, and thereby include and improve the client experience of health (Bryant-Lukosius & DiCenso, 2004).

PAR draws on and integrates worldviews

As research history has evolved from a modern to post-modern to participatory worldview, there has become a blending of that which is useful and a distancing from the irrelevant (Park, 2001; Rowan, 2001). Reason and Bradbury (2001) discuss the basis for modernism as a 'quest for certainty', in response to historical challenges of war and devastation. Certainty became truth and truth became objectivity. This positivist, western-known, paradigm is criticized for separating the subjective of everyday life from the object of study, and the objective knowledge produced (Maguire, 1987). Positivism, taken up by science and medicine with a purpose of alleviating suffering, has excluded the everyday experience of suffering (Kemmis, 2001). As an empirical-analytic approach, researchers separate mind, body, spirit, and reality in the objective world of the individual, and split again from community and the wider natural world (Reason, 1998). Fals Borda (2001) notes 'we [action researchers] started to appreciate in fact that science is socially constructed, therefore that it is subject to reinterpretation, revision and enrichment' (p. 28). Mediating discourse of subject-object, knowledge-power, and research validity of the personal, emerged as a post-modern perspective (Gaventa & Cornwall, 2001; Gustavsen, 2001; Kemmis, 2001; Maguire, 1987).

Social science explored a new paradigm of qualitative and humanistic experience. Power imbalances of individualistic society, race and culture, gender relations, knowledge ownership, and hierarchical structures were revealed (Bell, 2001; Lincoln, 2001b; Maguire, 1987). A consciousness transpired of multiple and socially constructed realities in a changing world (Avramidis & Smith, 1999; Reason, 1998). Feminism, perceived as a universal ontology, yet with differing perspectives in ways of knowing and ways of being, illustrates the multiplicity in feminist epistemology (Maguire, 1987, 2001; Treleaven, 2001; Wallerstein & Duran, 2003). Foucault's work on power and knowledge, as inextricably bound, contributed to an era of post-structuralism (1982). Repressive power was translated to productive and relational, where knowledge as power strengthens resistance, empowerment, and enabling action (Chavez, Duran, Baker, Avila, & Wallerstein, 2003; Gaventa & Cornwall, 2001; Pasmore, 2001). Yet, the interpretive constructionist paradigm was seen to maintain researcher distance from

the object of study (Bradbury, 2001). 'After all, much which goes under the label of qualitative research is just old empiricist research without numbers' (Rowan, 2001, p. 121). Maguire (1987) notes in her story telling approach of giving voice to women that 'research is not a neutral tool for the creation of supposedly "apolitical" knowledge' (p. 24). Growing awareness of researcher complicity in design and control of politics, process, and outcomes was instrumental to an emergent participatory worldview (Fals Borda, 2001; Lincoln, 2001b; Lincoln & Guba, 2000; Marshall, 2001). The aim of PAR is to 'connect the personal to the political' (Park, 2001, p. 92; Nelson et al., 2004, p. 394).

While the participatory worldview competes with both modernism and post-modernism, it also 'draws on and integrates both paradigms' (Reason & Bradbury, 2001, p. 7). In acknowledging the 'real' reality of natural sciences, PAR is able to utilize the benefits of positivist knowledge, framed within a human context (Greenwood & Levin, 1998). From a qualitative and critical social paradigm, 'communicative action' of social, gender, political, and cultural influences, in the construction of reality, are advanced from 'what is' to what is possible' (Kemmis, 2001; Park, 2001). PAR is described as a *vivencia* necessary for the achievement of progress and democracy; a complex of attitudes and values that would give meaning to our praxis in the field' (Fals Borda, 2001, p. 31). As an ontological philosophy of life, PAR is also seen as an epistemological approach to constructing useful knowledge, and as a research methodology for collective consciousness and participative action (Heron, 1996; Reason & Bradbury, 2001; Schwandt, 2001).

Self-reflection: PAR integrates my many perspectives

My formative years were highly influenced by my biologist father and many visits to the university lab, where I examined cats and rats splayed out on tables poked with multiple colored pins. I became a nurse, contemplated the life of a doctor, and went back to school to obtain a science degree. I became the dissector in the lab. However, there were other parts of my young years that gave me multiple perspectives, such as students of other race and country that came home to dinner, my mother a war-bride, the family struggles of many children to feed and care for, and of course, the social movements of feminism and student activism.

As a nurse, I was drawn to both the technical aspects of nursing, like ER and OR, and the human aspects of my profession, such as maternity and mental health. Leslie and McAllister (2002) speak of 'nursedness', a unique character and ability of nurses to be empathic, trusted, and practical. Community health nursing won over my passion because of its complexity and challenges. Community health work is messy and I am an organized kind of person; multi-

plicity is inherent in its diversity and I am a logical kind of thinker; it calls for participation and I like to be in control of my destiny. These dichotomies stretch me, challenge me to be innovative, and have kept me open to life-long learning and change.

PAR takes me to an inspiring place, where I strive to create a community of inquiry, apply my creativity, and be futuristic. I long ago reconciled the duality of subjective/objective in master's program debates of qualitative and positivist doctrines, and I am ready to move beyond an ethnographic approach to research. I appreciate the integration of paradigms offered by PAR, the opening up of possibilities for graduate learning, and the giving back to community that PAR promises me (Bradbury, 2001). It seems a good fit for the discipline of nursing, and appropriate for nurse practitioners whose practice straddles biomedical and humanistic knowledge of health (Brant-Lukosius & DiCenso, 2004; Kelly, 2005; White, Suchowierska & Campbell, 2004). PAR suits my topic of interprofessional collaboration, where disciplines with varying knowledge and worldviews come together to reconcile power relations, sharing perspectives, and making sense of the team dynamics; and these congruences reinforces my commitment once again (Munoz & Jeris, 2005; Nelson et al., 2004).

Dimensions of knowing and participation: reflexivity and validity

Participatory action researchers describe forms of knowledge and participation necessary to broaden existing epistemology. Park (2001) introduced a framework of representational, relational, and reflexive knowledge. Representational knowledge is both functional in correlating variables, and interpretative in making meaning of these connections. Relational knowledge captures the understanding we have for each other as human beings. Reflective knowledge connects the social nature of human life to the problematic, with critical analysis of moral and values based actions. These multidimensional forms of knowing are interdependent and reflexive in linking theory and practice in the creation of knowledge (Gaventa & Cornwall, 2001; Schwandt, 2001). Finlay (2002) defines reflexivity as 'thoughtful, conscious self-awareness' (p. 532) in constructing interpretations and 'moving back and forth in a dialectic between experience and awareness' (p. 533). In PAR, a reflexive dialogue occurs amongst participants, where they examine their motivations, assumptions, various roles, tensions and power imbalances, to create a congruence and credibility in what and how is researched (Naylor et al., 2002; Rowan, 2001). The researcher's practice of self-reflexivity, with attention to their own everyday life, is key to being present in dialogue with others (Reason, 1988; Treleaven, 2001).

