

Go Teams! A Situational Analysis of Interdisciplinary Primary Care Teams in Ontario

by

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Dedication Page

For you, my beautiful family

and

in loving memory of:

Anastasia Oleksyn (1913-2007)

Theresa Haydt (1965-2009)

Steven Larkman (1969-2010)

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Abstract

Arguably, no reform in health care in the past decade has generated as much attention, idealism, and optimism as the movement toward interdisciplinary teams. Since the early 2000s, the Canadian federal government has made access to interdisciplinary primary care teams a policy priority. Ontario has been one of Canada's most active provinces in promoting teams in primary care, investing approximately \$938 million since 2004 into three models of interdisciplinary primary care team: Family Health Teams, Community Health Centres, and Nurse Practitioner-led Clinics. Analysing a variety of documents (n=383) and key informant interviews (n=15), and drawing on techniques and assumptions of situational analysis, I critically examine the development of these three models of interdisciplinary primary care teams in Ontario since 2004. Specifically, I focus on how teams are talked about and acted on by the provincial government and opposition parties, and the leadership organizations of four health professions: family medicine, nurse practitioners, dietetics, and chiropractic. While all the groups in this study talk about teams in the usual idealized terms as beneficial and necessary, they also talk about teams in ways that attempt to advance their particular interests. In government, teams are used to promote political agendas and lay claim to political legacies. Family medicine uses a variety of discursive strategies about teams in an attempt to maintain autonomy and a dominant position vis-à-vis other professions. The nurse practitioner and dietetic professions use discursive strategies about teams to justify attempts to expand their respective scopes of practice. Chiropractic talks about teams in ways that reinforce and expand its longstanding project to legitimize the profession. Further, my analysis reveals that while the three models are accepted equally among the nurse practitioner, dietetic, and chiropractic professions, both the provincial government and family medicine favor the largely physician-led Family Health Team model more than the other models, with possible implications for the future of teams in Ontario and other provinces.

List of Abbreviations Used

AOHC	Association of Health Centres of Ontario
CCO	College of Chiropractors of Ontario
CDO	College of Dietitians of Ontario
CFHT	Community Family Health Team
CHC	Community Health Centre
CNO	College of Nurses of Ontario
CPSO	College of Physicians and Surgeons of Ontario
DC	Dietitians of Canada
FHG	Family Health Group
FHN	Family Health Network
FHT	Family Health Team
FTE	Full Time Equivalent
HPRAC	Health Professions Regulatory Advisory Council
IMPACT	Integrating family Medicine and Pharmacy to Advance primary Care Therapeutics
MOHLTC	Ministry of Health and Long-term Care
MPP	Member of Provincial Parliament
NDP	New Democratic Party
NP	nurse practitioner
NPAO	Nurse Practitioners' Association of Ontario
NPLC	Nurse Practitioner-led Clinic
OCA	Ontario Chiropractic Association
OCFP	Ontario College of Family Physicians
OFHN	Ontario Family Health Network
OHIP	Ontario Health Insurance Plan
OMA	Ontario Medical Association
PC	Progressive Conservative
PCCCAR	Provincial Coordinating Committee on Community and Academic Health Science Centre Relations
PCP	primary care physician
RD	registered dietitian
RHPA	Regulated Health Professions Act
RN(EC)	Registered Nurse, Extended Class (formal term for nurse practitioner in Ontario)
RNAO	Registered Nurses' Association of Ontario

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Chapter One

Introduction

Arguably, no reform in health care in the past decade has generated as much optimism as interdisciplinary teams. The strong appeal of interdisciplinary teams is acknowledged in literature from a variety of nations. Swedish researcher Suzanne Kvarnström (2008) notes that “[g]reat hopes are currently pinned on improving the quality of public health and healthcare through interprofessional collaboration” (p. 191). Canadian researchers Wael Haddara and Lorelei Lingard (2013) assert that interdisciplinary teams have become popular to the point of having become common sense (p. 1). Peter Nugus and colleagues (2010) note the “strong cultural currency” given to the ideal of health care professionals working in teams (p. 902) in Australia. British researchers Rachael Finn and colleagues (2010) assert that “...the idea of teams is now widely accepted in our culture as something inherently positive” (p. 1148), and have further characterized the literature on teams in health policy literature as nothing short of evangelistic (ibid).

