Nursing Practice in Rural and Remote Canada

RURAL AND REMOTE NURSING PRACTICE:

AN ANALYSIS OF POLICY DOCUMENTS

A Research Project Supported by the Canadian Health Services Research Foundation

Documentary Analysis Final Report:
Policy Analysis for The Nature of Rural and Remote Nursing Practice in Canada

RURAL AND REMOTE NURSING

PRACTICE:

AN ANALYSIS OF POLICY DOCUMENTS

Judith C. Kulig, RN, DNSc
Elizabeth Thomlinson, RN, PhD
Fran Curran, RN, MPA
Deana Nahachewsky, RN, BN
Martha Macleod, RN, PhD
Norma Stewart, RN, PhD
Roger Pitblado, PhD

The Nature of Nursing Practice in Rural and Remote Canada
Website: http://ruralnursing.unbc.ca
Telephone: 1-866-960-6409

R03-2003 JUNE, 2003

ACKNOWLEDGMENTS

This report has been developed as part of the national study, "The Nature of Nursing Practice in Rural & Remote Canada." This three year project (2001-2004), is designed to examine and define registered nursing practice in different settings including primary and acute care, community health, home and long-term care in rural and remote Canada. This study will examine what nursing is really like in rural and remote communities, and explore how nurses can best be educated and supported in their work.

This final documentary analysis report was made possible through the funding designated for The Nature of Nursing Practice in Rural & Remote Canada.

A number of individuals contributed to the documentary analysis upon which this report is based. Thank you to the numerous reviewers of various nursing and government organizations who took the time to read it and provide suggestions.

In addition, heartfelt thanks are extended to the:

- Principal Investigators: Martha Macleod, Norma Stewart and Roger Pitblado
- Co-Investigator of the Documentary Analysis: Elizabeth Thomlinson
- Advisory Board Member of the Documentary Analysis: Fran Curran
- Project Coordinator for The Nature of Nursing Practice in Rural and Remote Canada: Donna Bentham
- Research Assistants:
  Cathy Meyer,
  Melissa Hart (Chinook Research Summer Award from the University of Lethbridge, 2001),
  Deana Nahachewsky (Chinook Research Award from the University of Lethbridge, 2002),
  Karen Houweling (Chinook Research Award from the University of Lethbridge, 2003)
- And to Brenda Nixon for her superb secretarial skills.

Judith C. Kulig
Lethbridge, AB
June, 2003

TABLE OF CONTENTS

Acknowledgments i

Table of Contents ii

Executive Summary iv

Rural and Remote Nursing Practice: An Analysis of Policy Documents 1

Method 2

Findings 7

- Key Health Reports 8
  - Key Provincial Health Reports 8
  - Key Federal Health Reports 12
- Rural Health Issues at the Federal Level 13
- Rural Health Issues at the Provincial Level: British Columbia as an Example 15
- The Nursing Shortage 18
- Developing a Nursing Workforce for Rural Settings 20
- Analyzing the Context of Rural and Remote Nursing Practice 29
  - Advanced Practice 30
  - Nursing Practice Issues in Aboriginal Communities 33
    - Transfer of health services control 35
    - Nurses and predicted shortage 39
    - Education of Aboriginal persons into nursing 40
  - Educational Preparation of Registered Nurses for Rural and Remote Areas 42
  - Physician Supply in Rural and Remote Areas 48
  - Health Care Delivery in Rural and Remote Areas 54
    - Current state of health care delivery 54
    - Alternative mode of health care delivery 56

Conclusions: Answering the Policy Questions 59

Recommendations 63

References 69

Acronym List 85

Appendices

Appendix A – The Nature of Nursing Practice in Rural and Remote Canada 88
Appendix B - Measurement Tool 93
Appendix C – Documentary Analysis – RIST Form 95
Appendix D – Documentary Analysis – Form B 103
Appendix E – Advanced Practice 105
Appendix F – Nursing Practice Issues in Aboriginal Communities 126
Appendix G – Educational Preparation of Registered Nurses for Rural and Remote Areas 159
Appendix H – Physician Supply in Rural and Remote Areas 166
Appendix I – Health Care Delivery in Rural and Remote Areas 177

Tables and Figures

Table 1 - Advanced Practice – Fact Sheet 125
Figure 1 – First Nation & Inuit Control Activity 151
Figure 2 – First Nation & Inuit Control Activity Total 152
Figure 3 – First Nation & Inuit Population by Community 153
Figure 4 – First Nation & Inuit Population by Community Type 154
Figure 5 – Current & Projected Transfers – Atlantic 155
Figure 6 – Current & Projected Transfers – Quebec 155
Figure 7 - Current & Projected Transfers – Ontario 156
Figure 8 - Current & Projected Transfers – Manitoba 156
Figure 9 - Current & Projected Transfers – Saskatchewan 157
Figure 10 - Current & Projected Transfers – Alberta 157
Figure 11 - Current & Projected Transfers – Pacific 158
Figure 12 - Current & Projected Transfers – TOTAL 158

EXECUTIVE SUMMARY

This documentary analysis final report is the result of the collection and analysis of policy statements, technical reports, nursing practice regulations and standards and reports related to nursing education for rural and remote areas. It is one aspect of The Nature of Nursing Practice in Rural and Remote Canada research project (Appendix A). A more in-depth understanding of nursing practice in rural and remote Canada will be achieved from a combination of four methods: secondary analysis of the Registered Nurses Database (RNDB), documentary analysis, narratives and survey. An integrated final report of all methods will be available in 2004.

The documentary analysis was conducted to achieve a contextual understanding of the policy and practice environment within which rural and remote nurses practice. Relevant English-language documents were analyzed over a 20-month period. A framework was developed from three components of the policy cycle, which are policy formulation, policy implementation, and policy accountability (Rist, 1994). Two guides, with accompanying questions, were developed from the framework to assist in the analysis of the documents (Appendix C & D). Documents were retrieved through web-based searches, contacting organizations, and locating materials through members of the larger research team.

One of the challenges in locating and analyzing documents is the overall limited discussion of the terms rural and remote and the implications for nursing practice in Canada. Generally speaking, this is due to the lack of analysis regarding the theoretical and practical meaning of rural. Overall, the documents that were reviewed give the

impression that the meaning and significance of rural has been taken for granted. Finally, a number of documents emphasize the challenges of recruiting and retaining physicians to rural and remote areas while they fail to address the same issues for other health providers who also practice in these areas.

As mentioned, there has been little discussion or analysis of the terms rural and remote in the policy documents. These terms are often associated with a specific geographic meaning, which is equated with financial reimbursement for a particular type of nursing practice (www.hc-sc.gc.ca/fnihb-dgspni/fnihb/pptsp/hfa/ten_years_health_transfer/index.htm). The lack of attention to the meaning of rural and remote, and the diversity of such settings, simplifies the complexity of nursing practice in such locales.

The analysis of the documents revealed five thematic areas:

- Advanced Practice,
- Nursing Practice Issues in Aboriginal Communities,
- Educational Preparation of Registered Nurses in Rural and Remote Areas,
- Physician Supply in Rural and Remote Areas, and
- Health Care Delivery in Rural and Remote Areas.

Each of these themes has been discussed in detail in the appendices of this report and are summarized in the main body of the report.

Advanced practice has generated a considerable amount of discussion in a variety of documents in the last few years. Changes to legislation and registration are ongoing across the country. Overall, there is support for this role as exemplified by the

availability of graduate programs to prepare nurses to work in advanced practice and the increased number of individuals working in such positions. Although the documents do not always discuss advanced practice in rural and remote settings, nursing practice in these locales will be enhanced by the availability of advanced practice nurses.

Nursing practice issues in Aboriginal communities includes understanding the band transfer process of health services because increasingly nurses employed in Aboriginal communities will be band-employed. Despite this significant change, the documents that were reviewed are limited in their discussion about the challenging employment conditions of a band-employed nurse. However, the Aboriginal Nurses Association of Canada has taken the lead in addressing such issues. In addition, the educational preparation of Aboriginal persons for the nursing profession is becoming recognized as an issue that needs attention. A recent report identified the barriers and challenges experienced by Aboriginal students in nursing programs and recommended, for example, that additional financial support be provided for relocation costs associated with attending school (Health Canada, 2002).

Educational preparation of nurses for rural and remote areas of Canada has not been discussed at length in the documents that were reviewed. There are only a few nursing programs in Canada that formally prepare nurses for such geographic settings and no evaluation reports of these programs could be located. In addition, there is no indication that the appropriate number of nurses is being prepared for rural or remote areas, or how many of those who are prepared for such settings actually work in them

upon graduation. Some of the programs do prepare nurses for rural and remote areas under challenging circumstances. Furthermore, many of the programs that prepare nurses for rural and remote areas do so at great financial cost because of the resources needed to place students in clinical settings in these areas. In addition, despite the emphasis in the documents on the need for telehealth to be used in rural and remote areas, there has been no investment in equipment or finances to prepare nurses for such technology. The documents revealed the general lack of government assistance to support the additional costs associated with educational preparation of nurses in rural and remote areas.

Documents related to physician supply in rural and remote areas were reviewed for several reasons including that rural health care is a multi-professional challenge and that legislation related to the role of nurses is influenced by physician availability, roles and expectations. In addition, physicians have developed rurality indexes, data on physicians and physician practice problems is most available, and physicians are the most politically organized to address issues related to rural and remote areas. Several key reports have examined the challenges of recruiting and retaining physicians for rural areas and note the importance of nurse practitioners (NPs) (Appendix H) in providing care in rural areas (Barer & Stoddart, 1999; OMHLTC, 2001b). Although considerable effort has been made in developing indexes related to rurality, these scales remain untested and their applicability and usefulness to practice is unknown.

The final theme focuses on health care delivery in rural and remote areas. Alternative modes of delivery were noted in the documents, including the RN First Call

Program in British Columbia and the use of telehealth throughout rural and remote communities in various locations of Canada. The Canadian Nurses Association (CNA) and the provincial nursing associations have developed position statements regarding telehealth within nursing practice, an issue that will continue to lead to discussion about its implications for nursing practice.

The following seven recommendations are based upon the information generated from this documentary analysis.

Recommendation One:
Develop a national rural health human resource strategy by individuals with expertise in rural health issues

Recommendation Two:
Create alternative payment options for nurses and physicians in rural areas

Recommendation Three:
Develop scholarships and bursary programs for rural nursing students and rural-based nurses

Recommendation Four:
Implement initiatives to enable full scope of nursing practice, including advanced practice in rural areas with process and outcome evaluation in rural and remote areas

Recommendation Five:
Implement educational initiatives and complementary supports for nurses working with Aboriginal peoples

Recommendation Six:
Implement financial and technological support for universities with a rural-focused mission

Recommendation Seven:
Offer continuing education for nurses who work in rural and remote areas

RURAL AND REMOTE NURSING PRACTICE: AN ANALYSIS OF POLICY DOCUMENTS

This final report is the result of the collection and analysis of policy statements, technical reports, nursing practice regulations and standards and reports related to nursing education for rural and remote areas. It is one aspect of The Nature of Nursing Practice in Rural and Remote Canada research project (Appendix A). For this project, the Statistics Canada definition of rural and small town has been adopted, which refers to those who live outside the commuting zones of larger urban centres (du Plessis, Beshiri & Bollman, 2001). Rural nursing practice is largely an under-studied area and only recently it was identified that in 2000 there were 41,502 registered nurses (RNs) in rural and small town areas in Canada (Canadian Institute for Health Information [CIHI], 2002). Through the documentary analysis, combined with narratives, a survey and secondary analysis of the Registered Nurses Database (RNDB), this research project will lead to a more in-depth understanding of nursing practice in rural and remote Canada. An integrated final report of all four methods will be available in 2004.

This final report builds on the interim documentary analysis (Kulig et al 2002) in which some of the material was presented in a similar format. It begins with a general discussion of the documentary analysis, leading to an overview of the data method with highlights of the major findings focusing on major health policy documents (i.e., Romanow Report), rural health issues at the federal and provincial levels, and then issues related specifically to nursing. When conducting the documentary analysis, the following five major themes emerged:

1. Advanced Practice;
2. Nursing Practice Issues in Aboriginal Communities;
3. Educational Preparation of Registered Nurses for Rural and Remote Areas;
4. Physician Supply in Rural and Remote Areas; and
5. Health Care Delivery in Rural and Remote Areas.

These are discussed and expanded within the attached appendices (Appendix E-I inclusively). Finally, the report ends with concluding comments and recommendations.

Method

The documentary analysis has been conducted to achieve a contextual understanding of the policy and practice environment within which rural and remote nurses practice. Relevant English language Canadian documents were systematically obtained and analyzed over a 20-month period (May, 2001 to January, 2003). Documents included policy statements, technical reports, nursing practice regulations and standards, and reports related to the nursing education for rural and remote areas. Sources were regional, provincial and national government offices, medical associations and professional nursing organizations. French language documents were not included due to a lack of resources for translation.

A framework was developed from the three components of the policy cycle, which are policy formulation, policy implementation, and policy accountability (Rist, 1994). In this analysis, policy formulation includes examining whether or not past and current policy has been developed in relation to rural and remote nursing practice. Policy implementation refers to determining if policy related to rural and remote

nursing practice was implemented. Policy accountability investigates whether there has been accountability by government and professional associations regarding policies and programs directed at rural and remote nursing practice.

The policy cycle framework was used to develop a guide (Appendix B) to analyze individual documents. Questions were developed for each component of the policy cycle to ensure that all facets of rural and remote nursing practice were addressed. Questions regarding policy formulation included:

- What are the definitions of rural and remote?
- Has rural and remote nursing practice changed since these definitions were forwarded?
- What education programs and/or courses were developed and implemented to prepare nurses to work in rural and remote settings?

To address policy implementation, questions included:

- Is the appropriate number of nurses available in rural and remote parts of Canada to meet the needs of the residents?
- Were there changes in nursing regulations that enhanced or inhibited nursing practice in rural and remote areas?

Finally, for policy accountability, the following questions were used:

- What were the anticipated and unanticipated outcomes resulting from the development of policies and programs in relation to rural and remote nursing practice?
- Has the program or policy also changed with more current circumstances?

These questions focused the analysis of the documents while permitting an in-depth understanding of the policies and their implications.

In order to allow easy access by all members of the research team the checklist was converted into a web-based form (Appendix C). When it was converted, additional information was included such as the name of the individual submitting the form, the document title and author, document date, discipline addressed in the document, field of practice (i.e., nursing, medicine), geographic area, intended audience and type of document. The web-based form was developed so that it could be automatically submitted to the principal investigator's (Kulig) email address when completed. Once it was received, it was converted into a word-based document and printed. A list of all the documents that were read was also compiled at this time. Finally, a webCT site was designed exclusively for the documentary analysis team. This site contained the list of documents that were read, a bibliography of materials and a discussion area. A user-friendly feature of this computer program is that messages can be categorized by subject making it easier to retrieve and access older messages.

To test out the web-based form, each team member read the same document and submitted a completed form (Appendix C). During this process, it was discovered that the form did not fit well with documents that discussed other health professions such as medicine. A number of questions were inappropriate or not applicable, resulting in large blank areas on the submitted form. Hence, a second, shorter form was developed for the reports that discuss topics such as rural physicians (Appendix D). The questions from this form were chosen from the initial checklist and captured the broad picture of

rural and remote health issues and the potential impact on rural and remote nursing practice.

A number of activities were used to identify and locate reports and documents that were used in the analysis.

1. Three research assistants (Meyer, Hart & Nahachewsky) conducted web-based searches on policy as it related to general subject headings such as nursing, rural nursing, advanced practice in nursing, medicine and other health professionals, recruitment and retention of health professionals, and nursing standards and regulations.
2. More specific searches were completed on topics such as preparation of First Nations individuals in nursing.
3. Searches were also conducted on provincial and federal government web sites to identify documents related to the nursing profession and health policy in general, and rural health policy more specifically, and government direction in relation to recruitment and retention of health professionals in rural and remote areas.

The initial listing of documents was posted on the rural and remote nursing practice research group listserv, which the entire research team received. Individual members reviewed the list of documents, suggested other reports, and supplied copies of reports that were in their possession. It was deemed important to locate reports and documents that covered broad health care delivery content and then review them to determine their applicability to the subject at hand.

During this time, meetings were held with the documentary analysis research team. When the research study was developed, individual co-investigators and advisory team members were asked to self-select the research methods within which they wanted to participate. A teleconference meeting was held with the co-investigator (Thomlinson) in April 2001 to discuss the actual process of conducting the documentary analysis. A face-to-face meeting was held with the co-investigator and two research assistants in June 2001. It was at this time that retrieved documents were perused and lists of other documents to locate and activities to complete were compiled. Another teleconference call was conducted in September 2001 with the co-investigator and two advisory team members (Curran & Brunskill) to further update the team on the progress of the retrieval of documents, and to discuss the analysis process.

A face-to-face meeting with the co-investigator, one advisory team member (Curran) and the research assistants was held in February 2002, which allowed for further discussion of the documentary analysis and a demonstration of webCT. By the time this meeting occurred, the web-based forms had been tested and revised and all members had read a sample of documents. This meeting was helpful in identifying potential themes and an outline for the interim report. Specific questions were also developed to assist in focusing the reading of the remaining documents in preparation of the preliminary documentary analysis report (Kulig et al, 2002), which was distributed in July 2002. Another meeting was held with the co-investigator (Thomlinson) in October 2002 to re-prioritize the documents and finalize plans for the final report. Due to distance issues, telephone and email discussions occurred with the

advisory team member (Curran) to address any concerns or issues with the preparation of the final report.

The four Co-Principal Investigators had meetings on a regular basis--by teleconference approximately every two months and face-to-face meetings bi-annually. At these meetings, the documentary analysis process and preliminary and final reports were discussed, and ideas were shared regarding method, retrieved documents and the development of recommendations.

Findings

One of the challenges in locating and analyzing documents is the overall limited discussion about rural and remote and the implications for the nature of nursing practice in Canada. In part this is due to *the lack of analysis regarding the theoretical and practical meaning of rural*. The Rural and Small Town Analysis Bulletin, which is a recent electronic bulletin sponsored by Statistics Canada (du Plessis, Beshiri & Bollman, 2001), is assisting with rectifying this situation. In addition, the reviewed documents give the impression *that the meaning and significance of rural has been taken for granted and is therefore not specifically considered or discussed*. For example, the scope of practice documents for the Northwest Territories (NWT) not only lack definitions of rural and remote, but also do not reflect the uniqueness of nursing practice in the north in the nine principles that are enunciated (Northwest Territories Registered Nurses Association [NWTRNA], 1994). Consequently, the principles could describe the scope of practice in any province or territory in Canada. One other illustration of rural being taken for granted is that a number of the documents are “urbancentric.” For example, in

the original Registered Nurses Association of British Columbia (RNABC) policy report on professional conduct, a comment is made that the nurse should excuse himself or herself from caring for a client when there is a pre-existing social relationship[1] (RNABC, 2000). In rural environments, this would be difficult to achieve given the longstanding social relationships and connections between residents of small communities. Finally, a number of documents *emphasize the challenges of recruiting and retaining physicians to rural and remote areas while they fail to address the same issues for other health providers who also practice in these areas* (CIHI, 2002). The following reports illustrate these concerns, with a number demonstrating that despite the interest in preserving the health of rural Canadians, few of the identified concerns will be addressed without accountability plans and political support.

Key Health Reports

Preserving the health of Canadians and creating a sustainable health care delivery system has increasingly been a focus of reports at the provincial and national levels. This discussion will focus on the most significant of these reports in regards to their applicability to rural nursing practice. The reports provide a cross-country view of what is being discussed regarding health issues.

Key Provincial Health Reports

A case in point is the province of Ontario, which addressed the need for health services restructuring by focusing on primary health care (Primary Health Care,

[1] The most recent version of this policy statement has been revised and emphasizes that caring for individuals with whom you have a personal relationship changes the relationship to a professional one, which needs clarification. Furthermore, it states that if clarification cannot occur, then the nurse should withdraw from providing care (RNABC, 2002b).

recommendations to Witmer, 1999). Definitions of rural and remote focus on access to health services (i.e., rural refers to being able to reach a primary care centre within one hour whereas remote refers to anything beyond the hour). This approach is commonly used in reports that discuss physicians, however, this allows for a limited understanding of these concepts. The overall recommendation of this report is to develop primary health care groups that will include multi-disciplinary teams of physicians and primary health care-nurse practitioners (PHC-NPs). There is discussion of the need to increase the number of available nurse practitioners (NPs) and to combine this role with midwifery to further expand nurses' functions while ensuring such independent practices are viable. An accountability plan and time line is included to ensure that the suggestions are put in place.

Saskatchewan Commission on Medicare (Fyke, Commissioner 2001) addressed concerns about sustaining a quality medicare system in Saskatchewan in a recently released report. In his report, Saskatchewan is considered to be a rural province (although the term rural was not defined) that has had continuous difficulties recruiting and retaining health care professionals. Despite this ongoing challenge, it was noted that quality should not be jeopardized. There was acknowledgement that nurses' skills are not being fully utilized and if these skills were to be used, then health care delivery concerns within the province would be at least partially addressed. Despite the acknowledgement that the province is mostly rural, there were few recommendations that specifically focused on the unique needs of rural residents. Instead, there were recommendations scattered throughout the report that addressed the needs of

aboriginal residents, specifically those who live in the northern area of the province. The recommendations focused on support for holistic health and the need to support the preparation of aboriginal people in health-care related careers. Like many other reports, there is no accountability plan, including a timeline, to ensure that the recommendations are implemented.

A number of recommendations included in the report, however, could potentially have an impact on rural nursing practice. For example, a recommendation for developing a province-wide plan for specialty care can potentially reduce waiting times for rural residents. Developing a 24-hour telephone advice system could also improve access to health care services for all residents, including those who are rural-based. The report neglected to offer suggestions on how to address the shortages of health care providers and the low morale that exists among this group. Although it notes that nurses can have expanded roles, it does not offer any suggestions regarding how this could occur (Saskatchewan Commission on Medicare [Fyke, Commissioner], 2001).

In Alberta, A Framework for Reform (Mazankowski, 2001), which is commonly referred to as the Mazankowski report, was released in December, 2001. This report on health written for the Alberta government suggested strategies for reorganizing the provincial health care system. One underlying theme of the report is that the average Albertan should have a choice in health care services between private and public health care delivery, an approach that is currently not philosophically supported at the national level even though health is a provincial responsibility. Another theme is that

individuals need to take the responsibility to make healthy choices in their lives, which would then help to decrease the use of the system's resources (Mazankowski, 2001).

There are only a few instances in the report where rural is specifically discussed: these emphasize the shortage of physicians in rural Alberta and the shortage of facilities for those with mental health concerns. Recruitment and retention of health care providers is also noted as a chronic concern. Although a number of recommendations are provided, none specifically addresses the unique needs of the rural and remote areas of the province, but some of the recommendations, such as the more effective use of NPs, will impact the rural areas. As well, expanding the role of the licensed practical nurse (LPN) could also potentially change how care is delivered in rural areas (Mazankowski, 2001). The report failed to outline an accountability plan or opportunities for follow-up to ensure that the recommendations were put into place.

At the territorial level, the newly formed Nunavut is just beginning to develop long term plans regarding health services and hence no reports were available to review. The NWT has released a number of reports in which the notion of rural is taken for granted rather than specifically addressed. As well, the issues and concerns of the territories are often described as related to their northern geographic location, rather than being rural or remote. Finally, concerns in the north are linked to aboriginal self-government issues and considered to be political in nature. Nonetheless, a recent report from the NWT (Cuff, 2001) notes the use of Telehealth and the development of the NP program to allay some of the identified concerns in the NWT. In total 56 recommendations were included and a number are of significance to the current

discussion. One specific recommendation suggested that the number of service delivery regions be reduced from nine to three and that clusters of service be developed so that professionals are available in the geographic areas that need them. They also suggested that a Professional Resources Recruitment Team be developed to address recruitment of health care and social service providers. The authors also recommended that any health centres staffed by only one nurse be closed and alternative, but unexplained, plans be implemented to ensure that the community receives care. Finally, it was suggested that graduates be adequately financially compensated to support entering the NP program.

Key Federal Health Reports

"The Health of Canadians—The Federal Role" (Kirby Report), the final report prepared by the Standing Senate Committee on Social Affairs, Science and Technology (2001), also addressed rural health issues. Proposed solutions to issues such as the nursing shortage and difficulties in providing quality care in aboriginal communities included:

- sustaining federal support of telehealth in rural and remote areas;
- providing the resources needed to train aboriginal people to become health care providers; and
- developing a national health human resource strategy.

The Romanow Report has echoed or mirrored these recommendations.

The Commission on the Future of Health Care in Canada, more commonly referred to as the Romanow report, was released in November 2002 to much anticipation regarding health care reform and sustainability in Canada. The Romanow

Report focuses on several areas of particular relevance to our discussion, including health care providers, rural and remote communities and aboriginal health. The challenges and issues associated with these three areas are presented by Romanow based upon a collaborative consultation process. Recommendations include establishing a Rural and Remote Access Fund to improve access to care for residents in rural and remote settings as well as recruit and retain an appropriate mix of health care providers in those rural and remote communities. Another recommendation that supports rural nursing practice is to reexamine and change the current roles of RNs so that they may perform expanded duties. The Commission also recommends expanding telehealth as one way to improve access to care. Romanow recommends that aboriginal health funding be consolidated and managed through a newly created group, Aboriginal Health Partnerships (AHP), to better organize and deliver health services to this population.

In summary, several key health reports have been released in the last few years, but only the Romanow report makes a conscious effort to specifically address rural health issues. The recommendations of this report have the potential to impact rural nursing practice providing the financial and political support is in place.

Rural Health Issues at the Federal Level

A national rural health strategy was announced June 12, 2000 by former Health Minister Allan Rock to:

1. address the shortage of health care providers,
2. foster research and support health information technology,

3. improve primary health care,
4. improve the rural health infrastructure, and
5. establish a National Rural Health Council.

Through summits and riding workshops (Health Canada, 2001), rural residents identified issues and made recommendations which have the potential to enhance rural nursing practice. Several of the recommendations were implemented, including the development of the Ministerial Advisory Council on Rural Health in 2001 (Rural Health in Rural Hands, 2002). A recent report from this group examined the rural health challenges in Canada and made over 40 recommendations ranging from how to build healthier rural communities to addressing health information technology in rural areas. Of specific concern to our discussion are the following recommendations:

- to support research on rural health services delivery;
- to enhance telehealth for rural settings across Canada, including supporting research that evaluates such projects;
- to develop a national health human resources strategy to address recruitment and retention in rural, remote and Aboriginal communities;
- to support opportunities for rural residents to gain easier access to health professional education and to provide more financial support for rural residents to receive such an education; and
- to increase opportunities for access to education that incorporates material related to rural areas in academic institutions across the country (Ministerial Advisory Council on Rural Health in 2002).

There has been limited distribution of the report and no indication that the recommendations will be implemented. However, the Romanow report recommended the establishment of a Rural and Remote Access Fund to expand telehealth, address health care provider shortages, and fund new approaches to health care in rural and remote communities (Romanow, 2002). In addition, from the 2003 federal budget, $1.3 billion will be directed to First Nations and Inuit health programs specifically to be directed to nursing and capital development on reserves. The most recent federal budget has also earmarked funding of telehealth applications, which are seen as essential in rural areas (Department of Finance Canada, 2003).

Rural Health Issues at the Provincial Level: British Columbia as an Example

There are few provincial reports that exclusively address health issues and health care delivery for rural residents. Some of the exceptions are the documents from the British Columbia Ministry of Health (BCMOH). Of all provincial and territorial governments, British Columbia (BC) has expended considerable effort in attempting to understand and address rural and remote health issues. In 1995, the BC government released the Report of the Northern and Rural Health Task Force, which identified human resource and program needs for northern and rural areas and included a number of recommendations to resolve outstanding issues (Northern and Rural Task Force, 1995). This report defined rural and remote communities as small population centres over a large geographic area often with single resource bases and large distances between communities (Northern and Rural Task Force, 1995).

A follow-up report on enhancing health services for rural and remote communities (BCMOH, 1999) does not define rural, but referred to rural as being equated with geographic location and distance from more elaborate health services. The numerous challenges associated with delivering health services in rural areas are discussed, and future directions are noted, such as focusing on health care service delivery, service coordination, and human resources. More specifically, the recommendations focused on increased involvement of aboriginal peoples to ensure more appropriate health service delivery, the use of telehealth to enhance rural and remote health services, and the examination of transportation problems for residents in rural areas.

A second follow-up report to the BCMOH focused on reforming the health system, also addressed rural health issues (BCMOH, 2001b). Although rural is not specifically defined, there is discussion about the special needs of rural residents in terms of accessing health care. Of the 25 recommendations, a number specifically focused on the nursing profession, such as improving working conditions and making better use of nurses' skills. One of the recommendations supports the use of NPs while another discusses the need for educational options to increase access for individuals across the province. Assistance with tuition and linking tuition assistance to areas where there are nursing shortages were proposed. If put into place, the recommendations have the potential to have a positive impact on rural nursing practice by recruiting local residents into the profession.

The Assess and Intervene Report (Report to the Minister of Health on the Recruitment and Retention of Registered Nurses and Registered Psychiatric Nurses in British Columbia, 2000) included a section on rural and northern nursing. Unlike other reports, there is discussion of three types of rural nurses: those who have remained or returned to their rural home, those who have unexpectedly moved to a rural setting (most often due to spousal employment), and those who consciously chose to relocate to a rural area.

The specific challenges for rural nurses, such as the duality of roles in being both a community member and professional, and the social and professional isolation are noted. As in other reports, the difficulties in recruiting and retaining RNs in rural and northern environments are also acknowledged. Recommendations focused on creating an aboriginal nurses' entry program to increase the number of aboriginal nurses, expansion of the RN First Call program, implementation of nursing support programs through the internet to decrease professional isolation, and examination of other health care delivery system models (i.e., Red Cross Hospitals) that have been successful at retaining nurses to incorporate lessons learned to other health care delivery models in BC.

In the appendices of this report, there is a focus on aboriginal nurse recruitment and retention strategies (Appendix F), and the information directly applicable to rural nursing and nursing practice in aboriginal communities (Appendix F). Recommendations include the establishment of summer employment programs for nursing students, especially those who are First Nations members, and efforts to ensure

that First Nations that have transferred health services to band control have sufficient funds to support nursing staff. The report also points out that the recommendations have costs associated with them, but the savings in recruitment costs will help balance the initial start-up funds.

The Nursing Shortage

There is a growing realization by government departments and agencies that recruiting and retaining nurses for rural and remote areas will be even more challenging in light of the predicted nursing shortage. A number of annual reports from provincial governments make specific note of the forecasts for fewer nurses in rural areas and the concomitant affects on health care (Report to the Minister of Health on the Recruitment and Retention of Registered Nurses and Registered Psychiatric Nurses in British Columbia, 2000; Saskatchewan Health, 2000; Nova Scotia Department of Health, 2001, 1999; East Prince Health Board, 2000).

An essential underlying factor is the nursing shortage which has been predicted for some time. Ryten (1997) conducted a cohort analysis to determine supply and demand for nurses and found that the need for nurses would increase due to the aging of the population. Given this scenario, Ryten found that there were not enough individuals entering and graduating from nursing programs. The most recent report on nursing human resource projections (Canadian Nurses Association [CNA], [Ryten], 2002d) identifies that by 2011, there will be a shortage of 78,000 nurses that will reach 113,000 by 2016. One discussion paper (CNA, 1997) and follow-up submission to the federal government discussed the predicted nursing shortage and requested that the

federal government undertake initiatives to rectify the projected shortage despite provincial responsibility for health (CNA, 1998a). That same year another document was released that identified the recruitment and retention issues for nurses, noting the specific challenges for northern, rural and isolated areas (CNA, 1998b). In a similar vein, the CNA (2000b) conducted a labor market integration evaluation and found that nurses were underemployed due to higher rates of part-time employment and the fact that two out of 10 nurses decide to leave the profession within three years of graduation. Although not directly linked to rural and remote nursing practice, the findings generated from these reports have a direct impact on this field of nursing because of the decreased number of nurses in general that will be available for recruitment to rural areas.

At the federal level, discussion about the pending nursing shortage and the need to strengthen the nursing workforce began in 1999 with the nursing strategy released in 2000 (Advisory Committee on Health Human Resources [ACHHR], 2000). Further support regarding the reality of the nursing shortage is discussed in Commitment and Care (Baumann, et al, 2001), which emphasizes that unhealthy workplaces have contributed to the nursing shortage. Although these document do not specifically address rural and remote nursing practice issues, the suggestions regarding addressing the nursing shortage will affect the number of nurses available to work in rural and remote areas.

A number of organizations echoed the need for a national nursing strategy in Canada. The Nurses Association of New Brunswick (NANB), (2002) submitted a brief to

Commission on the Future of Health Care in Canada noted that the need for such a national strategy as one of three pressing issues. The report identifies immediate policy interventions such as supporting the recruitment of candidates to the nursing profession and ensuring that nurses have access to continuing education. The federal government was asked to work with the national, provincial and territorial nursing associations to implement such policies (NANB, 2002).

Developing a Nursing Workforce for Rural Settings

Rural nurses have been referred to as generalists, with a range of practice, extending from outpost to institutional nursing that includes specific activities such as home care, health promotion and telephone advice (Report to the Minister of Health on the Recruitment and Retention of Registered Nurses and Registered Psychiatric Nurses in British Columbia, 2000).

Several reports have addressed the link between a sustainable health care system and a workforce that experiences a balance between job satisfaction and recruitment and retention. A case in point is the report to the Deputy Minister of Health for Saskatchewan, which discussed health human resource challenges among all front-line health care providers in that province (Backman, 2000). The goal of the report was to provide recommendations to Saskatchewan Health to address such challenges. This lengthy, comprehensive report included stakeholder meetings, discussion groups and solicitation of briefs to ensure a full understanding of the issues was achieved. Similar to other reports, the term rural is not specifically addressed, but the report does address rural practice issues among health care providers. It is recognized that rural areas have

greater difficulties with recruitment and retention and that the province can no longer rely on rural women returning as nurses to their home communities. Of the 30 recommendations, those relevant to rural nursing focus on advanced practice nurses and their development through the offering of an appropriate educational program, as well as bonuses as incentives for rural nurses. Financial assistance with tuition costs for nursing refresher courses for those who have left the nursing profession (RNs, LPNs or psychiatric registered nurses [PRN]) was implemented since the report was released (Backman, 2000).