Reason (1998) extends dimensions of participation as political, epistemo-

logical, ecological, and spiritual imperatives. From a political perspective, participation addresses human rights and flourishing. Epistemology, inextricably linked to participation, views the world as not separate, but instead, as 'relationships, which we co-author' (p. 7). An ecological dimension affirms human persons as part of the natural world and universe. A spiritual imperative of participation ensures human inquiry is about healing and holism. Participatory action researchers take into account the wholeness of the inquiry and through reflexive looking, learning, and action co-generate meaningful practical knowledge (Greenwood & Levin, 1998).

Concerned with the practical and the applied, PAR is a process of choosing and framing an issue, creating relational experiences, effecting changes in practice, and actualizing the significance of that 'truly worthy of human aspiration' (Reason & Bradbury, 2001, p. 12). Cooperative inquiry, a form of participatory research, applies repeated cycles of reflection as co-researchers, and action as co-subjects. Understanding is deepened and validated by the group's authentic collaboration and balancing of consensus, collusion, tensions and distress (Heron & Reason, 2001; Reason, 1999). Through a collective process, validity procedures are designed to assess group performance in solving problems (Levin & Greenwood, 2001; Reason, 1988; Whitehead et al., 2003). Lincoln (2001a) describes validity as 'mindfulness of self and others', a practical nature to the research, and a commitment to action (p. 48). Reason and Bradbury (2001) discuss quality of action research as choice-points: being explicit of relational participation, cultivating critical consciousness, guided by reflexivity and pragmatic outcomes, inclusive of multidimensional knowing, having significance to human flourishing, and contributing to new enduring infrastructure.

Self-reflection: first-person reflexivity reconciles multiple roles and knowing

Located now in academia, first-person reflexivity helps me to explore the everyday transitions of multiple roles and transformation that comes with learning. As a doctoral student in the role of learner with other students who see the world from varying perspectives, I am both a health leader in bringing forward knowledge and practice, and a novice with much learning to assimilate. As an educator, I share knowledge with my students about empowerment, being with clients, social inequities of poverty, and an understanding of health as holistic. As an advanced practice nurse, I gain a broader sense of my nursing profession and strengthen my disciplinary relations. As a researcher, I develop new associations, craft innovative partnerships, and reconstruct my network with NPs in their primary health care context. I encounter the inklings of being a scholar, when my previous experience, access to new knowledge, and renewed status influence the

academic world and organizational leaders. These roles of student, leader, educator, nurse, researcher, and scholar integrate with my personal life of being mother, wife, friend, and citizen (Gibbon, 2002; Rowan, 2001). Each part I play necessitates clarity, which in turn raises my critical consciousness and makes congruent my wholeness (Heen, 2005). Reflexivity helps to separate and integrate these parts of me, and ensure congruence in my research process. In so doing, first person cycles of reflection and action validate the 'stepping into' of graduate level research (Munoz & Jeris, 2005; Reason & Marshall, 2001).

I appreciate the privilege of knowledge and power in the academy, and at the same time experience power relations, hierarchies, and rules and regulations of the university. Yet, I feel safe as a student in the university setting, where I have a certain status, support, and flexibility. I am more anxious in my role as advanced practice nurse without a health care setting, and researcher without a sanctioned research project. Excited by moments of synchronicity in my new academic life, I gain confidence that my path is right and my efforts are worthwhile (Marshall, 2001). Making sense of feelings and emotions, such as these, are indicators of my critical subjectivity and self-awareness (Heen, 2005; Nolan, 2005).

However, the social relations and organizational structures of power and politics still loom large in my praxis of transformational learning and change. As I explore my profession of nursing, the complexities of interprofessional collaboration, and the context of primary health care, endorsement and support is needed from the university, the health care organization, and nursing leaders. My challenge in the early research stage is to resituate myself in this health context, in a new role of scholar, and trust my knowledge and experience will be welcomed by my community partners. There are many unknowns and hurdles yet to overcome. First-person inquiry assists me in revealing next steps of this grand, yet improvised plan, as I explore my assumptions and discover the principles, promises, and perils of PAR (Gibbon, 2002).

Uncovering PAR principles, promises, and perils and processes

PAR is a collective dynamic process that encourages a high degree of participation, where community members become co-learners, co-researchers, and co-activists of a common concern. Challenges begin early in determining who is the community or actual participants of the research (White et al., 2004). Partnerships may include representatives of health organizations, academia, practitioners, and community members (Israel et al., 2003; Mitton & Patten, 2004; Sullivan, Chao, Allen, Kone, Pierre-Louis & Krieger, 2003). The researcher models self-study and mentors participants in reflective learning and critical sub-

jectivity (Koch et al., 2005; McTaggart, 1997). Group members gain facilitation skills, meaningful roles, and make it their own (Heron & Reason, 2001; Koch et al., 2005; Sullivan et al., 2003; Wadsworth, 2001). As real-life issues emerge and are defined through collective engagement, participants articulate agreement to discover and create knowledge for practical human flourishing (Israel et al., 2003; Reason & Bradbury, 2001). Friedman (2001) refers to 'building theories in practice' by identifying practice puzzles and making sense of them (p. 161). Positive questioning, as illustrated in appreciative inquiry, encourages participants to gain hope, excitement, and ownership of their future (Ludema et al., 2001).

A common identity develops with recognition of each other's knowing and expertise. Yet group members have varying degrees of expertise and experiences of power. As diversity is explored, the group shares the personal and practical, gaining group confidence for shared decision-making (Lawson et al., 2003). Disclosure creates a sense of trust, cooperation, and mutual obligation. Issues of time and commitment arise to threaten decision-making and group sense of equality (Whitmore & McKee, 2001). Differences in worldview, multiple perspectives, differing goals, and changing agendas strengthen and jeopardize solidarity, yet at the same time, enrich construction of new meanings (Friedman, 2001; Levin & Greenwood, 2001; Munoz & Jeris, 2005). 'Conscious and unconscious, discussable and undiscussable' surface and interconnect for deeper meaning (Wadsworth, 2001, p. 425). Questions of control emerge and are resolved through dialogue, listening, and learning (Lincoln & Guba, 2000; Martin, 2001). Differences poorly negotiated run the risk of the research agenda superseding the community perspective (Wallerstein & Duran, 2003). Relationship-building and attention to a democratic process, as equal to, or more important than the outcomes, consolidates group dynamics (Gustavsen, 2001; Sullivan et al., 2003). Ideally, the researcher comes to share the same goals and values taken up by group participants (Lincoln, 2001a). Common language and understanding reinforces collaboration and contributes to group empowerment, mutual decision-making, and power sharing (Friedman, 2001; Israel et al., 2003).

Design planning accommodates diverse research methodology and draws on quantitative and qualitative methods (Reason & Bradbury, 2001). This versatility may cause undue complexity and unwieldy group process. Starting small and using iterative cycles of action and reflection, aids the unfolding research process, and balances agendas of knowledge creation and transformation (Heron & Reason, 2001). Participants record changes in their progress of activities, practices, relationships, and expertise (McTaggart, 1997). Again, the limitless boundaries of the inquiry may cause group chaos and time demands (Lawson et al., 2003; Reason, 1988, 1999; Whitehead et al., 2003). Long-term commitment, often difficult for participants and student researchers, is overcome by the value participants place on the research (Minkler & Hancock, 2003). Collaboration in all aspects of the research process validates a more accurate and authentic

dialogue, analysis of social reality, and fostering of findings and solutions (Israel et al., 2003; McTaggart, 1997; Reason, 1988).

