Supporting primary health care nurse practitioners' transition to practice

Maureen Sullivan-Bentz RN MScA Jennie Humbert NP-PHC MHSc Betty Cragg RN EdD Frances Legault RN PhD
Célyne Laflamme NP- PHC MScN(C) P.H. Bailey RN PhD Suzanne Doucette RN OPN MHA

ABSTRACT

OBJECTIVE To examine role transition and support requirements for nurse practitioner (NP) graduates in their first year of practice from the perspectives of the NPs and coparticipants familiar with the NPs' practices; and to make recommendations for practice, education, and policy.

DESIGN Descriptive qualitative design informed by focused ethnography and narrative analysis using semistructured, in-depth, qualitative interviews.

SETTING Primary health care (PHC) settings in Ontario in which NPs worked.

PARTICIPANTS Twenty-three NPs who had graduated from the Ontario Primary Health Care Nurse Practitioner program, and 21 coparticipants including family physicians, NPs, and managers who were familiar with the NPs' practices.

METHODS Anglophone and francophone NPs in their first year of practice in PHC settings were contacted by e-mail or letter. Participating NPs nominated colleagues in the workplace who could comment on their practice. Interviews were conducted within the first 3 months, at 6 months, and at 12 months of the NPs' first year of practice and were transcribed verbatim and coded. Job descriptions and organizational charts demonstrating the NPs' organization positions were also analyzed. The researchers collaboratively analyzed the interviews using a systematic data analysis protocol.

MAIN FINDINGS Familiarity of colleagues and employers with the NP role and scope of practice was an important element in successful NP role transition. Lack of preparation for integrating NPs into clinical settings and lack of infrastructure, orientation, mentorship, and awareness of the NP role and needs made the transition difficult for many. One-third of the NPs had changed employment, identifying interprofessional conflict or problems with acceptance of their role in new practice environments as reasons for the change.

CONCLUSION The transition of NP graduates in Ontario was complicated by the health care environment being ill-prepared to receive them owing to rapid changes in PHC. Strategies for mentorship and for the integration of new NPs into PHC settings are available and need to be implemented by health professionals and administrators. Recommendations for family physicians to support NP graduate transition into practice are provided.

EDITOR'S KEY POINTS

- Nurse practitioner (NP) graduates in Ontario experience a common transition to practice. Successful transition to the role is facilitated when interprofessional relationships and supports are in place before new NPs enter the place of employment.
- In some cases the health care environment is ill-prepared to support new NPs' transition to practice, owing to recent rapid changes in primary care.
- Strategies for mentorship and for the integration of new NPs into primary health care settings are available. Use of these tools would assist health professionals and administrators as they strive to ease the transition process for newly graduated NPs.

This article has been peer reviewed.
Can Fam Physician 2010;56:1176-82

Faciliter le passage à la pratique des infirmières praticiennes en milieu de soins primaires

Maureen Sullivan-Bentz RN MScA Jennie Humbert NP-PHC MHSc Betty Cragg RN EdD Frances Legault RN PhD
Célyne Laflamme NP- PHC MScN(C) P.H. Bailey RN PhD Suzanne Doucette RN OPN MHA

RÉSUMÉ

OBJECTIF Examiner le changement de rôle et le besoin de support des infirmières praticiennes (IP) diplômées durant leur première année de pratique en tenant compte de leurs points de vue et de ceux de collaborateurs qui sont familiers avec leur type de pratique, et faire des recommandations concernant la pratique, la formation et les politiques.

TYPE D'ÉTUDE Étude qualitative descriptive basée sur une ethnographie ciblée et sur une analyse narrative utilisant des entrevues qualitatives semi-structurées en profondeur.

CONTEXTE Milieux de soins primaires (MSP) de l'Ontario où travaillaient des IP.

PARTICIPANTS Trente-trois IP diplômées du programme du *Ontario Primary Care Health Nurse Practioner* et 21 collaborateurs, incluant des médecins de famille, des IP et des administrateurs familiers avec le travail des IP.