The shortages of providers in rural areas prompted two potential solutions: either eliminate the service due to the lack of providers or offer the service through a different mix of providers. Other recommendations that support rural health care providers, and decrease the professional isolation, include a formalized peer support system and continuing education opportunities. Finally, although aboriginal health issues are noted in the report, there are no specific nursing education recommendations that address this concern. Instead, it is recommended that aboriginal educational institutions and Saskatchewan Institute of Applied Science and Technology (SIAST) jointly offer courses for home care aides and special care aids. In 2003, the Nursing Education Program for Saskatchewan (NEPS) was extended to a Prince Albert site, where 40 new baccalaureate education seats are available for aboriginal students in a collaborative arrangement between the Saskatchewan Indian Federated College (SIFC) and the College of Nursing, University of Saskatchewan (U of S). In the other two sites for the NEPS program (Saskatoon and Regina), there are currently 88 students.

Working conditions and satisfaction in general among nurses has been the focus of a number of reports in the last several years. Remus, Smith & Schissel (2000) conducted a study to identify nursing environment issues that affect the recruitment, retention and practice of nurses. The 631 respondents in this study noted a number of frustrations with their workplace and their role, including the lack of nurses available to work leading to increased overtime and call-backs, decreases in support staff leading to more clerical duties being conducted by nurses, and feeling that they cannot provide safe, competent care given the heavy patient loads and lack of resources. The report clearly indicates the high level of stress of nurses including physical and psychological abuse they face from co-workers, patients, families, and employers. Of the entire sample, 24% experienced physical abuse (27% of institutional nurses compared to 13% of community nurses); and 39% reported psychological abuse (42% of institutional nurses and 26% of community nurses) (Remus, Smith & Schissel, 2000). Nurse safety was also noted as a problem because of the lack of support staff (i.e., security personnel) during night shifts at hospitals, having to leave community buildings alone late at night after presentations, and worries during home visits when domestic violence has been identified as an issue. These are compounded in rural areas where the settings are much more isolated.

The findings acknowledge the challenges that lie ahead for recruitment and retention of nurses in rural areas. Within the next 5 years, 40% of the rural nurses surveyed expect to retire and this figure jumps to 66% in the next 10 years. In comparison, of the urban nurses surveyed, 34% plan to retire in the next 5 years and

50% plan to retire in the next 10 years. The percentage declaring interest in retirement, combined with the predicted nursing shortage and the lack of support for nursing students to complete clinical placements in rural parts of Saskatchewan, will adversely affect the recruitment and retention of nurses for rural Saskatchewan (Remus, Smith & Schissel, 2000). Interestingly, a labor market analysis of Saskatchewan nursing (including LPNs) paints a much brighter picture (Elliot, 1999). In describing the nursing shortage in the northern parts of Saskatchewan, Elliot rightfully comments that the difficulties in recruiting in 1998 were no different than in the past but fails to specifically address what will happen in these regions in the future given the predicted national nursing shortage.

The Remus et al report includes a total of 21 recommendations that range from paid leave and relief staff to allow for continuing education among nurses, to work safety issues. There are several recommendations that focus specifically on rural issues including that clinical experiences be increased in rural areas for nursing students, that nursing education programs be delivered in multiple formats so that students can remain in their communities as long as possible, that Saskatchewan Health and health districts provide financial support for nursing students while they are completing rural nursing clinical placements, and that rural health districts provide bursaries to nursing students to encourage them to return to rural areas (Remus, Smith & Schissel, 2000).

Workplace quality of life has been raised as an ongoing concern in a number of the reports that were reviewed. Dussault et al (1999) held an invitational roundtable of stakeholders in nursing including RNs, LPNs and PRNs, to examine labor issues for

nursing. This report included a comprehensive review of the literature and identified the concerns regarding the nursing labor workforce (i.e., aging workforce, poor quality work environments), the impact on nursing practice (i.e., heavy workload and inability to provide quality care to clients), the response of the nursing profession to the changes in the health care delivery system (i.e., models for practice and changes to practice) and recommendations by the stakeholders (i.e., improve working conditions, incentives for nurses to return to the profession).

Although rural nursing practice is not specifically addressed in the Dussault et al report, nursing services in aboriginal communities were discussed. In addition, the issues that were addressed throughout the report all apply to rural areas, and in some cases, are an even greater challenge in that setting. For example, recruitment and retention of nurses for rural communities is even more difficult than for urban locales. Although many of the suggestions have been discussed in other reports, it is noteworthy that the same themes continue to emerge. Specific policies and initiatives have the potential to make the necessary changes thereby improving the overall work environment for nurses. One other strength of this report was the identification of several gaps in the literature that if filled, would assist in policy creation and implementation. Information is needed about mobility of nurses between provinces, nursing services to aboriginal communities where access is an ongoing issue, and the capacity of nursing programs to prepare master's prepared nurses. There is, however, no discussion regarding how these gaps could be filled and no specific follow-up or

accountability plan to ensure the recommendations discussed in the report are implemented.

The CNA has responded to worklife issues by hosting a workshop on the Quality of Worklife Indicators (QWI) for Nurses in Canada, which was held in Ottawa, April, 2002 (CNA, 2002e). In total, eight indicators were generated (span of control, leadership, overtime hours, full-time, part-time / casual ratios, autonomy / scope of practice, professional development opportunities, absenteeism, & grievances). The indicators were not specifically developed for rural nurses, and are to be used cautiously when discussing the quality of worklife for rural nurses. The indicators do, however, provide direction for policy development in regards to nurses' worklife.

The CNA has pointed out the significance of nurses who provide care in rural and remote areas of Canada. In the 2001 brief to the Romanow Commission, the CNA notes the link between rural community sustainability and the location of health care facilities and employees (CNA, 2001a). The CNA pre-budget submission to the House of Commons Standing Committee on Finance (CNA, 2002f) recommends incentives to attract health professionals to rural and remote areas. However, no specific activities are suggested to meet this recommendation.

Other nursing associations have been vocal about the need to prepare, recruit and retain nurses in rural areas. For example, the 2001 RNABC brief to the Ministers of Health Planning and Health Services specifically addressed the need for changes and suggested that nurses can contribute to a reorientation of the health system (RNABC, 2001). The brief addressed an overall plan to change and thereby improve the BC health

care system. This provincial association highlighted the need to (1) improve the effectiveness of the health care system, (2) reorient the health care system through, for example, the acceptance of NPs in providing primary care, and (3) implement strategies to meet the health human resource needs. The latter refers not only to actual numbers of available nurses but also to the need for a healthy workplace, which is equated with success in retaining nurses and commitment to care (RNABC, 2001). Rural nursing is not specifically addressed, but a number of the comments are directly relevant to this area of nursing.

There are 11 recommendations in total under the three main areas as noted above. One of the recommendations is to continue to support the RN First Call program (Appendix I). In this program nurses use clinical practice guidelines to provide care for selected clinical problems in emergencies in rural and remote areas, thereby decreasing the amount of on-call time by the physician while improving health care access for the public (MacKinnon Williams, 2000). Another recommendation formally supports the need to educate, regulate and employ NPs in BC. The final recommendation of interest here is that resources be provided for nursing programs to allow for specialty courses in rural and remote practice. Comments are included about the current distance learning opportunities available for nurses throughout the province, and the need to continue such programming to be cost-effective while increasing accessibility (RNABC, 2001). Interestingly, a cursory examination indicates that the recommendations have little connection to rural nursing. It is only after an extensive perusal of the entire brief that the linkages between rural nursing and the recommendations become evident. This

points to the need to examine documents carefully to ensure that the relevance to rural areas is identified.

A recent report on health human resource planning in Canada concludes that we need a national health human resource coordinating agency to attend to our need for an adequate and well-prepared supply of health care providers (Fooks, Duvalko, Baranek, Lamothe, & Randeau, 2002). The authors note that we need to determine the actual number and mix of health personnel required, because addressing the shortfall in numbers is not effective in long range planning for health care service delivery. Four forecasting models are presented with acknowledgement that their application to nursing is unclear due to the manner in which nursing positions are funded. If we add to this the complexity of the rural settings, identifying an adequate forecasting model becomes even more difficulty (Fooks, et al, 2002).

A number of comments in the report are supportive of nursing and identify the need to expand the nursing role through more formal acceptance of NPs. Overall, very little mention of rural is made and when it is discussed, there is an emphasis on rural physicians. The authors acknowledge that the complexity of the issue requires a national effort through a health human resources coordinating agency, which would focus on activities such as conducting an environmental scan of the current health personnel in Canada, trend identification (i.e., trends in numbers), and developing indicators of the health of Canada's health work force (Fooks, et al, 2002).

The Nursing Strategy for Canada was developed by the ACHHR to present ideas that would strengthen the nursing profession (ACHHR, 2000). The report focuses on the

current educational preparation of nurses, the importance of creating quality workplaces, and the predicted nursing shortage. Eleven strategies were forwarded that would attend to collecting information on the current nursing workforce, preparing more nurses by increasing the numbers of nursing education seats, and developing retention strategies. One other strategy suggested was the development of a nursing advisory committee to focus on nurse human resource planning and management (ACHHR, 2000).

This committee, known as The Canadian Nursing Advisory Committee (CNAC), was established in 2001. It released its report, "Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses" (CNAC, 2002) in the fall of 2002. The committee evolved from the recommendations of the National Nursing Strategy (CNAC, 2002). The report addressed not only RNs, but also registered psychiatric nurses and LPNs, and specifically focused on quality of worklife because this was seen as most crucial to the future of the nursing profession. A thorough discussion of the many factors that impact on the quality of life of nurses is discussed. For example, the lack of access to continuing education and violence in the workplace were both noted. The committee acknowledges that there are insufficient numbers of aboriginal nurses prepared in Canada and that education for rural and remote areas is also deficient (CNAC, 2002).

A total of 51 recommendations are provided ranging from student loan forgiveness to creating practice environments that attract and retain nurses. There are only a few recommendations that focus specifically on rural and remote issues. One

recommendation is for the federal and provincial/territorial governments to collaborate with schools of nursing to maximize technological and face-to-face educational opportunities for nurses who work in rural and remote areas, including those who work and reside in Aboriginal communities. A further suggestion was that this recommendation be in place by 2003. Another recommendation is for the government to invest in nurses working in rural and remote settings to ensure recruitment, retention and improved working conditions. Although the other recommendations do not specifically identify rural, they may still affect rural settings and rural nursing practice because the recommendations are supportive of nursing in general (CNAC, 2002). However, like other policy documents, there is no apparent accountability plan to ensure that the recommendations are put into action.

A number of the above reports note solutions to address the overwhelming concerns within the nursing profession. However, when reports are prepared in an attempt to address such issues, rural nursing practice is more often omitted. For example, a report on nursing skill mix and health care outcomes only discusses rural nursing by referring to published literature from Australia (Hailey & Harstall, 2001). Attention needs to be paid to developing reports that address the full range of settings within which nurses practice.

Analyzing the Context of Rural and Remote Nursing Practice

The broad, contextual issues that have been discussed shape the nature of rural and remote nursing practice. However, there are five specific areas that warrant detailed discussion and consideration when examining and analyzing the current state

of rural and remote nursing practice. Those areas are: (1) advanced practice, (2) nursing practice issues in aboriginal communities, (3) educational preparation of RNs for rural and remote areas, (4) physician supply in rural and remote areas, and (5) health care organization and delivery in rural and remote areas.

Advanced Practice

Terms such as NP, clinical nurse specialist and advanced practice nurses have been used interchangeably in a country that has displayed a tenuous relationship at best with the expanded role of nurses (CNA, 1993). Over the years, a number of documents have been produced that have attempted to clarify the meaning of advanced practice, the educational requirements and the legislation of the individuals who are working in these roles.

The CNA has viewed advanced nursing practice (ANP) as “an umbrella term” (CNA, 2000a, p 1) to describe “an advanced level of nursing practice that maximizes the use of in-depth nursing knowledge and skill in meeting the health needs of clients” (CNA, 2000a, p 1). In the initial report on advanced practice, the CNA prepared a framework to address the issues related to this expanded role of nursing. This framework indicated that the ANP would be a role of the nurse but not a legislated title like “registered nurse.” According to the framework there are five competencies of an advanced nursing practitioner: clinical, research, leadership, collaboration, and change agent. To accomplish these competencies, it is preferred that an ANP undertake graduate preparation. Furthermore, some of the roles of an ANP would include clinical

nurse specialist[2] and NP. The domain of practice for such individuals would predominantly be clinical practice with their regulation maintained within the existing regulatory bodies (CNA, 2000a). The more recent revised CNA document on advanced practice (CNA, 2002a) takes a stronger stand noting that the minimal educational preparation for advanced practice is a graduate degree in nursing.

Furthermore, a recent review of NP competencies in Canada indicated a high level of congruency of provincial competency statements (L. Little, Personal Communication, May 8, 2003).

Discussion on ANP focuses on expanding the role of nurses for the benefit of the profession, whereas others merely perceive such expansion as an alternative to recruitment and retention of physicians in rural areas. Topics such as this are of particular concern when examining nursing practice in rural and remote areas. A case in point is the Saskatchewan Government release of a Memorandum to Cabinet "Improving Access to Rural Health Care" (Bruni, DeWolfe, Nakamura & Stokes, 2001). This particular memorandum defines rural as a population of less than 10,000 but does not exclude communities that are in proximity to larger centres. The recommendations include improving the delivery of primary health care to rural Saskatchewan by permitting nurses to take on more responsibility, thereby alleviating the pressure on physicians. Despite this intention, the report states that resistance will be met by members of the Saskatchewan Medical Association, a not uncommon finding among

[2] However, in another CNA document on the clinical nurse specialist (CNS) (1993), it is implied that a CNS is an individual who focuses on care rather than diagnostic activities adding further confusion when using these terms.

other medical associations across Canada. The strategies highlight the benefits of partnerships between NPs and physicians and the creation of roles that are complementary. The report notes that the government would only be prepared to fund NPs that are committed to providing care in rural areas.

Not all physician groups have raised concerns about the integration of NPs in the delivery of health care services. At the 1998 Annual Policy Conference of the Society of Rural Physicians of Canada, the focus was on NPs and rural medicine (Society of Rural Physicians of Canada, 1998). The report is actually a dialogue that includes presentations from physicians, nurses and health ministers discussing the concept of the NP in relation to providing care to rural residents. The conference participants forwarded five resolutions, but there was no formal action or apparent mechanism of accountability for their implementation.

The Institute for the Advancement of Public Policy (IAPP) (2001) report on the nature of the extended / expanded nursing role in Canada and notes that NPs are expected to work autonomously and collaboratively with physicians in a variety of settings because of the shifting supply of other health care providers. In remote areas, there has been more acceptance of the expanded role of the nurse due to the limited supply of physicians. Although the IAPP report includes a number of recommendations, there is no plan for accountability to ensure that they are implemented.

Provincially, Newfoundland and Labrador recognized NPs at an earlier date than other provinces (Association of Registered Nurses of Newfoundland [ARNN],

1997b). However, as noted in Table 1, other provinces have passed legislation since then to formally acknowledge the NP role. The specific name applied to this role varies from province to province but there is general consistency in the role across the country. The primary health care or family NP provides health care management for individuals, families and communities including prescribing medications. Most provincial nursing associations in Canada have developed nursing practice standards for nurses and a list of competencies. Other roles for the primary health care or family NP include participating in research, working with communities in community development initiatives and professional leadership. Acute care NPs focus on working in institutional settings providing care to unwell individuals in settings such as cardiac rehabilitation units.

Educational preparation for the NP role has varied from a certificate program after completion of a nursing diploma (Chaytor Educational Services, 1993) to a masters level NP program. The nursing documents and reports foresee the NP role as one of natural expansion for the profession, exemplifying collegiality and collaboration (CNA, 1993, 2000a, 2002a; IAPP, 2001). However, the differences in names and roles from one provincial nursing association to another, and the lack of consistency in nursing education for the role, undermines the expansion in scope.

Nursing Practice Issues in Aboriginal Communities

A major component of nursing practice in remote Canada is nursing and health care delivery in Aboriginal communities. Since the early 1900s nurses have been on the front-line providing care in an expanded practice model in these communities (The

Musk-Ox Circle Paper Three Health Services in Northern Canada, 1974). Many nurses work collaboratively with community members and other health and social service personnel to address the health and social needs identified at the local level. To understand the issues faced by nurses who are often the only health care providers within these communities it was necessary to examine government documents and policies relating to the delivery of service. Several crucial factors have, and will continue to have, an important role in the development and delivery of health care. These include:

- transfer of health care delivery to tribal council or local band control;
- the introduction and integration of traditional healing methods;
- the current and predicted nursing shortage;
- the education of Aboriginal persons into nursing.

Knowledge of the impact of government and local policy on practice is critical in light of the rapid changes that are occurring across the country.

Health care delivery to First Nations and Inuit communities originally came under The Northern Health Service of Health and Welfare Canada and was instituted to address the high morbidity and mortality rates of persons in these communities (The Musk-Ox Circle Paper Three Health Services in Northern Canada, 1974). This department has undergone several name changes, first to Medical Services Branch (MSB) and now the First Nations and Inuit Health Branch (FNIHB) of Health Canada. Dependent on the date of the documents that are discussed, the acronym used will be that of the department at that time, recognizing that the responsibility has remained

within the same area of the federal government. Metis living south of the 60th parallel and Aboriginal people who reside off reserve negotiate health services control with the Metis and non-status Indians federal interlocutor (Health Canada, 1999c). When discussing Health Canada documents, the term First Nations will be employed. However, when the term aboriginal is used, it refers to First Nations, Inuit and Metis communities. When the term "Indian" is employed, it reflects the particular historical time period within which the document was published.

Transfer of health services control.

A key factor in health care delivery in First Nations communities officially began in 1986 (Indian and Inuit Nurses of Canada [IINC], 1990) with the transfer of responsibility for service delivery to individual tribal councils and bands. By 1999, 41% (or 244) of the 599 eligible First Nations and Inuit communities had signed Health Service Transfer Agreements (Health Canada, n.d. c). In the 1999/2000 Annual Report of First Nations and Inuit Control, it is noted that 81% of eligible First Nations and Inuit communities are involved in the First Nation/Inuit Control Process (Health Canada, 1999c) (Figure 1). The health transfer agreements apply only to those First Nations and Inuit communities south of the 60th parallel, and hence communities in the NWT, Yukon, Nunavut and the northern most areas of Quebec and Labrador negotiate the control of health services with Indian and Northern Affairs Canada (INAC). (For a more complete discussion of this process see Appendix F). FNIHB nurses work and often reside in rural and remote areas; the meaning of these terms is assumed, rather than explicitly defined. One report implies that remoteness is related to accessibility, access

to services, and support (Health Canada, 1993). In terms of accessibility, factors include how close the community is to other towns or cities, and whether a road or scheduled transportation is available. Access to services relates to the availability of stores, banks or recreation services. In this document, support was defined as the distance to the nearest physician, the frequency of the visits by such health personnel, as well as the availability of social service agencies and schools. A report on nursing and health care in First Nations communities by the Ontario Region and band transfer materials on the FNIHB website (www.hc-sc.gc.ca/fnihb-dgspni/fnihb/pptsp/hfa/ten_years_health_transfer/index.htm) note the following definitions:

- Non-isolated community refers to having road access less than 90 kilometres to physician services with an available health centre in the community;
- Semi-isolated community means that there is road access greater than 90 kilometers to physician services but it has either a nursing station or health centre with treatment component available;
- Isolated community refers to a community that has scheduled air transportation flights, good telephone service, but no roads; a nursing station is available for health services; and
- Remote, isolated community is a community in which there are no scheduled flights, minimal telephone or radio access and no roads; health services are provided through a nursing station.

Interestingly, as can be noted by these definitions, the degree of remoteness and isolation is defined by access to services, the type of health service locally accessible, and transportation and communication availability which are directly related to geographic restrictions.

The documents from MSB and FNIHB that were reviewed described the processes that various tribal councils and bands have undertaken and the steps that are to be followed in the transfer process (Health Canada, 1999c, d, & e). The impact on nursing practice and the challenges faced by nurses in this major devolution of service delivery were not available in the Health Canada documents but were discussed in reports produced by the Aboriginal Nurses Association of Canada (ANAC) formerly known as the IINC. The documents that were examined did not describe the financial arrangements made with the tribal council and bands nor was there any discussion of how these arrangements would evolve over time to address future needs (Health Canada, 1999c, d, & e).

A dominant theme throughout the documents was the emphasis on the shift in health care delivery that was to have taken place from the focus on acute care delivery to health promotion and disease prevention (Minister of National Health and Welfare, 1989). From the documentation there was no means of determining whether this shift in focus has occurred, nor to what degree nurses and transferred communities had embraced this change in health care delivery practice. The suggested focus on preventive care is consistent with proposals in the Romanow report (2002) that

emphasize the need to promote population health and therefore decrease the emphasis on acute care needs.

Issues in the transfer process that nurses have faced were identified by the ANAC, 1995, and IINC, 1990 in several band nurse workshops and by a survey of nurses working in First Nations' communities (IINC, 1990). Because of the impact the issues may ultimately have on recruitment and retention of nurses and on health care delivery, the ANAC are to be commended in their efforts to articulate the challenges and to make recommendations to rectify them. Medical Services has since released documents to assist band councils in hiring RNs (Health Canada, 1999c). One of the greatest problems nurses face is to gain acceptance within the community and be recognized for the fact they are professionals meeting standards of competency, ethical practice guidelines, and clear regulations for their practice. This factor is emphasized when non-nurses, who do not have a clear understanding of nursing competencies and professional expectations, administer nursing services.

Nurses register within the province within which they practice. Provincial registering bodies set the competencies and standards of practice for nurses within their jurisdiction. Some provincial associations have not developed advanced practice guidelines which means that nurses often continue to work under the auspices of federal legislation. It was not clear from the reports whether or how provincial nursing associations have participated in addressing registration and liability issues faced by nurses who practice in aboriginal communities, especially with the large numbers of

communities involved in the transfer process. As the process continues, the involvement of the registering bodies would seem to be an imperative.

A number of documents noted that nurses have not been involved in the transfer process although they will be required to implement the changes in delivery (Minister of National Health & Welfare, 1989; IINC, 1990; & ANAC, 1995). There remains a lack of clarity of exactly under which jurisdiction some projects and programs fall. Accountability may lie within FNIHB, the local band, or both. Professional practice liability coverage is another consideration when hiring nurses and must be recognized as an essential element for the nurse to be able to practice in that jurisdiction.

Nurses and predicted shortage.

The projected nursing shortage in Canada will have a significant impact on nursing within aboriginal communities as well. There have been recruitment and retention challenges with frequent turnover and vacancies in nursing positions within communities; a problem that has existed over many years. Multiple strategies have been suggested by MSB, First Nations authorities and the Professional Institute of the Public Service to address these challenges. These strategies include:

1) Developing an internship program with specialized education an integral part of the program (Health Canada, 1999b);
2) Identifying the profile of nurses who work in these communities (ANAC, 2000);
3) Provision of clinical support with adequate orientation and ongoing supervision and guidance from senior nurses (Health Canada, 1999b);

4) Addressing housing and lifestyle needs of nurses and their families (Health Canada, 1999b);
5) Developing congruency between the need to prevent excessive workload and "burnout" for the nurses and the expectations of the community for the service that is to be provided (CHCL Comprehensive Healthcare Consultants Ltd., 1995); and
6) Educating Aboriginal persons, particularly First Nations members, as RNs who are more likely to remain in the community (Nowgesic, 1990).

Although the ANAC is clearly the most proactive organization in advocating for aboriginal nurses, particularly within First Nation communities, the membership does not include all of the Aboriginal nurses in Canada. Aboriginal status is made known through self declaration and therefore, it is difficult to obtain accurate data regarding the numbers of Aboriginal RNs in Canada, as well as the numbers of Aboriginal students in nursing programs across the country.

Education of Aboriginal persons into nursing.

The most current report on the recruitment and retention of Aboriginal students into nursing has been produced by a joint task force under the auspices of the Canadian Association of University Schools of Nursing (CAUSN) now renamed the Canadian Association of Schools of Nursing (CASN) in conjunction with Health Canada, FNIHB, and the ANAC. The research team for Against All Odds: Aboriginal Nursing (Health Canada, 2002) sought information from CAUSN member schools, Aboriginal students, provincial education / government officials, Aboriginal organizations, FNIHB, and regional nursing officers and associations. An extensive literature and report review

was conducted by the report's authors to thoroughly examine previous discussions and studies on the issue. The issues and challenges faced by Aboriginal students, as well as multiple recommendations are outlined in this report. Recommendations focused on funding for aboriginal students for expenses such as child care, housing and relocation costs, and availability of counselors who are trained to specifically deal with aboriginal issues (Health Canada, 2002).

Programs that discuss the educational preparation of aboriginal nurses will be discussed in the following section, Educational Preparation of Registered Nurses for Rural and Remote Areas. In addition to preparing aboriginal RNs, specialized programs to prepare nurses to practice in remote areas were developed between MSB and Dalhousie University and later McMaster University. The development of advanced clinical skills programs that provide credits toward degrees are now in place in several educational institutions, with support for nurses to attend provided by FNIHB. Examples of such programs include the primary or advanced skills courses at the University of Manitoba, the University College of the Cariboo (Kelowna), and Aurora College (Yellowknife).

In summary, the reports reviewed for this section identified the 1) personal and work related challenges faced by nurses in aboriginal health care delivery (IINC, 1990); 2) difficulties discerning whether the multiple recommendations that were made by the writers of governmental and other documents were followed (e.g., Health Canada, 1999a & b); and, 3) challenges in identifying who is responsible for implementing the recommendations.

Educational Preparation of Registered Nurses for Rural and Remote Areas

The current and projected nursing shortage will have a potentially dramatic effect in rural regions as the present cohort of nurses retires. An integrated and collaborative effort between governments, regional health authorities where they exist, nursing associations / colleges, and educational institutions that will prepare nurses for practice in rural and remote settings is essential.

Despite an extensive study of government, educational institutions, and nursing association documents and web sites, little literature was found regarding the education of RNs to work in rural and remote regions of the country (Appendix G). For example, the Standards for Nursing Education in New Brunswick (NANB, 1997) does not mention rural but implies it as an issue, as noted in its 4th principle adopted from the College of Nurses of Ontario: "Accessibility—Accessibility suggests that nursing education programs reduce barriers to access, such as geographic location (emphasis added), language and culture" (p. 1). Other standards of nursing education documents from New Brunswick that were reviewed do not mention rural in their discussion (NANB, 1997). Entry-level competencies developed for the provincial and territorial nursing associations are further examples of documents that have been generically developed without inclusion of specific comments or information about rural or remote nursing practice settings (Manitoba Association of Registered Nurses [MARN], 2000).[3]

The majority of the literature that did address education for remote practice focused on ANP and First Nations and Inuit health care needs and preparation. For

[3] The title and acronym of this nursing association reflects that used in the specific report. Thus, two names and acronyms are used due to the recent change in name of this nursing association.

example, the University of Manitoba, Brandon site, offers a rural nursing/rural health care focus within their four-year curriculum (The University of Manitoba, 1999). Aurora College in the NWT offers a Bachelor of Science in Nursing program from which the students can graduate with a diploma after three years. Due to the geographic location of the program, students engage in rural nursing throughout the entirety of the program (Aurora College – Your Career Starts Here, n.d. a). Aboriginal students are given priority for entrance into the program. The maximum number of students that can be accommodated is 40 and in September, 2002, there were 30 enrolled students (N. Moulton, Personal Communication, February 21, 2003). Aurora College also offers a 16-month certificate Primary Health Care—Nurse Practitioner (PHC-NP) program, which is available through a brokering arrangement with the Centre for Nursing Studies in St John's Newfoundland. Students complete their practicum components throughout the territories, and upon completion the PHC-NP graduates are eligible for registration with NWTRNA (Aurora College – Your Career Starts Here n.d. b). Finally, Aurora offers the Grant MacEwan College Nurse Refresher Program for RNs who need to become reinstated.

In September, 2002 the SIFC offered a four-year nursing program based on the U of S curriculum at the Prince Albert SIFC site (D. Campbell, Personal Communication, February 21, 2003). The program is limited to 30 students with preference given to aboriginal individuals. The physical location of the program dictates that the clinical settings will be predominantly rural. The U of S offers a rural nursing clinical option in the post Bachelor of Science in Nursing program. The program allows students the

opportunity to experience nursing in a rural site to help them increase their knowledge and skills that are needed essential to working in rural areas. The University of Northern British Columbia (UNBC) offers numerous rural-related courses and certificates. For example, rural courses are offered in the undergraduate nursing program. Both theory and practicum components focus on rural and northern-related health issues in many nursing areas including mental health, obstetrics, emergency, and so on. The UNBC also offers a rural option as part of the student's final focus area in the Post-Diploma Program, which is similar to the one offered in the undergraduate program. The Northern Collaborative Baccalaureate Nursing Program (NCBNP), which is offered through UNBC, also has rural-focused options as well as First Nations options for those students who wish to pursue these areas of practice. Finally, the UNBC offers a "Certificate in Rural and Northern Nursing".

In the province of Alberta, baccalaureate nursing programs at Lethbridge, Red Deer, Grand Prairie, Edmonton, Calgary and Medicine Hat place students in rural settings for clinical practica. In the senior year the University of Calgary students can select placements in rural settings that then entails theoretical content on issues in health care and nursing. As a mandatory component of the University of Calgary at Medicine Hat Program, all students must take rural nursing with clinical practice in rural settings. Content of this program focuses on rural populations, environmental health issues, history of nursing in rural communities, and issues for practice. The University of Lethbridge Nursing Program also explicitly focuses on rural nursing

practice and has a mandatory rural nursing course, although rural clinical placements occur throughout the program.

Many educational programs have students who may complete some of their studies in practicums at rural sites. Usually these students are preceptored by nurses who work in rural facilities and home care programs. Placement in a rural setting is often by choice and is not a specific requirement of the nursing program that students have a rural experience. A few programs offer a course in rural nursing and health care practice and theory within the curriculum. No government documents were found addressing the need to provide educational opportunities and assistance for students in rural sites.

The advent and potential expansion of telehealth to rural and remote sites will have a significant impact on the delivery of health care. It was not clear whether any programs were including education on the use of this technology within their nursing programs, even at a preliminary stage. Current nursing students are knowledgeable in the use of computers and computer assisted learning which has become integral to many programs. As telehealth and telemedicine expands, educators will have to think of innovative ways to include the use of this technology within the curricula. As well, technological infrastructure and financial assistance to do so, will be required within the educational institutions.

The availability of the infrastructure within rural facilities and organizations for computers and internet access varies greatly across the country. A FNIHB (2001) information sharing session recommended increased access to clinical information via

computers and teaching their nursing employees about health informatics. Many centres have access to computers for internal use in the facility but dependent on where or how access is provided differs substantially be it in southern Alberta, in an outpost in Newfoundland, in a small town in northern Ontario, or a health centre in the Yukon. There are financial implications to providing such a service and in times of restraint and cutbacks there was no documentation found regarding how or by whom such service should be provided.

One model for the recruitment and retention of RNs for rural practice could be based on the Alberta Rural Physician Action Plan (RPAP) that is supported by Alberta Health (available at www.RPAP.ab.ca). In agreement with medical faculties at the Universities of Alberta and Calgary, support is provided for mandatory and elective rural rotations for medical students and family medicine and specialty residents. Students receive accommodation and travel reimbursement. In addition, they are provided with technological supports such as computer access. Residents in the second year of their program are given tuition re-imbursement for Advanced Trauma Life Support (ATLS) and Advanced Cardiac Life Support (ACLS) courses they take. A key component of the RPAP program is development support for rural physicians who preceptor these medical students. If such a program were to be implemented for nursing students it would require a commitment from government to provide financial support for students who choose to complete rural practicums with the goal of attracting these students to a rural practice. However, such support could be an effective recruitment and retention strategy for nurses in rural sites.

Other programs might include an extended mentoring or orientation program during which time newly employed RNs could develop the breadth of skills required in rural settings. The BCMOH supports mentors and preceptors in the health field, with the goal being to reduce the number of nurses who leave the profession soon after their graduation. In this program, a mentor is an experienced nurse who provides ongoing support to a newly hired graduate nurse, and a preceptor provides support to a student nurse during their final year in the nursing education program. In both instances, the program allows for training and professional development for both the mentors and preceptors, and allows these individuals to have a reduced patient load in order to function effectively within this special role. Health authorities and affiliates of First Nation and aboriginal health organizations within BC were all eligible to apply for special funding from the BCMOH to participate in this program (BCMOH, 2001a). Although this program is not specifically targeted at rural and remote areas, it offers benefits and assistance for nursing practice and nurses within these areas. An unpublished document from the CNA conducted an environment scan on incentives offered to professionals who work in rural and remote areas (CNA, 2002c) Hopefully, a complete examination of the cross-Canada incentives will lead to national recommendations on this matter. At the provincial level, recommendations were made to the Ontario Ministry of Health and Long-Term Care (OMHLTC) to offer nursing students free tuition if they were willing to practice in a rural community after graduation (Registered Nurses Association of Ontario in collaboration with the Registered Practical Nurses Association of Ontario, 2000).

Physician Supply in Rural and Remote Areas

A section in relation to physicians has been included for several reasons: (1) rural health care is a multi-professional challenge and therefore it is necessary to review documents relevant to other health professionals, and discuss the impact that they have on the nurses who practice in rural and remote areas, (2) legislation related to the role of nurses, particularly those in ANP, are influenced by physician availability, roles and expectations, (3) physicians have developed rurality indexes and alternative definitions for the terms rural and remote, which would benefit from more detailed critique, (4) data on physicians and physician practice problems is more often available because it is tied to remuneration; (5) physicians are the health professionals who are most organized and politically prepared to address issues related to health services in rural and remote areas.