The goals of PAR are realized, as willingness for self-scrutiny, enhanced awareness, and self-reliance develops, in an individual and joint spiral of learning and change (Martin, 2001). As part of creating change, the researcher shares with participants ways of influencing decision-makers and community leaders for relevant policymaking (Lincoln, 2001a; Themba & Minkler, 2003). Together they discover and co-author knowledge, create innovation, and validate their collective efforts, by mobilization of others and transformation of systems and social culture (Reason & Bradbury, 2001). As learning and knowledge development take place, issues of knowledge ownership and individual and joint publications are addressed, along with agreements on dissemination and knowledge translation (Hills, 2001; Israel et al., 2003; Reason, 1988). These are particularly important matters to graduate students, who must prove themselves through academic publishing, conference presentations, and ownership of their dissertation. Closure of this lengthy process is also an essential element that requires attention. PAR, done well, has tangible results, where group participants gain a stronger sense of self, enhanced knowledge of the issue explored, a sustained network to draw upon, a more democratic structure for humanistic policymaking, and an improved status in the lives of the people who are beneficiaries (Greenwood & Levin, 1998; Hall, 2001; McTaggart, 1997).

Self-reflection: revealing my beliefs and assumptions integrates my wholeness

The many and varied roles I live cannot be subdivided or compartmentalized. PAR, being context-bound (Levin & Greenwood, 2001), and yet open to multiplicity (Maguire, 1987), permits me to be situated and synergistic in my multiple roles and interests in research. My roles of student, leader, educator, nurse, researcher, scholar, participant, and community member come together in a balancing act of staying true to PAR. Hierarchy has no place in the flourishing of community, yet challenges us daily with structures and regulations. My life experience has taught me that congruency in what I believe in and what I do keeps me healthy in mind, body, and spirit. My research topic of interprofessional collaboration with nurse practitioners in their context of teamwork presents a congruency with PAR that is hard for me to ignore. The synchronicity of opportunities in academia, thus far, reinforces my path.

My commitment to PAR comes from working in and with community organizations, where I experienced the isolation of limited resources, including access to and influence of research. I came to the academy with the intent of improving this inequity. I believe PAR has a contribution to make in reconnecting

universities and communities in co-generation and co-ownership of knowledge (Levin & Greenwood, 2001). I have confidence in collective problem-solving. Learning about collaboration is an important contribution to collective endeavors. Hall (2001) speaks of the research process as being genuinely and organically situated. The knowers and known in a community come together with academia to allow learning and action to emerge. Validity is measured by the depth of relationship, plurality of knowing, practical significance, and enduring nature of inquiry (Bradbury & Reason, 2001). First-person research allows me to explore what I bring to the relationships within community and this strengthens my validity as a researcher and participant.

Challenges will come and go. I remind myself daily in moments of anxiousness or over exertion, and confusion and complexities resolve as the process of learning unfolds. I willingly abandon research results and give over to the power of process, as I believe there is rarely a quick fix. The process is the learning that makes for transformation. Heen (2005) describes her uneasiness in first-person inquiry to over inquire, and suggests instead to 'let the wholeness be' (p. 275). I too have discomfort in first-person research, particularly in revealing my self-inquiry of private thoughts and tensions, yet this is the process that creates my wholeness.

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Appendix B: PAR Community of Inquiry Principles

Definition: Participatory Action Research is “an integrated three-prong process of social investigation, education, and action designed to support those with less power in their organization or community settings” (Hall, 2001, p. 171).

Definition: Action research is a participatory, democratic process concerned with developing practical knowing. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people and more generally the flourishing of individual persons and their communities (Reason & Bradbury, 2001, p. 1).

Principles of PAR:

- Participatory: PAR is an approach to research and has features of authentic participation and transformative improvement (McTaggart, 1991; Reason & Bradbury, 2001).
- Co-ownership: Participants, as co-learners, co-researchers, and co-activists, address real life issues to form a sense of community (Kelly, 2005; Marshall, 2001; McTaggart, 1991).
- Relational: PAR is relational and reflexive in understanding theory and practice for the aim of enriching care and culture (Gustavsen, 2001; Park, 2001)).
- Community: Engages a community of practice to build a sense of trust and mutual commitment as a community of inquiry (Friedman, 2001; Reason & Bradbury, 2001).
- Knowledge translation: Fosters information sharing, creation of new knowledge, and group confidence to engage in planned actions (White et al., 2004).
- Practical: Emphasizes local relevance, critical reflection, multiple perspectives and systems thinking (Park, 2001; Torbert, 2001).
- Collaborative: Facilitates collaborative and equitable partnerships, contributing to empowerment, mutual decision-making, and power sharing (Baum et al., 2007).
- Reflexive: Strives for balance using iterative cycles of learning, reflection, and action (Heron & Reason, 2001)
- Transformative: Promotes capacity building, innovation, and transformation of social and organizational structures (Kemmis & McTaggart, 2005).
- Authentic: Assures more accurate and authentic analysis and validates research rigor, by way of collaborative reflections and effectiveness of actions (Herr & Anderson, 2005).

Appendix C: UVic Invitation to Participate

UVIC Invitation to Participate in a Graduate Student Research Study

The Health Authority is forwarding this invitation on behalf of Judy Burgess. Judy is an interdisciplinary doctoral student at the University of Victoria, located within: the School of Nursing, HSD (primary) and Curriculum and Instruction, Education (secondary). She has not been given your direct contact information, and instead will rely on your e-mail or phone response to her, indicating your interest in the research study.

Participatory Action Research with Primary Health Care Nurse Practitioners on Relevance of Interprofessional Collaboration to NP Integration

Hello

My name is Judy Burgess and I am a PhD candidate. I am inviting you to attend an introductory meeting to learn about and request your participation in a research study that I am conducting. The research study is titled **Participatory Action Research with Primary Health Care Nurse Practitioners on Relevance of Interprofessional Collaboration to NP Integration**.

The purpose of this health services study is to determine nurse practitioner (NP) patterns of interprofessional collaboration (IPC) within regional implementation of primary health care (PHC). The relevance of IPC to NP integration will be revealed, and strategies of IPC explored in order to advance NP integration. As NPs in a community of practice, you are being asked to come together to create a community of inquiry. By using a participatory action research approach we will collaborate to explore and document the interplay of theory and practice, and engage in and evaluate action strategies. As co-researchers you will gain research competence in knowledge development, leadership in practice and system change, and strategies to advance role integration.

As a registered nurse with 15 years practice in primary health care, I came to know the vital community role of NPs. As UVic doctoral student and educator, I am involved in a Health Canada funded Interprofessional Education Project in BC. This experience has extended my view of IPC as a broader construct of organization and team culture. I see NPs as well positioned to practice holistic health care and champion IPC. As well, IPC contributes to NP integration within PHC.