MÉTHODES Des IP francophones et anglophones dans leur première année de pratique en MSP ont été contactées par lettre ou courrier électronique. Les participantes ont indiqué des collègues de travail susceptibles de commenter leur travail. Des entrevues ont été effectuées dans les 3 premiers mois, à 6 mois et à 12 mois de la première année de pratique des IP, pour ensuite être transcrites mot à mot et codées. Les descriptions d'emploi et les organigrammes indiquant la position des IP dans l'organisation ont aussi été analysés. Les chercheurs ont analysé les entrevues en collaboration, à l'aide d'un protocole d'analyse systématique des données.

PRINCIPALES OBSERVATIONS Le fait, pour les collègues et les employeurs, de bien connaître le rôle et le champ de pratique des IP était un élément important pour permettre aux IP de réussir leur passage à la pratique. Un manque de préparation à l'intégration des IP au milieu clinique et l'absence d'infrastructure, de directives, de mentorat et de connaissance du rôle et des besoins des IP rendaient la transition difficile pour plusieurs. Le tiers des IP avaient changé d'emploi, invoquant comme raisons un conflit interprofessionnel ou des problèmes avec l'acceptation de leur rôle dans leur nouveau milieu de pratique.

CONCLUSION Le passage à la pratique des IP de l'Ontario s'est avéré compliqué dans des milieux de soins primaires mal préparés pour les recevoir en raison de changements rapides dans les MSP. Des stratégies existent pour le mentorat et l'intégration des nouvelles IP dans les MSP, et elles doivent être mises en place par les professionnels de la santé et les administrateurs. Des recommandations incitant les médecins de famille à faciliter le passage des IP à la pratique sont également indiquées.

POINTS DE REPÈRE DU RÉDACTEUR

- Le passage à la pratique est le même pour toutes les infirmières praticiennes (IP) diplômées en Ontario. La réussite de cette transition est favorisée lorsqu'il existe de bonnes relations interprofessionnelles et de l'aide avant leur arrivée au lieu de travail.
- En raison des récents changements rapides dans les soins primaires, il arrive que le milieu de travail soit mal préparé pour faciliter le passage à la pratique des IP.
- Il existe des stratégies pour fournir un mentorat et pour intégrer les nouvelles IP au milieu de soins primaires. Le recours à ces stratégies aiderait les professionnels de la santé et les administrateurs dans leurs efforts pour faciliter le passage à la pratique des IP nouvellement diplômées.

Cet article a fait l'objet d'une révision par des pairs.
Can Fam Physician 2010;56:1176-82

Nurse practitioner (NP) graduates in their first year of practice have reported considerable challenges in the transition to their new role.[1-3] A supportive environment and realistic professional expectations of the newly graduated NP can positively influence the transition of the new NP into primary health care (PHC) practice.[2] In Ontario, there is a requirement that NPs work collaboratively with physicians in providing PHC. The professional relationship that new graduates form with family physicians is an important factor to ease the transition experienced by NPs.

A number of researchers from the United States have examined the role transition of NPs.[1-6] These researchers suggest that the increase in autonomy and the collaborative practice expectations of this new role make the shift from registered nurse to NP complex and demanding. Since 1995, the Primary Health Care Nurse Practitioner (PHCNP) program in Ontario, through a consortium of 10 university schools of nursing, has been preparing NPs to work in PHC settings. The program completed by the NP participants in this study was a 7-course certificate completed after the nursing baccalaureate that could be completed in 1 year of full-time study or longer-term part-time study. It is now in the process of being raised to the graduate level and incorporated into master's degrees in nursing.

Enrolment of nurses in NP programs in Ontario has now doubled to fill the need in PHC. A number of initiatives in Ontario in the past 5 years (eg, family health teams that require interprofessional practice, pilot projects to reduce emergency wait times, hospital clinics for specific populations, and PHCNPs in long-term care facilities) have increased the demand for PHCNPs. No Canadian research exists about the experiences and support requirements of NP graduates and their employers or factors that influence role transition of the PHCNP graduate during the first year of practice. This research seeks to develop an understanding of the experiences and support requirements of new PHCNP graduates.

In this paper, we examine the influence of interprofessional relationships, particularly those with family physicians; explore the factors influencing and hindering successful transition into NP practice; and recommend ways to support new NP graduates.