Hence, an examination of the recruitment and retention of physicians in rural and remote Canada can be useful for the nursing profession.

Of all health services groups, the documents related to physicians are the most focused when discussing the impact of rural and remote geographic settings and issues such as recruitment and retention of physicians. The Canadian Medical Association (CMA) has a task force that addresses rural and remote health issues and some medical specialties have specific committees that address rural and remote issues. For example, the Canadian Association of Emergency Physicians (CAEP) has its own Rural Committee. In addition, The Canadian Society of Rural Physicians (CSRP) has

provincial and territorial chapters across Canada; they communicate with their members through their web site, a peer-reviewed journal and a newsletter.

Some of the reports use the term “underserved” (The CMA, 1992) without critiquing the meaning of this term. Terms such as underserved are largely drawn from the American experience, which may not be suitable in the Canadian context. A number of the articles include definitions of rural and remote and several of them focus on combining geographic distance with variables such as time required to transport individuals who require medical attention at a major health centre.

Another definition of rural focuses on rural practice, which is defined as “practice in non-urban areas where most medical care is provided by a small number of general practitioners” and there is limited access to specialists and advanced facilities (Rourke 1997 as cited in Iglesias, Grzybowski, Klein, Gagne & Lalonde, 1997, p 2). Other physicians have published rurality indexes (Leduc, 1997; Magee, 2000), but there has been limited comparison and critique of the indexes, and there has been no formal testing to determine their applicability to rural health in general.

Other individuals within the medical profession have focused on developing a national framework of rurality (Buske, Yager, Adams, Marcus & Lefebvre, 1999). A rurality index is not intended to define a community as rural, but to “determine its relative degree of ruralness relative to an established norm or relative to another community” (Buske et al, 1999, p 11). A joint project of the CMA, CNA, Society of Rural Physicians of Canada, and the Canadian Pharmacists Association (2003) developed an

index for rurality to assist in the recruitment of health care providers, but it has been too soon to test its applicability.

Overall, the reports that focus on physicians in rural and remote areas address recruitment and retention issues and stress the importance of financial incentive programs, the need to expose students to rural practice during their training, promoting community involvement as a way to attract physicians (CMA, 1992), and regionalizing care such that rural areas are connected to regional centres in order to ensure adequate support for providing quality care (CAEP, 1997). More specific recommendations are often drawn from the broad strategies but there is rarely an accountability process in place to determine whether or not the recommendations were adopted (CAEP, 1997). Related CMA documents address the need for quality care, including quality maternity or emergency care, and provide recommendations to reach this goal. The recommendations, however, focus on training and preparation of physicians and do not recognize the advanced practice nurse as being a colleague. These reports also do not include an accountability process to determine the success of adopting the recommendations (The College of Family Physicians of Canada, the Society for Rural Physicians, and the Society of Obstetrics and Gynecologists of Canada, 1999; Iglesias, Grzybowski, Klein, Gagne, & Lalonde, 1997).

In 2000, the CMA released its policy on rural and remote practice issues (The CMA, 2000). The 28 recommendations address issues such as training, compensation and work/lifestyle support. The policy was prepared to help groups such as communities, policy-makers and governments address the recruitment and retention

challenges of physicians in rural areas. In this brief, they suggest using the Statistics Canada Rural and Small Town Canada definition of rural (those who live outside the commuting zones of larger urban centres, (du Plessis, Beshiri & Bollman, 2001), but also include in their definition the four characteristics of rural communities as identified by the 1999 survey of rural physicians outlined above (CAEP, 1997).

Various reports are available from the Centre for Health Services and Policy Research at the University of British Columbia. Often the reports do not include a definition of remote but have defined rural as less than 10,000 inhabitants with urban considered to be greater than 10,000 inhabitants. The studies that have been completed by the Centre for Health Services and Policy Research have concluded that practice location choices by physicians are determined by the influence of physician spouses, community factors such as presence of schools, and opportunities for spousal employment (Kazanjian, Pagliccia, Apland, Cavalier & Wood, 1991; Pagliccia, Apland & Kazanjian, 1993).

Provincial policy approaches to address problems with the recruitment and retention of physicians in rural communities have led to a variety of programs including subsidized incomes or guaranteed minimum income for physicians in rural areas, funded rural locum programs, tying student loans to return for service commitments in rural areas, and funding for rural physicians to partake in continuing education (Barer, Wood, & Schneider, 1999). The authors conclude that the majority of Canadian incentives for physicians are financial (and hence not appropriate for nursing given the differences in payment systems); the lack of a national mechanism to address

shortages of health professionals partly because health is viewed as a provincial responsibility; and the inconsistency regarding the employment of non-physicians to provide care in “underserved” areas. For example, there is limited education and legislation to prepare and support NPs in an expanded role.

A discussion paper prepared for the Federal / Provincial / Territorial Advisory Committee on Health Human Resources (Barer & Stoddart, 1999) revisited the issue of recruitment and retention of physicians in rural and remote communities. While the focus is on physicians, a discussion about the use of NPs is included in the recommendations for providing health care in rural areas. The need for educational opportunities, regulatory modifications to allow activities such as prescribing medications, and administrative funding arrangements to employ such individuals, is noted. The authors emphasize that NPs are capable of providing primary care in regions that are lacking adequate health services, although the challenges remain in terms of recruiting and retaining them. It is postulated that NP programs will have greater success in attracting rural individuals who wish to return to reside in those locales with their expanded knowledge.

An Alberta study identified practical strategies that communities can employ to recruit and retain physicians (Alberta Health, 1994). They found that community success in recruiting as based on the physical location and catchment size, number of individuals in the established medical practice, incorporation of a partnership approach, and community efforts toward making the new physician and family feel welcome in a community, which demonstrated that they had “fun”. The report

furthermore identified a seven-step recruitment process that was utilized (Alberta Health, 1994).

The McKendry report (OMHLTC, 2000c) was prepared in response to the absence of an Ontario physician human resource policy or plan. This report focuses on examining the current state of policy in relation to the availability of physicians, and on providing recommendations to create a resource plan. The intended effects of the recommendations are presented from the physician viewpoint (i.e., reducing physician workload) rather than viewing NPs as colleagues of physicians and members of the team.

A number of recommendations from the McKendry report were accomplished by OMHLTC as noted in Shaping Ontario's Physician Workforce: Report of the Expert Panel on Health Professional Human Resources (OMHLTC, 2001b). Canadian physicians who took their postgraduate training in the United States are supported to refresh their skills through updated training for the Canadian environment. The number of personnel to assist rural communities in recruiting health professionals was also increased. The Ontario government also expanded the telehealth program (another of McKendry's recommendations) to southern Ontario leading to the hiring of over 100 nurses for this program, which was expected to reduce unnecessary emergency room visits (OMHLTC, 2001b).

The remaining McKendry report recommendations were referred to the Expert Panel on Health Professional Human Resources for further attention. This Panel had two other McKendry recommendations addressed by the OMHLTC, namely the

development of a more reliable physician database and provision of funding for interim increases in undergraduate and postgraduate positions (OMHLTC, 2001b).

Unlike other documents, the report developed by the Expert Panel openly acknowledges not only the shortage of physicians, but other health professionals in rural areas. It also notes how NPs can be used effectively to address the shortage in these areas. The OMHLTC has targeted new funding to increase the number of NPs in underserviced areas and aboriginal communities. More specific issues that need to be addressed in regards to the shortage of physicians in Ontario are discussed in 30 other recommendations in the report, which range from providing incentives to specialists to encouraging physicians to provide more services (OMHLTC, 2001b). Timelines and mechanisms of accountability regarding the recommendations were included in the report with the first to be implemented in 2002. Ongoing evaluation of the Expert Panel's success is required.

Health Care Delivery in Rural and Remote Areas

The present economic climate, the growing number of informed consumers and increased demand for broader health services all combine to affect on nursing practices in rural and remote areas.

Current state of health care delivery.

Several reports discuss the unique issues impacting the current state of health care organization and delivery in rural and remote areas. One such report, from the Saskatchewan Home Care Workshop 2000 (Fontaine Associated Consulting Services Inc., 2000), discusses challenges for rural nurses such as the lack of volunteers,

recruitment / retention of RNs, cultural uniqueness of Aboriginal populations, and service delivery over large geographic distances. A report by Manitoba Health (Manitoba Health, n.d. a) outlines types of core health services available to Manitoba residents, however, which of these services are available in rural and northern areas is not clearly defined.

The Ontario Nursing Task Force (OMHLTC, 2000b) recommended that money be designated to the training and hiring of NPs. Recent business plans for Ontario's Ministry of Health and Long-Term Care support improving health care access within Ontario's rural and northern regions (OMHLTC, 1999a; 2000a; 2001a). The goal of the 1998 / 99 business plan was to increase the number of physicians in areas where the numbers are lower than the provincial average. While the 1999 / 00 plan acknowledges the role of NPs in providing care, particularly among Aboriginal populations, this plan most often refers to recruiting physicians for these areas rather than focusing on the NP's role (OMHLTC, 2000a).

The emphasis of the Ontario business plans, short term, is on the NP providing care to individuals who reside within geographic areas where there are no physicians. The implication is that when educational preparation for physicians includes more rural and northern training, and recruitment techniques are successful, the current limited availability of health care providers will be resolved (OMHLTC, 1999a). There is no mention of enhancing nursing education to include rural experience.

Two significant reports on health in the NWT (2000b Final Report of the Minister's Forum on Health and Social Services for the NWT; Minister's Response to the

1999 Forum on Health and Social Services, 2000a) emphasize the need to put previous recommendations in place to improve service delivery. The reports focus minimally on recommendations specifically to nursing. The emphasis was on long-term plans such as providing northerners with opportunities for education such as NP programs, at local colleges (Northwest Territories Health and Social Services, 2000a Minister's response to 1999 forum).

Alternative mode of health care delivery.

Alternative modes of health care delivery may assist nurses in meeting the challenges of providing health care in rural areas. The RN First Call Program in British Columbia (MacKinnon Williams, 2000) was a pilot program started in 1996/97 using RNs in rural and remote emergency departments, to manage minor, uncomplicated injuries and health problems. Following additional educational preparation, RNs assess, diagnose and treat clients with the use of established clinical protocols. Both the British Columbia Nursing Union and the RNABC supported the project. Even though MacKinnon Williams (2000) suggests cautions in the interpretation of the program evaluation due to a limited response, the authors recommended the program be expanded.

The Rural Nurse Responder Program available in the Palliser Health Authority in Alberta is another example of alternative delivery. A nurse first responder is available within their rural community to provide both health information and assistance in emergency situations. Additional education in emergency skills was provided for the nurse (L. Ferguson, Personal Communication, December 2002). This

program is currently under review since health telephone advice lines are now available in the area (L. Ferguson, Personal Communication, January 2003).

The use of telehealth is increasing across the country as another alternative delivery method. Defined as “the use of communications and information technology to deliver health care services and information over large and small distances” (CNA, 2001c), telehealth is most often seen in remote settings, using telecommunication for consultation and diagnosis. Visual images are sent to a health professional or consultant often saving the client a trip out of the community.

Conflict arises between the pressure to use telehealth in remote and isolated areas, and the lack of sufficient policies and resources to support nursings’ role within it. A discussion paper commissioned by the Aboriginal Nurses’ Association of Canada (ANAC, 2001) notes that telehealth may challenge nurses’ scope of practice beyond their educational preparation or their practice guidelines. In addition, nurses’ workload may actually increase with telehealth. The ANAC report recommends nursing programs provide education in technology of telehealth as well as providing distance continuing education programs in telehealth. Educational institutions will require adequate resources to allow all students the opportunity to develop the skills required in the use of telehealth.

Some authors point out potential liability issues of telehealth (Lee, 1997). Health Canada supports these concerns, finding that RNs are not sufficiently prepared (Dal Grande, 2001). This concern is also identified in a Nova Scotia report on telenursing.

Telenursing, one aspect of telehealth, is defined by RNANS[4] as "using electronic links to establish communication with client and or other health professionals, in order to deliver professional nursing services" (Registered Nurses Association of Nova Scotia, 2000). In Newfoundland, an Association of Registered Nurses of Newfoundland and Labrador (ARNNL) statement (2002a) emphasizes the importance of the nurse providing advice in an accountable and competent manner, ensuring they do not work outside of their scope of practice. The ARNNL recommend that agencies develop policies and guidelines for nurses who provide telenursing.

Based on a 1999 recommendation to the OMHLTC, 1999(b) a telephone health advisory / triage program was implemented in 2001 for all Ontario residents (OMHLTC, 2001b). The 1999 report recognized that such a service would be efficient, effective and often decrease visits to health providers. RNs answer calls using a combination of Decision Support software, clinical guidelines and clinical judgment. The service is available 7-days / week, 24 hours / day for all Ontario residents. Access and confidentiality may be compromised in rural areas where party lines are still present and telephones are not available in all homes.

A recent NWT health action plan (Northwest Territories Health and Social Services, 2000b) recommended that telehealth be more available to all NWT residents, ultimately assisting health providers in providing service as well as accessing continuing education.

[4] The RNANS has since changed its name to the College of Registered Nurses of Nova Scotia (CRNNS).

CONCLUSIONS: ANSWERING THE POLICY QUESTIONS

This documentary analysis has been part of a national study that is examining the nature of nursing in rural and remote Canada. Examining documents such as educational standards, materials on band transfers of health services and governmental reports on rural health issues has provided a contextual understanding of the policy environment within which rural and remote nurses practice. When combined with the secondary analysis of the RNDB, the survey results and analysis of the narratives, a more complete understanding of the complexity of rural and remote nursing practice will be achieved.

The framework for examining the documents focused on policy formulation, policy implementation and policy accountability (Rist, 1994). Within these three aspects, a series of questions were used to guide the reading and analysis of the documents (see page 3 and Appendices A-C). Furthermore, five thematic areas (advanced practice; nursing practice issues in Aboriginal communities; educational preparation of RNs for rural and remote areas; and health care delivery in rural and remote areas) were identified after the initial perusal of the documents. The major issues related to these themes have been discussed at length in the individual attached appendices and summarized in this part of the report.

Returning to the questions raised at the onset of the documentary analysis, this section focuses on the answers that were generated within the documents. Of significance is the lack of clear definitions for the terms “rural” and “remote.” Documents from organizations such as Health Canada (from MSB, currently FNIHB)

link the definitions of these terms with financial reimbursement for nursing practice. Many of the documents that were reviewed fail to include any discussion whatsoever of these terms. It is taken for granted that the theoretical meaning of this term is understood by all individuals within the organization that is preparing the document or by the audience for whom it is developed. Furthermore, such a lack of definitions does not take into account the range of diverse rural and remote communities that exist across Canada. The lack of attention to the meaning of rural and remote and the diversity of such settings simplifies the complexity of nursing practice in such locales.

Advanced practice is a topic within nursing that has generated considerable interest in the last few years. Several provincial government reports have noted the importance of using advanced practice nurses in rural and remote areas as one measure to address the concerns of recruiting and retaining other health professionals, such as physicians (OMHLTC, 2001b; Saskatchewan Commission on Medicare [Fyke, Commissioner], 2001). Of late, the documents that discuss advanced practice have identified more specifically the meaning of this term and the types of competencies and educational preparation required to work within this role (CNA, 2002a). Thus far, the documents have not specifically noted the impact on rural or remote nursing practice but have generally discussed the importance of the expansion of nursing's role to the profession and to the health status of individuals (IAPP, 2001). It is therefore anticipated that the recent changes in policies regarding advanced practice will enhance nursing practice in rural and remote areas.

Nursing practice issues within Aboriginal communities have been longstanding in that working in remote areas has required not only a high level of nursing skill but also the personality and skills to successfully live within such settings. More recent issues revolve around band transfers of health services in Aboriginal communities south of the 60th parallel, which are becoming common place. The impact of such band transfers are widespread due to:

- The increased number of nurses who will work as band-employed health personnel; 60% of the transfers are expected to be completed by 2005 (Health Canada, n.d. c),
- The need for an understanding by the band and community about the meaning of transferring health services to their jurisdiction,
- The need for a clear understanding by both the band and nurse about the contract within which the nurse will be hired,
- The need for a clear set of competencies and educational preparation to ensure the appropriate level of care is provided at the community level, and
- The need for provincial nursing licensure to ensure competencies and liability insurance coverage are met.

Although these impacts are easily identified, the documents are limited in their discussion about them especially in light of their significance for nursing practice. There is also limited discussion about the difficult employment conditions under which the band-employed nurse is working. The ANAC has acknowledged the need to address

such circumstances through a series of workshops and through continuous political advocacy. In addition, FNIHB has also been increasingly proactive of late to ease the challenges associated with band transfers.

Educational preparation of Aboriginal persons within the nursing field has once again drawn greater attention but few of the documents discuss policies to increase the number of such persons in the nursing field. A recent exception is the report Against All Odds: Aboriginal Nursing (Health Canada, 2002), which focused on the barriers and challenges experienced by Aboriginal students' entry to nursing programs. The comprehensive list of recommendations that is included has the potential to rectify the current shortage of Aboriginal nurses in Canada. This is significant because many will work in rural and remote areas of this country.

Educational preparation of nurses for rural and remote areas of Canada is another area that has not been the focus of documents which address rural health. There are several universities that prepare students for rural and remote settings, but no documents could be found that address: (1) an evaluation of such programs, (2) the actual numbers of graduates who work in rural and remote areas, or (3) the impact of the number of nurses prepared for rural and remote areas compared to the number required.

Inter-related with the preparation of nurses for rural and remote areas is the emphasis on the use of technology to deliver health care. One example is the use of telehealth. However, there is no evidence that this technology is being used in the educational preparation of rural and remote nurses. Such a lack of congruence between

policies and associated activities demonstrates the need for policy accountability. Overall, policy accountability is not evident in most of the documents that were reviewed for this report. Consequently, it is difficult to identify the outcomes of the policies in regards to nursing practice in rural and remote areas.

In summary, the documents that were reviewed indicate that there are few policies that specifically address rural and remote nursing. Instead, the discussion focuses on nursing practice in general with the assumption that the policies will be directly applicable to rural nursing. This is not always the case, however, and hence the recommendations in the following section are meant to address some of these limitations.

RECOMMENDATIONS

A national nursing consortium consisting of the Office of Nursing Policy (ONP), CNA, FNIHB, and CASN can work together to advocate for the implementation of the following recommendations. The use of experts from provincial and territorial nursing associations, nursing unions and nursing programs by this consortium is also important to help ensure that the recommendations will be implemented. It is imperative that the consortium be formulated by Fall 2003 due to the urgency of the issues noted in this report. Financial assistance is required from governments in order to address the following ideas; this is a necessary step in order to strengthen rural nursing practice and hence achieve quality care for Canadians living in rural and remote settings. Examples of activities are included with each recommendation but are not an exhaustive list.

Rather, the national nursing consortium would be responsible for generating a complete list of activities.

Recommendation One:

Develop a national rural health human resource strategy by individuals with expertise in rural health issues

Stage(s) of Policy Cycle addressed: Policy Formulation and Policy Implementation

Issues addressed:

- Complexity of rural nursing
- Quality of worklife
- Recruitment and retention issues
- Unique challenges of rural areas
- University-health region collaboration to address rural health

Activities:

- Development of a committee to oversee the national rural health human resource strategy
- Development and distribution of a discussion paper on rural nursing through the CNA office
- Development of multi-disciplinary health programs and initiatives that address the unique challenges of rural health issues

Accountable Agencies: CNA, FNIHB, Office of Nursing Policy (ONP), and the provincial and territorial nursing and government representatives as well as nurse educators

Timeline: Spring 2004

Recommendation Two:

Create alternative payment options for nurses and physicians in rural areas

Stages of Policy Cycle addressed: Policy Formulation

Issues addressed:

- Full scope of practice for nurses
- Support for advanced practice

Activities:

- Examination of health regions that currently have alternative payment options
- Implementation and evaluation of alternative payment options in select rural and remote areas across Canada
- Implementation of alternative payment options in rural and remote settings across Canada based upon results of above activity

Accountable Agencies: Governments and health regions

Timeline: Spring 2005

Recommendation Three:

Develop scholarships and bursary programs for rural nursing students and rural-based nurses

Stages of Policy Cycle addressed: Policy Implementation

Issues addressed:

- Rural residents need to be encouraged to return to their home areas
- Recruitment and retention of aboriginal peoples in nursing
- Encourage nurses with lapsed licenses to return to practice
- Support rural nurses in their continuing education efforts

Activities:

- Examination of current scholarship and bursary programs for rural residents in nursing
- Development of corporate sponsored scholarship and bursary programs, i.e., with sponsors that are rural-focused such as farming businesses and natural resource companies
- Joint university-health region scholarships and bursaries

Accountable Agencies: Governments, health regions and universities

Timeline: Fall 2004

Recommendation Four:

Implement initiatives to enable full scope of nursing practice, including advanced practice in rural areas with process and outcome evaluation in rural and remote areas

Stages of Policy Cycle addressed: Policy Implementation

Issues addressed:

- Full scope of practice
- Integration with physicians and other health professionals
- Consistent roles, titles of NPs within Canada
- Mobility of NPs in Canada

Activities:

- Evaluative research on full scope of nursing practice projects and advanced practice
- Implementation of collaborative university-health region programs and initiatives that support full scope of practice but are appropriate for the specific community
- National regulatory framework for NPs
- National set of standard competencies for education in preparation of the nurse practitioner role

Accountable Agencies: CNA, provincial and territorial nursing associations / colleges, ONP, CASN, universities, CMA, governments, health regions and Canadian Student Nurses Association

Timeline: Spring 2005

Recommendation Five:

Implement educational initiatives and complementary supports for nurses working with Aboriginal peoples

Stage(s) of Policy Cycle addressed: Policy Implementation and Policy Accountability

Issues addressed:

- Broader supports for band-employed nurses
- Continued support of the FNIHB Internship Program
- Need for monitoring of current nursing education for Aboriginal peoples
- Need for examination of nursing education for non-Aboriginal peoples who will work with Aboriginal peoples

Activities:

- Creation of distance learning opportunities for nurses working in rural and remote areas with Aboriginal peoples including telehealth
- Annual workshops and bi-annual conferences for nurses working with Aboriginal people to address issues such as being a band-employed nurse

- Evaluation of existing nursing and continuing education programs for those working with Aboriginal peoples and implementation of findings in further program development

Accountable Agencies: FNIHB, ANAC, CNA, CASN, nurse educators, Aboriginal bands

Timeline: Fall 2004

Recommendation Six:

Implement financial and technological support for universities with a rural-focused mission

Stage(s) of Policy Cycle addressed: Policy Implementation and Policy Accountability

Issues addressed:

- Preparation of graduate faculty to enhance rural research agenda and create future rural nurses
- Incentives and rewards for rural-based clinical faculty
- Examination of current nursing programs that are rural-focused
- Monitoring of suitability of current rural clinical placements
- Availability and use of technology such as telehealth

Activities:

- Select university sites where telehealth will be available
- Development of graduate programs in rural health and rural nursing
- Examination of incentive models for rural-based clinical faculty and recommendations regarding best practices for incentives and rewards
- Examination of nursing curriculum that is rural focused

Accountable Agencies: Government, universities, CASN, nurse educators, health regions

Timeline: Spring 2004

Recommendation Seven:

Offer continuing education for nurses who work in rural and remote areas

Stage(s) of Policy Cycle addressed: Policy Formulation and Policy Accountability

Issues addressed:

- Financial support based on a national index
- Workplace professional support
- Quality of worklife

Activities:

- Use of distance delivery methods to deliver continuing education
- Collaborative university-health region projects to provide continuing education opportunities for front-line nurses

Accountable Agencies: health regions, universities

Timeline: Spring 2004

References

Aboriginal Nurses Association of Canada. (1995). Band nurse workshops summary report (29 page report). Ottawa: Author.

Aboriginal Nurses Association of Canada. (2000). Survey of nurses in isolated First Nations communities: Recruitment and retention issues (73 page report). Ottawa: Author.

Aboriginal Nurses Association of Canada. (2001). Impact of technology on Aboriginal nursing: A discussion paper (93 page report). Ottawa, ON: Author.

Advisory Committee on Health Human Resources. (2000). The nursing strategy for Canada (47 page report).

Alberta Association of Registered Nurses. (1995). Competencies for registered nurses providing extended health services in the province of Alberta. Edmonton, AB. Retrieved June 25, 2001, from http://nurses.ab.ca/pdf/Competencies_for_Registered_Nurses_Providing_Extended_Health_Services_in_the_Province_of_Alberta.pdf

Alberta Association of Registered Nurses (Re-endorsed February 2000 for two years). Prescribing and distributing guidelines for registered nurses in advanced practice providing primary health care services. Edmonton, AB. Retrieved May 21, 2002, from http://www.nurses.ab.ca/pdf/Prescribing_and_Distributing_Guidelines_for_Registered_Nurses_in_Advanced_Nursing_Practice_Providing_Primary_Health_Care_Services.pdf

Alberta Association of Registered Nurses. (2002a). Nurse practitioner (NP) competencies. Edmonton, AB: Author. Retrieved October 27, 2002 from, http://www.nurses.ab.ca/pdf/Nurse-Practitioner-Competencies.pdf

Alberta Association of Registered Nurses. (2002b). Prescribing and distributing guidelines for nurse practitioners. Edmonton, AB: Author. Retrieved October 27, 2002 from, http://www.nurses.ab.ca/Prescribing%20and%20Distributing%20Guidelines.pdf

Alberta Health. (1994). Pockets of good news: Physician recruitment in rural Alberta. Conducted by Hutchinson Associates, Edmonton, AB.

Alberta Statutes and Regulations. (1999). Nursing Profession Act, Nursing profession extended practice roster (AR 16/99). Edmonton, AB: Queens Printer for Alberta. Retrieved June 25, 2001, from http://www.gov.ab.ca/qp/ascii/regs/1999_016.TXT

Alberta Statutes and Regulations. (2002). Public Health Act, Appendix, Nurse practitioner regulation. Edmonton, AB: Queens Printer for Alberta. Retrieved February 7, 2002, from http://www2.gov.ab.ca/home/publications/orders_in_council/2002/602/2002_298.html

Association of Registered Nurses of Newfoundland. (1997a). Council position statement. St. John's, NF: Author.

Association of Registered Nurses of Newfoundland. (1997b). Plan of action for the utilization of nurses in advanced practices throughout Newfoundland & Labrador. NF: Author.

Association of Registered Nurses of Newfoundland. (1999). Standards interpretation: Dispensing by registered nurses. St. John's, NF: Author.

Association of Registered Nurses of Newfoundland and Labrador. (1998a). Competencies for nurse practitioner – Primary health care. St. John's, NF: Author. Retrieved October 27, 2002 from, http://www.arnn.nf.ca/links/np_competencie.htm

Association of Registered Nurses of Newfoundland and Labrador. (1998b). Nurse practitioner – Standards of practice. St. John's, NF: Author. Retrieved October 27, 2002 from, http://www.arnn.nf.ca/links/np_phc_standards.htm

Association of Registered Nurses of Newfoundland and Labrador. (2000). Competencies for nurse practitioner – Specialist. St. John's, NF: Author. Retrieved October 27, 2002 from, http://www.arnn.nf.ca/links/np-specialist%20competencies.htm

Association of Registered Nurses of Newfoundland and Labrador. (2002a). Telephone nursing care: Advice and information. St. John's, NF: Author. Retrieved October 27, 2002 from, http://www.arnn.nf.ca/links/telephone_advice_draft_feedback_2002.htm

Association of Registered Nurses of Newfoundland. (2002b). The professional regulatory framework for nurse practitioners Province of Newfoundland & Labrador. St. John's, NF: Author.

Aurora College – Your Career Starts Here. (n.d. a) Bachelor in Science of Nursing. (n.d.). Retrieved February 10, 2003, from http://www.auroracollege.nt.ca/prog_template.asp?id=160

Aurora College – Your Career Starts Here. (n.d. b) Nurse practitioner. Retrieved February 10, 2003, from http://www.auroracollege.nt.ca/prog_template.asp?id=462

Backman, A. (2000). Job satisfaction, retention, recruitment and skill mix for a sustainable health care system. Report to the Deputy Minister of Health for Saskatchewan. Health Workplace Opportunities, Resources and Challenges for Saskatchewan. Retrieved June 30, 2001, from http://www.health.gov.sk.ca/info_center_pub_WDRCS.pdf

Barer, M.L., & Stoddart, G.L. (1999). Improving access to needed medical services in rural and remote Canadian communities: Recruitment and retention revisited. Ottawa, Ont. Retrieved February 9, 2001, from http://www.srpc.ca/librarydocs/BarSto99.htm

Barer, M.L., Wood, L., & Schneider, D.G. (1999). Toward improved access to medical services for relatively underserved populations: Canadian approaches, foreign lessons. (HHRU 99:3) Vancouver, BC: University of British Columbia, Centre For Health Services and Policy Research.

Baumann, A., O Brien-Pallas, L., Armstrtong-Stassen, M., et al. (2001). Commitment and care: The benefits of a healthy workplace for nurses, their patients and the system, A policy synthesis. The Change Foundation.

British Columbia Ministry of Health. (1999). Enhancing health services in remote and rural communities of British Columbia. Retrieved June 25, 2001, from http://www.moh.hnet.bc.ca/rural/rap.pdf

British Columbia Ministry of Health, BC's Health Action Plan: Putting Patients First. (2001a) Mentorship/preceptorship grant program. Retrieved June 25, 2001, from http://www.bchealthaction.org/nursementor.html

British Columbia Ministry of Health, BC's Health Action Plan: Putting Patients First. (2001b). Nurse practitioners. Retrieved June 25, 2001, from http://www.bchealthaction.org/nurseprac.html

British Columbia Ministry of Health. (2002). Enhancing health services in remote and rural communities of British Columbia (November 1999). An update on former recommendations (April 2002).

Bruni, I., DeWolfe, J., Nakamura, G., & Stokes, D. (2001) Memorandum to Cabinet: Improving access to rural health care. Retrieved June 30, 2001, from http://qsilver.queensu.ca/~wolfer/082MPA/MCs/Grp4.pdf

Buske, L.M., Yager, S.N. Adams, O.B., Marcus, L., & Lefebvre, F.A. (1999). Rural community development tools from the medical perspective: A national framework of rurality and projections of physician workforce supply in rural and remote areas of Canada. Ottawa: Canadian Medical Association.

CHCL Comprehensive Healthcare Consultants Ltd. (1995). Study of extra duty resources, Indian and Northern Health Services, Health Canada. Ottawa, ON.

Canadian Association of Emergency Physicians. (1997). Recommendations for the management of rural, remote and isolated emergency health care facilities in Canada. Ottawa: Author.

Canadian Institute for Health Information (CIHI). (2002). Canada's Health Care Providers. Ottawa: Author.

Canadian Medical Association (CMA), Canadian Nurses Association (CNA), Society for Rural Physicians of Canada, & Canadian Pharmacists Association. (2003). The development of a multistakeholder framework/index of rurality. Final Report to Health Canada: Rural and Remote Health Innovations Initiative. Ottawa, ON: Canadian Nurses Association.

Canadian Nurses Association. (1993). The nurse practitioner: A discussion paper. Prepared by J. Haines, RN, BFA. Retrieved May 27, 2002, from http://www.cna-nurses.ca/pages/resources/nurse_practitioner.pdf

Canadian Nurses Association. (1997). The future supply of registered nurses in Canada (File: 492-481). Ottawa: Author.

Canadian Nurses Association. (1998a). Registered nurse human resources: Recruitment and retention issues (File: 492-492). Ottawa: Author.

Canadian Nurses Association. (1998b). The quiet crisis in health care (File: 492-507). Ottawa: Author.

Canadian Nurses Association. (2000a). Advanced nursing practice: A national framework. Ottawa: Author.

Canadian Nurses Association. (2000b). Labour market integration of graduates in nursing in Canada 1986-1997 A Report prepared by the Canadian Council on Social Development for the Canadian Nurses Association. Ottawa, ON.

Canadian Nurses Association. (2001a). Brief to the commission on the future of health care in Canada: Optimizing the health of the health system. Ottawa, ON: Author.

Canadian Nurses Association. (2001b). Clinical nurse specialist. Ottawa, ON: Author. Retrieved May 28, 2001, from wysiwyg://rbottom.84/http://www.can-nurses.ca/pages/policies/clinical_nurse.html

Canadian Nurses Association (2001c). Position statement: The role of the nurse in telepractice. Ottawa, ON: Author.

Canadian Nurses Association. (2002a). Advanced nursing practice: A national framework. Revised April 2002. Ottawa: Author.

Canadian Nurses Association. (2002b). Fact Sheet: Legislation & regulation of the nurse practitioner in Canada. Ottawa, ON: Author. Retrieved January 9, 2003, from http://www.cna-nurses.ca/pages/policies/fact_sheet/legltn_regltn_np.pdf

Canadian Nurses Association. (2002c). Incentives offered to professionals working in rural, remote or northern communities in Canada. Unpublished.

Canadian Nurses Association. (2002d). Planning for the future: Nursing human resource projections. [E.Ryten]. Ottawa, ON: Author.

Canadian Nurses Association. (2002e). Quality of worklife indicators for nurses in Canada. Retrieved October 27, 2002 from, http://www.can-nurses.ca/pages/resources/quality_workplace_indicators.pdf

Canadian Nurses Association. (2002f). The health system nurses want: A pre budget submission to the House of Commons Standing Committee on finance on behalf of Canada's nurses. Ottawa, ON: Author.

Chaytor Educational Services. (1993). Preparing for outpost practice: An evaluation of the outpost and community health nursing program at Dalhousie University. Unpublished Research Report.

College of Nurses of Ontario. (1998). Standards of practice for registered nurses in extended class (Primary health care nurse practitioners).