This study is based on the overriding research question: How does IPC advance NP role integration within PHC? This research is important as there is limited understanding of

team dynamics in PHC, lack of clarity on what constitutes a culture of IPC, and inadequate knowledge of NP role integration. Yet, NP role integration is associated with effective patterns of collaborative practice, and IPC is integral to complex client care delivery, practitioner work satisfaction, issues of recruitment and retention, and innovative models of care. Further research is needed to understand NP role integration, with respect to IPC.

NPs who are employed with the Health Authority are being invited to participate in this study. The two HAs are included in this study, as a way to ensure adequate participation of NPs. Each community of inquiry will benefit from 6-12 participants. As well, including two HAs will inform knowledge development with respect to similarities and differences of NP implementation, and support knowledge uptake.

If you agree to voluntarily take part, your participation includes an introductory meeting, and 3-5 research meetings of about 2 hours per meeting that will be audio-taped. Times and locations of these meetings will be organized at the first introductory meeting to best suit your schedules and availability. Inquiry meetings will be held from November 2007 to April 2008. Preference is for face-to-face monthly meetings; however teleconference capability will also be provided to reduce travel if problematic. Your time commitment for this study is estimated at 16 hours, plus travel time, and optional time for participating in data analysis. This estimated time involved with meetings and journaling will be paid by your employer, as well as travel time and costs to and from inquiry meetings. Please see attached employer letter indicating support for this research.

It is important to make clear that your decision to participate is entirely voluntary, and in no way influences your employment status. Due to the small group nature of the study, confidentiality and anonymity can only be requested of group participants, but not guaranteed; however anonymity of participants in regards to communicating specific research findings can be assured. A consent form will be provided at this introductory meeting and must be signed in order for you to participate in subsequent audio-taped research meetings.

To prepare NPs with a baseline for the study an education package with a few articles on topics related to primary health care, interprofessional collaboration, participatory action research, and NP role developments will be provided to you at the introductory meeting.

I would very much like to meet with you to discuss your interests in a participatory action research study. **Please contact me at the following e-mail or phone to indicate your interest in attending the introductory session, or to discuss any further questions.**

E-mail: jburgess@uvic.ca

Phone: office @ 250-472-5428 or home @ 250-598-2915.

*** You are invited to attend an Introductory meeting to discuss this research study on November 28, 2007 at 1:00 - 3:00 at _____. **It is important that you e-mail me back to indicate your interest in attending this meeting.**

Sincerely, Judy

Appendix D: First Meeting Materials

Agenda Introductory Meeting for Community of Inquiry

Finding a Balance: PAR with PHC- NPs on Relevance of IPC to NP Integration

1. Review of Research Proposal Summary
2. Research Plan with PAR
3. Guiding Principles
4. Who is missing from group
5. Links to decision-makers
6. Commitments of NPs (time, process, journaling, analysis, dissemination)
7. Ownership and Agreement
8. Meeting schedule (times and locations)
9. Consent
10. Questions and final considerations

SUMMARY**Running head: RESEARCH PROPOSAL****DOCTORAL STUDY RESEARCH PROPOSAL****Finding a Balance:****Participatory Action Research with Primary Health Care Nurse Practitioners on
the Relevance of Interprofessional Collaboration to NP Role Integration**

**Judy Burgess, RN, MN, PhD candidate
Interdisciplinary Graduate Program
University of Victoria
CIHR Doctoral Award Recipient
Student of CHSRF / CIHR Advanced Practice Nursing Chair**

**PhD Committee:**

Primary Supervisor: Dr. Marjorie MacDonald, School of Nursing, University of Victoria

Co-Supervisor: Dr. Budd Hall, Faculty of Education; Office of Community Based

Research Member: Dr. Marcia Hills, Centre for Community Health Promotion Research

Member: Dr. Irving Rootman, Faculty of Human and Social Development

Date: October 16, 2007

Research Study Aim and Relevance

The aim of this study is to explore the theory and practice of interprofessional collaboration (IPC), and its relevance to advancing primary health care (PHC) nurse practitioner (NP) role integration. BC formalized introduction of the NP role in 2005, with emphasis on NP role implementation in PHC settings. There is limited understanding about interprofessional team dynamics in PHC. Yet, success of NP role integration is associated with effective patterns of collaborative practice. IPC is also cited as integral to complex client care delivery, practitioner work satisfaction, issues of recruitment and retention, and innovative models of care. Further research is needed to understand NP role implementation and integration, with respect to IPC.

Selection of Research Partners

NPs are an important research partner, as they are well positioned to generate knowledge about IPC, NP role integration, and PHC as a care delivery model. NPs employed by HAA and HAB will be invited to participate as co-researchers in respective inquiry groups. The student-researcher has received a letter of support from the Chief of Professional Practice and Nursing. The purpose of having two inquiry groups is to assure adequate numbers of NP participants, and to benefit from understanding varying processes of regional implementation.

Research Study Benefits

This study adds to the knowledge base of how NPs collaborate in PHC settings, what constitutes and influences IPC, and how NPs can champion a collaborative work culture. The study also extends the knowledge and meaning of NP role integration in PHC, and how IPC has relevance to NP role integration. The literature has indicated a real need for studies to conceptualize and explore both IPC and NP role integration. By participating in the study NPs enhance their knowledge and leadership of IPC and NP role integration, and develop research competence in evidence-based practice. The study also contributes to client-centered care, workplace recruitment and retention, and PHC sustainability.

Research Approach

This health services research study is designed as a participatory action inquiry. PAR is defined by Hall as “an integrated three-prong process of social investigation, education, and action designed to support those with less power in their organization or community settings” (2001, p. 171). Thus PAR in this study is a social investigation with NPs, to generate education and knowledge on IPC and NP integration, and to elicit action to advance collaborative practice in PHC. NPs will be invited to engage in 4-5 research meetings during a timeframe of November 07 to April 08; dates and locations to be determined by participant consensus. Research meetings will take the form of face-to-face NP group encounters, and/or teleconference arrangement when travel is difficult. Participant-researchers will also be encouraged, but not required, during monthly intervals to reflect on practice and journal these reflections to share at subsequent meetings. Research meeting discussions will be audio-taped and transcribed for data analysis. Participant-researchers will be invited to participate in data analysis, reporting and dissemination.

Research Purpose, Questions, and Timeline

The purpose of this health services study is to determine NP patterns of IPC within regional implementation of PHC, so as to understand the relevance of IPC to NP role integration, and explore IPC strategies to advance NP role integration. As a community of inquiry, NPs and researcher explore and document collaborative learning of theory and practice, and engage in and evaluate action strategies of IPC, and relevance to NP role integration. By employing participatory action research (PAR), NPs as co-researchers gain research competence in knowledge development, leadership in interprofessional practice, and strategies to advance role integration.

Research Study Question: How does IPC advance NP integration within PHC?

Informative Stage of Inquiry: **Timeline: November, 2007 – January, 2008**

Research Questions:

- **What is the current status of NP collaborative practice?**
How are NP roles and practice patterns developing in PHC settings?
What matters to NPs in respect to IPC?
What factors facilitate or enable NP collaborative practice?
What barriers impede NP collaborative practice?
What are the qualities of IPC; what does it look like?
- **What is the interpretation of NP role integration?**
What does integration mean to NPs?
What are the qualities/components of integration?
What facilitates or enables NP integration?
What barriers impede NP integration?
How does IPC contribute to NP integration?