METHODS

A descriptive qualitative design,[7-9] informed by focused ethnography[10,11] and narrative analysis,[12-17] was used to develop an understanding of the role transition of NPs during the first year of practice in PHC. Brown and Olshansky's[2] theoretical model, "From Limbo to Legitimacy," was the conceptual framework. This model of the transition to the PHCNP role includes 4 phases: 0 to 1 month, "Laying the Foundation"; 1 to 3 months, "Launching"; 6 to 12 months, "Meeting the Challenge"; and 12 months forward, "Broadening the Perspective." These phases guided the questions used in both the NP and nominated coparticipant interviews.

Ethics approval was granted by the University of Ottawa Research Ethics Board. The study was completed over a 2-year period. Semistructured telephone interviews were conducted within the first 3 months, at 6 months, and at 12 months of practice. All interviews were recorded and transcribed for qualitative analysis using NVivo software. Documents (including internal documents such as job descriptions and organizational charts supplied by participants, and policies from employing agencies, regulators, professional organizations, and government ministries) provided contextual data and triangulation. The researchers collaboratively analyzed the interviews using a systematic eclectic form of narrative data analysis developed by Bailey.[14]

Narrative analysis is based on the understanding that individuals make sense of their experiences and communicate these understandings by constructing stories, "discrete unit[s] of discourse, topically centered and temporally organized."[15] We worked in groups of 2 or 3 to identify stories. More than 500 stories were identified and saturation was achieved by the end of the interview process. We then jointly developed 5 main themes. Subsequently, in the same author groupings, we examined the stories from 1 or 2 of the main themes to identify content, meaning, and interpretation of each theme.

Participants included a purposive sample of 17 anglophone and 6 francophone NPs from one cohort of graduates and coparticipants (physicians, NP colleagues, or administrators) nominated by the NPs who could comment on the NPs' practices. Participants represented a range of PHC rural and urban practice. Anglophone NPs ranged in age from 29 to 61 years (mean [SD] 42.8 [9.7] years). Most had numerous years in clinical practice (mean [SD] 19.2 [11.1] years), predominantly in emergency (10 of 17) or critical care (4 of 17) settings. All had bachelor's degrees in nursing and 3 had master's degrees. The francophone NPs ranged in age from 27 to 46 years (mean [SD] 37.7 [6.5] years). Their years in clinical practice ranged from 3 to 23 years (mean [SD]14.3 [7.0] years), mainly in emergency and critical care. One was master's-prepared. The 15 nominated anglophone coparticipants included 6 physicians, 5 nurse practitioners, and 4 administrators, 2 of whom were nurses. They had, on average, 17.8 years of professional experience and only 6 of 15 had previous experience working with NPs. Two NPs were unable to secure nominated coparticipants to participate in the study owing to strained working relationships. The 6 nominated francophone coparticipants included 3 physicians and 3 NPs. They had an average of 25.5 years of professional experience; 5 of 6 had previous experience working with NPs.

FINDINGS

Five themes were identified in the NPs' and coparticipants' stories: transition to the NP role, contextual factors affecting NP role transition, interprofessional relationships, provincial policies and politics, and educational preparation. Content analysis of the documents collected identified many factors influencing NP transition and practice, such as employers' readiness for NPs and policies affecting NP ability to practise to their full scope of practice. **Table 1** summarizes the 5 main themes identified in the analysis of interviews and documents.

DISCUSSION

The reports of the NPs and their nominated coparticipants reflected many of the findings of Brown and Olshansky,[2] particularly in how the NPs described achieving greater confidence by the end of their first year of practice. These NPs evolved from feeling overwhelmed in their new role to feeling confident in their ability to function, and began to look for opportunities to improve care with population-based strategies and health promotion. In contrast to the work of Chang and colleagues,[4] addressing a collaborative but dependent NP-physician relationship within acute care, the model of practice within the organizations participating in this study varied. Although all the NP participants collaborated with a variety of health care professionals, including physicians, as primary care NPs, they worked in an autonomous role. While Brown and Olshansky focused on the perceptions of NPs,[1,2] this study also sought the perceptions of nominated coparticipants. Colleagues who had previously worked with NPs were more aware of the need to support and mentor the new NPs, but many coparticipants in new PHC environments knew little of the anxieties or the obstacles new NPs faced.