College of Nurses of Ontario. (2002). RN(EC) drug and lab lists. ON: Author. Retrieved January 8, 2002, from http://www.cno.org/index_publications.html

College of Registered Nurses of Manitoba. (2002). Draft discussion document: Registered nurse (advanced practice) regulation. Winnipeg, MB. Retrieved October 27, 2002 from, http://www.crnm.mb.ca/regul-AP.htm

College of Registered Nurses of Nova Scotia. (2002a). Nurse practitioner competencies. Halifax, NS. Retrieved October 27, 2002 from, http://www.crnns.ca/documents/nursepractitionercompetences.pdf

College of Registered Nurses of Nova Scotia.(2002b). Standards for practice: Nurse practitioners. Halifax, NS. Retrieved October 27, 2002 from, http://www.crnns.ca/documents/standardsforpracticenursepractitioenrs.pdf

Council of Ontario University Programs in Nursing. (1999). Ontario primary health care nurse practitioner programme. ON. Retrieved July 10, 2001, from http://np.village.ca/info.html

Cuff, G.B. (2001). "It's time to act" A report on the health and social services system of the Northwest Territories. Retrieved June 30, 2001, from http://www.hlthss.gov.nt.ca/publicat/its%20time%20to%20act%20-%20report%20and%20appendices.pdf

Dal Grande, E. (2001). Issues faced and lessons learned: Implementation of Telehealth in First Nations communities. Unpublished presentation. Ottawa: Health Canada.

Department of Finance Canada. (2003). Building the Canada we want. Budget 2003. Investing in Canada's Health Care System. (Cat. No. F1-23/2003-4E). Her Majesty the Queen in Right of Canada.

du Plessis, V., Beshiri, R., & Bollman, R.D. (2001). Definitions of rural. Rural and Small Town Canada Analysis Bulletin, 3(3), 1-17.

Dussault, G., Fournier, M.A., Zanchetta, M.S., Kérouac, S., Denis, J.L., Bojanowski, L., Carpentier, M., & Grossman, M. (1999). The nursing labour market in Canada: Review of the literature. Report presented to The Invitational Roundtable of Stakeholders in Nursing. Retrieved June 28, 200, from http://buildingthefuture.ca/e/study/background/en_report.pdf

East Prince Health Board. (2000). PEI Annual report of 2000. Retrieved June 30, 2001, from http://www.gov.pe.ca/photos/original/EPH_99-00Annual.pdf

Elliott, D. (1999). Labour market analysis: Saskatchewan nursing. A report for: Saskatchewan Health, Saskatchewan Post-Secondary Education and Skills Training. Retrieved June 25, 2001, from http://www.health.gov.sk.ca/info_center_pub_nursestudy.pdf

Epstein, I.E., Kazanjian, A., & MacAulay, D. (2001). Post-hearing update of preliminary report: Licensed practical nurses. Government of British Columbia, Ministry of Health and Ministry Responsible for Seniors, Health Professions Council. Retrieved June 25, 2001, from http://www.hlth.gov.bc.ca/leg/hpc/review/part-i/update-lpnurse.html

Faculty of Nursing Annual Report 2000-2001. (2001a). Addressing the supply of registered nursing in MB. Winnipeg, MB: University of Manitoba.

Faculty of Nursing Annual Report 2000-2001. (2001b). Faculty of nursing proud to announce the graduation of its first Norway House BN program students. Winnipeg, MB: University of Manitoba.

First Nations and Inuit Health Branch (FNIHB). (2001). Information sharing session: Discussion of potential strategies to support nursing practice in First Nations and Inuit communities. Ottawa: Health Canada.

Fontaine Associated Consulting Services Inc. (2000). Home Care Workshop, Saskatchewan Health, Saskatoon, SK. February 17-18, 2000.

Fooks, C., Duvalko, K., Baranek, P., Lamothe, L., & Rondeau, K. (2002). Health human resource planning in Canada: Physician and nursing work force issues. Summary Report, Health Human Services, Ottawa, ON: Canadian Policy Research Networks Inc.

Goodwill, J. (1984). Barriers to employment and retention of native nurses. Ottawa, ON: Indian & Inuit Nurses of Canada.

Goss Gilroy Inc. (2001). Report on the evaluation of implementation of the role of nurse practitioner – primary health care in Newfoundland and Labrador. Prepared for Health and Community Services, Province of Newfoundland and Labrador.

Hailey, D., & Harstall, C. (2001). Nursing skill mix and health care outcomes. Alberta Heritage Foundation for Medical Research (AHFMR), Edmonton, AB. Retrieved May 6, 2002, from http://www.ahfmr.ab.ca/publications.html

Health Canada. (n.d. a) Competency assessment program for community health nurses working with First Nations and Inuit health branch. Retrieved May 21, 2002 from, http://www.hc-sc.gc.ca/fnihb/chp/nursing/publications/competency_assessment/index.htm

Health Canada. (n.d. b). Nursing in First Nations communities. Retrieved January 17, 2003, from http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/ons/nursing/introduction.htm

Health Canada. (n.d. c). Ten years of health transfer First Nation and Inuit control. First Nations and Inuit Health Branch. Retrieved June 28, 2002, from http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/pptsp/hfa/ten_years_health_transfer/index.htm

Health Canada. (1993). Discussing employment: A guide for medical services branch nurses. (Cat. H34-56/1993-1) Ottawa: Minister of Supply and Services Canada.

Health Canada. (1999a). A guide for First Nations on evaluating health programs. Retrieved December 7, 2001, from http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/pptsp/hfa/transfer_publications/evaluating_health_programs.pdf

Health Canada. (1999b). Action on nursing: National nurse retention and recruitment strategy. First Nations and Inuit Health Branch. Retrieved May 21, 2002 from, http://www.hc-sc.gc.ca/fnihb/chp/nursing/publications/actiononnursing/pdf

Health Canada. (1999c). Transferring control of health programs to First Nations and Inuit communities. Handbook 1 – An introduction to three approaches. Retrieved May 23, 2002, from http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/pptsp/hfa/transfer_handbooks/handbook_1.pdf

Health Canada. (1999d). Transferring control of health programs to First Nations and Inuit communities. Handbook 2 – The health services transfer. Retrieved May 23, 2002, from http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/pptsp/hfa/transfer_handbooks/handbook_2.pdf

Health Canada. (1999e). Transferring control of health programs to First Nations and Inuit communities. Handbook 3 – After the transfer – The new environment. Retrieved May 23, 2002, from http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/pptsp/hfa/transfer_handbooks/handbook_3.pdf

Health Canada. (2000a). Community health programs: 1999-2000 annual review index. First Nations and Inuit Health Branch. Retrieved May 21, 2002 from, http://www.hc-sc.gc.ca/fnihb/chp/annualreview/nursing.htm

Health Canada. (2000b). National information sharing & feedback session on the potential future of telehealth in First Nations and Inuit Communities: Final report. First Nations and Inuit Health Branch. Retrieved May 23, 2002, from http://www.hc-sc.gc.ca/fnihb/chp/telehealth/publications/information_sharing_sessions.pdf

Health Canada. (2001). Canada's rural health strategy: A one-year review. Minister of Public Works and Government Services Canada: Author. Retrieved October 27, 2002 from, http://www.hc-sc.gc.ca/english/media/releases/2002/pdf_docs/2001_76ebk1.pdf

Health Canada. (2002). Against the odds: Aboriginal nursing. National Task Force on Recruitment Strategies. Ottawa, ON: Author.

Health Canada. (2003). Nursing in First Nations communities. Retrieved January 17, 2003, from http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/ons/nursing/jobs/bonuses.htm

Health Canada, First Nations and Inuit Health Branch, Ontario Region. (n.d.) Nursing and Health Care in First Nations Communities.

Howard Research and Instructional Systems Inc. (2000). Advancing primary health care in Alberta: Final evaluation report. Edmonton: AB. Retrieved June 25, 2001, from http://www.health.gov.ab.ca/key/phc/resource/FinalReportV6.pdf

Iglesias, S., Grzybowski, S., Klein, M.C., Gagne, G.P., & Lalonde, A. (1997). Joint position paper on rural maternity care. The College of Family Physicians of Canada. www.cfpc.ca/ruralmathom.htm

Indian and Inuit Nurses of Canada. (1990). Band nurse workshop III on the transfer of health services. Ottawa: Author.

Jennett, P., Scott, R., Hailey, D., Ohinmaa, A., Thomas, R., Anderson, C., Young, B., Lorenzetti, D., Hall, L.A., Milkovich, L., Claussen, C., Perverseff, T., Brownell, S., Jadavji, A., Sanguins, J., & Yeo, S. (2002). Socio-economic impact of telehealth: Evidence now for health care in the future. Calgary, AB: Health Telematics Unit, University of Calgary.

Kazanjian, A., Pagliccia, N., Apland, L., Cavalier, S., & Wood, L. (1991). Study of rural physician supply: Practice location decisions and problems in retention (HHRU 91:2). Vancouver, BC: University of British Columbia, Centre For Health Services and Policy Research.

Kulig, J.C., Thomlinson, E., Curran, F., Macleod, M., Stewart, N., & Pitblado, R. (2002). Recognizing and addressing the challenges: The impact of policy on rural and remote nursing practice. Documentary Analysis Interim Report: Policy Analysis for The Nature of Rural and Remote Nursing Practice in Canada. Lethbridge, AB: University of Lethbridge.

Lakehead University. (2001). Native nurses entry program. Thunder Bay, ON: Author.

Leduc, E. (1997). Defining rurality: A general practice rurality index for Canada. Canadian Journal of Rural Medicine, 2(2): 125 [On-line]. Retrieved July 16, 2002, from http://www.cma.ca/cma/common/displayPage.do?pageId=/staticContent/HTML/NO/12/cjrm/vol-2/issue-3/0125.htm

Lee, M. (1997). Telehealth in Canada: Clinical networking, eliminating distances. CANARIE Inc. Retrieved May 27, 2002, from http://www.canarie.ca/press/publications/pdf/health/telehealth.pdf

MacKinnon Williams. (2000). Evaluation of the RN first call program, final report. Vancouver: Registered Nurses Association of British Columbia/British Columbia Nurses' Union.

Magee, G.C. (2000). A procedural skills rurality index for the medical community. Canadian Journal of Rural Medicine, 5(1): 18. Retrieved July 16, 2002, from http://www.cma.ca/cma/common/displayPage.do?pageId=/static/Content/HTML/NO/12/cjrm/vol-5/issue-1/0018.htm

Manitoba Association of Registered Nurses. (2000). Entry level competencies for registered nurses in Manitoba 2000-2006.

Manitoba Health. (n.d.). Core health service categories and inventory of existing services. Retrieved June 25, 2001, from http://www.gov.mb.ca/health/rha/core.pdf

Martin-Misener, R., Vukic, A., & May, R. (1999). Lessons learned from the Dalhousie outpost nursing program. In W, Ramp, J. Kulig, I. Townshend, & V. McGowan (Eds)., Health in rural settings: Contexts for action. (pp. 203-213). Lethbridge, AB: University of Lethbridge.

Minister of National Health and Welfare. (1989). Handbook on nursing. Ottawa: Health and Welfare Canada.

Ministerial Advisory Council on Rural Health. (2002). Rural health in rural hands: Strategic directions for rural, remote, northern and Aboriginal communities.

North Network. (2003). North network: The ABC's of telehealth.

Northern and Rural Task Force. (1995). Report of the northern and rural task force (RA771.7.C32B74 – ISBN 0-7726-2533-6). British Columbia: Rural Health Services, Medical Care, Ministry of Health and Ministry Responsible for Seniors.

Northwest Territories Health and Social Services. (2000a). Minister's response to the 1999 forum on health and social services. Retrieved June 30, 2001, from http://www.hlthss.gov.nt.ca/publicat/pdf/response.pdf

Northwest Territories Health and Social Services. (2000b). Our communities our decisions: Let's get on with it!. Final Report of the Minister's Forum on Health and Social Services. Retrieved June 30, 2001, from http://www.hlthss.gov.nt.ca/publicat/pdf/Minister's%20Forum%20Report.pdf

Northwest Territories Registered Nursing Association. (1994). Determining scope of practice: Guidelines for NWT nurses. Yellowknife: Author.

Northwest Territories Registered Nurses Association. (2002). Legislation. Retrieved October 27, 2002 from, http://www.nwtrna.com/legislation.htm

Nova Scotia Department of Health. (1999). Minister's task force on regionalized health care in Nova Scotia Final report and recommendations July 1999. Retrieved July 9, 2001, from http://www.gov.ns.ca/health/taskforce/default.htm

Nova Scotia Department of Health. (2001). Nova Scotia's nursing strategy. www.gov.ns.ca/health/downloads/strategy.pdf

Nowgesic, E. (1990). Survey of native and non-native nurses working in native communities and the number of native students studying nursing. Ottawa, ON: Indian & Inuit Nurses of Canada

Nunavut Arctic College Nunatta Campus. (n.d.) Bachelor of Science in Nursing (Arctic Nursing). Iqaluit, NU.

Nurses Association of New Brunswick. (1997). Standards for Nursing Education in New Brunswick. Retrieved June 25, 2001, from http://www.nanb.nb.ca/english/nursed.html

Nurses Association of New Brunswick (2002). Submission to the commission on the future of health care in Canada. Fredericton, NB. Retrieved October 27, 2002 from, http://222.nanb.nb.ca/en/pdf-e/Publications/Briefs_&_Presentations/Submission_to_the_Commission_on_the_Future_of_Health_Care_in_Canada_April_19_2002_E.pdf

Ontario Ministry of Health and Long-Term Care. (n.d.), Telehealth Ontario: Questions and answers. Retrieved June 30, 2001, from http://www.gov.on.ca:80/MOH/english/pub/ministry/telehealth_2.html

Ontario Ministry of Health and Long-Term Care. (1999a). Business plan 1998-1999. Retrieved June 25, 2001, from http://www.gov.on.ca:80/MOH/english/pub/ministry/bplan98/bplan98.html

Ontario Ministry of Health and Long-Term Care. (1999b). Recommendations for a telephone health education and triage/advisory service. Retrieved June 25, 2001, from http://www.gov.on.ca:80/MOH/english/pub/ministry/telehealth.html

Ontario Ministry of Health and Long-Term Care. (2000a). Business plan 1999-2000. Retrieved June 25, 2001, from http://www.gov.on.ca:80/MOH/english/pub/ministry/bplan99/bplan99.html

Ontario Ministry of Health and Long-Term Care. (2000b), Good nursing, good health: An investment for the 21st century. Report of the Nursing Task Force. Retrieved June 30, 2001, from http://www.gov.on.ca:80/MOH/english/pub/ministry/nurserep99/letter.html

Ontario Ministry of Health and Long-Term Care. (2000c). Physicians for Ontario: Too many? Too few? For 2000 and beyond. Prepared by R. McKendry. Retrieved June 25, 2001, from http://www.gov.on.ca:80/MOH/english/pub/ministry/mckendry/mckendry.html

Ontario Ministry of Health and Long-Term Care. (2001 a). Business plan 2000-2001. Retrieved June 30, 2001, from http://www.gov.on.ca:80/MOH/english/pub/ministry/bplan00/bplan00.html

Ontario Ministry of Health and Long-Term Care. (2001b). Shaping Ontario's physician workforce. The Expert Panel on Health Professional Human Resources. Retrieved May 10, 2002, from http://www.gov.on.ca/MOH/english/pub/ministry/workforce/workforce.pdf

Pagliccia, N., Apland, L.E., & Kazanjian, A. (1993). Study of rural physician supply: Perceptions of rural and urban (HHRU 93:1). Vancouver, BC: University of British Columbia, Centre For Health Services and Policy Research.

Pong, R.W. (2001). Sharing the learning, The health transition fund, Synthesis series, Rural health/telehealth. Sudbury, ON: Health Canada. Retrieved October 27, 2002 from, http://www.hc-sc.gc.ca/htf-fass/english/rural_en.pdf

Poole, K., Morton, A.M., & Boone, M. (1997). Understanding attrition of Aboriginal nursing students. Lakehead University. Funded by the Health Careers Program, Medical Services Branch, Health Canada.

Pottinger, M.E. (1994). A preceptorship model for nurses in rural health care facilities (Rural Education Research Series No. 2). Brandon, MB: Brandon University, The Rural Development Institute.

Premier's Advisory Council on Health for Alberta. (2001). A Framework for Reform (Mazankowski Report). Edmonton, AB.

Primary Health Care Strategy, Health Services Restructuring Commission. (1999). Advice and recommendations to the Honourable Elizabeth Witmer, Minister of Health.

Registered Nurses Association of British Columbia (RNABC) Policy Statements. (2000). Nurse-client Relationships: Establishing Professional Relationships & Maintaining Appropriate Boundaries. Retrieved May 28, 2001, from www.rnabc.bc.ca/pracsupp/position.htm

Registered Nurses Association of British Columbia. (2001). Better system, better health care. RNABC Brief to the Ministers of Health Planning and Health Services. BC: Author.

Registered Nurses Association of British Columbia. (2002a). Nurse practitioner project update. Retrieved October 27, 2002 from, http://www.rnabc.bc.ca/newnews/nursepractitionerupdate.htm

Registered Nurses Association of British Columbia. (2002b). Nurse-client relationships. Vancouver, BC: Author.

Registered Nurses' Association of Nova Scotia. (1999). Position paper on advanced nursing practice. Halifax: NS. Retrieved May 27, 2002, from http://crnns.ca/documents/advancednursing.pdf

Registered Nurses' Association of Nova Scotia. (2000). Guidelines for telenursing practice. Halifax: NS. Retrieved May 30, 2002, from http://www.crnns.ca/documents/telenursingpractice.pdf

Registered Nurses Association of Ontario Advanced Clinical/Practice Fellowship for Nurses (ACPF). (2001), NORTH Network/NorWest Community Health Centre Final Report. ON: Author.

Registered Nurses Association of Ontario in collaboration with the Registered Practical Nurses Association of Ontario. (2000). Ensuring the care will be there: Report on nursing recruitment & retention in Ontario.

Remus, G., Smith, B., & Schissel, B. (2000). Creating supportive environments for registered nurses in Saskatchewan. Saskatoon, SK: University of Saskatchewan.

Report to the Minister of Health on the Recruitment and Retention of Registered Nurses and Registered Psychiatric Nurses in British Columbia. (2000). Assess and intervene. Rural and Northern Nursing Retrieved June 25, 2001, from http://www.hlth.gov.bc.ca/cpa/publications/rpnurses/assessintervene.pdf

Rist, R. (1994). Influencing the policy process with qualitative research. In N. Denzin & Y. Lincoln (Eds.), Handbook of qualitative research. (pp. 545-557). Thousand Oaks, CA: Sage.

Romanow, R.J. (2002). Building on values: The future of health care in Canada. Ottawa, ON: Canadian Government Publishing Communications Canada.

Ryten, E. (1997). A statistical picture of the past, present and future of registered nurses in Canada (50 page report). Ottawa: Canadian Nurses Association.

Saskatchewan Commission on Medicare. (2001). Caring for Medicare: Sustaining a quality system. [K.J. Fyke, Commissioner]. Regina, Saskatchewan Health.

Saskatchewan Health. (2000). Annual report 1999-2000. Regina, SK: Government of Saskatchewan, Medical Services and Health Registration Branch. Retrieved June 30, 2001, from http://www.health.gov.sk.ca/info_center_pub_SaskHealth%201999-00%20Annual%20Report.pdf

Saskatchewan Health. (2001). Healthy people. A healthy province. The action plan for Saskatchewan health care. Regina, SK: Author.

Saskatchewan Registered Nurses' Association. (1990). Roles and functions for registered nurses employed by Indian Health Authorities in northern Saskatchewan 1990. ISBN: 0-9690350-6-3.

Saskatchewan Registered Nurses' Association. (2003). Registered nurse (Nurse practitioner) RN(NP) Standards & core competencies. Regina, SK: Author.

Schreiber, R., MacDonald, M., Davidson, H., Crickmore, J., Moss, L., Pinelli, J., Regan, S., Pauly, B., & Hammond, C. (2003). Advanced nursing practice: Opportunities and challenges in British Columbia – Final Report. British Columbia.

Society of Rural Physicians of Canada, Annual Policy Conference. (1998). Nurse practitioners and rural medicine: Voices from the field. St. John's, Newfoundland, May 5, 1998. Retrieved June 30, 2001, from http://www.srpc.ca/librarydocs/NPpolyco.htm

Society of Rural Physicians of Canada. (2002). About the SRPC. St. John's Newfoundland. Retrieved June 6, 2003, from http://www:srpc.ca

The Canadian Medical Association (CMA). (1992). Report of the advisory panel on the provision of medical services in underserved regions. Ottawa: Author.

The Canadian Medical Association. (2000). Rural and remote practice issues. Canadian Medical Association Journal, 163(8), Ottawa, p. 1047-1050.

The Canadian Nursing Advisory Committee. (2002). Our health, our future: Creating quality workplaces for Canadian nurses. Retrieved September 5, 2002, from http://www.hc-sc.gc.ca/english/pdf/Office-of-NursingPolicy.pdf

The College of Family Physicians of Canada, the Society of Rural Physicians of Canada and the Society of Obstetricians and Gynaecologists of Canada. (1999). Joint position paper on training for rural family practitioners in advanced maternity skills and caesarean section, Journal SOGC [On-line], 80. Available: Retrieved June 4, 2001, from http://www.sogc.org/SOGCnet/sogc_docs/common/guide/pdfs/ps80.pdf

The Institute for the Advancement of Public Policy (IAPP). (2001). Final Report, The nature of the extended/expanded nursing role in Canada. A Project of the Advisory Committee on Health Human Resources (Project Identifier – NA321). St. John's, NF.

The Musk-Ox Circle Paper Three Health Services in Northern Canada. (1974). Unpublished Speech.

The University of Manitoba, Application guide & form, Canadian aboriginal peoples. (1999). Retrieved July 12, 2001, from http://www.umanitoba.ca/student/admissions/guide/aboriginal.shtml

University of Saskatchewan. (n.d.) Undergraduate degree courses. Retrieved May 30, 2003, from http://www.usask.ca/calendar/nurs/

University of Saskatchewan College of Nursing. (n.d.). Native access program to nursing. Retrieved July 12, 2001, from http://www.usask.ca/nursing/NAPN_Program.html

The Standing Senate Committee of Social Affairs, Science and Technology. (2002). Speaking notes, The health of Canadians – The federal role: Recommendations for reform. [M.J.L. Kirby, Chair]. Ottawa, ON: Author.

Williams, S., Meyer, R., & Price, S. (2002). Nursing education think tank 2002 final report: RNAO centre for professional excellence. Toronto, ON: Registered Nurses Association of Ontario.

Acronym List

Aboriginal Health Partnerships	AHP
Aboriginal Nurses Association of Canada	ANAC
Advanced Cardiac Life Support	ACLS
Advanced Nursing Practice	ANP
Advanced Practice Nurse	APN
Advanced Trauma Life Support	ATLS
Advisory Committee on Health Human Resources	ACHHR
Alberta Association of Registered Nurses	AARN
Association of Registered Nurses of Newfoundland	ARNN
Association of Registered Nurses of Newfoundland and Labrador	ARNNL
Bachelor of Nurses	BN
Band Council Resolution	BCR
British Columbia	BC
British Columbia Ministry of Health	BCMOH
Canadian Association of Emergency Physicians	CAEP
Canadian Association of Schools of Nursing	CASN
Canadian Association of University Schools of Nursing	CAUSN
Canadian Institute for Health Information	CIHI
Canadian Medical Association	CMA
Canadian Nurses Association	CNA
Canadian Nursing Advisory Committee	CNAC

Canadian Society of Rural Physicians	CSRP
Clinical Nurse Specialist	CNS
College of Nurses of Ontario	CNO
College of Registered Nurses of Nova Scotia	CRNNS
Community Health Plan	CHP
Comprehensive Health Care Consultants	CHCL
Council of Ontario Universities Programs in Nursing	COUPN
Critical Incident Stress Management Services	CISMS
First Nations and Inuit Health Branch	FNIHB
Indian and Inuit Nurses of Canada	IINC
Indian and Northern Affairs Canada	INAC
Institute for the Advancement of Public Policy	IAPP
Licensed Practical Nurse	LPN
Manitoba Association of Registered Nurses	MARN
Medical Services Branch	MSB
Native Nurses Entry Program	NNEP
Newfoundland Outport Nursing and Industrial Association	NONIA
Northern Collaborative Baccalaureate Nursing Program	NCBNP
Northwest Territories	NWT
Northwest Territories Registered Nurses Association	NWTRNA
Nurse Practitioner	NP
Nurse Practitioner – Specialist	NP-S

Nurses Association of New Brunswick	NANB
Nursing Education Program for Saskatchewan	NEPS
Ontario Ministry of Health and Long-Term Care	OMHLTC
Primary Health Care – Nurse Practitioner	PHC-NP
Psychiatric Registered Nurse	PRN
Quality of Worklife Indicators	QWI
Registered Nurse	RN
Registered Nurses Association of British Columbia	RNABC
Registered Nurses' Association of Nova Scotia	RNANS
Registered Nurses Database	RNDB
Rural Physicians Action Plan	RPAP
Saskatchewan Indian Federated College	SIFC
Saskatchewan Institute of Applied Science and Technology	SIAST
Saskatchewan Registered Nurses Association	SRNA
University of Northern British Columbia	UNBC
University of Saskatchewan	U of S

The Nature of Nursing Practice in Rural and Remote Canada

Funding provided by:
The Canadian Health Services Research Foundation – Nursing Fund
Michael Smith Foundation for Health Research
Alberta Heritage Foundation for Medical Research
Nova Scotia Health Services Research Foundation
Saskatchewan Department of Economic and Co-operative Development
Ontario Ministry of Health and Long-Term Care
Government of Nunavut
British Columbia Rural and Remote Health Research Institute – University of Northern British Columbia
Provincial and Territorial Nursing Associations (in kind)

The aim of this three-year project is to examine and define registered nursing practice in different settings including primary and acute care, community health, home and long- term care settings in rural and remote Canada. The study will examine what nursing is really like in rural and remote communities, and explore how nurses can best be educated and supported in their work.

The specific objectives are to:

- Articulate the roles and functions of registered nurses in rural and remote Canada;
- Develop a definition of rural and remote nursing;
- Compare the roles and functions of nurses practicing in various work environments;
- Examine how different work circumstances and situations contribute to nurses developing professional expertise;
- Identify areas of rural and remote nursing that should be priorities for organizational support, policy support and basic and ongoing education; and,
- Contribute to policy and management discussions on nurses' practice, recruitment, retention, and education in rural and remote Canada.

To accomplish this, several methods are being employed:

- Analysis of the Canadian Institutes of Health Information (CIHI) Registered Nurses Database (RNDB) to provide statistical and demographic profiles of rural and remote nurses;

- An analysis of documents, such as those describing standards and policies of nursing practice;
- A survey of 6500 nurses in provinces and territories regarding their rural and / or remote nursing practice; and,
- Analysis of narratives from nurses who describe their rural and remote nursing practice.

The study commenced May, 2001 and will be completed by February, 2004. The research team consists of four principal investigators, 13 co-investigators and 22 advisory team members from all provinces and territories.

Principal Investigators:

Martha MacLeod, RN, PhD (Lead Co-PI)
Nursing Program
University of Northern British Columbia
3333 University Way
Prince George, BC V2N 4Z9

Judith Kulig, RN, DNSc
School of Health Sciences
University of Lethbridge
4401 University Drive
Lethbridge, AB T1K 3M4

Norma Stewart, RN, PhD
CIHR Scientist (Regional Partnership Program)
College of Nursing
University of Saskatchewan
107 Wiggins Road
Saskatoon, SK S7N 5E5

J. Roger Pitblado, MA, PhD
Department of Geography
Centre for Rural and Northern Health Research
Laurentian University
Ramsey Lake Road
Sudbury, ON P3E 2C6

Principal Decision-Maker:

Marian Knock
Executive Director, Primary Health Care
Strategic Change Initiatives
British Columbia Ministry of Health Planning
2-2-1515 Blanshard Street
Victoria, BC V8W 3C8

Co Investigators:

Ruth Martin-Misener, RN, MN
School of Nursing
Dalhousie University
5869 University Avenue
Halifax, NS B3H 3J5

Ginette Lazure inf. PhD
Faculté des sciences infirmières
Université Laval
Québec, G1K 7P4

Jenny Medves, RN, PhD
School of Nursing
Queen's University
90 Barrie Street
Kingston, ON K7L 3N6

A. Michel Morton, RN, MSN
School of Nursing
Lakehead University
955 Oliver Road
Thunder Bay, ON P7B 5E1

Carolyn Vogt, RN MN
Faculty of Nursing
University Manitoba
Winnipeg, MB R3T 2N2

Gail Remus, RN, MN
College of Nursing (retired)
University of Saskatchewan
Saskatoon, SK S7N 5E5

Debra Morgan, RN, PhD
The Institute of Agricultural, Rural
and Environmental Health
University of Saskatchewan
Wing 3E, Royal University Hospital
103 Hospital Drive
Saskatoon, SK S7N 0W8

Dorothy Forbes, RN, PhD
College of Nursing
University of Saskatchewan
Room 448, Ellis Hall
107 Wiggins Road
Saskatoon, SK S7N 5E5

Barbara Smith, RN, MCEd
College of Nursing
University of Saskatchewan
107 Wiggins Road
Saskatoon, SK S7N 5E5

Carl D'Arcy, PhD
Department of Psychiatry, and,
Applied Research
College of Medicine
Saskatoon, SK S7N 0W8

Elizabeth Thomlinson, RN PhD
Faculty of Nursing
University of Calgary
2500 University Drive N.W.
Calgary, AB T2N 1N4

Kathy Banks, RN, MSN
Nursing Program
University of Northern British Columbia
3333 University Way
Prince George, BC V2N 4Z9

Lela Zimmer, RN, PhD(c)
Nursing Program
University of Northern British Columbia
3333 University Way
Prince George, BC V2N 4Z9

Advisory Team

Denise Alcock
1 Massey Lane
Ottawa, ON K1J 6C7

Fran Curran
7170 – 7th Avenue
Whitehorse, Yukon Y8A 2C6

Madge Applin
Hay River Community Health Board
#3 Gaetz Drive
Hay River, NT X0E 0R8

Fjola Hart Wasekeesikaw
Aboriginal Nurses Association of Canada
Box 929
Norway House, MB R0B 1B0

Rachel Munday
Department of Health and Social Services
Box 390
Kugluktuk, NU X0B 0E0

Cecile Hunt
Regional Health Authority #10
1092 – 107 Street
North Battleford, SK S9A 1Z1

Donna Brunskill
Saskatchewan Registered Nurses Association
2066 Retallack Street
Regina, SK S4T 7X5

Kathleen MacMillan
Office of Nursing Services
First Nations & Inuit Health Branch
Jeanne Mance Bldg, 20th Floor
Tunney's Pasture
Ottawa, ON K1A 0K9

Elizabeth Cook
Aurora College
H214-900 Lanky Court
Yellowknife, NWT X1A 2G4

Maria MacNaughton
Office of Nursing Services
First Nations & Inuit Health Branch
Room 2097D, Jeanne Mance Bldg.
1920D Tunney's Pasture
Ottawa, ON K1A 0L3

Marta Crawford
College of Registered Nurses of Manitoba
647 Broadway
Winnipeg, MB R3C 0X2

Suzanne Michaud
Quebec Hospital Association
505 Boulevard de Maisonneuve Ouest, Office 400
Montreal, QC H3A 3C2

Debbie Phillipchuk
Alberta Association of Registered Nurses
11620 – 168 Street
Edmonton, AB T5M 4A6

Francine Roy
Canadian Institute for Health Information
Suite 200, 377 Dalhousie Street
Ottawa, ON K1N 9N8

Marlene Smadu
Regina Site, College of Nursing
University of Saskatchewan
4500 Wascana Parkway
Regina, SK S4P 3A3

Roxanne A. Tarjan
Nurses Association of New Brunswick
165 rue Regent Street
Fredericton, NB E3B 7B4

Cathy Ulrich
Northern Health Authority
1444 Edmonton Street
Prince George, BC V2M 6W5

Adele Vukic
Dalhousie University
5869 University Avenue
Halifax, NS B3H 3J5

Joyce England
34 Russet Avenue
Charlottetown, PE C1E 1B7

Anne Ardiel
Ministry of Health Services
2-2-1515 Blanchard Street
Victoria, BC V8W 3C8

Barb Oke
Deputy Minister's Office
Department of Health
Joseph Howe Building
1690 Hollis Street, 4th Floor
P.O. Box 488
Halifax, NS B3J 2R8

For further information, contact:
Nursing Practice in Rural and Remote Canada
Telephone: (250) 960-6409
1-866-960-6409
Fax: (250) 960-5744
E-mail: rrn@unbc.ca
http://ruralnursing.unbc.ca

"This is Appendix A from Kulig et al (2003)
Rural and Remote Nursing Practice: An Analysis of Policy Documents"

Measurement Tool
RC1 0548-10

The Nature of Nursing in Rural and Remote Canada:
Documentary Analysis Framework
Adapted from Rist, R. (1994). Influencing the policy process with qualitative research. In N. Denzin & Y. Lincoln (Eds.), Handbook of qualitative research. (pp. 545-557). Thousand Oaks, CA: Sage.

The documents (i.e., policy statements, technical reports, nursing practice regulations and standards, relevant reports related to nursing education, and relevant reports from non-nursing professional licensing bodies) will be read and analyzed according to the three components of the policy cycle. More specifically, each component, as noted below, has been further differentiated into a number of sub-questions. In this way, the documents can be individually assessed in order to arrive at a contextual understanding of the policy and practice environment within which rural and remote nurses practice.

I Policy Formation: addressing this component will determine whether or not past and current policy has been supportive of rural and remote nursing practice.

1.0 What do we know about the issue at hand?
- 1.1 What are the definitions of rural and remote?
- 1.2 What are the definitions of rural and remote nursing practice?
- 1.3 Who generated these definitions?
- 1.4 Has rural and remote nursing practice changed since these definitions were forwarded?