Transformative Stage of Inquiry: **Timeline: February – April, 2008**

Research Questions

- **How do IPC strategies advance NP role integration?**
What IPC strategies enable NP collaborative practice?
How can these IPC strategies be put into action?
What is the evidence for IPC advancing collaborative practice?
What is the evidence for IPC advancing NP role integration?
What is the evidence that links IPC strategies to NP role integration?

Hall, B. (2001). I wish this were a poem of practices of participatory research. In P. Reason & H. Bradbury (Eds.), *Handbook of action research: Participative inquiry and practice* (pp.171-178). London: Sage Publications.

Readings Content

- Pogue, P. (2007). The Nurse practitioner role: Into the future. *Nursing Leadership*, 20(2), 34-38.
- Gould, O., & Wasylkiw, L. (2007). Nurse practitioners in Canada: Beginnings, benefits, and barriers. *Journal of the American Academy of Nurse Practitioners*, 19, 165-171.
- Bryant-Lukosius, D., DiCenso, A., Browne, G., & Pinelli, J. (2004). Advanced practice nursing roles: Development, implementation and evaluation. *Journal of Advanced Nursing*, 48(5), 519-529.
- Jones, L., & Way, D. (2007). Healthy workplaces and effective teamwork: Viewed through the lens of primary healthcare renewal. *Healthcare Papers*, 7(Sp), 92-97.
- Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care*, 19(Suppl. 1), 188-196.
- Herbert, C., Bainbridge, L., Bickford, J., Baptiste, S., Brajtman, S., et al. (2007). Factors that influence engagement in collaborative practice. *Canadian Family Physician*, 53, 1318-1325.
- Baum, F., MacDougall, C., Smith, D. (2006) Participatory action research. *Journal of Epidemiology and Community Health*, 60, 854-857.
- Marshall, J. (2001). Self-reflective inquiry practices. In P. Reason, P., & H. Bradbury. *Handbook of action research: Participative inquiry and practice* (pp. 433-439). London: Sage Publications.
- Corbett, A., Francis, K., & Chapman, Y. (2007). Feminist-informed participatory action research: A methodology of choice for examining critical nursing issues. *International Journal of Nursing Practice*, 13, 81-88.
- Lofman, P., Pelkonen, M., & Pietila, A. (2004). Ethical issues in participatory action research. *Scandinavian Journal of Caring Science* 18, 333-340.

Appendix E: Participant Consent Form

Participatory Action Research with Primary Health Care Nurse Practitioners on Relevance of Interprofessional Collaboration to NP Integration

You are being invited to participate in a research study titled **Participatory Action Research with Primary Health Care Nurse Practitioners on Relevance of Interprofessional Collaboration to NP Integration**. This research is being conducted by Judy Burgess, who is an interdisciplinary doctoral student at the University of Victoria, located within: the School of Nursing, HSD (primary) and Curriculum and Instruction, Education (secondary). You may contact her by e-mail or phone.

E-mail: jburgess@uvic.ca

Phone: office @ 250-472-5428 or home @ 250-598-2915.

As a graduate student, I am required to conduct research for an interdisciplinary doctoral degree. This study is being conducted under the supervision of Dr. Marjorie MacDonald. You may contact my supervisor at 250-472-4265.

The purpose of this health services study is to determine NP patterns of IPC within regional implementation of PHC, so as to understand the relevance of IPC to NP role integration, and thus explore strategies of IPC to advance NP role integration. As a community of inquiry, NPs and researcher explore and document collaborative learning of theory and practice, and engage in and evaluate action strategies of IPC for NP role integration. By employing participatory action research (PAR), NPs as co-researchers gain research competence in knowledge development, leadership in interprofessional practice and system change, and strategies to advance role integration.

The objectives of this study are to contribute threefold to the knowledge base: First is to understand how NPs collaborate in PHC and what components influence a culture of IPC; second to understand the meaning and components of NP integration, and third to explore IPC strategies to advance NP integration. Research of this type is important, as there is limited understanding of team dynamics in PHC, lack of clarity on what constitutes a culture of IPC, and inadequate knowledge of NP role integration. Yet, success of NP role integration is associated with effective patterns of collaborative practice, and IPC is seen as integral to complex client care delivery, practitioner work satisfaction, issues of recruitment and retention, and innovative models of care. Further research is needed to understand NP role integration, with respect to IPC.

NPs employed by HAA and HAB are invited to participate in this study. By including two HAs, adequate NP participation can be assured. Each community of inquiry will benefit from having 6-12 NP participants. Including two HAs will also better inform knowledge development and uptake, with respect to similarities and differences of NP implementation.

If you agree to voluntarily take part, your participation includes an introductory meeting and 3-5 reflection and action meetings:

- 1) At an introductory meeting the researcher will outline the research plan; times and locations for further meetings will be determined by consensus. The researcher will discuss the consent form and respond to any questions. In order for NPs to participate in audio-taped data collection, NPs must first sign the consent form. To support NPs with baseline understanding related to participatory action research, primary health care, NP implementation, and interprofessional collaboration, the researcher will provide an educational package of readings at the first introductory meeting.

An informative stage of inquiry begins the data collection phase of the research, where participants share their knowledge and experience (reflection), and plan for the intervening month of reflection. All inquiry meetings of data collection will be audio-taped. The student researcher role in the informative stage is to share knowledge of inquiry process, facilitate meetings, ask deeper questions, reflect back, transcribe and summarize data collection and bring back findings to the next meeting

- 2) (November 2007). The second meeting focuses on NP reflections of current status of NP collaborative practice, identifies enablers and barriers, and specifies preliminary components and indicators of IPC. In the interval month of action, co-researchers are encouraged to keep a journal of components and indicators of IPC, as they develop a deeper understanding of their practice.
- 3) (January 2007) For the third meeting NPs authenticate a more fully developed conceptual framework, reflect on the meaning and components of NP integration, and conceptualize a comparable framework. For the interval month of action, co-researchers keep a journal of components and indicators of NP integration, and how IPC contributes to NP integration.

At this time a transformative stage of inquiry commences, where knowledge developed in the study is applied to an action stage and evaluated for relevance and effectiveness. . This stage may lead to the inquiry group sharing their reflexive learning and knowledge with key stakeholders, and articulating their discoveries. The inquiry group will agree within the group as to what can be shared with outsiders, in order to ensure confidentiality of group participants. The student-researcher role is to assist NPs to develop action plans, adapt tools and methods to evaluate actions, assure transcription of data collection, and bring back preliminary analysis and findings to the next meeting.

- 4) (February 2008) For the fourth meeting, NPs review the NP integration framework. NPs then consider action strategies to advance IPC and explore tools and methods to evaluate actions. In the interval month NPs take up action strategies of IPC and journal their experience. During this time the student-researcher assists NPs to finalize action and evaluation processes.
- 5) (March 2008) NPs come together to share action strategies and progress. Issues of inquiry and evaluation are discussed and learning of the research process is further explored
- 6) (April, 2008) For the final meeting, NPs reflect on learning, share and assess their evidence-based community of inquiry, and discuss plans for knowledge translation and uptake.