Mentorship by a colleague during the NP's first year of practice had a positive effect on the transition to the new role. All newly hired NP graduates would benefit from formal mentorship when beginning practice, preferably with experienced NPs or physician colleagues. Previous studies of NP practice recommended that the government implement mentorship programs to support NPs in their transition process.[18,19]

When hiring a newly graduated NP into a practice setting, it is essential that physicians, administrators, receptionists, and nurses understand how NPs can work effectively within the PHC team (**Box 1**). Employers should ensure job descriptions and organizational charts are in place. In 2005, an Ontario study on the Integration of Nurse Practitioners into Primary Health Care[18] identified poor understanding of the NP role and professional territoriality as some of the barriers to integration of the NP role. In 2006, the Canadian Nurse Practitioner Initiative developed an *Implementation and Evaluation Toolkit for NPs in Canada,*[20] which was designed as a guide for employers to support successful integration and evaluation of NPs into PHC and to ease the transition.

We found that many factors complicated the NP role transition. Many new NPs were hired into settings that had no previous experience with NPs. Lack of knowledge of what the NP could contribute to PHC forced new, inexperienced NPs to develop their roles, create new interprofessional relationships, and carve out both physical and professional space for practice. These added responsibilities and imposed unusual stresses on the NP already experiencing the normal difficulties of role transition. During the study, 9 NPs changed or planned to change positions because of organizational and interprofessional difficulties.

When physicians were the NPs' employers but unfamiliar with the NP role, the interprofessional relationship was challenging for both groups. For example, physicians might not understand that prescribing limitations made their sign-off on some medications necessary. The situation was exacerbated by funding policies for physician-performed procedures, which led to competition for clients and procedures based on billing opportunities rather than optimal client care. The philosophy

Box 1. Summary of recommendations for family physicians to support NP graduates' transition into practice

If employing new NPs, ensure ...
- that new NPs receive formal mentorship and support from physicians and NPs familiar with the role and
- that written resources and colleagues are available for consultation and support.

First-time employers of NPs should ...
- collaborate with an experienced NP to assist with understanding the NP role and job description;
- develop organizational charts, evaluation structures, and continuing education opportunities before hiring the NP;
- ensure all employees understand the NP role;
- provide office and examination room space and equipment; and
- devise interprofessional protocols to facilitate NP referrals.

Colleagues or consultants to the new NP should ...
- familiarize themselves with the scope of practice, organizational expectations for the position, and the limitations on NP practice imposed by regulations;
- plan additional time to consult and support the NP during the first few months of practice;
- plan for continuity of care for the NP with selected patients so that therapeutic relationships can be established; and
- meet regularly in interprofessional teams to identify and resolve any interprofessional problems.

Table 1. Summary of themes on transition to practice: *Themes marked + promote transition, those marked - impede transition, and those marked+/- might help or impede transition.*