2.0 What took place previously in response to rural and remote nursing practice?
- 2.1 What programs and/or courses were developed and implemented to prepare nurses to work in rural and remote settings?
- 2.2 What programs and/or projects were implemented to assist with the recruitment and retention of nurses in rural and remote areas in Canada?
- 2.3 What other programs and/or projects were implemented to address the issues related to rural and remote nursing practice?
- 2.4 Who developed the above programs and/or projects?
- 2.5 Are the programs and/or projects still ongoing? If not, why not?
- 2.6 Were these programs and/or projects successful?
- 2.7 What outcomes resulted because of the programs and/or projects?
- 2.8 What other outcomes and/or impacts were a result of these programs and/or projects, i.e, were organizations developed or specific nursing courses created?

3.0 What is known about previous efforts in relation to rural and remote nursing practice?
- 3.1 What was the time period before the outcomes and/or impacts were noted?
- 3.2 Has there been continuous support of rural and remote nursing practice by the public? by health care services administration? by government departments? Has there been less support of this issue by any of these groups?
- 3.3 Have interest groups been developed in relation to rural and remote nursing practice?
- 3.4 What are the similarities between the programs and/or projects in relation to the outcomes?
- 3.5 What are the differences between the programs and/or projects in relation to the outcomes?

II Policy Implementation: addressing this component will determine if policy related to rural and remote nursing practice was appropriately implemented.

4.0 Are the policies meeting the needs of both rural and remote residents and practicing nurses?
- 4.1 Are the appropriate number of nurses available in rural and remote parts of Canada to meet the needs of the residents?
- 4.2 If special recruitment and retention programs for nurses in rural and remote parts of Canada were put in place, were they effective? What are the geographic differences, if any?
- 4.3 What is the satisfaction level of rural and remote residents with nursing services and practice? Do they feel that they are well served?

5.0 How has the issue changed over time and has the implementation of policy changed with it?
- 5.1 Were there changes in nursing regulations that enhanced or inhibited nursing practice in rural and remote areas?
- 5.2 What other health-related policies for rural and remote communities were put in place that also had an impact on rural and remote nursing practice?
- 5.3 Were there subsequent complimentary changes within policies related to rural and remote nursing practice?
- 5.4 How successful have individuals been in matching their standards and regulations related to rural and remote nursing practice with ongoing changes?

6.0 What institutions or agencies have responded to the issue?
- 6.1 How have relevant institutions or agencies (i.e., nursing professional organizations, health regions) defined and contextualized rural and remote practice?
- 6.2 Have these institutions' and agencies' understandings of rural and remote nursing practice been transformed over time?
- 6.3 Do policy makers and program managers have the same understanding of the issue?

III Policy Accountability: addressing policy accountability will determine if there has been accountability in relation to policies and programs directed at rural and remote nursing practice.

7.0 Were the objectives met?
- 7.1 What were the anticipated and unanticipated outcomes in relation to rural and remote nursing practice?
- 7.2 Were these changes in the understanding of rural and remote nursing practice due specifically to the policy or a specific program?
- 7.3 What social changes, if any, resulted from the program or policy?
- 7.4 What were the strengths and weaknesses or the organizational structure that was used to implement the program?

8.0 What changes occurred within the issue?
- 8.1 Has the program or policy also changed with the more current circumstances?

9.0 How accountable was the organization in the implementation of the policies?
- 9.1 Was the program appropriately managed and supervised?
- 9.2 Was data regarding rural and remote nursing practice used in decision-making?
- 9.3 What is the degree of congruence between leadership and staff of the unit responsible for the program?

APPENDIX C

Documentary Analysis

Measurement Tool

RC1 0548-10

The Nature of Nursing in Rural and Remote Canada:

Documentary Analysis Framework

Adapted from Rist, R. (1994).Influencing the policy process with qualitative research. In N. Denzin & Y. Lincoln (Eds.), Handbook of qualitative research. (pp. 545-557).Thousand Oaks, CA: Sage.

The documents (i.e., policy statements, technical reports, nursing practice regulations and standards, relevant reports related to nursing education, and relevant reports from non-nursing professional licensing bodies) will be read and analyzed according to the three components of the policy cycle. More specifically, each component, as noted below, has been further differentiated into a number of sub-questions. In this way, the documents can be individually assessed in order to arrive at a contextual understanding of the policy and practice environment within which rural and remote nurses practice.

Your Name:

Document title and author:

Document Date:

Field of practice (long term care, emergency, obstetrics etc.) Be specific:

Geographic area:

Intended Audience:

Type of document (Policy, Standards, Management, Government regulations, Other specific):

I Policy Formation: addressing this component will determine whether or not past and current policy has been supportive of rural and remote nursing practice.

1.0 What do we know about the issue at hand?

1.0

1.1 What are the definitions of rural and remote?

1.1

1.2 What are the definitions of rural and remote nursing practice?

1.2

1.3 Who generated these definitions?

1.3

1.4 Has rural and remote nursing practice changed since these definitions were forwarded?

○ Yes ○ No ○ Unknown ○ N/A

2.0 What took place previously in response to rural and remote nursing practice?

2.0

2.1 What programs and/or courses were developed and implemented to prepare nurses to work in rural and remote settings?

2.1

2.2 What programs and/or projects were implemented to assist with the recruitment and retention of nurses in

rural and remote areas in Canada?

2.2

2.3 What other programs and/or projects were implemented to address the issues related to rural and remote nursing practice?

2.3

2.4 Who developed the above programs and/or projects?

2.4

2.5 Are the programs and/or projects still ongoing? If not, why not?

2.5

2.6 Were these programs and/or projects successful?

○ Yes ○ No ○ Unknown ○ N/A

2.7 What outcomes resulted because of the programs and/or projects?

2.7

2.8 What other outcomes and/or impacts were a result of these programs and/or projects, i.e, were organizations developed or specific nursing courses created?

2.8

3.0 What is known about previous efforts in relation to rural and remote nursing practice?

3.0

3.1 What was the time period before the outcomes and/or impacts were noted?

3.1

3.2 Has there been continuous support of rural and remote nursing practice by the public? by health care services administration? by government departments? Has there been less support of this issue by any of these groups?

3.2

3.3 Have interest groups been developed in relation to rural and remote nursing practice?

O Yes O No O Unknown O N/A

3.4 What are the similarities between the programs and/or projects in relation to the outcomes?

3.4

3.5 What are the differences between the programs and/or projects in relation to the outcomes?

3.5

3.6 Other comments.

3.6

II Policy Implementation: addressing this component will determine if policy related to rural and remote nursing practice was appropriately implemented.

4.0 Are the policies meeting the needs of both rural and remote residents and practicing nurses?

O Yes O No O Unknown O N/A

4.1 Are the appropriate number of nurses available in rural and remote parts of Canada to meet the needs of the residents?

O Yes O No O Unknown O N/A

4.2 If special recruitment and retention programs for nurses in rural and remote parts of Canada were put in place, were they effective? What are the geographic differences, if any?

4.2

4.3 What is the satisfaction level of rural and remote residents with nursing services and practice? Do they feel that they are well served?

4.3

5.0 How has the issue changed over time and has the implementation of policy changed with it?

5.0

5.1 Were there changes in nursing regulations that enhanced or inhibited nursing practice in rural and remote areas?

5.1

5.2 What other health-related policies for rural and remote communities were put in place that also had an impact on rural and remote nursing practice?

5.2

5.3 Were there subsequent complimentary changes within policies related to rural and remote nursing practice?

O Yes O No O Unknown O N/A

5.4 How successful have individuals been in matching their standards and regulations related to rural and remote nursing practice with ongoing changes?

5.4

6.0 What institutions or agencies have responded to the issue?

6.0

6.1 How have relevant institutions or agencies (i.e., nursing professional organizations, health regions) defined and contextualized rural and remote practice?

6.1

6.2 Have these institutions' and agencies' understandings of rural and remote nursing practice been transformed over time?

O Yes O No O Unknown O N/A

6.3 Do policy makers and program managers have the same understanding of the issue?

6.3

6.4 Other comments.

6.4

III Policy Accountability: addressing policy accountability will determine if there has been accountability in relation to policies and programs directed at rural and remote nursing practice.

7.0 Were the objectives met?

O Yes O No O Unknown O N/A

7.1 What were the anticipated and unanticipated outcomes in relation to rural and remote nursing practice?

7.1

7.2 Were these changes in the understanding of rural and remote nursing practice due specifically to the policy or a specific program?

O Yes O No O Unknown O N/A

7.3 What social changes, if any, resulted from the program or policy?

7.3

7.4 What were the strengths and weaknesses or the organizational structure that was used to implement the program?

7.4

8.0 What changes occurred within the issue?

8.0

8.1 Has the program or policy also changed with the more current circumstances?

O Yes O No O Unknown O N/A

9.0 How accountable was the organization in the implementation of the policies?

9.0

9.1 Was the program appropriately managed and supervised?

O Yes O No O Unknown O N/A

9.2 Was data regarding rural and remote nursing practice used in decision-making?

O Yes O No O Unknown O N/A

9.3 What is the degree of congruence between leadership and staff of the unit responsible for the program?

9.3

9.4 Other comments.

9.4

Submit Analysis | Reset Form

APPENDIX D

Documentary Analysis

Form B

Nursing Practice in Rural and Remote Canada

RC1 0548-10

Your Name:

Document title and author:

Document Date:

Field of practice (long term care, emergency, obstetrics etc.) Be specific:

Geographic area:

Intended Audience:

Type of document (Policy, Standards, Management, Government regulations, Other specific):

1.0 How was rural and remote defined?

1.0

2.0 Which health professional group was discussed in this report?

2.0

APPENDIX D

3.0 What issues in particular were addressed?

3.0

4.0 What is the impact of the issues on rural and remote nursing practice?

4.0

5.0 What policies were suggested to address the issue? Were they effective?

5.0

6.0 What programs/projects were developed to address the issues? Were they effective?

6.0

7.0 What will be the impact on rural and remote nursing practice?

7.0

8.0 Other comments.

8.0

Submit Analysis | Reset Form

Advanced Practice

Expanded roles for nurses, including the role of nurse practitioner (NP), need careful examination in order to fully understand the provincial and territorial differences, and hence the range of health care and services, that are available across rural and remote settings of Canada. This appendix addresses definitions and roles of NPs, current legislation regarding this role and educational preparation for this group of nurses.

Definitions

Terms such as NP, clinical nurse specialist (CNS) and advanced practice nurses (APNs) have been used interchangeably in a country that has displayed a tenuous relationship with the expanded role of nurses (Canadian Nurses Association (CNA), 1993). Over the years, a number of documents have attempted to clarify the meaning of "advanced practice", the educational requirements and the legislation of the individuals who are working in these roles.

The CNA has viewed advanced practice as "an umbrella term" (CNA, 2000a, p 1) to describe "an advanced level of nursing practice that maximizes the use of in-depth nursing knowledge and skill in meeting the health needs of clients" (CNA, 2000a, p 1). In the initial report on advanced practice, the CNA prepared a framework to address the issues related to this expanded role of nursing. This framework indicated that APN would be a role of the nurse but not a legislated title like that of "registered nurse." According to the framework there are five competencies of an APN: clinical, research, leadership, collaboration, and change agent. To accomplish these competencies, it is

preferred that an APN undertake graduate preparation. Furthermore, some of the roles of an APN would include CNS[1] and NP. According to the CNA (2000b), the domain of practice for such individuals would predominantly be clinical practice with their regulation maintained within the existing regulatory bodies. The more recent revised CNA document on advanced practice (CNA, 2002a) notes that a minimal educational preparation for advanced practice is a graduate degree in nursing. In addition, a recent review of NP competences in Canada indicated a high level of congruency of provincial competency statements (L. Little, Personal Communication, May 8, 2003).

A recent report presents the findings of a research study that was conducted in British Columbia (BC) on ANP (Schreiber, R., MacDonald, M., Davidson, H., Crickmore, J., Pinelli, J., Regan, S., Pauly, B., & Hammond, C., 2002). A variety of health care professionals and employers were surveyed to discover their understanding of this role including how NP can be used in the future in BC. The study noted the confusion of terms that are being used to describe a nurse working in an ANP role and the lack of consistency in legislation.

The researchers found that the biggest barrier to ANP in rural areas was the public resistance to the role. Despite this, rural and remote areas were most often identified as having the largest potential for the development of ANP. Nurses from these settings also participated in the study; these individuals worked at settings such as Red Cross Outposts, RN First Call sites, BC Health Guide Nurse Line. For these

[1] However, in another CNA document on the CNS (2000b; 1993), it is implied that a CNS is an individual who focuses on care rather than diagnostic activities, adding further confusion when using these terms.

individuals, regardless of the educational level that they had achieved, past clinical experience was identified as being their primary source of knowledge for their positions. However, most of these nurses are diploma-prepared with a variety of post-diploma certificates. All nurse participant in this study identified needing additional formal education beyond basic nursing education in order to function in an ANP role, such as outpost or northern nursing programs.

This study identified a variety of themes and priorities for action including the need for clarification of the role of nurses practicing within an advanced role. For example, distinctions between experienced RNs, APNs, CNSs and NPs needs to be achieved. Another issue that needed to be addressed was the need to monitor NP in rural and remote areas to prevent burnout from occurring.

The Role of the Nurse in Advanced Practice

Discussion of APN focuses on expanding the role of nurses for the benefit of the profession, whereas some policymakers and physicians merely perceive such expansion as an alternative to recruitment and retention of physicians in rural areas. Topics such as this are of particular concern when examining nursing practice in rural and remote areas. A case in point is the Saskatchewan Government release of a Memorandum to Cabinet “Improving Access to Rural Health Care” (Bruni, DeWolfe, Nakamura & Stokes, 2001). This particular memorandum defines rural as having a population of less than 10,000 but does not exclude those communities that are in proximity to larger centres. The recommendations include improving the delivery of primary health care to rural Saskatchewan by permitting nurses to take on more responsibility, thereby

alleviating the pressure on physicians. Despite this intention, the report states that resistance will be met by members of the Saskatchewan Medical Association, which is not an uncommon finding among other medical associations across Canada. The strategies that were offered to this end focus on highlighting the benefits of partnerships between NPs and physicians and creating roles that are complementary. The report notes that the government would only be prepared to fund NPs that are committed to providing care in rural areas.

Some of the literature addresses the issue of nurses in advanced practice prescribing and distributing specified drugs (Alberta Association of Registered Nurses (AARN), 2000). In this context, the APN is subject to agency policies, if in place, in addition to the guidelines set out by the AARN, in order for prescribing and distributing of drugs to occur. Within this document there is no mention of the impact this would have for rural health care delivery or the practice of nursing in rural and remote areas. The Registered Nurses' Association of Nova Scotia (RNANS) has created a paper on APN (RNANS, 1999), which outlines the belief that graduate preparation is needed for an APN and that new legislation and policies are needed to address the changes in nursing scope of practice in this regard.

The Nature of the Extended / Expanded Nursing Role in Canada report (The Institute for the Advancement of Public Policy [IAPP], 2001) emphasizes that NPs can address health issues in rural areas. However, the only definition offered in this report of rural is remote or isolated communities that are accessible only by air. This report is the result of a national study that evaluated the expanded role of nurses in Canada. It

identified a lack of consistency regarding legislation, education, roles, titles, and payment schedules for this group of nurses. It aptly pointed out that NPs are expected to work autonomously and collaboratively with physicians in a variety of settings, based on the shifting supply of health care providers and the willingness of other providers to accept collaborative practice arrangements. This expectation has been coupled with inconsistent support from government, based on the shortage or excess of health providers for both rural and urban areas. Rural nursing had less public support because rural community residents prefer physician coverage, whereas in remote areas, the expanded role of nurses is accepted due to the increased autonomy in health services and a decreased reliance on physicians for the delivery of those services. In addition, nursing practice in rural areas changes with the availability of physicians, whereas in remote areas, the chronic shortage of physicians has meant that nursing practice has remained more consistent over the years. The IAPP report ends with recommendations, but there is no plan of action for follow-up to determine if these recommendations were implemented. The recommendations focused on legislation for the role of nurses in expanded practice, development of core competencies and continuing education for these nurses, development of consistent language and titles, creation of collaborative practice arrangements between physicians and nurses in expanded roles in all practice settings, creation of alternative funding plans for physicians, and development of ongoing monitoring of the quality of primary health care services (IAPP, 2001).

Newfoundland and Labrador present informative case studies on APN offering historical insights from their past experiences of incorporating nurses in an expanded role. On further examination, there are both similarities and differences amongst nurses who have worked in Newfoundland and Labrador, nurses who have worked in remote areas and nurses who have worked with aboriginal communities in other geographic areas of Canada. Unlike health services in northern remote areas of Canada, Newfoundland and Labrador have had a more organized health delivery system that recognized nurses as independent practitioners at a much earlier date (Association of Registered Nurses of Newfoundland [ARNN][2], 1997). The first Grenfell nurses came from England with Dr. Grenfell in 1893 (G. Hillyard, Personal Communication, June 3, 2003). Subsequenty, by 1920, nurse midwives were recruited to rural areas of Newfoundland to provide health care. These nurses, known as Newfoundland Outport Nursing and Industrial Association (NONIA) nurses, were well known for providing care under difficult conditions that included lack of professional support, lack of equipment and resources, adverse transportation conditions and limited communication. The Grenfell Regional Health Services employed nurses in remote areas of Newfoundland and Labrador. In 1934, the development of cottage hospitals, where at least one physician was available to provide health care, signaled the end of the NONIA nurses working with such independence. There were growing concerns

[2] The title and acronym of this nursing association reflects that used in the specific report. Thus, two names and acronyms are used due to the recent change in name of this nursing association. Association of Registered Nurses of Newfoundland (ARNN) to Association of Registered Nurses of Newfoundland and Labrador (ARNNL).

about physicians losing fees and subsequently the nurses relinquished their expanded role (ARNN, 1997).

A recent evaluation of the role of primary health care-nurse practitioner (PHC-NP) in Newfoundland and Labrador focused on the extent to which this role has been implemented, the impact of the PHC-NP role on both community and health services systems and the identification of future plans for this role (Goss Gilroy, 2001). The 1998 and 1999 graduates from the Centre for Nursing Studies NP programs were surveyed; key informant interviews were held with individuals at the provincial level who were involved with integrating these roles, as well as with key informants in two other provinces (Alberta and Ontario) where the NP had been implemented. Collection of data such as workload and activity patterns for the NP, as well as a review of recent literature, were all included. The NP was defined as a nurse who meets the requirements for licensure as an NP within the primary health care model (Nurse Practitioner Primary Health Care Regulations of the Province of Newfoundland and Labrador, 1999 as cited in Goss Gilroy, 2001).

The PHC-NP role was implemented during a time when it was particularly difficult to recruit and retain physicians for rural areas of Newfoundland and Labrador. The incorporation of the PHC-NP role was seen as one solution in resolving access to health care services. However, the urgency of the situation left the perception that the role was “fast-tracked”; hence, parts of the role definition and regulations were not seen as fully developed (i.e., health promotion and prevention aspects), even though the

work activities of the PHC-NP role fell within the ARNNL scope of the practice (Goss Gilroy, 2001).

The graduates included in the survey were primarily employed in rural areas from where they originated before commencing the program. The survey results indicated that the majority (80%) of the PHC-NP role time is spent conducting clinical work including curative, and rehabilitative, work, and injury/illness prevention. However, there was little time for activities such as health promotion projects. Although most felt that the collaborative arrangement with the physician was effective, a common constraint to implementation was a lack of understanding of the roles of health professionals such as the PHC-NP. Other issues included a lack of acceptance of this role by physicians, lack of an overall human resource plan, and challenges surrounding issues such as fee for service (Goss Gilroy, 2001).

A number of recommendations emerged from the report including involving senior management of all provincial and regional level organizations in reviewing the report and developing an action plan to address the constraints impinging on the successes of the role; assisting regional boards in understanding the role; clarifying legal liability implications for collaborating physicians; and, having the Department of Health and Community Services continue to seek remuneration approaches (Goss Gilroy, 2001).

Legislation for Nurses in Advanced Practice

Newfoundland was initially one of the only provinces to have legislation to prepare nurses to assume the role of an NP (Table 1). Current legislation allows NPs to

work in all areas of Newfoundland and Labrador because they are defined and regulated in legislation by the nursing association. Prior approval of the Newfoundland and Labrador Medical Association was at one time required to transfer regional nurse practice (ARNN, 1997b).

Like other documents that discuss APN, 1997b ARNN document uses several terms to describe similar roles within nursing. Thus, they make one strategic recommendation that a CNS should be a masters prepared individual who works within a client-centred model, and who specializes in areas such as health promotion or rehabilitative care. In contrast, they define an PHC-NP as an individual with one year of education beyond the baccalaureate level who provides comprehensive nursing care to individuals, families and communities. Furthermore, this individual has “advanced preparation in nursing and medical science who practices within the primary health care model” (ARNN, 1997[a], p 1). It is in this role that the ARNN advocates for nurses to work in rural hospitals and community health centres, and for aboriginal bands (ARNN, 1997b).

The report notes that the Nurse Practitioner-Specialist (NP-S) is generally equivalent to the clinical nurse associate and the acute care NP that exist in Manitoba, New Brunswick and Ontario. Such an individual is formally defined as a nurse who has “advanced preparation in nursing and medical sciences who practices health care management for a specific population of clients” (ARNN, 1997a, p 1). Despite the confusion caused by the terms and definitions, it is recognized that there is the need for

nurses with advanced skills to address the recruitment and retention concerns of health personnel in rural and remote communities throughout Newfoundland and Labrador.

The ARNN (1998b) standards of practice for NPs notes that the NP regulations were approved in 1998. They were subsequently amended in 2000 to facilitate the inclusion of the NP-Ss practice, and in 2001, became the first jurisdiction in Canada to license this group of nurses. The regulations emphasize clinical skills expected of this nurse, such as diagnosing and treating illness. The standards of practice apply to both the NP-S and the PHC-NP.

The ARNN has developed two sets of competencies for each type of NP. The competencies for the PHC-NP include practitioner, educator and leader (ARNN, 1998a). The specific competencies outlined illustrate that the role and scope of the PHC-NP is not only to diagnose and treat acute illness but also to provide more comprehensive care to individuals, families and communities through activities such as health promotion and community development. This type of nurse is therefore suitable for both urban and rural settings and will contribute to the overall health of communities and their residents.

In contrast, the competencies for the NP-S emphasize the nurse's work with specific populations and thus, there is less emphasis on community development and planning and more emphasis on the researcher, leadership and consultant competencies (ARNNL, 2000). Both kinds of NPs are licensed and able to provide care that leads to diagnosis and treatment but the additional activities they perform are differentiated as noted above.

A comprehensive report from the ARNNL provides all regulations, materials and licensure information related to both types of NPs in Newfoundland and Labrador (ARNNL, 2002b). Currently the PHC-NP education program in Newfoundland is a one-year post-diploma program with ongoing dialogue to ensure it achieves the ARNNL minimum education standard. The PHC-NP and NP-S both require a minimum of a Bachelor of Nursing (BN) with a one-year NP program. The NP regulations are also included as are the specific details about which medications the NP has authority to prescribe, the diagnostic tests they can order and the specific clinical procedures they can undertake. Finally, guidelines are included to assist nurses in having their competency assessed for licensure as an PHC-NP (ARNNL, 2002b).

The Standards Interpretation: Dispensing by Registered Nurses (ARNN, 1999) discusses dispensing of medications by registered nurses (RNs) in this province, a practice that is normally part of the pharmacist's role. However, as noted in the document, there are some areas of Newfoundland and Labrador, presumably rural and remote areas, where there is limited access to a pharmacist. The document provides guidelines to assist nurses to meet the expected standard of care while ensuring that dispensing medications falls within the nurses' scope of practice.

The 1999 Position Paper on Advanced Nursing Practice published by the RNANS, points out that "advanced nursing practice can enhance client access to effective, integrated and coordinated health care" (p. 3). Rather than focusing on titles, this document emphasizes the characteristics of the nurse in such a role. Hence, nurses who work in advanced practice integrate nursing knowledge with clinical expertise and

research findings. This earlier document emphasized that graduate programs would be the most effective in preparing a nurse to work within an advanced nurse practice role. In a subsequent document, this same association defined NPs as "registered nurses with advanced skills and knowledge in health assessment, promotion and management, as well as disease prevention" (College of Registered Nurses of Nova Scotia (CRNNS)[3], A contemporary article, 2002a, p 4). Furthermore, NPs provide "essential health services within a holistic model of care, in collaboration with clients, physicians and other health care professionals" (CRNNS, A contemporary article, 2002a, p 4). Their practice therefore includes making diagnoses and communicating the same to clients; ordering and interpreting screening tests; prescribing appropriate drugs; and performing procedures necessary for client care. The core competencies for NPs are health promotion and illness prevention; management of health; advocacy; community development; and professional leadership. Specific examples of competencies in relation to each core competency are included. For example, under management of health it is expected that the NP determine the need for screening tests, interpret the same and communicate the results with the client (CRNNS, 2002a).

The 2002 Standards of Practice: Nurse Practitioners (CRNNS, 2002b) identifies two types of NPs: primary health care nurse practitioner who is a member of a specialized practice which provides primary health care services (i.e., through a community-based health setting or primary health care organization); and a specialty

[3] The title and acronym of this nursing association reflects that used in the specific report. Thus, two names and acronyms are used due to the recent change in name of this nursing association. Registered Nurses' Association of Nova Scotia (RNANS) to College of Registered Nurses of Nova Scotia (CRNNS).

nurse practitioner who is a member of a collaborative health care team which provides specialized health services to specific client populations (i.e., through an acute care facility or specialty clinic). Only those RNs who meet the criteria for licensure in the NP class as noted in the RN Act and RN Regulations subsequently may refer to themselves as an NP, a Primary Health Nurse Practitioner or a Specialty Nurse Practitioner. In addition to the standards expected of all RNs, NPs are also expected to meet four additional standards: accountability and responsibility; continuing competence; application of knowledge; and, advocacy. Specific guidelines for each of the standards are provided to ensure the role and activities of the NP are clearly articulated. For example, when prescribing drugs, the NP can "repeat or continue a drug originally prescribed by a physician only if it is included on the schedule of drugs that the NP is authorized to prescribe" (CRNNS, 2002b, p 5). NPs may also only order and interpret screening and laboratory tests that have been approved by the Diagnostic and Therapeutics Committee. Furthermore, in order to practice as an NP, a formal collaborative agreement needs to be made with a physician or group of physicians and subsequently approved by the Diagnostic and Therapeutics Committee (CRNNS, 2002b).

Ontario was one of the original provinces that supported NPs in 1998 (CNA 2002b). This province uses the phrase "registered nurse in the extended class" (EC) or "primary health care nurse practitioner" to describe a nurse with "advanced knowledge and decision making skills in assessment, diagnosis, and health care management" (College of Nurses of Ontario (CNO), 1998, p3). Such nurses provide comprehensive

health services such as health promotion and rehabilitative services but also can communicate a diagnosis, order diagnostic tests and prescribe a limited range of medications (CNO, 1998). Like other nursing associations, the CNO provides standards of practice for nurses in the extended class and lists the medications they can prescribe and diagnostic tests they can order (CNO, 1998; 2002). Ten universities in Ontario provide the NP program, which can be entered with a minimum of a diploma in nursing (CNO, 1998). The Council of Ontario Universities Programs in Nursing (COUPN) is responsible for the design and delivery of the program, which ensures standardization of content and a more efficient use of faculty resources (COUPN, 1999). Preference is given to Ontario nurses who can take the program either part- or full-time with distance learning offered for all of the courses. Aboriginal content is offered in all five of the mandatory courses because many of the graduates work within aboriginal communities.

NPs have been supported in Manitoba since 2001 (CNA 2002b). In this province, they are not categorized separately but are regulated as RNs who have also successfully completed an NP program (CNA 2002b). A draft discussion document on RN (advanced practice) (RN(AP)) regulations notes that this role has evolved partly because of the underserved and underserviced communities in Canada (College of Registered Nurses of Manitoba, 2002). The interpretation of these terms is left to the reader but can be applied to rural and remote communities as well as aboriginal groups. The document outlines the competences of the RN(AP), which include assessment and diagnosis, health care management including prescribing medication,

and health promotion. In Manitoba, a graduate program to prepare NPs is available through the University of Manitoba Faculty of Nursing (CNA 2002b).

The SRNA has standards and competencies for the NP role that were approved in Spring, 2003. Licensure of nurses in this role will commence Fall, 2003 (D. Brunskill, Personal Communication, May 29, 2003). To ensure integration of NPs into the Saskatchewan health system, the SRNA is maintaining a Nurse Practitioner Advisory Committee with stakeholders such as the College of Physicians and Surgeons, the University of Saskatchewan, Saskatchewan Medical Association, & Saskatchewan Indian Federated College (D. Brunskill, Personal Communication, May 29, 2003).

The SRNA Registered Nurse (Nurse Practitioner) RN(NP) Standards and Core Competencies of 2003 recognizes and outlines the tasks and procedures that RN who are qualified to work as a NP, can engage in. By definition, RN(NP) are "integral members of the health care team who provide and coordinate initial, continuing and comprehensive advanced nursing services in rural, remote and urban areas of the province / RN(NP) serve the ethnoculturally diverse populations of Saskatchewan across the continuum, of health-care throughout the life span" (Saskatchewan Registered Nurses' Association [SRNA], p. 5). They are able to order, interpret tests; prescribe and dispense drugs; perform minor surgical and invasive procedures; and diagnose and treat common medical disorders.

In Alberta, the phrase "RNs providing extended health services" (AARN, 1995) was used to describe what are now referred to as NPs (AARN, 2002a). The most recent document by the AARN is much more sophisticated in identifying the competencies

and skills expected of the NP. In addition, this document articulates the AARN stand that an NP is an individual who has 1) three to five years of practice as an RN, 2) a baccalaureate degree in nursing, with Masters preparation preferred, and 3) successful completion of an approved program that specifically prepares them for their role as an NP (AARN, 2002a). When these criteria are met, the nurse's name will be included on the Extended Practice Roster, a specialty roster created within the Nursing Profession Act (AARN, 2002a). The AARN specifically notes that an NP will demonstrate competencies in the following areas: clinical; leadership and collaboration; knowledge-based practice; and, professional responsibility. Specific competencies are included that identify that NPs are to not only diagnose and address health issues, but also apply evidenced-based practice, work in collaboration with other health care providers, and contribute to research on health issues (AARN, 2002a).

Furthermore, the Lieutenant Governor, along with the Province of Alberta (Alberta Statutes and Regulations, 1999), has also passed the Nursing Profession Extended Practice Roster Regulation. It remains in effect until January 31, 2004, at which time it will be assessed for its currency and relevancy, and revised accordingly. This document outlines the criteria for nurses to be recognized as able to practice in an advanced role. For example, in order to be entered on the roster, the RN must have a BN or equivalent education; a minimum of three years of satisfactory practice experience; successful completion of an extended practice education program; and, the sufficient knowledge, practice and skills to practice in an extended practice role. In this document, the phrase "extended practice" is used to describe nurses on this roster, thus

introducing a different term for this type of nurse. The Registration Committee of the AARN evaluates the application of the nurse and hence determines if the applicant's education is equivalent to a baccalaureate degree. Written notification is provided to the applicant within 30 days and if approved, the individual may practice in the roles outlined in the application.

The NP in Alberta is governed under the public health act which specifically states that the NP can diagnose and treat as well as order laboratory tests and prescribe drugs (Alberta Statutes and Regulations, 2002). The legislation is in effect until June 2012 at which time it will be reviewed for relevance and updated as necessary.

To further assist NPs, the AARN also has a document regarding prescribing and distributing medications (AARN, 2002b). Details are provided under each guideline (i.e., prescribing and distributing) such as recommendations about choosing drug therapy, accessing best practice guidelines, administering controlled substances under federal legislation, and distributing drugs through prescriptions or through the NP when a pharmacist is not available. The document addresses in detail the absence of a pharmacist, noting that this situation will likely only occur in a remote setting. Thus, the NP is provided with guidance in terms of preparing and recording the administration of the prescription (AARN, 2002b).

In Alberta, a recent evaluation of the provincial Primary Health Care Project, which included 27 projects across this province, discovered that the potential exists for a creative redesign of health care services in both urban and rural settings (Howard Research and Instructional Systems Inc., 2000). Of importance to the current discussion,

rural and remote access to health services was identified as an issue. In two of the projects, an NP was hired to provide primary health care in rural communities. Suggestions are made that other rural communities may be able to use a similar model in the delivery of their health services.

The British Columbia Ministry of Health (BCMOH) had committed to implementing NPs in their health system by 2002 (BCMOH, 2001b). However, the implementation date was delayed to 2003 (Registered Nurses Association of British Columbia [RNABC], 2002a) and then to 2004 due to delays in the introduction of amended umbrella legislation (J. Wearing, Personal Communication, May 5, 2003). An earlier document from the health professionals council (Epstein, I.E., Kazanjian, A., & MacAulay, D. 2001) began to pave the way for acceptance of the NP in BC by formally supporting advanced practice and recommending that the necessary legislative or regulatory mechanisms be established.

The Northwest Territories (NWT) have put in place interim measures to recognize NPs while the Nursing Profession Act is being updated in 2002 (Northwest Territories Registered Nurses Association [NWTRNA], 2002). These interim measures allow for a separate register of NPs who are within collaborative practice agreements. The announcement notes that registration of NPs is anticipated by this territorial nursing association. In Nunavut, changes to the nurses act are also expected that would legally support NPs in this territory (CNA 2002b). The Yukon currently has support for NPs through the Registered Nurses Profession Act 1992 and the Pharmacists Act 1998 (CNA 2002 b).

Developing Collegial Relationships

To be successful as a NP, collaborative relationships are essential but not always possible. Not all physician groups have raised concerns, however, about the integration of NPs in the delivery of health care services. For example, at the 1998 Annual Policy Conference of the Society of Rural Physicians of Canada, the focus was on NPs and rural medicine (Society of Rural Physicians of Canada, 1998). The report is actually a dialogue that includes presentations from physicians, nurses and health ministers discussing the concept of the NP in relation to providing care to rural residents. The conference participants forwarded five resolutions, but there was no formal action or apparent mechanism of accountability for their implementation.