In choosing to participate in this research study, there are no foreseeable inconveniences beyond time commitment associated with participation, which is estimated at 16 hours in total. This time estimate includes 2 hours per meeting for up to 5 meetings, and one hour of journaling per month for six months. Travel time and optional data analysis time is not included here, as it is variable to participants. Action plans would be related to practice, also variable to time, and would be considered as part of evidence based practice, not specifically research.

There are no known or anticipated risks to you by your voluntary involvement. Your participation is important in adding knowledge and understanding to IPC and NP integration in PHC. In addition, involvement in a participatory action study will enhance your knowledge of research inquiry and support your research competencies in annual performance assessment. Finally, the study is intended to strengthen NP integration, and thus enrich client-centered care, workplace recruitment and retention, and PHC sustainability.

You will be compensated for your time, while participating in the research, that is, you will be paid by your employer for your 16 hours of time related to the study and for travel time and costs to attend the meetings. You will not incur undue costs. It is important for you to know that it is unethical to provide undue compensation or inducements to research participants and, if you agree to be a participant in this study, this paid compensation to you must not be coercive. Your decision to participate must be entirely of your choosing.

Your participation in this research study must be completely voluntary. If you do participate, you may withdraw at any time without any consequences or any explanation. Compensation for your involvement will not be affected by your decision to withdraw, nor will your job be affected in any way by your decision to withdraw. If you do withdraw from the study, your input to the audio taped inquiry meetings will be used, because it is impossible to remove it from group discussion. By choosing to continue to attend monthly meetings, this indicates your ongoing willingness and consent to participate over an extended period of time, November 2007 to April 2008. You will be verbally reminded by the researcher of the importance of your voluntary consent at the beginning of each meeting. Any other data from you individually will only be used with your permission. In the event you wish individual time with the researcher or a resource person to debrief your inquiry experience, this can be arranged by the researcher.

Due to the way audio taped inquiry meetings are structured, it is not possible to guarantee confidentiality or anonymity of information shared within meetings. Members of the group are asked to refrain from sharing information discussed in the group with persons outside the group setting. In terms of protecting anonymity, all written materials and audio tapes will be coded so that your name will not appear in any of the data material. Any communication of research findings will not identify individuals.

To assure your confidentiality and confidentiality of the data, access to the data will be limited to the researcher, except in instances where consultation with the supervisor is necessary. An assistant researcher (PhD student) may accompany the researcher to meetings for recording research process and planning. In addition, a paid transcriber, unknown to participants will have access during this task. Both will be asked to sign a confidentiality agreement. A list of codes with names and the data will be stored in a separate locked file cabinet and in password protected computers of the researcher. The list of code names will be destroyed when all data has been analyzed. The paper data will be disposed of by shredding and computer files will be erased 7 years after the research study is completed. In the event that NPs would like the data saved for future research, this decision and consent will be finalized at the end of the study, in which case

all names and identifiers will be removed from the data and the data will be stored in the office of supervisor, Dr. Marjorie MacDonald. Future use of this data will be submitted for ethics approval.

It is anticipated the results of this study will be shared with others in the following ways: A dissertation document prepared by the graduate student for doctoral submission requirements is considered in the public domain; submission of publications to scientific journals, by the graduate student and/or through joint papers of NPs and research student; and presentation of results at educational and/or scholarly conferences. You will have access to any final documents by requesting this from the researcher, or by way of public domain access.

In addition to being able to contact the researcher and/or their supervisor at the above phone numbers, you may verify ethical approval of this study, or raise any concerns you might have, by contacting the office of the Associate Vice-President, Research at the University of Victoria (250-472-4545).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher. The researcher will provide you with a copy of your signed consent once received.

Name of Participant

Signature

Date

Please retain a copy of this consent form for your records.

Appendix F: Inquiry Agendas and Questions

HAB Research Study Question:* **How does IPC advance NP integration within PHC?*

Research Questions: Informative Stage of Inquiry: ***Timeline: November, 2007 – January, 2008***

First Meeting January 9, 2008

What is the current status of NP collaborative practice?

How are NP roles and practice patterns developing in PHC settings?

- I am interested in learning about your patterns of practice?
 - What does an average practice day look like?
 - What do you do on an average day?
 - Who do you see? Clients, practitioners, others?
 - How is your day structured?

- I am interested in learning what IPC means to you?
 - What matters to NPs in respect to IPC? Is IPC different than collaborative practice?
 - How do you as a NP perceive your role in IPC?

- What factors facilitate or enable NP collaborative practice?
 - What are the strengths of IPC in healthcare?

- What barriers impede NP collaborative practice?
 - What are the deficiencies of IPC in healthcare?

- I am interested in understanding what IPC looks like in practice?
 - Who do you collaborate with in healthcare
 - Describe a typical experience of IPC that was particularly positive?
 - Describe a typical experience that was difficult or challenging?

- What do you think are the qualities of IPC?
 - How is IPC supported and by whom?

Second Meeting February 11, 2008

- **Reading and Discussion of Analysis**

Explanation of my analysis and interpretation

- I tried to capture some of the challenges and tensions of role start-up that dominated quite a bit of the first part of our discussion.
- Did I take too much liberty, tried to keep my interpretation close to data
- It is an early interpretation, which will evolve as we move forward and you provide me with further direction and your own interpretations

- What are your first impressions
- Is this an accurate account of our discussions, are the sub-themes salient
- Do you want to change anything, add anything
- How much liberty do you want me to take in writing up analysis
 - Example - time and funding;
 - Example - Themes relate to principles of PHC (universal access, health promotion & social justice, community & public participation, intersectoral approaches, technologies & resources (WHO, 2003, ch 7)

- What is the value or significance of this information
- What can this information be used for, is there any action yet to be taken

- **What can we add here about NP practice patterns and the value added of NPs**

- **Examination of IPC Framework**

- Overview of levels and influences on IPC
- Data supporting concepts
- Data not supporting concepts - why
- Would you make changes to these levels or to these concepts
- What matters most in this framework
- Where does the client fit, as a influence or as an outcome or both

Third Meeting April 3, 2008

- **Power Point and Discussion of Analysis**
 - Caveats of my analysis and interpretation
 - I further explored the alignment of NP practice patterns and PHC principles
 - I examined the triumphs and tensions of role development
 - Community or practice counters these role tensions and creates role capacity
 - The elements of CoP are explored
 - The data contributed to shifting elements of the IPC framework
 - What are your first impressions
 - Do you want to change anything, add anything

What is your interpretation of NP Role Integration?
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- What does integration mean to NPs?
- What can you envision NP role integration to look like in 5 years if everything goes well
- What are the qualities/components of integration?
- What will facilitate or enable NP integration?
- What do NPs need to be recognized and valued for, as vital contributing practitioners?
- What parts of current practice do you need to protect, or change?
- How does IPC contribute to NP integration?
- How will you know your roles are secure and sustainable?
- How will you evaluate your effectiveness?
- What barriers will impede NP integration?
- What will you need/expect from other stakeholder groups?
- Create actions to advance NP role development.
- Explore collaborative strategies to advance NP role integration.
- Have we considered levels
 - Structural changes or supports needed for integration
 - Organizational supports / actions needed
 - Team, program or workplace changes or approaches needed
 - Practitioner development and supports, ex. Communities of practice
 - Client involvement and support