THEME	QUOTE
Transition to the role	
Role adjustment + High NP self-expectations in first year - Organizational and professional unfamiliarity with the NP role and needs - Coparticipants frequently not aware of NPs' struggles	I'm very pleased .... It was probably a pretty stressful year for her. She was a new NP coming into this chaotic system (coparticipant 17 at 12 mo)
Mentoring + Experienced coparticipants arranged mentoring support for NPs - Some NPs designed their own practices and explained their role while they were still learning it, and they often had to request their own supports	There is certainly a responsibility of us when a nurse practitioner comes, to mentor her through (coparticipant 12 at 6 mo)
Previous experience + NPs had many years in ICU or ED and brought life experience	Experience [is] the number one thing .... I had almost 30 years when I entered the program ... I've moved around a lot, so have met change ... over the years and that's been ... huge in flowing into this role (NP 4 at 12 mo)
Time management - Much overtime in first 3 mo, decreased by end of first year; increased time doing new-patient assessments and learning EHRs	I know another NP who is new and she's in trouble. She's from the FHT and the other NPs are seeing 20-some [patients] a day .... They are booking her the same. And she's going in on days off to chart (coparticipant 12 at 3 mo)
Contextual factors	
Ongoing changes in PHC system in Ontario - Emerging contextual factors: new FHTs, pilot projects in EDs, NP-led clinics, and physician assistants - Funding available for NPs but no infrastructure to support them	The biggest challenge is space ... I don't have an office. I don't have a space to call my own. So I still have a little cart, and when I was hired the understanding was that would change. Moving buildings, it's going to be another year (NP 1 at 12 mo)
Hiring + Fit with agency important to coparticipants	We're very picky .... If we have the right person [with] the right willingness to learn and the right attitude—"get it done" kind of attitude—we can teach them (coparticipant 11, 3 mo)
Orientation - Often NPs identified own needs and planned own programs	There wasn't actually an orientation .... you sort of show up one day and start to work and work the bugs out as you go (NP 2 at 3 mo)
Continuing education - NPs had to fight for time and reimbursement	Just having to always remind them that money is there for me and there's really no reason why I can't have that ... most of the teams are getting between 5 and 10 days a year and they're getting $1500 to pay for conferences and hotel rooms (NP 8 at 12 mo)
Evaluation - Many NPs did not have formal evaluation system in place to obtain feedback from employers - Often no job description or professional expectations existed	Recently the office ... without the nurse practitioners knowing, sent out an evaluation form to the physician partners without any input from us. Quite a few of the physicians went to the nurse practitioners and said, "What is this?" (NP 2 at 3 mo)
Interprofessional relationships	
Professional colleagues +/- Teams included physicians, RNs, other NPs, and support staff	The physicians .... claim that they were told, that we're nurses, so we therefore don't require nursing support (NP 9 at 3 mo)
NP role confusion - Workplaces that did not understand the role and scope of practice of the NP were confused about what could be expected of the NP - 9 NPs changed jobs over the course of the study (7 anglophones and 2 francophones) owing to challenges in their workplaces	They didn't know what my scope was. So we're just sort of learning as we go, all of us, trying to figure out how I fit into [the practice] (NP 2 at 3 mo)
Relationships dependent upon ... +/- culture and experience of agency +/- organizational position of NP +/- employee status (hired by physician, hired by PHC agency, independent practice)	I don't think it's as much respect. I just think it's ... the knowledge base that should be there to ... understand what the issues are and what kinds of supports and programming need to be in place. [The administrator will say] "You have to see more patients like the doctors do." And I keep telling him, "One, nurse practitioners don't work like a physician, and two, I don't have the support. I can't see more people until I get those supports" (NP 17 at 12 mo)
Policy and politics	
Provincial legislation and regulations - Limits on scope of practice and prescription authority requiring medical directives - Frustration of NPs and medical colleagues about prescribing restrictions	[Physicians] expect that you can manage everything, and again, with medications, prescriptions, they can't understand, "Why do I have to co-sign for this?" (NP 10 at 6 mo)
Insecure funding - Continued NP funding for pilot projects announced shortly before end of contracts	We were funded for a full year but we were worried about funding for the [next] year, and we were afraid we were going to lose her, so we actually put her on staff (coparticipant 15 at 12 mo)
Government agencies and insurance companies - NP referrals and forms are not accepted by some departments and companies such as WSIB and the Ministry of Transportation	Certain insurance companies won't recognize my notes. The Ministry of Transportation will not recognize any work done by a nurse practitioner, yet I can do disability stuff (NP 10 at 6 mo)
Physician funding mechanisms - Decisions about whether physicians or NPs saw some patients were based on remuneration formulas, which led to restrictions on NP practice	Right now, as far as the rules go for remuneration for physicians, I can't function to my full scope. But as far as my practice, my relationships with my patients, and my collaborating physician, I am able to function within my full scope of practice (NP 16 at 12 mo)
Educational preparation	
Role transition preparation needs identified by NPs - Educational preparation needs to include what to expect when entering practice, interprofessional conflict and conflict resolution, more clinical time, more exposure to "particular" client groups	During that 3-month final placement, you were actually working full-time and the criticism I do have is that I don't think there's enough clinical time during the rest of the program (NP 9 at 3 mo)

ED—emergency department, EHR—electronic health record, FHT—family health team, ICU—intensive care unit, NP—nurse practitioner, PHC—primary health care, RN—registered nurse, WSIB—Workplace Safety and Insurance Board.

and personality of the physician in some situations was a barrier to a positive relationship. This was also identified in the NP integration study.[18] Thus, an interdisciplinary collaboration framework and interprofessional education for NPs and family practitioners are needed.

Although rostering all patients to a physician, even though the NP is the provider of all or most of the care, has been adopted by PHC settings employing NPs, this practice contributes to confusion for patients and the health care team. It also creates tensions in interprofessional relationships and challenges for new NP graduates.