Educational Preparation of Nurses in Advanced Practice

The preparation of APNs is another topic discussed in the literature. Beginning in 1967, the Outpost Nursing Program was established at Dalhousie University. At one time, Dalhousie University was one of four universities that offered a program in outpost and community health nursing[4]. Nurses who worked in remote, isolated areas often completed the course and were expected to function as NPs. The original program evaluations, which were completed between 1977 and 1980 on all four of the programs, identified that participants felt positive about the programs and felt they had developed the appropriate skills to work in northern, isolated areas. When these programs began in the 1960s, one of the motives was to assist with the shortage of physicians. However,

[4] The program was nine months in length for baccalaureate prepared nurses and 15 months for diploma prepared nurses (Dalhousie University, 1993 as cited in Chaytor Educational Services, 1993)

as the numbers of physicians increased and baccalaureate programs became increasingly popular, it led to a decreased interest in NP programs. Despite another positive evaluation of the Dalhousie program in 1993 (Chaytor Educational Services, 1993), it was closed and their efforts have since been diverted to the four-year baccalaureate program in Iqaluit, Nunavut (Martin-Misener, Vukic & May, 1999).

TABLE 1: ADVANCED PRACTICE FACT SHEET

	BC	*AB	**SK	**MB	*ONT	QUE	**NB	*NS	PEI	*NFLD/ LAB	YUKON	NWT/ NUNAVUT
Legislation passed	to be passed in 2003	1995	2001	2001	1998	no	yes, but in progress announced 2001	yes, but have to work in collaboration with physicians	in initial stages only	1998	have authority to practice under RN-Profession Act & Pharmacists Act	was to be passed in 2002
Designated / Possibly designated title	NP (primary & specialized)	NP RN(EP)	NP (primary & specialty)	NP (categorized as RN)	RN(EC) (primary health care)	NP-Primary NP-Specialist		NP Primary & Specialist		NP-PHC NP-Specialist	NP	NP
Currently practicing RNs in expanded practice roles in R&R areas	yes	yes, designated areas only			yes	yes					yes	
Currently practicing RNs in expanded practice roles in urban areas	yes	yes, designated areas only				yes (in NICUs only)						
Scope of Practice Actual or Proposed												
Able to write prescriptions of some / all drugs		yes	yes	yes	yes	yes		yes				Yes
Dx & / or treat common disorders		yes	yes		yes (communicate Dx only)	Yes		yes				
Conduct minor surgical procedures			yes	yes				yes, specified				
Provide ER services		yes										
Make referrals		yes										
Order & / or receive reports of Dx Tests				yes	yes	yes		yes				
Core competencies exist to regulate practice	being developed	yes	in progress	yes	yes			being developed				
NP programs exist	no	being developed	yes, as pilot program only		yes		yes	yes	yes			Yes
Programs for RNs working in expanded roles or in APN roles	yes	yes	yes (advanced clinical nursing)	yes		yes		yes				
Education entrance requirements into NP program	not stated	studies are at graduate level	Post BScN									

Compiled from Provincial and Federal Documentation

APN = Advanced Practice Nurse; **NP** = Nurse Practitioner; **EP** = Extended Practice; **NP-PHC** = Nurse Practitioner-Primary Health Care

***** = provinces have enacted legislation to support NP role

****** = provinces have either recently introduced or are making amendments to Acts in near future (i.e., MB, SK, NB)

Nursing Practice Issues in Aboriginal Communities

To understand remote nursing, information related to aboriginal health issues, particularly information from Health Canada and the Aboriginal Nurses Association, must be included. Nurses have a lengthy history of working with aboriginal people in remote and isolated areas of Canada with minimal resources and support. They have been consistently on the front line working, in expanded roles, in these types of areas. The Northern Health Service began in 1954 in response to the exceedingly high morbidity and mortality rates among northern residents (The Musk-Ox Circle Paper Three Health Services in Northern Canada, 1974). The service was renamed Medical Services Branch (MSB) within Health and Welfare Canada, and in 2000 it was again renamed First Nations and Inuit Health Branch (FNIHB). FNIHB is housed within Health Canada and provides services to First Nations and Inuit communities. When discussing Health Canada documents, the term First Nations will be employed. However, when the term aboriginal is used, it refers to First Nations, Inuit and Metis communities. When the term "Indian" is employed, it reflects the particular historical time period within which the document was published. Throughout this appendix the acronym used will be that specific to the document being discussed, recognizing that the department has continued under the guise of different names.

Within FNIHB, nurses work in either health centres, i.e., focusing on public health and health promotion with communities, or nursing stations, i.e., focusing on assessment and management of common health problems (Health Canada, 2003). FNIHB nurses work and often reside in rural and remote areas; the meaning of these

terms is assumed, rather than explicitly defined. One report implies that remoteness is related to accessibility, access to services, and support (Health Canada, 1993). In terms of accessibility, factors include how close the community is to other towns or cities, and whether a road or scheduled transportation is available. Access to services relates to the availability of stores, banks or recreation services. In this document, support was defined as the distance to the nearest physician, the frequency of the visits by physicians, as well as the availability of social service agencies and schools.

One other report refers to a "non-isolated" First Nations community in the southeastern corner of British Columbia, with a population of 466 with the only health services being a Health Station (Annual Report First Nations and Inuit Control 1999-2000). Finally, a report on nursing and health care in First Nations communities by the Ontario Region and band transfer materials on the FNIHB website (www.hc-sc.gc.ca/fnihb-dgspni/fnihb/pptsp/hfo/ten_years_health_transfer/index.htm) note the following definitions:

- Non-isolated community refers to having road access less than 90 kilometres to physician services with an available health centre in the community;
- Semi-isolated community means that there is road access greater than 90 kilometers to physician services but it has either a nursing station or health centre with treatment component available;

- Isolated community refers to a community that has scheduled air transportation flights, good telephone service, but no roads; a nursing station is available for health services; and
- Remote, isolated community is a community in which there are no scheduled flights, minimal telephone or radio access and no roads; health services are provided through a nursing station.

Interestingly, as can be noted by these definitions, the degree of remoteness and isolation is defined by access to services, the type of health service locally accessible, and transportation and communication availability which are directly related to geographic restrictions.

Transfer of Health Services Control to First Nations and Inuit Communities

The transfer of the control of health services from the federal government to individual tribal councils and bands was a process that, according to the Indian and Inuit Nurses of Canada (IINC) (1990), began in 1986. However, documents from Health Canada clearly note that the notion of transfer of health services was related to the 1979 Indian Health Policy (Health Canada, 1999c). The main impetus of this policy was the low level of health among many Indian[1] people and an acknowledgement by the Federal Government that only Indian communities themselves can alter this situation. The goal was, therefore, to increase the health of Indian people based upon three pillars: (1) community development, or socio-economic, cultural and spiritual development to

[1] The term Indian is used here as it reflects the term used in the Federal Indian Policy and hence the particular decade within which the document was prepared.

address the conditions of poverty and apathy; (2) the traditional relationship between the Federal Government and Indian people, which was one of advocacy, needed to be strengthened to also emphasize capacity building among Indian people, and (3) the Canadian health system, which would continue to be inter-related with Indian bands to ensure that public health and acute care were available to Indian people.

From 1983 – 1986 there were demonstration community projects sponsored by the FNIHB (Health Canada, n.d. b). The overall purpose of the projects was to provide the federal government and First Nations communities with information about First Nations control of health services.

The official signing of the Health Transfer Agreements occurred in 1988 and included a process that permitted program control to move at a pace comfortable for the community, with the development of health programs that met specific community needs and did not prejudice treaty or Aboriginal rights. Moreover, the programs were required to have public health and treatment programs and to operate within current legislation. The transfer of health services remained an option for Indian communities and there were allowances for multi-year agreements. The program was designed to be flexible while strengthening the accountability of Chiefs and Council to community members. By 1989, the Federal Treasury Board had given approval to the financial authorities to allow pre-transfer planning and to provide funds for community health management structures. The first transfer occurred in 1989 in Quebec with ten First Nations communities being the first to initiate this process (Health Canada, n.d. c).

In 1994, an alternative program was developed for Bands which were not interested or ready for the Transfer program. This program, Integrated Community-Based Health Services, allowed a First Nations or Inuit community to control specific types of community health services rather than all aspects of health service delivery. In order for this program to proceed, approval for financial resources was requested and received from the Federal Treasury Branch. Finally, in 1995, the Federal Government approved the Inherent Right to Self-Government Policy, which emphasizes that inherent rights are part of the existing Aboriginal rights that can be exercised within the constitutional framework. This policy led to a third option within the health transfer program, namely one of self-government.

The health transfer agreements apply only to those First Nations and Inuit communities south[2] of the 60th parallel, and hence communities in the Northwest Territories (NWT), Yukon, Nunavut and the northern most areas of Quebec and Labrador negotiate the control of health services with Indian and Northern Affairs Canada (INAC). FNIHB is not involved in these negotiations. However, it is noteworthy that the transfer of health service delivery in the Yukon to the Yukon Territorial Government occurred April 1, 1997 after 43 years of Federal control[3]. Metis living south of the 60th parallel and Aboriginal people who reside off reserve negotiate health services control with the Metis and non-status Indians federal interlocutor (Health Canada, 1999c).

[2] Communities north of the 60th parallel are not reflected in the attached tables.
[3] The Yukon Territory had asked for assistance from the Federal Government in 1954 when a polio epidemic occurred exhausting the territory's resources.

Based on the history of legislation policy, there are three main approaches available for First Nations and Inuit communities to consider with regard to transfer agreements. The first is the Health Service Transfer Approach, which allows for a gradual takeover of responsibility and resources for both community health services and programs. This process "includes the transfer of knowledge, capacity and funds so that communities can manage and administer their health resources based on their own community needs and priorities" (Health Canada 1999c, p 5). The overall goals of this type of transfer are to provide communities with flexibility in the delivery of health programs and services, maintain mandatory programming (i.e., public health), allow for community-based and designed programs and services, and enhance and strengthen community leaders' accountability to their community members. Eligibility criteria include a Band Council Resolution (BCR) for approval of the transfer, and evidence of successful financial and administrative experience in implementing programs.

Services eligible under this type of transfer include community health services (i.e., nursing services, health education), environmental health services, and health careers (excluding bursaries and scholarships). Regional services, such as a regional nursing officer, are available in a consultative manner to a band that has undergone health transfer, although some bands also control this aspect of health service delivery. Furthermore, some programs, such as communicable disease control, remain mandatory and must be offered by the band. Details such as how a health transfer is conducted, accountability frameworks (i.e., including information about the

accountability of the Chiefs and Council to community members, Minister and parliament), and the responsibilities of the Band and of MSB, now called First Nations and Inuit Health Branch, are all clearly outlined in Handbook One (Health Canada, 1999c). For example, MSB would be responsible for protection against health risks if an immediate response were required such as when a communicable disease outbreak occurs.

The second approach is referred to as the Integrated Community-Based Health Services Contribution Program, which is the gradual transfer of health services. It includes the signing of Contribution Agreements by the First Nations and Inuit communities for particular kinds of community health services. This approach allowed for more intensive preparation of the community by MSB, such as provision of training in management of programs and handling budgetary issues. The two key items within this approach are the development of a global funding arrangement and the creation of a community health management structure.

MSB suggested that the Integrated Community-Based Health Services style may be the most suitable for some communities while others may use it as a stepping stone to the health transfer or self-government agreements. This style also provides opportunities for capacity building in First Nations and Inuit communities and facilitates community involvement. Services and programs are shared with MSB but new programs outside the MSB mandate are not allowed. Communities are eligible for this approach if they already deliver health programs funded through MSB Contribution Agreements, are willing and agree to develop a health management

structure with trained personnel, and begin a planning process to identify community needs and complimentary services. The handbook also includes information about planning for this approach, required components of the work plan, and community responsibilities (Health Canada, 1999c).

The final approach is self-government, which refers to control of all aspects of the life of First Nations and Inuit communities. Unlike the other two approaches, the role of the MSB would be minimal because the federal mandate for self-government falls under INAC rather than Health Canada (Health Canada, 1999c).

The second handbook in this series, "The Health Services Transfer" (Health Canada, 1999d), focuses on the actual transfer process, including the completion of the community health plan (CHP) by the specific community. Emphasis is on: 1) the pre-transfer phase (i.e., initiation of the process including completing the first four components of the CHP; 2) the bridging phase (i.e., development of the memorandum of understanding and completion of the next eight components of the CHP); 3) the implementation phase (i.e., signing of the Health Services Transfer Agreement); and, 4) completion of the last three components of the CHP within a year of the signing. Throughout the handbook, explicit details are provided about the requirements for mandatory programs such as immunization, the management and delivery of community health programs, and the roles of individuals such as medical officers of health. Liability and malpractice insurance is also discussed, as are reporting mechanisms to the community and MSB. Information specific to the hiring, supervision and legal requirements for nurses is also included. For example, it is noted that a

community health nurse needs to be supervised by a senior qualified nurse, whereas a nurse in an expanded role (i.e., advanced practice nurse) needs to be supervised by a senior qualified nurse who would be expected to consult with a physician. Throughout the document, the message is one of responsibility and accountability by the First Nations and Inuit community that enters the agreement (Health Canada, 1999d).

The final handbook in this series, "After the Transfer—The New Environment," (Health Canada, 1999e), focuses on the environment of health services delivery after the transfer has occurred. It emphasizes that MSB and the community continue to maintain a relationship of mutual support with an overall goal of integration and harmony in relation to health services. The roles and responsibilities of the participating parties, including the community, the regional transfer officer, and medical services, are outlined. The main emphasis in the document is on an accountability framework, which explains the importance of evaluating the health services, and demonstrates the importance of accountability for Chief and Council, community members, Minister of Health and Parliament, and MSB. Examples of information required for reporting purposes are provided to the different groups noted above. Issues such as defaulting on the transfer agreement and dispute resolution between the community and MSB are outlined. Nurses are specifically addressed through the discussion of critical incident stress management services (CISMS) in case of events that lead to reactions within the community. The purpose of CISMS is to provide assistance to the individual who is the recipient of the reaction. Telephone numbers and addresses are provided so that they are available to the community (Health Canada, 1999e).

By 1999, 41% (or 244) of the 599 eligible First Nations and Inuit communities had signed Health Service Transfer Agreements (Health Canada, n.d. c). In the 1999/2000 Annual Report of First Nations and Inuit Control, it is noted that 81% of eligible First Nations and Inuit communities are involved in the First Nation/Inuit Control Process (Health Canada, 1999c). Furthermore, of this 81%, 46% or 138 of 276 communities have assumed greater responsibility through transfer agreements, 21% or 99 communities have signed integrated community-based health services agreements, and 14% or 57 communities are involved in pre-transfer planning. The report also includes a breakdown of community type (i.e., semi-isolated, remote-isolated) and stage of transfer. For example, the table notes that there are 400 non-isolated communities of which 192 are under transfer, 86 semi-isolated communities of which 39 are under transfer, 93 isolated communities of which 38 are under transfer and 20 remote-isolated communities of which 7 are under transfer. They conclude that of the 388,712 residents of First Nations and Inuit communities eligible for transfer, 193,092 or 46% are living in transferred communities (Health Canada, 1999c). (See attached tables[4]).

A regional analysis of current and projected transfers indicates that of the total of 599 communities eligible for transfer, 276 or 46% have transferred as of March 31, 2000. Quebec has the highest regional percentage with 82% (23 out of 28 communities have transferred) whereas Alberta has the lowest with 7% (4 out of 58 communities).[5] The projections to March 31, 2005 note that Quebec will have achieved 100% transfer, with

[4] The tables include zones as specified by FNIHB.
[5] In Alberta, band transfers of health services are low because of First Nations interpretation of the treaty rights and fiduciary relationships. There are only three transfer agreements representing four out of 45 bands in Alberta (Personal Communication, G. Corrigal, January 29, 2003).

the Atlantic region anticipated to be at a 90% level, Manitoba at an 84% level, and Saskatchewan at an 82% level. Alberta will remain the lowest with the projection of 17%. Overall, across the regions, 60% of the transfers are expected to be complete (Health Canada, 1999c).

Impact on Nursing Practice in First Nations and Inuit Communities

Nurses and nursing practice have been, and will continue to be, influenced by the significant change the policy to implement band control of health care has produced. A number of documents were reviewed and are discussed here to begin to understand the complexity of this entire process at the practical level.

Reports from Health Canada and from the Aboriginal Nurses Association are most useful in understanding the significance of the transfer of health services for nursing practice. The Handbook on Nursing (Minister of National Health and Welfare, 1989) explicitly states, “The prime focus of the nurse’s role is changing from that of a provider to one of a facilitator, with health promotion as the main component” (p 4). To aid in making the whole process go smoothly, the booklet was developed to assist band and tribal councils to “understand nursing in general and increase their ability to make choices and decisions on the type of health care delivery system that will meet identified community health needs” (p 6). This joint publication by the IINC (since renamed the Aboriginal Nurses Association of Canada [ANAC]) and MSB includes definitions of specific community health programs (i.e., communicable disease control), discussion of nursing standards, qualifications (i.e., the differences between diploma and baccalaureate preparation) and scope of duties.

The booklet encourages band and tribal councils to have policies and procedures in place to cover their legal responsibility in terms of personnel, facilities and procedures. Overall, it is a guidebook to assist band and tribal councils in preparing for their new role of directly employing nurses. The document even provides specific suggestions on how bands can recruit nurses. For example, the booklet suggests speaking to third- and fourth-year university students about employment opportunities in First Nations communities (Minister of National Health and Welfare, 1989).

To further aid in the transfer of health services to band or tribal control, the ANAC held a series of Band Nurse Workshops in 1986 with a subsequent workshop in 1987. A third workshop, held in 1990, noted that there were approximately 80 nurses working in situations where health services were being transferred (Indian & Inuit Nurses of Canada, 1990). The workshops provided opportunities for nurses to learn from each other and from government officials about the transfer process at both a theoretical and practical level. For example, benefits, pensions, and liability issues for nurses employed by bands were discussed. Some band-employed nurses have found that they received a reduction in pay and benefits from when they were employed by MSB. The overall goal of the workshops was to provide a supportive atmosphere for nurses who were at the front lines of significant change, while continuing to provide care to First Nations communities.

Sufficient concerns about transferred services were raised such that a survey was conducted of band-employed nurses (Indian & Inuit Nurses of Canada, 1990). The results, which showed the inadequate inclusion of nurses' input in the transfer process,

led to the 1994 Band Nurse Workshop on the transfer of health services (ANAC, 1995). Workshop participants recommended that the ANAC: 1) prepare and circulate information on Band-employed nursing; 2) conduct a national survey on Band-employed nurses to ascertain unresolved personnel issues; and, 3) develop a list of resources related to Band-employed nurses.

Medical Services continued to release documents in relation to the health transfer. One report, "Discussing Employment" (Health Canada, 1993), encouraged nurses to be prepared to ask questions to ascertain if there was an appropriate match between themselves and the community. The tone underlying this report is one of obligation to former MSB nurses who were finding themselves in changing employment circumstances with little perceived support to adapt to those changes. In a similar fashion, Health Canada developed a guidebook to assist First Nations in evaluating their health programs (Health Canada, 1999a).

Subsequently, the MSB within Health Canada developed three handbooks in 1999, that were updated accounts of policies related to "transferring control of health services to First Nations and Inuit communities south of the 60th parallel across Canada" (Health Canada, 1999c, p iii). The first handbook explicitly states that the 1999 handbooks are the most current policy statements and replace any previous policies. It is also noted that periodic review of Medical Services policies is routine and reflects an evolving relationship between the federal government and Aboriginal people.

Handbook 1, "An Introduction to Three Approaches," was developed for band councils, tribal councils, other First Nations organizations and managers, and transfer

officers within Medical Services. The main goal of this first handbook is to discuss the three main types of transfer of health services control from the federal government to First Nations and Inuit communities (Health Canada, 1999c, p iii).

In addition, emphasis has been placed on acknowledging and documenting the expanded role of nurses within First Nations and Inuit communities. Hence, FNIHB developed the Competency Assessment Program in 1999/2000 to ensure that graduating nurses are competent to work in such expanded roles (Health Canada, 2000a; Health Canada n.d. a). The program includes the broad areas of nursing such as nursing knowledge, skills, abilities, attitudes and judgment. The Competency Program includes a self-assessment and study guide, multiple choice testing for community health and therapeutic interventions, and a clinical skills assessment process. A survey of health professionals in the field was used to validate the required competencies for the expanded role in nursing. Overall this program is supposed to ensure that nurses who are hired by FNIHB meet the required competency level for remote areas, thus addressing quality assurance for the First Nations and Inuit communities, while also identifying ongoing continuing education needs for nurses.

Band-Employed Nurses

Band-employed nurses must respond directly to provincial nursing standards and laws when practicing nursing because they are not considered federal employees (Personal Communication, K. MacMillan, FNIHB, November 21, 2002). In some cases, bands have taken responsibility for their health services but continue to hire federal nurses because federal legislation allows for nurses to work in an expanded role, i.e.,

advanced nursing practice, whereas not all provincial legislation supports this (Personal Communication, K. MacMillan, November 21, 2002).

The Saskatchewan Registered Nurses' Association (SRNA, 1990) with assistance from MSB and the IINC, prepared a document specifically addressing the roles and functions of registered nurses employed by Indian Health Authorities in Saskatchewan. The Association acknowledges the expanded role of the nurse under such circumstances, which includes medical and pharmaceutical responsibilities. Consequently, the Registrars for the College of Physicians and Surgeons of Saskatchewan and the Saskatchewan Pharmaceutical Association have also signed the document. The prerequisites for the nurse to work in an expanded role are clearly articulated, i.e., current registration with the SRNA (and general nursing skills are discussed within the context of existing policy statements and documents on standards of nursing practice available through SRNA). The specific skills for nurses working in expanded roles with Indian communities are addressed through a focus on primary care skills, namely assessment, intervention and drug therapy interventions. Roles and practice standards are specifically outlined but SRNA also includes a statement about the personal and professional accountability of the registered nurse working in such an environment. This document indicates the provincial nursing association's support for band-employed nurses but is unique in that no other such documents could be located from the other provincial nursing associations. This document was revised in 1990 to more generally address the roles and functions of registered nurses providing primary health care in Northern Saskatchewan (SRNA, 1990). This second document identifies

the nurse as working with either Northern Health Services or MSB (now FNHIB) in northern Saskatchewan. Otherwise the roles and functions remain the same.

The number of current transfers, as well as the projections for future transfer agreements noted earlier, indicate the increased need for band-employed nurses working in such communities.

Research Related to Nursing Practice in First Nations and Inuit Communities

Both Health Canada and The ANAC have conducted research on issues related to remote nursing practice, particularly the barriers to employment and retention of aboriginal nurses (Goodwill, 1984). The research identified perceived discrimination, poor work environments, poor administrative practices, alienation, and conflicting policies as impediments for aboriginal nurses pursuing a career with Health Canada (Goodwill, 1984). Another survey focused on the characteristics of nurses who have worked, or are currently working, in isolated aboriginal communities, in addition to identifying factors that motivate nurses to remain in or leave isolated aboriginal communities (ANAC, 2000). This survey was conducted as a result of the recommendations of the Band Nurse Workshop.

The major findings conclude that nurses who have worked in the same community for greater than five years are aboriginal, and are either originally from the north, or are from a southern rural area and have a partner who lives in the community. Recommendations from the survey address recruitment and retention of nurses, the need for increasing the number of aboriginal nurses, and the need for developing an appropriate management structure within FNIHB and band-transferred communities.

A summation of key issues for nursing and health care delivery that ANAC have identified include: 1) liability issues regarding nursing scope of practice that varies between provinces; 2) a lack of clarity regarding accountability for programmes that may rest within FNIHB, local community control, or both; 3) a lack of nursing supervision when nurses report to non-nursing personnel who do not understand the complexity of nursing practice; 4) the need for nurses to be able to fully participate in health care program development and implementation; 5) a lack of personnel and resources to be able to fully integrate cultural and traditional knowledge and practice; 6) the difficulty for nurses to become involved as fully participating community members; and, 7) the need for all participants to be fully cognizant of professional regulations and statutes under which nurses must practice.

FNIHB has attempted to address the recruitment and retention challenges of nurses in remote communities. The National Nurse Retention and Recruitment Strategy (Health Canada, 1999b) was formulated based upon recommendations by a working group consisting of nurses from the main offices and regions of MSB, First Nations authorities and the Professional Institute of the Public Services. The strategy emphasizes creating a living environment in First Nations communities to which nurses will want to come, and recruiting the most appropriate nurses for the job.

Several strategies were mentioned such as creating a national internship program, which would provide opportunities for new graduates to obtain the necessary experience to work in remote areas. This national strategy was implemented in 2000, and is referred to as the Nurse Internship Program. It is limited to participants who are

of First Nation ancestry with less than one year of clinical experience since graduation from an accredited nursing program. When enrolled in the program, the participant must complete the Northern Nursing Clinical Practice Program (NCPP) and Community Health Nursing in First Nations Communities (CHNIFNC) if they are a diploma-prepared nurse, as well as be willing to work for a minimum of 12 months for FNIHB (Health Canada, FNIHB, n.d.).

Another strategy included identifying the profile of nurses who work in remote areas; this survey was completed in 2000 by ANAC (2000). Other examples of strategies include providing clinical support to nurses such as an orientation to the role and provision of regular guidance and feedback; management support for nurses through management training; examining concerns the nurses had voiced about the quality of housing, lifestyle and safety; and, implementing a concerted recruitment effort by emphasizing the recruitment of First Nations nurses and designating a nurse recruitment officer based upon regional needs (Health Canada, 1999b). The clinical support program has since been nationally implemented and includes an orientation of one to four weeks, depending upon the learning needs of the nurse, continuing education in the clinical setting, and support and direction to the internship program (Clinical Support Program, Ontario Region). These goals have been achieved through structured teleconferences, on-site education sessions, and workshops.

Nurses who work with FNIHB for a continuous time period of 12 months are also entitled to recruitment bonuses ($4500, half paid in the month of hiring and the remaining paid at the end of twelve calendar months) and retention bonuses ($375 per

month after 12 months of employment). Other benefits to encourage recruitment and retention are: education allowance, isolated post allowance, sponsorship in the clinical skills training, paid transportation out of isolated communities according to their specifications, and financial monthly bonus in recognition of work in an expanded practice role ($500 per month) (Health Canada, 2003).

A study from Indian and Northern Health Services (CHCL Comprehensive Healthcare Consultants Ltd., 1995) examined the practice of "extra duty" (i.e. call backs while on 24 hour on-call). The study revealed that a factor precipitating extra duty hours was the support of the chief and council in provision of services. In other words, if the band administration expected the nurse to provide services at any time of the day, the nurse's extra duty hours would be very high. Communities with a high volume of extra duty call backs can lead to an overall higher workload for the nurse, and the potential for burn-out and relocation to less remote areas that have a decreased workload (CHCL, 1995). This is one example of lifestyle support issues (i.e., personal and family-related concerns such as schooling of children and limited personal free time) that influence nurses' decisions to stay in remote areas, although this concept was not frequently discussed in the reviewed documents.

Educational Preparation of Aboriginal Nurses

Understanding policies for rural and remote nursing practice also includes examining policies in relation to preparing aboriginal nurses, who are most often from rural and remote areas and are therefore likely to be major contributors to nursing practice in these areas. A continual issue for First Nations communities has been the

desire to hire aboriginal nurses to provide nursing care. Within Canada there has been limited success in preparing aboriginal women and men as nurses, either at the diploma or baccalaureate level. The Aboriginal Nurses Association attempted to determine the number of aboriginal nurses working in First Nations communities and the number of aboriginal nursing students (Nowgesic, 1990). However, the response rate was insufficient to meet the goals of the research.

There have been several initiatives to address the challenge of preparing aboriginal people as registered nurses. The national Native Access Program to Nursing (NAPN) commenced in 1985 as a joint partnership between the College of Nursing (University of Saskatchewan) and the Saskatchewan Indian Federated College (SIFC), (University of Regina) (www.usask.ca/nursing/NAPN_Program.html). In the original program, a nine-week orientation took place in Saskatoon, which brought together all enrolled aboriginal students from baccalaureate programs across Canada. The purpose of the program was to help students develop a support network and to enhance skills they would require in their programs, such as writing, science, and mathematics. The coordinator maintained contact with the students and their respective schools while they progressed through the educational program.

NAPN has now evolved into a support program for aboriginal students who are dealing with the academic challenges of the nursing program and thus it is limited to students on two participating campuses (University of Saskatchewan and SIFC at the University of Regina).

The program continues to partner with tribal councils and aboriginal groups and receives funding from Health Canada. The goal of the program is to improve the health of First Nations communities by preparing aboriginal nurses to work with these communities. Thus, efforts are made to recruit aboriginal high school students into the program and while enrolled, students are provided with assistance regarding academic and personal issues.

Lakehead University has a specific pre-entrance program for aboriginal students who are interested in nursing. The Native Nurses Entry Program (NNEP) commenced in 1987 as a result of a consultation workshop with government officials, educators, and community leaders (Poole, Morton & Boone, 1997). NNEP is a nine-month preparation program to improve the student's academic skills to help ensure their success with the degree program. Students may enroll with a minimum of grade 10 but are encouraged to have Chemistry and Biology courses beyond that level. Criteria for program admission include reflection on their life experiences and an evaluation of the support systems in their lives (Lakehead University, 2001). Evaluation of this program has led to further recommendations including revising the entry criteria and increasing the academic rigor of the NNEP to prepare students for the demands of the four year program (Poole, Morton & Boone, 1997).

Two other programs are at Norway House, Manitoba and Iqaluit, Nunavut. The program at Norway House is a partnership between the University of Manitoba, FNIHB, the Manitoba Keewatinowi Okimakanak, and Keewatin Community College. This unique BN program began in 1996 to provide individuals, such as aboriginal

peoples and residents of northern Manitoba, with an opportunity to complete a university-based degree. The program provides nursing education within an aboriginal context, and it is hoped it will address the shortage of aboriginal nurses available in Canada (Faculty of Nursing Annual Report 2000-2001, 2001a&b).

The partners acknowledged that the previous programs in Manitoba did not adequately prepare nurses to work in the northern context (Personal Communication, M. Courtenay, November 13, 2002). The newly developed University of Manitoba nursing program, which replaces all previous curriculum, has several unique features:

- The program is offered at several different sites to allow for access by the target group;
- The students complete the first two years over a three-year period in Norway House, with the subsequent years of the program completed in a northern setting, such as Thompson, the Pas, or in Winnipeg to ensure exposure to a variety of acute clinical experiences;
- Aboriginal leadership (i.e., Chief, Council and Community Council), community agencies, and members of Norway House and the Norway House Indian Hospital are involved in the program throughout its implementation;
- In September 2000 a 10-month Health Education Access Program was implemented to help ensure that students who want to enter the nursing program have the appropriate developmental and academic skills to do

so. Students undertake courses such as Chemistry and Biochemistry that help ensure success once enrolled in the nursing program;

- In the first two years of the program, workshops on topics such as self-esteem, study skills, and conflict management are offered. The content of these workshops complements the academic content, while assisting the students to develop the personal skills necessary to complete the program, particularly while facing the challenges of multiple roles (i.e., student / mother / wife) and subsequent family challenges (i.e., family role changes) simultaneously;
- There are on-site counselors and an academic advisor at Norway House to work with the students and help enhance their success in the program (Personal Communication, M. Courtenay, November 13, 2002). To date, there have been four graduates from this program. Although this is a small number, the partners in this initiative deserve recognition for the challenges they continue to face.

Similarly, the four-year Bachelor of Science in Nursing (Arctic Nursing) program at Iqaluit began in 1999 to meet the health care needs of the Inuit people (Nunavut Arctic College Nunatta Campus, n.d.). It includes an eight-month health program that students complete first to become prepared for the rigours of academic life. The Northwest Territories Registered Nurses Association (NWTRNA) has given this program a four-year approval.

Aurora College in the NWT works in collaboration with University of Victoria in offering an on-site four-year nursing program. Preference is given to aboriginal students who are interested in a career in nursing. An "Access Year," which focuses on Math, English and Science pre-requisites is offered for students who lack the requirements. The program can accommodate 40 students and currently has an enrollment of 30. The program was offered for the first time in Fall, 2002 and hence there have been no graduates. Students may complete a degree or decide to graduate with a diploma (www.auroracollege.nt.ca and N. Moulton, Personal Communication, February 21, 2003).

One other nursing program has recently been offered to attract aboriginal individuals. The Prince Albert site of the SIFC offered the University of Saskatchewan four-year nursing program as of September, 2002. They hope to attract 30 aboriginal students per year (D. Campbell, Personal Communication, February 21, 2003).