April 7 @ 10:30-4:00

NP Research Action Day with Dr. Marjorie MacDonald

- Current state of NP record keeping and practice data
- Burning to know and burning to show: what are your goals, what can you measure?
- Theories underlying practice
- Logic Model Evaluation Approach
- Other Approaches to Evaluation Measurement
- Links to decision-makers
- Other plans or actions
- Questions, final considerations, feedback on day

Fourth Meeting @ 2:30-4:30 May 26, 2008 Large Meeting Room School of Nursing

Discussion of PP Presentation and Preparation for Meeting with PPO Leaders

PP Presentation to PPO Leaders

Interview Meeting with PPO Leaders

- Tell us about how you planned NP role implementation?
- What strategies or processes are used for implementation?
- How do you feel NP role development is progressing?
- What are your future goals for NP role development?
- How did the community of practice come about?
- What do you see as elements of a strong community of practice?
- Where do you see NPs fitting into HAB service design?
- What can you envision NP role integration to look like in 5 years if everything goes well?
- What indicators / outcomes will you expect to see?
- What roles or actions can NPs take up to strengthen role integration & sustainability?

Fifth Meeting 4:30 – 6:00 Small Meeting Room School of Nursing

- 1. NP Data Collection Discussion**
- 2. What further action research interests do you have to advance IPC & NP role integration?**
 - Action research interests as a community of practice?
 - Action research interests related to your own unique roles, teams, and settings?
 - Action research interests with a particular population or client group?
 - Other
- 3. Reflecting on Community of Inquiry**
 - Talk about this experience of coming together in PAR?
 - What was the social investigation?
 - What knowledge or education was created from the experience?
 - What actions transpired or will be generated from this inquiry?
 - Any more thoughts?

HAA Research Study Question: How does IPC advance NP integration within PHC?

Research Questions: Informative Stage of Inquiry: Timeline: November, 2007 – January, 2008

First Meeting December 7, 2007

What is the current status of NP collaborative practice?

How are NP roles and practice patterns developing in PHC settings?

- I am interested in learning about your patterns of practice?
 - What does an average practice day look like?
 - What do you do on an average day?
 - Who do you see? Clients, practitioners, others?
 - How is your day structured?
- I am interested in learning what IPC means to you?
 - What matters to NPs in respect to IPC? Is IPC different than collaborative practice?
 - How do you as a NP perceive your role in IPC?
- What factors facilitate or enable NP collaborative practice?
 - What are the strengths of IPC in healthcare?
- What barriers impede NP collaborative practice?
 - What are the deficiencies of IPC in healthcare?
- I am interested in understanding what IPC looks like in practice?
 - Who do you collaborate with in healthcare
 - Describe a typical experience of IPC that was particularly positive?
 - Describe a typical experience that was difficult or challenging?
- What do you think are the qualities of IPC?
 - How is IPC supported, and by whom?

Second Meeting February 7, 2008

- **Reading and Discussion of Analysis**

Explanation of my analysis and interpretation

- Did not want to take too much liberty in theorizing, wanted to keep my interpretation close to the data)
- It is an early interpretation, which will evolve as we move forward and you provide me with further direction and your own interpretations

- What are your first impressions
- Is this an accurate account of our discussions, are the sub-themes salient
- Do you want to change anything, add anything
- Is there information / themes (subcategories) missing about practice patterns
- How much liberty do you want me to take in writing up analysis
 - Example time and funding;
 - Themes relate to principles of PHC (universal access, health promotion & social justice, community & public participation, intersectoral approaches, technologies & resources

- What is the value or significance of this information

- What can this information be used for, is there any action yet to be taken

- **Examination of IPC Framework**

- Overview of levels and influences on IPC

- Data supporting concepts

- Data not supporting concepts - why

- Would you make changes to these levels or to these concepts

- What matters most in this framework

- Where does the client fit, as a influence or as an outcome or both

*Third Meeting February 7, 2008***What is your interpretation of NP Role Integration?**

- What does integration mean to you?
- What can you envision NP role integration to look like in 5 years if everything goes well
- What are the qualities/components of integration?
- What will facilitate or enable NP integration?
- What barriers will impede NP integration?
- What parts of current practice do you need to protect, or change?
- How does IPC contribute to NP integration?
- Have we considered levels
 - Structural changes or supports needed for integration
 - Organizational supports / actions needed
 - Team, program or workplace changes or approaches needed
 - Practitioner development and supports, ex. Communities of practice
 - Client involvement and support
- Is autonomy another word for integration, or different??

Fourth Meeting April 17, 2008 9:00 - 12:00

Discussion of PP Presentation and Preparation for Meeting with PPO Leaders

PP Presentation to PPO Leaders

Interview Meeting with PPO Leaders

- What are your goals for NP role development?
- Tell us about how you planned NP role implementation?
- What strategies or processes were used in implementation?
- How did the community of practice come about?
- What are the elements of a strong community of practice?
- What can you envision NP role integration to look like in 5 years if everything goes well
- What indicators will you look for to determine success?
- What roles or actions can the NPs take up to strengthen role integration & sustainability?

Lunch Break

Fifth Meeting @ 1:00 – 3:30

Discussion about morning meetings

Review of NP Role Integration section?

- What does integration mean to NPs?
- What are the qualities/components of integration?
- What will facilitate or enable NP integration?
- What barriers will impede NP integration?
- How does IPC contribute to NP integration?

How do IPC strategies advance NP role integration?

- What IPC strategies enable NP collaborative practice?
- How can these IPC strategies be put into action?
- What is the evidence for IPC advancing collaborative practice?
- What is the evidence for IPC advancing NP role integration?
- What is the evidence that links IPC strategies to NP role integration?