Changes need to occur to the diagnostic and prescriptive authority of NPs to allow them to meet patients' needs within their competencies. The Health Professions Regulatory Advisory Council has reviewed the prescriptive authority of several professions, including nursing. At present, all 3 political parties are supportive of open authority for prescribing for NPs. Legislation has been drafted for third reading by the government.[21] Physicians can lobby for recognition of NPs' prescriptions and referrals to prevent wasting physician time for sign-off on prescriptions and referrals that are within the NP scope of practice. Increased familiarity with NP practice by the interprofessional team will reduce some difficulties encountered by new NPs. This study showed that organizations that had incorporated NPs into their culture were able to support them more effectively during the normal role transition of a new graduate. The francophone NPs had a more positive experience, partly because they were hired in established environments like hospital-based clinics and community health centres.

The NPs identified a number of changes to their educational program that could aid their transition and practice. Longer clinical rotations and graduate-level preparation are being implemented. The program should also prepare NPs for transition, for practice management, and for interprofessional practice.

The competence of NPs as PHC providers is not adequately acknowledged as the health system in Ontario now stands. This challenging health care environment produces tensions in interprofessional relationships and creates challenges for new NP graduates. The Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative[22] recommended principles and a framework for interdisciplinary collaboration in PHC. A central principle is trust and respect among health professions. A collegial environment that acknowledges the knowledge and skills of each profession and supports shared decision making, collaboration, and commitment to teamwork will improve health care outcomes, as well as provide a satisfying interprofessional work environment. However, practitioners must understand one another's roles and scopes of practice. Building joint learning experiences for medical students and family practice residents with NP students would be a step forward in promoting interprofessional understanding. Joint NP and registered nurse learning experiences can also build respect for the contributions each can make to PHC. All practitioners need time to learn to work together in true collaboration.

Limitations

The NP participants graduated from the Ontario provincial program, and their experience might not reflect that of NPs and coparticipants in other provinces. Future studies could include all new NPs practising in Canada. Because the study required that the NP nominate a colleague to also participate, some did not have willing coparticipants, thus limiting the number of eligible NPs who met the criteria defined in the sample selection.

Conclusion

Nurse practitioner graduates in Ontario experienced similar transitions over the first year of practice to those found in Brown and Olshansky's research.[1] However, their transition was complicated by the health care environment being ill-prepared to receive them owing to rapid changes in PHC. New NP graduates will have successful transitions to their role when interprofessional relationships and supports are in place before they enter their new place of employment. Strategies for mentorship and for the integration of new NPs into PHC settings are available and need to be implemented by health professionals and administrators.

Ms Sullivan-Bentz is the owner of Sullivan-Bentz Health Care Consultation Services and is a faculty member in the Nursing Simulation Program at the University of Ottawa in Ontario. **Ms Humbert** is a nurse practitioner at the Sudbury East Community Health Centre in Ontario. **Dr Cragg** is a Professor and Acting Director of the School of Nursing at the University of Ottawa. **Dr Legault** is the Eastern Regional Francophone Coordinator for the Ontario Primary Health Care Nurse Practitioner Program at the University of Ottawa. **Ms Laflamme** is a part-time Professor in the Nurse Practitioner Program at the University of Ottawa. **Dr Bailey** is a Professor at Laurentian University in Sudbury. **Ms Doucette** is the past Eastern Regional Francophone Coordinator for the Ontario Primary Health Care Nurse Practitioner Program at the University of Ottawa.

Acknowledgment

This research was funded by the Council of Ontario University Programs in Nursing through funds from the Ontario Ministry of Health and Long-Term Care. The views expressed in this paper are those of the authors and do not necessarily reflect the views of the Ontario Ministry of Health and Long-Term Care.

Contributors

All authors participated in the development of the original research proposal. Interviews were conducted by **Ms Sullivan-Bentz** and **Ms Laflamme**, and all authors participated in data analysis and in writing or reviewing the manuscript. All authors approved the final version for publication.