National Task Force on Recruitment and Retention

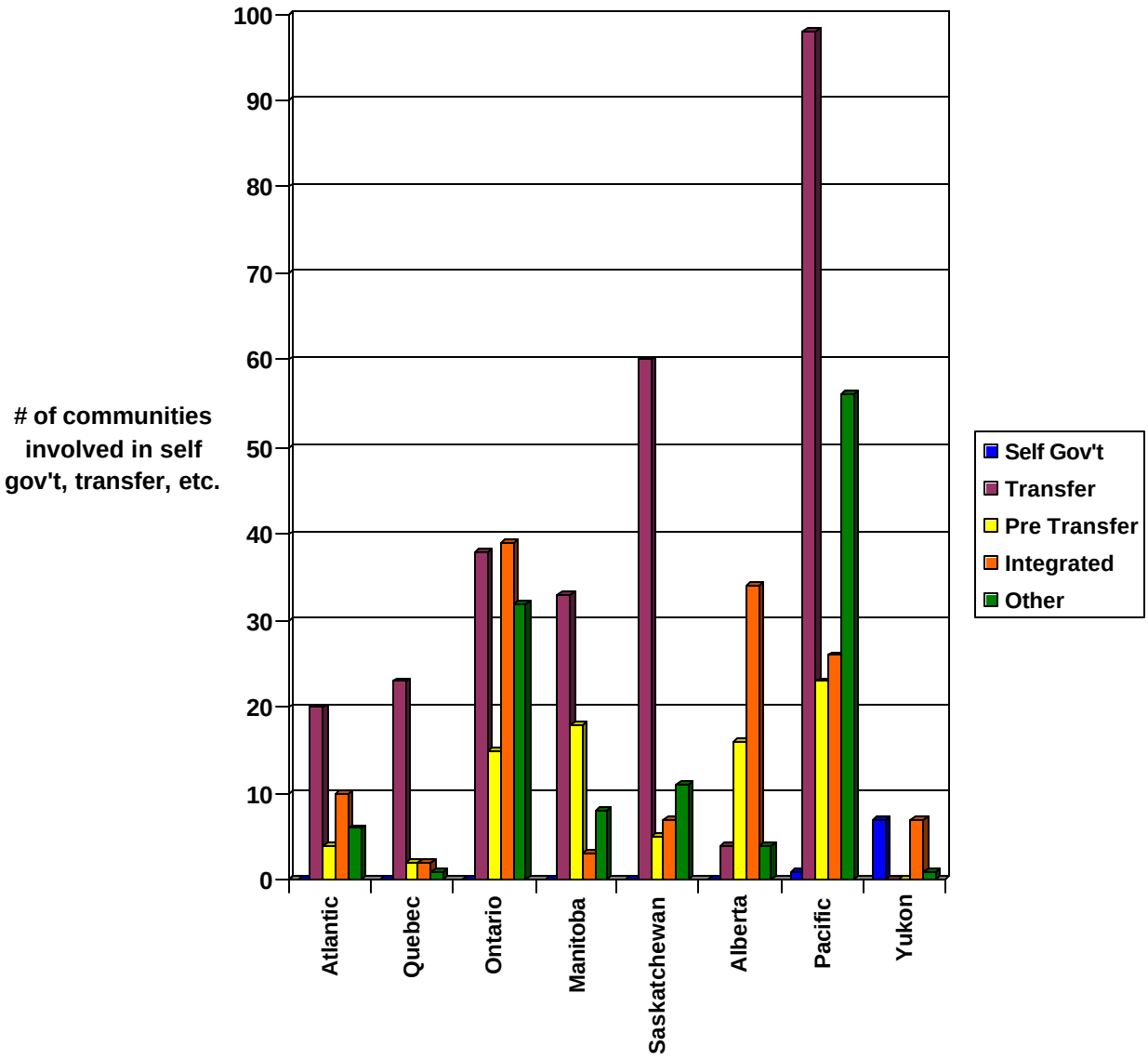
The most current report on the recruitment and retention of Aboriginal students into nursing has been produced by a joint task force under the auspices of the Canadian Association of University Schools of Nursing (CAUSN), now renamed the Canadian Association of Schools of Nursing (CASN) in conjunction with Health Canada, FNIHB, and the ANAC. The research team for *Against All Odds: Aboriginal Nursing* (Health Canada, 2002) sought information from CAUSN member schools, Aboriginal students, provincial education / government officials, Aboriginal organizations, FNIHB, and regional nursing officers and associations. An extensive literature and report review

was conducted to thoroughly examine previous discussions and studies on the issue. The benefits that an increased number of Aboriginal nursing students would bring to Aboriginal communities and to society at large are clearly recognized.

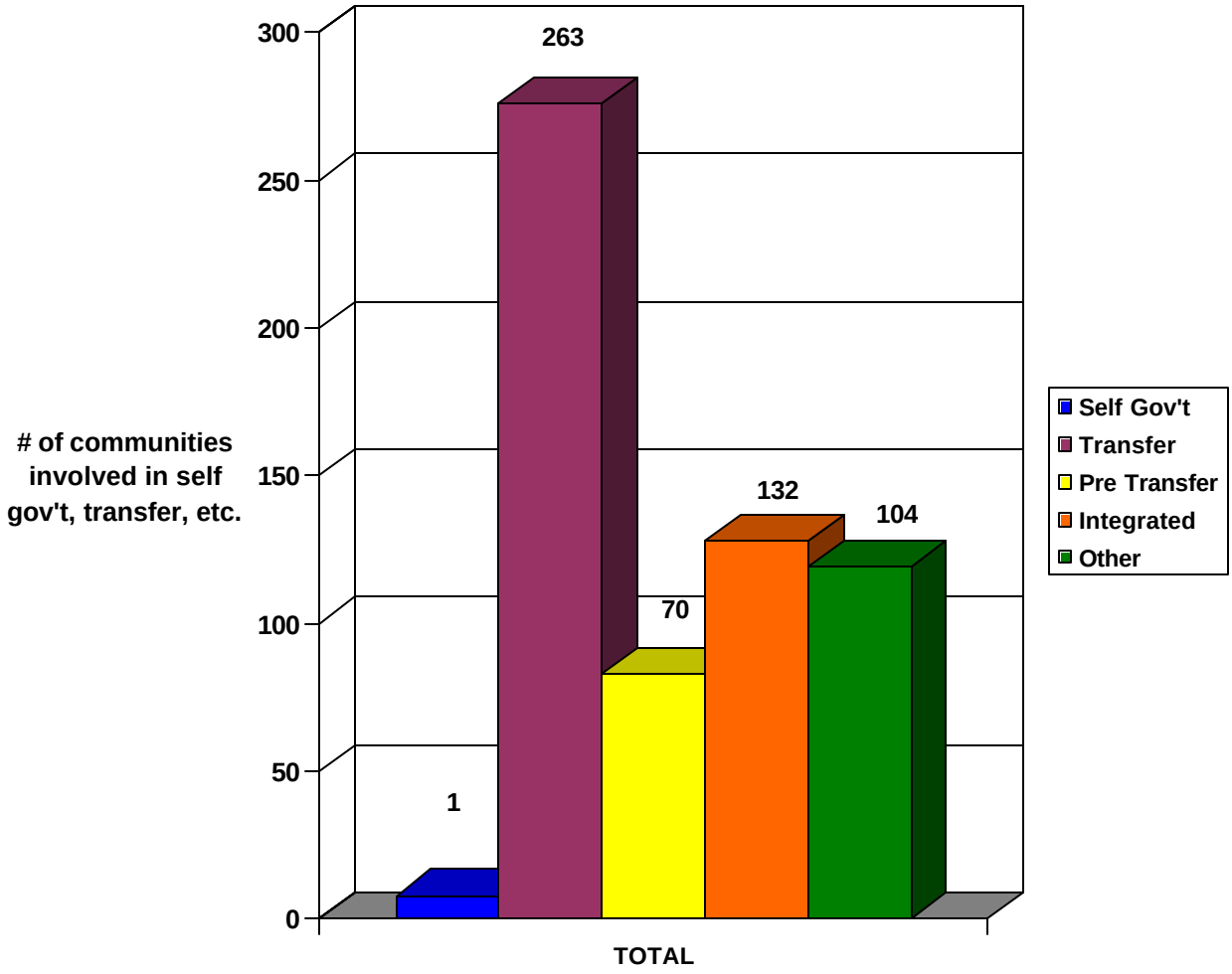
This comprehensive report presents the many barriers and challenges that Aboriginal persons face in obtaining higher education and careers within Canadian society. Of primary concern is the fact that many Aboriginal students do not graduate from high school, while those who do graduate lack the necessary courses in math, science and English to meet admission criteria for nursing programs. Multiple issues related to funding support were identified including long wait lists, insufficient funding available at the band level, and the requirement that students carry a full course load to qualify for support.

Over 100 recommendations were discussed such as funding for the aboriginal students' relocation costs and having counsellors available who are specifically trained to deal with aboriginal issues. These recommendations have implications for CASN members, Aboriginal organizations, FNIHB, provincial nursing associations and advisors, Aboriginal students, and funding bodies. A concerted effort is needed on the part of federal and provincial governments, educational institutions, Chiefs and Bands Councils, secondary school systems, and nursing organizations to facilitate the implementation of these recommendations.

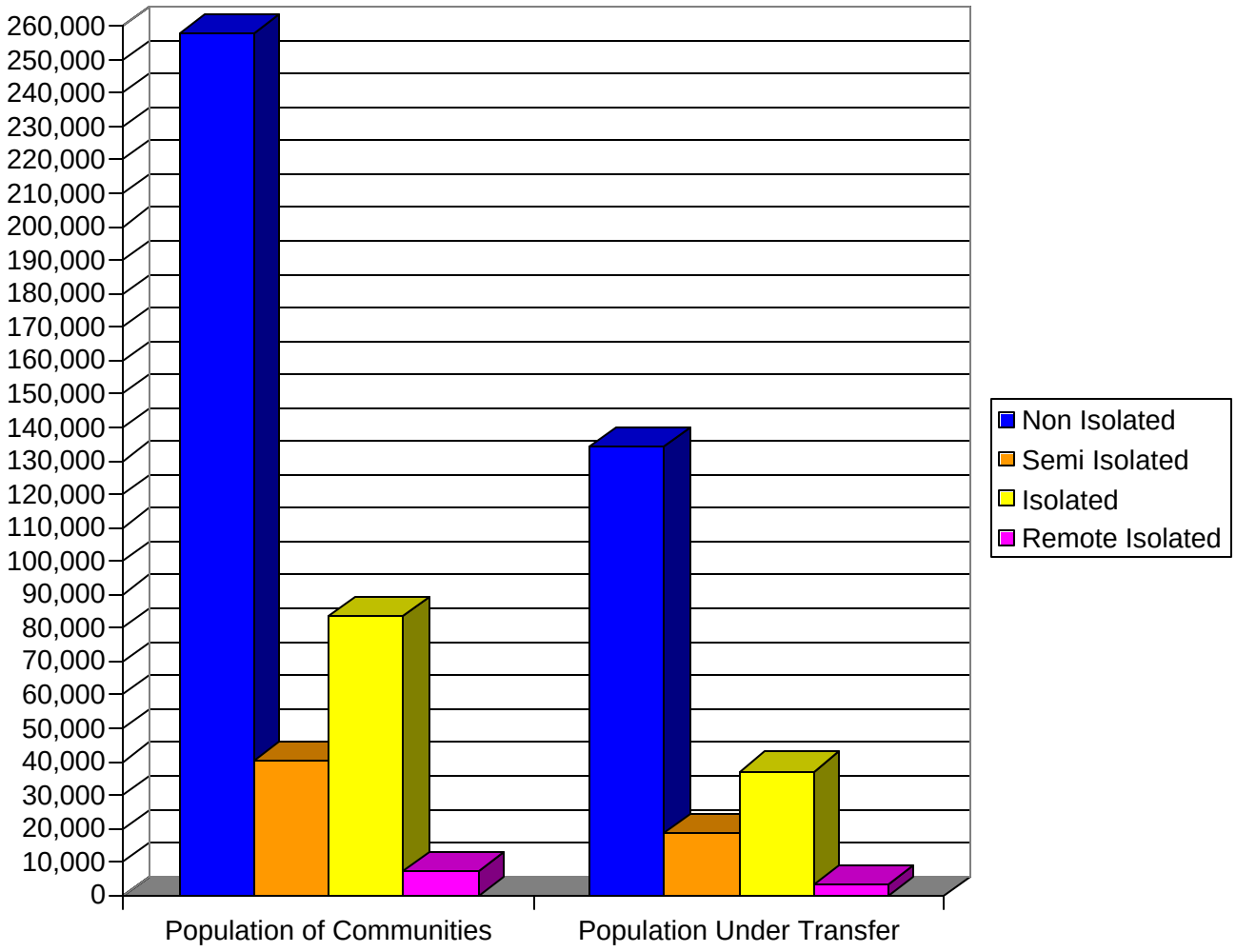
First Nation & Inuit Control Activity
as of March 31, 2000



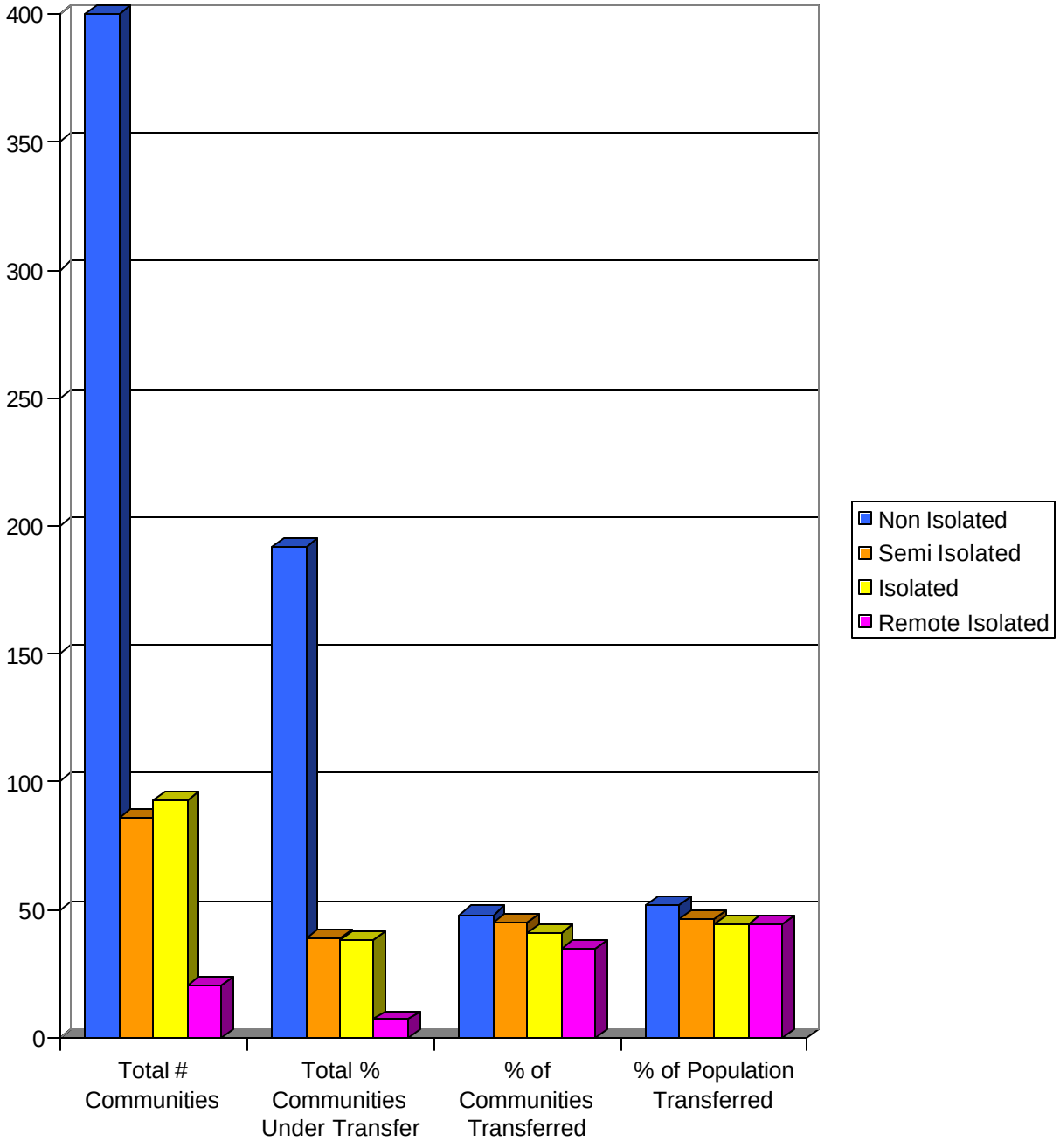
First Nation & Inuit Control Activity Total
as of March 31, 2000



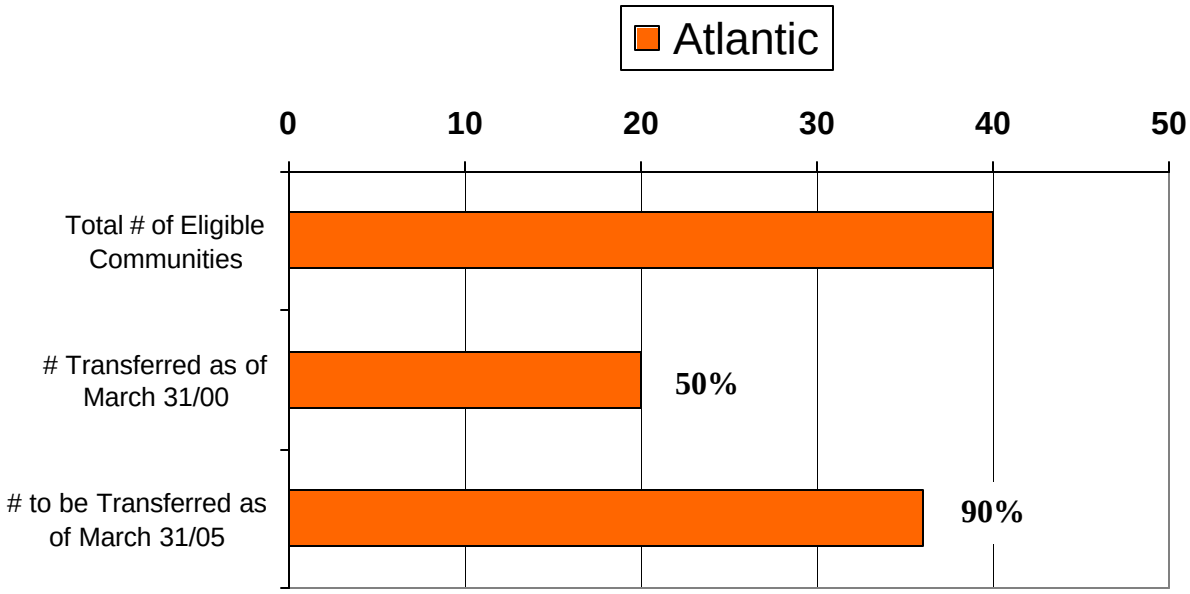
First Nation & Inuit Population
By Community

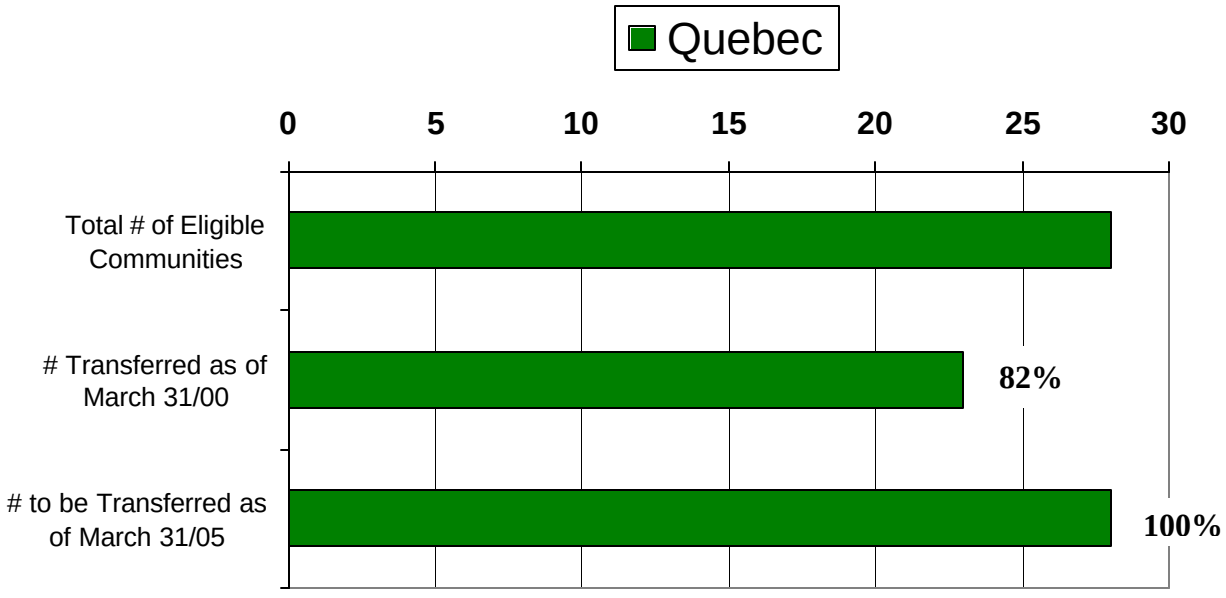


First Nation & Inuit Population
By Community Type

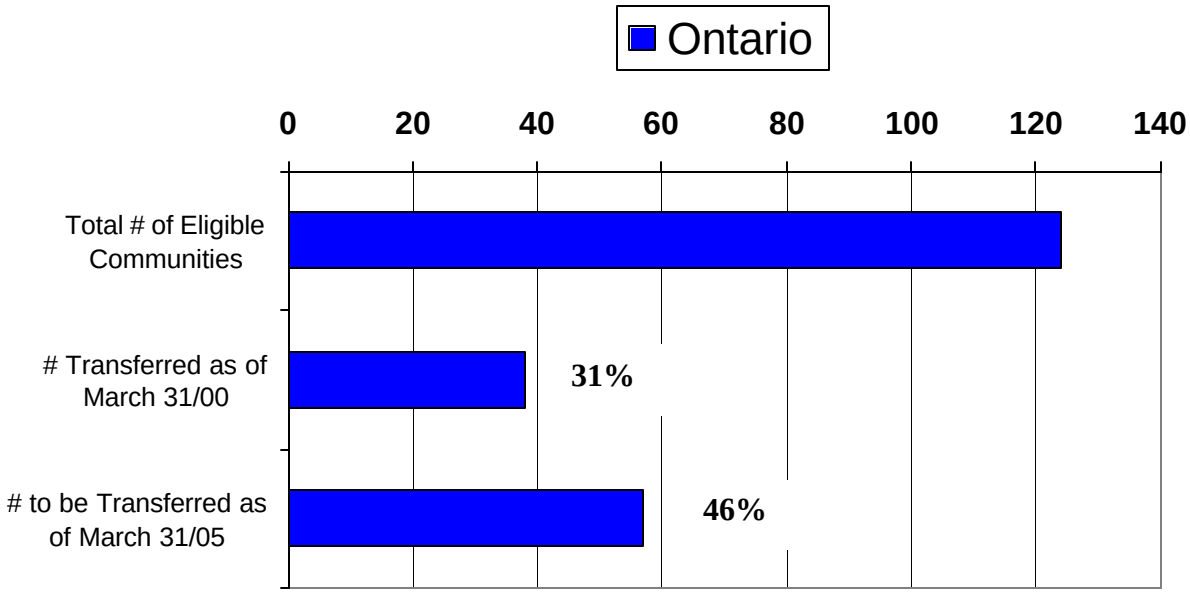


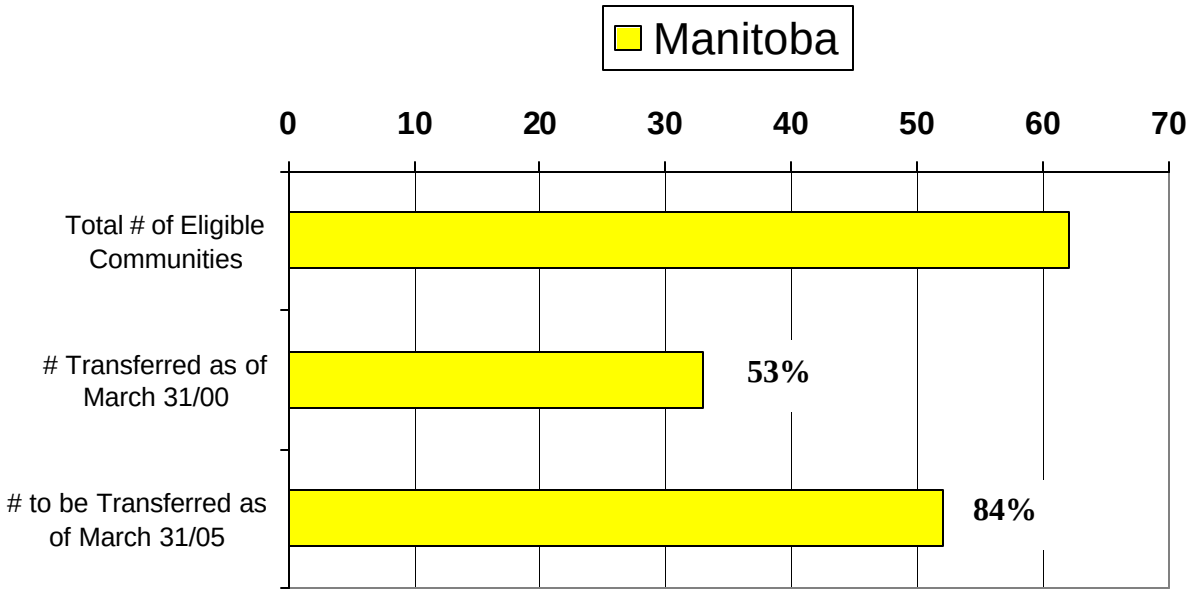
Current & Projected Transfers



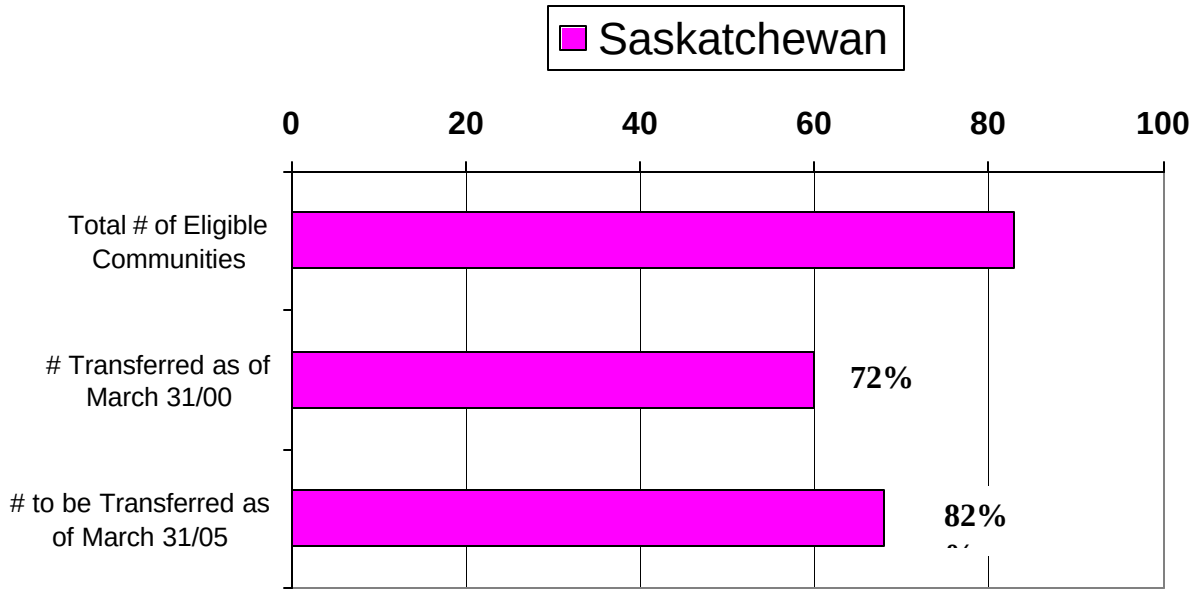


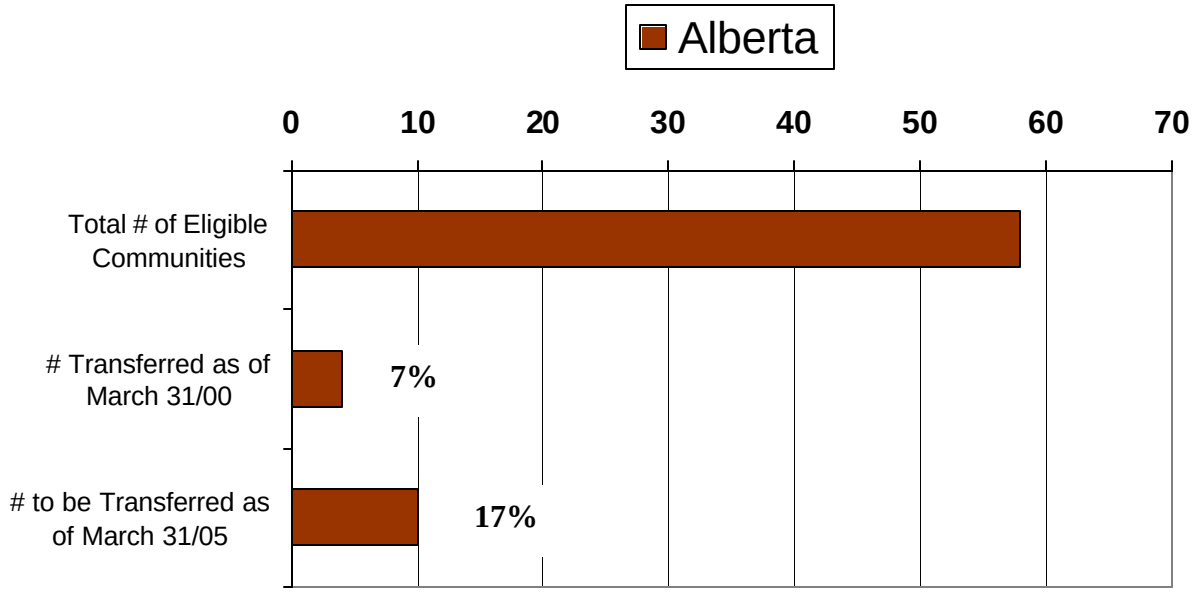
Current & Projected Transfers



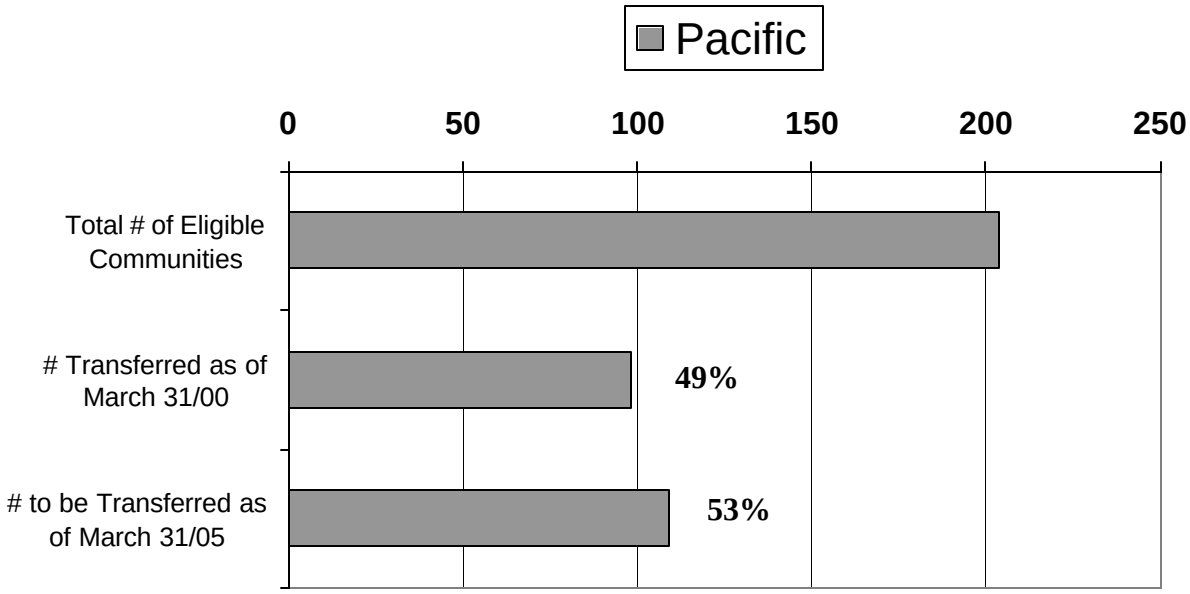


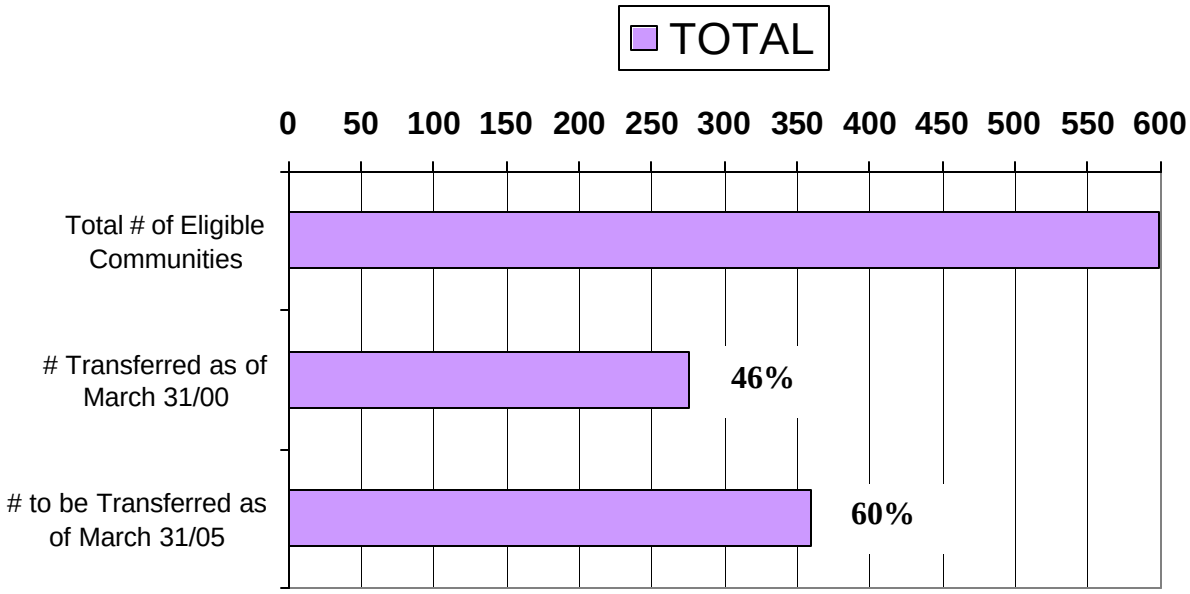
Current & Projected Transfers





Current & Projected Transfers





Educational Preparation of Registered Nurses for Rural and Remote Areas

Very few documents specifically address preparation for nurses to work in rural and remote areas, despite the relevance of this topic. For example, the Standards for Nursing Education in New Brunswick (Nurses Association of New Brunswick (NANB), 1997) does not mention rural but implies it as an issue, as noted in its 4th principle adopted from the College of Nurses of Ontario: "Accessibility—Accessibility suggests that nursing education programs reduce barriers to access, such as geographic location (emphasis added), language and culture" (p. 1). Other standards of nursing education documents from New Brunswick that were reviewed do not mention rural in their discussion (NANB, 1997). Entry-level competencies developed for the provincial and territorial nursing associations are further examples of documents that have been generically developed without inclusion of specific comments or information about rural or remote nursing practice settings (Manitoba Association of Registered Nurses [MARN], 2000).[1]

A recent national Nursing Education Think Tank 2002 Final Report (Williams, Meyer, & Price, 2002) identified four themes (curriculum, supply of nurses, practice education, and faculty supply) with corresponding priority activities (i.e., standardize tracking methods regarding student attrition, redefine clinical education to be broader in scope). Of all the priority activities, only one—design nursing programs to meet local needs—could be interpreted as addressing the uniqueness of rural settings.