Sixth Meeting April 18 @ 9:00-10:30**What further action research interests do you have to advance IPC and NP role integration?**

- Action research interests as a community of practice?
- Action research interests related to your own unique roles, teams, and settings?
- Action research interests with a particular population or client group?
- Other

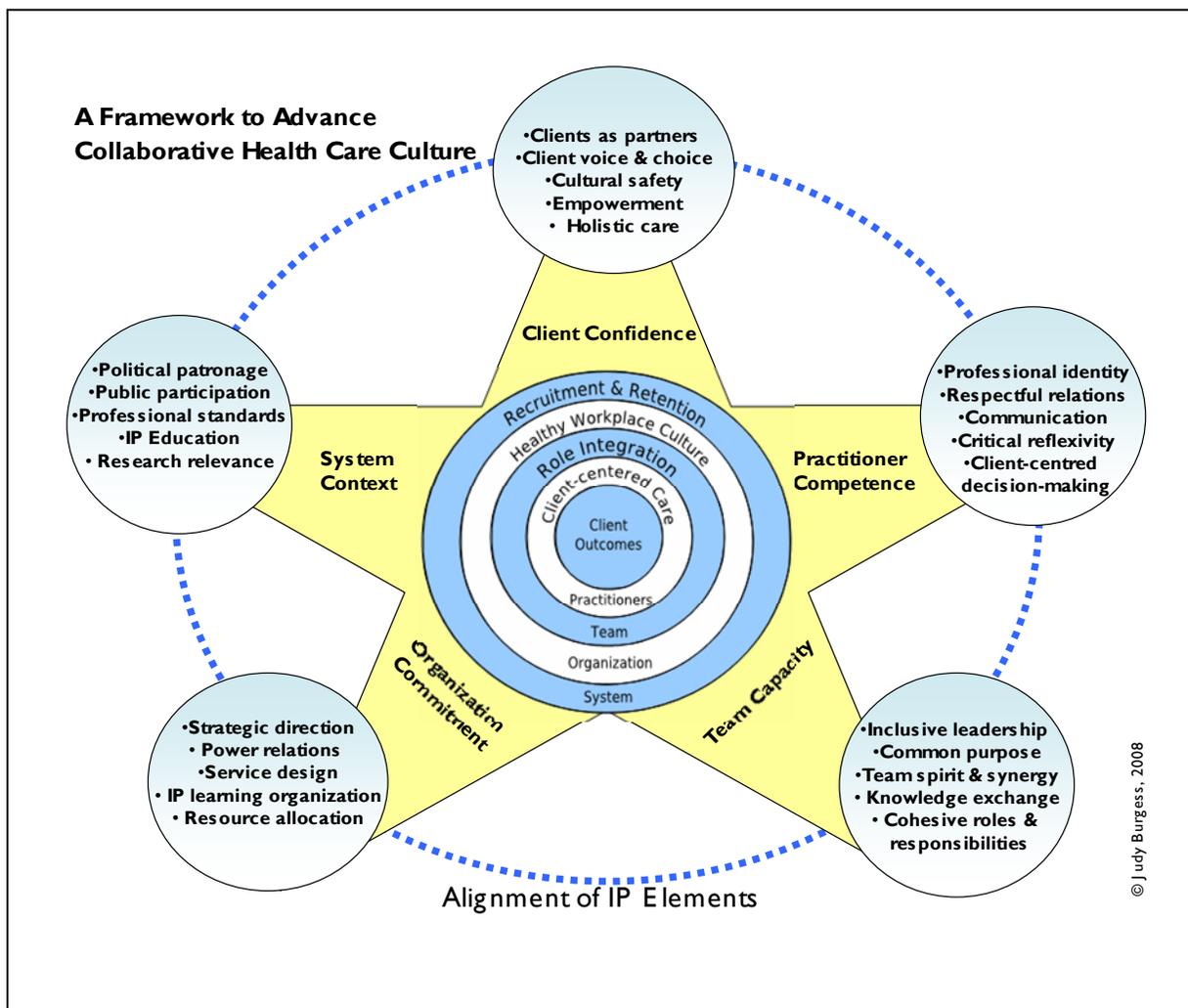
Reflecting on Community of Inquiry

- Talk about this experience of coming together in PAR?
 - What was the social investigation?
 - What was educational in the experience?
 - What actions transpired or will be generated from this inquiry?
 - Any more thoughts?
-

Research Action Day with Dr. Marjorie MacDonald**@ 10:30-4:00**

- Current state of NP record keeping and practice data
- Burning to know and burning to show: what are your goals, what can you measure?
- Theories underlying practice
- Logic Model Evaluation Approach
- Other Approaches to Evaluation Measurement
- Links to decision-makers
- Other plans or actions
- Questions, final considerations, feedback on day

Appendix G: Collaborative Health Care Culture Framework



Appendix H: Conference Poster

December 2018

Finding a Balance

Participatory Action Research with Primary Health Care Nurse Practitioners on Relevance of Collaboration to NP Integration

British Columbia, Canada

First-person PAR:

A Graduate Student Self-Inquiry

- ◊ Personal transformation
- ◊ Co-learner & co-researcher
- ◊ Issues of insider-outsider
- ◊ Values & assumptions
- ◊ Multiple roles & worldviews
- ◊ The nature of evidence
- ◊ Promises & perils of PAR



Wenger, 2006; Hui, 1991, 2018; Hui & Anderson, 2003; Rasmussen & Taylor, 2008

Community of Scholarship

An Ecological Framework to Advance Collaborative Health Care Culture

Reflexive Methodology

- ◊ PHC practice
- ◊ Scoping review
- ◊ NP Inquiry



Second-person PAR:

Entering into & Engaging Community of Practice

- ◊ Relational practice
- ◊ Network development
- ◊ Negotiating from top-down
- ◊ Design of methodological plan
- ◊ Ethics and more ethics
- ◊ NP recruitment rules
- ◊ Tension of time & ownership
- ◊ Giving us Inquiry control
- ◊ Trust the unfolding process



Wenger, 2002; Tolson, 2003; Anderson, 2000; Anderson, 2018

Community of Practice

A Comparative Analysis of Two NP Communities of Practice NP Role Development



HAB	CoP Elements	HAA
New CoP: 3 months & NP Participants	Context	Mature CoP: 18 months 12 NP participants
Managed leadership; Build trust	Collective	Share leadership; Social capital; Cohesive vision
Mentorship started; Learning not formalized	Education	Rich mentorship & learning; Mix of formal & informal
Mediating tensions of role development	Practice	Strategic in planning & advancing NP roles
Validating NP roles	Research	The value-added of NP roles
Consultative decision-making	Policy	Collaborative decision-making

Third-person PAR:

An Inquiry with NPs

- ◊ NPs sensitive, yet curious
- ◊ Researcher anxious, yet keen
- ◊ Data analysts added confidence
- ◊ Facilitation skills refined
- ◊ Disclosures deepened
- ◊ Participant ownership grew
- ◊ Relationships enriched
- ◊ Discoveries of learning together
- ◊ Strategic analysis & actions
- ◊ Inquiry enhanced by two groups



HAB: a developing process of social integration, education & action (HAB, 2005)

Community of Inquiry

Research Question: How does Collaboration Advance NP Integration within Primary Health Care?

Two concurrent NP-CoP groups met as co-researchers over a 6 month period

NP Practice Patterns Revitalize PHC Principles

- ◊ Role diversity & access
- ◊ Holistic assessment & care
- ◊ Collaborative practice
- ◊ Clients as partners
- ◊ Agents of change

- ◊ Equitable access
- ◊ Health promotion
- ◊ Intersectoral collaboration
- ◊ Public participation
- ◊ Appropriate technology

NP Collaborative Practice Advances Role Integration

- ◊ Practitioner competence
- ◊ Client confidence
- ◊ Team cohesivity
- ◊ Organization commitment
- ◊ System context

- ◊ NP autonomy & role enactment
- ◊ NP role clarity
- ◊ Interprofessional collaboration
- ◊ Value-added measures & evidence
- ◊ NP strategic alliances

Art & Science of Nursing

NPs champion collaboration as a foundation of practice



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