Competing interests

None declared

Correspondence

Maureen Sullivan-Bentz, University of Ottawa, School of Nursing, Simulation Laboratories, 200 Lees Ave, Ottawa, ON K1S 5S9; telephone 613 298-3022; e-mail **mbentz@uottawa.ca**

References

1. Brown MA, Olshansky E. Becoming a primary care nurse practitioner: challenges of the initial year of practice. *Nurse Pract* 1998;23(7):46, 52-6, 58.
2. Brown MA, Olshansky EF. From limbo to legitimacy: a theoretical model of the transition to the primary care nurse practitioner role. *Nurs Res* 1997;46(1):46-51.
3. Heitz LJ, Steiner SH, Burman ME. RN to FNP: a qualitative study of role transition. *J Nurs Educ* 2004;43(9):416-20.

4. Chang WC, Mu PF, Tsay SL. The experience of role transition in acute care nurse practitioners in Taiwan under the collaborative practice model. *J Nurs Res* 2006;14(2):83-92.
5. Kelly NR, Mathews M. The transition to first position as nurse practitioner. *J Nurs Educ* 2001;40(4):156-62.
6. Roberts SJ, Tabloski P, Bova C. Epigenesis of the nurse practitioner role revisited. *J Nurs Educ* 1997;36(2):67-73.
7. Thorne S. *Interpretive description*. Walnut Creek, CA: Left Coast Press, Inc; 2008.
8. Thorne S, Kirkham SR, MacDonald-Emes J. Interpretive description: a non categorical qualitative alternative for developing nursing knowledge. *Res Nurs Health* 1997;20(2):169-77.
9. Thorne S, Kirkham SR, O'Flynn-Magee K. The analytic challenge in interpretive description. *Int J Qual Methods* 2004;3(1):1-11.
10. Morse JM, Richards L. *Read me first for a user's guide to qualitative methods.* London, Engl: Sage Publications; 2002.
11. Muecke MA. On the evaluation of ethnographies. In: Morse JM, editor. *Critical issues in qualitative research methods.* Thousand Oaks, CA: Sage; 1994. p. 187-209.
12. Bailey PH. Assessing quality in narrative analysis. *West J Nurs Res* 1996;18(2):186-94.
13. Bailey PH. The dyspnea-anxiety-dyspnea cycle—COPD patients' stories of breathlessness: "It's scary when you can't breathe. *Qual Health Res* 2004;14(6):760-78.
14. Bailey PH. Death stories: acute exacerbations of COPD. *Qual Health Res* 2001;11(3):322-38.
15. Riessman CK. *Narrative methods for the human sciences.* London, Engl: Sage Publications; 2008.
16. Bailey P, Jones L, Way D. Family physician/nurse practitioner: stories of collaboration. *J Adv Nurs* 2006;53(4):381-91.
17. Bailey PH, Tilley S. Storytelling and the interpretation of meaning in qualitative research. *J Adv Nurs* 2002;38(6):574-83.
18. IBM Business Consulting Services. *Report on the integration of primary health care nurse practitioners into the province of Ontario.* Toronto, ON: IBM Business Consulting Services; 2005.
19. Hanna A. *OMA policy paper. Interprofessional care.* Toronto, ON: Ontario Medical Association; 2007. Available from: **www.oma.org/Resources/Documents/2007IPCPaper.pdf**. Accessed 2010 Sep 14.
20. The Canadian Nurse Practitioner Initiative. *Implementation and evaluation toolkit for nurse practitioners in Canada*. Ottawa, ON: Canadian Nurses Association; 2006. Available from: **www.cna-nurses.ca/cna/documents/pdf/publications/Toolkit_Implementation_Evaluation_NP_e.pdf**. Accessed 2010 Sep 14.
21. Health Professions Regulatory Advisory Council. *A report to the Minister of Health and Long-Term Care on the review of the scope of practice for registered nurses in the extended class (nurse practitioners).* Toronto, ON: Health Professions Regulatory Advisory Council; 2008. Available from: **www.hprac.org/en/projects/resources/HPRACExtendedClassNurseReportENGMar08.pdf**. Accessed 2010 Sep 14.
22. Enhancing Interdisciplinary Collaboration in Primary Health Care. *The principles and framework for interdisciplinary collaboration in primary health care.* Toronto, ON: Enhancing Interdisciplinary Collaboration in Primary Health Care; 2006. Available from: **www.caslpa.ca/PDF/EICP_Principles_and_Framework_final.pdf**. Accessed 2009 Nov 4.