[1] The title and acronym of this nursing association reflects that used in the specific report. Thus, two names and acronyms are used due to the recent change in name of this nursing association. Manitoba Association of Registered Nurses (MARN) to College of Registered Nurses of Manitoba.

Importantly, the authors devised an accountability plan that included identifying who is responsible for the detailed plan of action related to the priority activities and the specific timeframe for it to be completed.

Few documents specifically discuss rural and remote nursing preparation, a major portion of the documents are devoted to discussion the preparation of advanced practice nurses (APNs) and the work of nurses in First Nations communities. The few exceptions are included here. There is a preceptor manual that discusses, in general terms, how preceptors in rural areas can become prepared to work effectively with nursing students (Pottinger, 1994). In this document, rural is defined as having a population of less than 2,500, which is considered to be the most appropriate geographic size for a rural practicum because of the opportunities for learning.

Although there are some nursing programs that focus on rural health issues, no formal reports were located that discuss the goals and strategies of these programs/courses[2]. Information about these programs were retrieved from web-based searches. For example, the University of Manitoba, Brandon site, offers a rural nursing/rural health care focus within their four-year curriculum (The University of Manitoba, 1999). Aurora College in the Northwest Territories offers a Bachelor of Science in Nursing. Due to the geographic location of the program, students engage in rural nursing throughout the entirety of the program (Aurora College – Your Career Starts Here, n.d. a). This nursing program offers the University of Victoria collaborative nursing program. The students can choose to complete a diploma in Nursing within

[2] Discussion of nursing programs in the Northwest Territories and Nunavut is in Appendix F.

three years. Interestingly, program criteria state that applicants must be a minimum of 19 years of age to be considered for acceptance. Students who do not meet the requirements to enter the nursing program have the option of completing an "Access Year." This year includes courses such as Math, English and Science, which include relevant health information as well as an entire introductory health course. After successful completion of the access year, students may then register in the nursing program (Aurora College – Your Career Starts Here, n.d. a). Aboriginal students are given priority for entrance into the program. The maximum number of students that can be accommodated is 40 and in September, 2002, there were 30 enrolled students (N. Moulton, Personal Communication, February 21, 2003).

Aurora College also offers a 16-month post-RN certificate Primary Health Care—Nurse Practitioner (PHC-NP) program, which is available through a brokering arrangement with the Centre for Nursing Studies in St John's Newfoundland. Students complete their practicum components throughout the territories, and upon completion the PHC-NP graduates are eligible for registration with the Northwest Territories Registered Nurses Association (Aurora College – Your Career Starts Here n.d. b). Finally, Aurora offers the Grant MacEwan College Nurse Refresher Program for RNs who need to become reinstated.

In September, 2002 the Saskatchewan Indian Federated College (SIFC) commenced a four-year nursing program based on the University of Saskatchewan curriculum at the Prince Albert SIFC site (D. Campbell, Personal Communication, February 21, 2003). The program is limited to 30 students and preference given to

aboriginal individuals. The physical location of the program dictates that the clinical settings will be predominantly rural. The University of Saskatchewan (U of S) offers a rural nursing clinical option in the post Bachelor of Science in Nursing program. The program allows students the opportunity to experience nursing in a rural site to help them increase their knowledge and skills that are needed essential to working in rural areas. No similar programs were found to be offered in the undergraduate program at the U of S (http://www.usask.ca/calendar/nurse/results41-50.

When a search of the University of Northern British Columbia (UNBC) nursing website was done, it was discovered that the UNBC offers numerous rural-related courses and certificates. For example, rural courses are offered in the undergraduate nursing program. Both theory and practicum components focus on rural and northern-related health issues in many nursing areas including mental health, obstetrics, emergency, and so on. The UNBC also offers a rural option as part of the student's final focus area in the Post-Diploma Program, which is similar to the one offered in the undergraduate program. The Northern Collaborative Baccalaureate Nursing Program (NCBNP), which is offered through UNBC, also has rural-focused options as well as First Nations options for those students who wish to pursue these areas of practice. Finally, the UNBC offers a Certificate in Rural and Northern Nursing. This certificate course is available to experienced diploma prepared RNs who wish to pursue further education in rural and northern nursing.

In the province of Alberta, baccalaureate nursing programs at Lethbridge, Red Deer, Grand Prairie, Edmonton, Calgary and Medicine Hat place students in rural

settings for clinical practica. In the senior year the University of Calgary students can select placements in rural settings that then entails theoretical content on issues in health care and nursing. As a mandatory component of the University of Calgary at Medicine Hat Program, all students must take rural nursing with clinical practice in rural settings. Content of this program focuses on rural populations, environmental health issues, history of nursing in rural communities, and issues for practice. The University of Lethbridge Nursing Program also explicitly focuses on rural nursing practice and has a mandatory rural nursing course, although rural clinical placements occur throughout the course of the program.

Although the programs noted above are located in rural settings, there is no guarantee that the curriculum includes content or discussion about the territorial meanings of rural, or information about rural health issues or status. In addition, both Aurora College and the Prince Albert SIFC programs are urban-based nursing programs.

Preparation for nurses to work in rural areas not only includes the formal nursing programs, but also includes education initiatives after the students graduate. The British Columbia's Ministry of Health (BCMOH) supports mentors and preceptors in the health field, with the goal being to reduce the number of nurses who leave the profession soon after their graduation. In this program, a mentor is an experienced nurse who provides ongoing support to a newly hired graduate nurse, and a preceptor provides support to a student nurse during their final year in the nursing education program. In both instances, the program allows for training and professional

development for both the mentors and preceptors, and allows these individuals to have a reduced patient load in order to function effectively within this special role. Health authorities and affiliates of First Nations and aboriginal health organizations within British Columbia were all eligible to apply for special funding from the BCMOH to participate in this program (BCMOH, 2001a). Although this program is not specifically targeted at rural and remote areas, it offered benefits and assistance for nursing practice and nurses within these areas. Student loan forgiveness for individuals who commit to working in underserviced areas (equated with rural and remote settings) for five years after graduation has also been recommended in British Columbia (BCMOH, 2002).

The use of technology in preparing nurses to work in rural and remote areas has become increasingly relevant. First Nations & Inuit Health Branch (FNIHB) has taken the lead by hosting an information sharing session, which was designed to develop specific strategies to “fill in the gaps” in pursuing this endeavor (FNIHB, 2001). The key recommendations proposed at this session were for nurses to have access to current clinical information and access to a computer and to be educated in the use of computers. It was thought that having such access would facilitate peer support and consultation, which would help to mitigate some of the effects of isolation. In addition, the access would allow for increased continuing educational opportunities, which is another challenge faced by nurses in isolated settings. Some of the specific strategies that were suggested included: developing a comprehensive and secure website; developing an introductory health informatics course; and exploring other information

and communication technologies, including interactive videoconferencing and call centres.

Physician Supply in Rural and Remote Areas

A section in relation to physicians has been included for several reasons: (1) rural health care is a multi-professional challenge and therefore it is necessary to review documents relevant to other health professionals, and discuss their impact on the nurses who practice in rural and remote areas; (2) legislation related to the role of nurses, particularly those in advanced nursing practice, is influenced by physician roles and expectations; (3) physicians have developed rurality indexes and alternative definitions for the terms rural and remote, which would benefit from more detailed critique; and (4) of all health professionals, physicians are the most organized and politically prepared to address issues related to health services in rural and remote areas, and hence an examination of this process can be useful for the nursing profession.

Of all health services group documents, those related to physicians are the most focused when discussing the impact of rural and remote geographic settings on issues such as recruitment and retention of physicians. The Canadian Medical Association (CMA) has a task force that addresses rural and remote health issues and some medical specialties have specific committees that address rural and remote issues. For example, the Canadian Association of Emergency Physicians (CAEP) has its own Rural Committee. In addition, The Canadian Society of Rural Physicians (CSRP) has provincial and territorial chapters across Canada; they communicate with their members through their web site, a peer-reviewed journal and a newsletter. The mission of this society is to provide leadership for rural physicians as well as promote equitable health care for rural communities (www.srpc.ca).

Some of the reports use the term “underserved” (CMA, 1992) without defining the meaning of this term. For example, terms such as underserved are largely drawn from the American experience, which may not be suitable in the Canadian context.

A number of the reports include definitions of rural and remote. The CAEP (1997) forwarded the following definitions:

1. rural is “any area where health care is dispensed by general practitioners or non-physician providers and where immediate specialist support is limited or not available;”
2. rural isolated is “communities greater than 400 kilometers or about one to four hours transport in good weather from a major regional hospital;”
3. rural remote is “communities about 80-400 kilometers or about one to four hours transport in good weather from a major regional hospital;” and,
4. rural close is “communities that are within about 80 kilometers or one hour transport in good weather from a major regional hospital.”

Another way to define rural focuses on rural practice, which is defined as “practice in non-urban areas where most medical care is provided by a small number of general practitioners” and there is limited access to specialists and advanced facilities (Rourke 1997 as cited in Iglesias, Grzybowski, Klein, Gagne & Lalonde, 1997, p 2). Other physicians have published rurality indexes (Leduc, 1997; Magee, 2000), but there has been limited comparison and critique of the indexes, and there has been no formal testing to determine their applicability to rural health in general.

Other individuals within the medical profession have focused on developing a national framework of rurality (Buske, Yager, Adams, Marcus & Lefebvre, 1999). A rurality index is not intended to define a community as rural, but to "determine its relative degree of ruralness relative to an established norm or relative to another community" (Buske et al, 1999, p 11). To accomplish this, the CMA conducted a mail-out survey to all rural physicians (n = 5,347) in Canada. The instrument included a list of factors that can be used to determine the extent of ruralness or isolation. Through a series of ratings, the 1,658 respondents (response rate = 31%) chose the top ranked factors. A joint project of the CMA, CNA, Society of Rural Physicians of Canada, and the Canadian Pharmacists Association (2003) developed an index for rurality to assist in the recruitment of health care providers, but it has been too soon to test its applicability.

Four primary factors and six secondary factors were listed as determining the framework of rurality. The primary factors were: high level of on-call; long distance to secondary referral centre; lack of specialist services; and, insufficient General Practitioners / Family Practitioners. The secondary factors are: long distance to tertiary referral centre; absence of equipment such as x-rays and laboratory services; difficulty in obtaining locums; no ambulance service; inability to provide services such as obstetrics and general surgery; and, sparse population.

Overall, the reports that focus on physicians in rural and remote areas address recruitment and retention issues, and stress the importance of financial incentive programs, the need to expose students to rural practice during their training, promoting community involvement as a way to attract physicians (CMA, 1992), and regionalizing

care such that rural areas are connected to regional centres in order to ensure adequate support for providing quality care (CAEP, 1997). More specific recommendations are often drawn from the broad strategies, but there is rarely an accountability process in place to determine whether or not the recommendations were adopted (CAEP, 1997). Related CMA documents address the need for quality care, including quality maternity or emergency care, and provide recommendations to reach this goal. The recommendations, however, focus on training and preparation of physicians and do not explicitly refer to the advanced practice nurse as a colleague (The College of Family Physicians of Canada, the Society for Rural Physicians, Society of Obstetrics and the Gynecologists of Canada, 1999; Iglesias, Grzybowski, Klein, Gagne, & Lalonde, 1997).

In 2000, the CMA released its policy on rural and remote practice issues (CMA, 2000). There are 28 recommendations included which address three key issues: training, compensation, and work/lifestyle support. The policy was prepared to help groups such as communities, policy-makers and governments address the recruitment and retention challenges of physicians in rural areas. In this brief, they suggest using the Rural and Small Town Canada definition of rural, but also include the four characteristics of rural communities as identified by the 1999 survey of rural physicians outlined above (CAEP, 1997). The recommendations regarding training focus on issues such as identifying the factors that predispose medical students to choose rural practice, providing opportunities for rural physicians to teach in academic centres, and helping rural physicians achieve advanced skills to more adequately prepare them for their practice (CMA, 2000).

Compensation remains an ongoing issue for physicians; the CMA maintains it should be flexible in order to address the full range of the previously identified factors that exist in rural settings. Therefore, the recommendations include additional compensation for physicians working in rural areas, retention bonuses, and funded rural locum programs (CMA, 2000). The final issue identified in this policy document is work and lifestyle support issues, which include personal and family-related concerns such as schooling of children, employment opportunities for the physician's spouse, and limited personal free time. The challenge in addressing these issues is noted from the few recommendations that were included. Some examples are that there should always be two physicians available in a community regardless of its size, on-call weekends would be limited to one in five, and locum programs need to be available.

Various reports are available from the Centre for Health Services and Policy Research at the University of British Columbia. The reports more often do not include a definition of remote, but have defined rural as less than 10,000 inhabitants. The studies that have been completed by the Centre for Health Services and Policy Research have concluded that practice location choices by physicians are determined by the influence of physician spouses, community factors such as presence of schools, and opportunities for spousal employment (Kazanjian, Pagliccia, Apland, Cavalier & Wood, 1991; Pagliccia, Apland & Kazanjian, 1993).

Provincial policy approaches to the recruitment and retention of physicians in rural communities have been encapsulated under six headings: regulatory / administrative, direct funding--practice-related, direct funding—education

related, education / training, market-based initiatives, and other (Barer, Wood, & Schneider, 1999). Such policies have led to a variety of programs including subsidized incomes or guaranteed minimum income for physicians in rural areas, funded rural locum programs, tying student loans to return for service commitments in rural areas, and funding for rural physicians to partake in continuing education.

The authors conclude with some general observations, the most relevant are: the majority of Canadian incentives are financial (which will not be as effective for nursing given the different payment methods between the two professions); the lack of a national mechanism to address shortages of health professionals partly because health is viewed as a provincial responsibility; and the inconsistency regarding the employment of non-physicians to provide care in "underserved" areas.

A discussion paper prepared for the Federal / Provincial / Territorial Advisory Committee on Health Human Resources (Barer & Stoddart, 1999) revisited the issue of recruitment and retention of physicians in rural and remote communities. While its focus is on physicians, a discussion about the use of nurse practitioners is included in the recommendations for providing health care in rural areas. The need for educational opportunities, regulatory modifications to allow activities such as prescribing medications, and administrative funding arrangements to employ such individuals, is noted. The authors emphasize that nurse practitioners are capable of providing primary care in regions that are lacking adequate health services, although the challenges remain in terms of recruiting and retaining them. It is postulated that nurse practitioner

programs will have greater success in attracting rural individuals who wish to return to reside in those locales with their expanded knowledge.

The Rural Physician Action Plan commissioned a study on identifying practical strategies that communities can employ to recruit and retain physicians (Alberta Health, 1994). More specifically, the research questions were to identify what rural communities are doing to recruit and retain physicians, what is working in this regard, and what Alberta communities can do to address recruitment and retention issues. For the study, interviews were conducted with hospital administrators, community representatives (i.e., municipal officers, hospital board members) and medical community representatives (i.e., rural-based physicians, medical school personnel). In addition, focus groups were held with hospital board members, administrators and directors of nursing to generate feedback about their findings and suggested solutions. Meetings were also held with family practice residents at which time the participants were asked to respond to community profiles to determine reasons why specific communities were chosen (Alberta Health, 1994).

Unlike other studies, the Alberta one examined the relationship between the community and its success in recruiting and retaining physicians. They found that successful communities were those that: (1) were located within a two-hour drive of Edmonton / Calgary or were in southern Alberta; (2) had a catchment population of more than 10,000, or less than 10,000 but within west central or southern Alberta; (3) had a minimum of a four- or five-person medical practice or at least ways to compensate for a smaller practice (i.e., less on-call schedule); (4) used a partnership

approach to recruitment and retention such that the hospital and physicians worked together; (5) made the new recruits and their families welcome (i.e., they saw the recruitment as not just recruiting a physician but a neighbor, friend and community member); and (6) expressed happiness and fun (i.e., they identified their barriers in recruiting, but learned from them, and despite them, assumed they would be successful). Furthermore, the report noted the importance of open communication between physicians, hospitals and community representatives. Interestingly, financial incentives were not predictive of success in recruitment and retention (Alberta Health, 1994).

A seven-step recruitment process was identified which included clarifying community needs and expectations, assessing strengths and limitations of the community, seeking out potential candidates, establishing contact with potential candidates, introducing the community and the candidate, negotiating arrangements, and welcoming the physician and their family to the community (Alberta Health, 1994). The report also notes that communities which have had difficulties in recruiting and retaining physicians have addressed this by educating the community about realistic expectations regarding physician workload, opening clinics in other communities that do not have physicians, and using other health professionals, such as nurse practitioners (Alberta Health, 1994).

In response to the absence of an Ontario physician human resource policy or plan, the McKendry report (Ontario Ministry of Health and Long-Term Care, (OMHLTC, 2000c) examines the current state of policy in relation to the availability of

physicians, and provides recommendations to create a resource plan. The author includes short-, medium-, and long-term recommendations with specific time frames. Each recommendation includes both background information and intended effects increasing the utility, and ultimately, the adoption of the ideas. McKendry also discusses the need to expand the scope of other health professionals, and recommends a working group to determine the scope of these providers. At the same time, the intended effects of this recommendation are only seen from the physician viewpoint (i.e., reducing physician workload) rather than viewing nurse practitioners and other health professionals as colleagues of physicians; all a part of the same health team.

A number of recommendations from the McKendry report were implemented by OMHLTC as noted in Shaping Ontario's Physician Workforce: Report of the Expert Panel on Health Professional Human Resources (OMHLTC, 2001b) including: (1) provision of two years of postgraduate training for Canadian physicians who took their postgraduate training in the United States; (2) increase by 12 (from 24 to 36) the number of positions in the international medical graduate training program; (3) increase by six (from 24 to 30) the number of entry level residency positions in Sudbury and Thunder Bay within the northern family program; (4) increase by six (from four to 10) the number of third year family medicine positions in Sudbury and Thunder Bay; (5) expansion by 15 positions (from 25 to 40) within the re-entry program; and (6) increase by three (from three to six) the number of personnel to assist rural communities in recruiting health professionals. In addition to these recommendations being implemented, the Ontario government also expanded the Telehealth program (another

of McKendry's recommendations) to southern Ontario, which lead to the hiring of over 100 nurses that was expected to reduce unnecessary emergency room visits (OMHLTC, 2001b).

The remaining McKendry report recommendations were referred to the Expert Panel on Health Professional Human Resources for further attention. This Panel had two other McKendry recommendations addressed by the OMHLTC, namely the development of a more reliable physician database and provision of funding for interim increase in undergraduate and postgraduate positions (OMHLTC, 2001b).

The report developed by the Expert Panel openly acknowledges the shortage of physicians and other health professionals in rural areas and notes how nurse practitioners can be used effectively to address this shortage. It also notes that the OMHLTC has targeted new funding to increase the number of nurse practitioners in underserviced areas and aboriginal communities. The report summarizes four areas that need to be addressed in regards to the shortage of physicians in Ontario: (1) plan physician services to meet needs; (2) provide appropriate education; (3) produce the right supply and mix of physician services; and (4) attract and retain physicians where they are needed. Within these areas, 30 recommendations are made that include providing incentives to specialists to encourage them to provide more services, investing in continuing medical education, and developing a rurality index to quantify the degree of rurality and develop compensation accordingly (OMHLTC, 2001b). Timelines and mechanisms of accountability regarding the recommendations were

included in the report with the first to be implemented in 2002. Ongoing evaluation of the Expert Panel's success is therefore required.

Health Care Delivery and Rural and Remote Areas

Nursing practice in rural and remote areas is directly impacted by the health care delivery system. Changes to this system have occurred in response to the current economic climate and the requirement that all health agencies provide services with fewer human and financial resources.

Current State of Health Care Delivery System

Many reports discuss the current state of health care organization and delivery in rural and remote areas, yet they rarely include definitions of these terms. However, these reports are important and need consideration because their content is often focused on an expanded practice role for registered nurses (RNs). One relevant report included, the final report of the Ontario Nursing Task Force, examined how the delivery of health services in this province was affected by changes in the nursing profession. The report then proceeded to make recommendations about how the province's health care delivery system could be improved by designating money for the training and hiring of nurse practitioners (NPs) (Ontario Ministry of Health and Long-Term Care [OMHLTC], 2000b). Although rural and remote areas are not specifically identified in this report, it is apparent that the recommendations, if followed, will enhance health care delivery in these areas of Ontario (OMHLTC, 2000b).

Some reports acknowledge the implications of the unique issues of rural and remote settings on health care organization and delivery. For example, the 2000 Saskatchewan Home Care Workshop report (Fontaine Associated Consulting Services Inc., 2000), identified and discussed the following issues in rural areas: lack of

volunteers; difficulties in recruiting and retaining RNs; cultural uniqueness of Aboriginal populations; and, large geographic distances which make providing care (receiving resources and services such as continuing education) difficult. In contrast, the report by Manitoba Health, discusses core health services (Manitoba Health, n.d.) available for northern / rural regional health authorities, but fails to include definitions of these terms. Rather than specifically indicating which services are available in / to rural and northern areas, reference is made to services being available in "most or all" health regions; in "some" health regions; and, through a central site. The reader is, therefore, left to decipher what specific services are available in rural and northern regions.

Three recent business plans for Ontario's Ministry of Health and Long-Term Care (OMHLTC, 1999a; 2000a; 2001a) include specific statements that reflect this provincial government's support for improving health care access and status within its rural and northern regions (OMHLTC, Business Plan 1998 / 99; 1999 / 2000; 2000 / 2001). However, as noted in the 1998-1999 Business Plan, the specific goal is to increase the number of physicians in areas where the numbers are lower than the provincial average. The 1999-2000 Business Plan acknowledges the role of nurse practitioners in providing care, particularly among Aboriginal populations, and their commitment to ensuring that rural and remote communities have better access to health care. However, this commitment most often refers to recruiting physicians for these areas rather than focusing on the nurse practitioners' role (OMHLTC, Business Plan 1999a; 2000a). Similarly, the 2000-2001 Business Plan also emphasizes the need to recruit physicians

for rural and remote areas (OMHLTC, Business Plan 2001a). Despite Ontario's commitment to nurse practitioners, all three of these reports fail to openly acknowledge the importance of this expanded role of nursing practice to improve the quality of patient care. Instead, emphasis is on the nurse practitioner providing care to individuals who reside within geographic areas where there are no physicians (OMHLTC, Business Plan 1999a; 2000a; 2001a). In addition, an assumption is that when recruitment techniques for these areas are successful, the current limited availability of physicians working in these areas will be resolved (OMHLTC, Business Plan 1999a; 2000a; 2001a). Interestingly, no mention is made of enhancing nursing education to include rural exposure which could potentially assist with recruiting and retaining nurses for rural and remote regions of this province.

The 2000 Final Report of the Minster's Forum on Health and Social Services for the Northwest Territories (Northwest Territories Health and Social Services, 2000b) and the Minister's Response to the 1999 Forum on Health and Social Services (Northwest Territories Health and Social Services, 2000a) both emphasized the need to put in place the recommendations that were previously suggested through numerous assessments and reports (Northwest Territories Health and Social Services, 2000b). Although the NWT is exclusively rural and remote, there are no definitions of these terms within either report rather than an explicit discussion of these terms and their implications. There seems to be an inherent assumption that a common understanding of these terms exists. The recommendations emphasize the importance of the NWT being self-directed and independent in improving their services and subsequently the health of the

residents. Despite the historical and ongoing contribution of nurses to health care in the NWT, the report focuses only minimally on recommendations specifically for the nursing profession. Surprisingly there were no recommendations on recruitment and retention of health providers such as nurses or on the use of NPs. Instead, the emphasis was on providing northerners with opportunities for education at local colleges (Northwest Territories Health and Social Services, 2000b) including educating "homegrown" NPs (Northwest Territories Health and Social Services, 2000a). Such a goal is appropriate and will enhance social capacity of the region, but the extensive resources and length of time required to prepare local individuals will be considerable pointing to the need for a multi-prong approach to address the shortage of health providers.

Alternative Modes of Health Care Delivery

Focusing on alternative modes of health care delivery, and nurses' roles within them, provides another avenue for addressing the complexity within which nurses practice, and how nurses can be part of the solution for the challenges in providing health care in rural and remote areas.

A case in point is the RN First Call Program in British Columbia (MacKinnon Williams, 2000). This pilot program used RNs in emergency settings to manage minor, uncomplicated injuries and health problems. RNs assess, diagnose and treat clients with the use of established and accepted clinical protocols. Both the British Columbia Nursing Union and the Registered Nurses Association of British Columbia (RNABC) supported the project which commenced in 1996/7 and expanded to all rural and

remote hospitals in 1998. It began as a response to the continuing difficulties in recruiting and retaining physicians in rural settings. It is believed that if the call back time for physicians was reduced, physician turnover would decrease. Available statistics show that a number of individuals who visit emergency rooms do so for non-urgent matters and that an RN, with additional preparation and support, can effectively manage these cases while still working within the scope of nursing practice (MacKinnon Williams, 2000).

The RN First Call Program involved choosing the sites for the pilot, providing educational preparation for the participating RNs, and developing clinical protocols and an evaluation plan. In total 12 sites (nine fully and three partially) implemented the program and 254 RNs received the necessary preparation. Ten clinical protocols were developed for health problems such as lacerations and abrasions, otitis media, strains/sprains, and treatment for allergic reactions. The evaluation included surveys with clients, RNs, physicians and administrators regarding satisfaction with the program, as well as chart audits, analysis of workload, and emergency room logs. MacKinnon Williams (2000) caution on the interpretation of the evaluation results because of the limited responses, but suggest the program has the potential to successfully address non-urgent health concerns in emergency settings. The authors recommended the program be expanded to include a greater number of available clinical protocols and participating hospitals (MacKinnon Williams, 2000).

A second example is the Rural Nurse Responder Program available within the Palliser Health Authority in southeastern Alberta. The impetus for the program was the

geographic isolation for some of the communities in this region, which affected access to and delivery of health care services. As a result, community residents would often ask for assistance from RNs who lived in the community. The communities expressed the need for a more formalized system and the RNs requested additional assistance to ensure they were providing the most reliable advice. The position description of a nurse first responder is that the individual will be available to the residents of their community for general health information and in emergency situations. Some specific responsibilities for the RNs include managing medical and obstetrical emergencies, cardiopulmonary resuscitation, and establishing basic airways and oxygen supplementation (L. Ferguson, Personal Communication, December 2002).

Additional training in emergency skills and medical equipment was provided, and each nurse was given a cellular telephone. Beyond the physical skills noted here, the nurse first responder was expected to be familiar with their community and have the interpersonal skills to work effectively with the public. In order to qualify, the community had to be at least 30 minutes away from the nearest emergency department, have two nurses available in the community who were interested in providing the service, and community willingness to accept the service (L. Ferguson, Personal Communication, December, 2002). The nurse first responder program is still operating in two communities but is currently being reconsidered given other health telephone advice lines that are now available in the geographic area (L. Ferguson, Personal Communication, January 20, 2003).

Another alternative source for health care delivery is telehealth, which is "the use of communications and information technology to deliver health and health care services and information over large and small distances" (CNA, 2001c). This strategy is discussed more often in relation to remote settings, including aboriginal communities, where telecommunication is used to send visual images of clients to health professionals for consultation and diagnosis. Telenursing involves the use of electronic links to establish communication with clients and / or other health professionals, in order to deliver professional nursing services (Registered Nurses' Association of Nova Scotia [RNANS], 2000). The CNA position statement on telehealth recognizes it as being within the scope of nursing practice by all Canadian nursing jurisdictions (CNA, 2001c). The CNA has outlined a framework of principles for telenursing practice noting the importance of strong clinical knowledge and assessment skills, being accountable for one's actions, and obtained informed consent. The individual provincial and territorial nursing associations have their own position statements on telenursing modeled after the CNA one (see for example, RNANS, 2000).

A Discussion Paper commissioned by the Aboriginal Nurses' Association of Canada (ANAC, 2001) includes an outline of 14 issues related to the impact of telehealth, especially in aboriginal communities. The telehealth definition they have adopted in their report is from the Canadian Telehealth Society, and is comparable to the definition included at the beginning of this section. Of particular importance is the discussion on scope of practice. The author points out that telehealth may actually challenge the scope of practice of nurses beyond their educational preparation or their

practice guidelines. Nurses' workload may increase with telehealth, which ultimately questions the benefits of this technology. These points illustrate the pressure that exists to use telehealth in remote and isolated areas without sufficient policies and resources to support nursing's role within it. The report includes recommendations for nursing programs to provide education to future nurses about the technology of telehealth and the provincial standards of nursing care; it also recommends that telehealth programs be available through distance continuing education programs (ANAC, 2001).

A Nova Scotia report addresses the guidelines for telenursing practice and provides examples of telenursing such as using videoconferencing and hand-held cameras to receive consultation from a distance (RNANS, 2000). While the document does not specifically define rural and remote, the concept of telenursing is clearly a practice issue for nurses in rural and remote settings. The concerns of telenursing include the potential increase in liability for nurses and increased risks for breaching security and confidentiality.

In Newfoundland, the Association of Registered Nurses of Newfoundland and Labrador (ARNNL), (2002a) issued a statement regarding telephone nursing care. This association has adopted the telehealth definition of the Canadian Nurses Association (CNA), (2001c as cited in ARNNL, 2002a), which is "the use of communications and information technology to deliver health care services and information over large and small distances" (p 1). The ARNNL statement emphasizes the importance of the nurse providing advice and information in an accountable and competent manner. Thus, the nurse needs to ensure that they are not practicing outside of their scope of practice

when providing advice over the telephone. To assist with this, the ARNNL recommends that agencies develop and implement policies and clinical guidelines to outline the roles and responsibilities of nurses who provide telephone nursing care, and guide the nurse when engaging in this type of work.

Health Canada's experiences with telehealth for aboriginal people support these concerns, as they found that health providers were not sufficiently prepared to use the technology, thus the success of the program was decreased (Dal Grande, 2001). Consequently, some authors have pointed out that the potential for liability is an area that needs to be addressed (Lee, 1997; Health Canada, 2000b).

In 1998, NORTH Network (i.e., Northern Ontario Remote Telecommunication Health) commenced by providing continuing education, patient education, and specialist consultations to rural areas of Ontario (NORTH Network 2003). Some of the overall goals were to improve access to specialty care and access for professional continuing education. In this instance, it is viewed as enhancing current services and not filling in for the lack of available services. For example, a client can be located at a centre where telehealth is available and receive an examination and consultation through the telehealth system. The client is accompanied by a family physician or telehealth nurse for the examination (RNAO, 2001).

In 1999, the Ontario Telehealth Task Force recommended to the OMHLTC that a telephone health education and triage/advisory service be implemented for all Ontario residents (OMHLTC, 1999b). The rationale for providing such a service was that telephone health advice is both efficient and effective, and often decreases visits to

health providers and emergency departments. It was further recommended that RNs answer the calls and use algorithms, or clinical practice guidelines, to assist them during the calls. Furthermore, the nurse would also use decision support software combined with clinical judgment when giving telephone advice. The report included a number of recommendations, objectives and principles for the program, and was to be made available to all Ontario residents, regardless of geographic location. Thus rural residents could access the program. However, a notation was made that access and confidentiality may be compromised in rural areas where party lines still exist (OMHLTC, 1999).

Telehealth Ontario, a confidential, free telephone service for health advice or general health information from an RN, was subsequently implemented in 2001 (OMHLTC, n.d.). This service is available 24 hours a day, seven days a week to any resident in Ontario. The documents about this service emphasize that it is an advisory service that can also provide the names of clinics in the caller's home area. No specific discussion regarding the service for rural residents is included likely because the service is available to all Ontario residents.

A recent NWT health action plan (Northwest Territories Health and Social Services, 2000b) recommended that telehealth be more available to all NWT residents. This technology would ultimately assist health providers in diagnosing and caring for clients while being able to use this technology for professional continuing education.

Telehealth has been used in Saskatchewan to assist remote residents in accessing health care. Residents can access specialists in the southern portion of the province to

discuss conditions such as diabetes and acquired brain injuries (Saskatchewan Health, 2001). Alberta has just initiated Health Links, a 24 hour telephone health advisory line, one avenue of telehealth.

These alternative modes are further supported by a recent report from the Health Transition Fund (Pong, 2001) that believes telehealth will improve rural health services delivery. The report discusses over 30 telehealth projects that have been implemented across Canada ranging from the use of lay-workers to provide services and providing continuing education to health professionals. Although user satisfaction was noted, problems encountered included technical difficulties as well as a lack of support in using alternative health providers.

Finally, a state of the science review on the socio-economic impact of teleheath (Jennett, et al, 2002) notes the importance of examining the social, organizational, and policy aspects of this mode of health delivery. The authors found no studies in rural or remote communities that examined socio-economic outcome indicators. They caution that ownership of Telehealth Solutions needs to be addressed at the rural level and that appropriate connection with such communities to accomplish this is necessary.