Indeed, though the literature about interdisciplinary health teams is burgeoning, there appears to be little critical examination of interdisciplinary teams, excepting some recent pieces (e.g., Finn et al, 2010; Salhani & Coulter, 2009). To date, much attention has been paid in the literature to improving team function (e.g., Ateah et al, 2011; Ragaz et al, 2009; Bailey et al., 2006; Barker et al., 2005), or removing structural or cultural barriers hindering interdisciplinary care (e.g., Hall, 2005; Lahey & Currie, 2005). Interdisciplinary teams appear to have become what Adele Clarke calls a “going concern”

in health care, where “...certain assumptions about what activities are important and what will be done [are] taken for granted” (Clarke, 1991, p. 131).

In the absence of critical analysis, interdisciplinary teams may come to be viewed as natural or inherently logical extensions of the health system, rather than as resulting from complicated historical, political, and social processes. Interdisciplinary teams are easily idealized; they are often portrayed in literature as a promising solution to a myriad of problems in health care systems. Such idealization may mask less idealistic impulses also driving the implementation of interdisciplinary teams, such as government concern with cost savings, or the desire of health care professions to gain or maintain professional prerogatives. Such idealization may also account for why considerable resources have been expended in the restructuring of health systems to facilitate this particular form of care in Canada, despite as of yet weak evidence for the efficacy of teams on patient health outcomes.

In fact, interdisciplinary teams have become national policy in Canada, backed with considerable financial investment. In the course of two First Ministers’ Meetings (in 2000 and 2004) and the development of two First Ministers’ Health Accords (in 2003 and 2004) policy priorities reorganizing health care into teams had been set. The Accords promised that Canadians would receive the “most appropriate care, by the most appropriate providers, in the most appropriate settings” (Cote et al., 2008, p. 450). By 2011, “50 percent of Canadians would have access to a multi-disciplinary team of health providers, 24 hours a day, 7 days a week” (Bourgeault & Mulvale, 2006, p. 485). The Accords further promised that interprofessional and collaborative health education for health professionals would be improved (Cote et al., 2008, p. 450). To these ends, the Government of Canada created the Primary Health Care Transition Fund in 2000, which

allotted \$800 million for initiatives that would help jurisdictions throughout the nation introduce new approaches to primary health care delivery until 2006, including the development of multidisciplinary teams (Canada. Health Canada¹, 2007).

In contrast to the current body of literature that focuses largely on the anticipated benefits of interdisciplinary teams, or on how to optimize teamwork, my study contributes to the literature by providing a critical focus on how and why belief in interdisciplinary teams as an imperative came to be, and how the interests and actions of governments and health professions shape interdisciplinary teams in particular ways. The remainder of this chapter outlines more details about my study.

Provincial Context and the Models of Focus

For this project, I selected Ontario as the province of focus, as recent efforts to implement interdisciplinary teams there are among the most comprehensive, dynamic, and systematic in Canada. Two new models of interdisciplinary team-based models of primary care have been implemented since 2004 under the McGuinty government, these being Family Health Teams (FHTs) and Nurse Practitioner-led clinics (NPLCs); the latter are said to be the first of their kind in North America (Ontario. Office of the Premier,

¹ References to government texts in this dissertation follow a citation and reference style based on American Psychological Association (APA) style guidelines suggested by librarians at Simon Fraser University and Douglas College, as the APA Publication Manual (6th edition) does not give guidance on citing Canadian government documents. The suggested format for in-text citations of government texts is: (Jurisdiction. Department, Year). The suggested format for in-text citations of legislative debates (Ontario Hansard Reports) is: (Lastname, Year, Month Day). These guidelines are available at: <http://www.lib.sfu.ca/help/writing/gov-docs-apa> and <http://www.lib.sfu.ca/help/writing/gov-docs-apa> (both accessed March 29, 2014).

2010, n.p.). Since 2005, the province has established 170 fully functioning Family Health Teams, with plans to implement 30 more (Ontario. Ministry of Health and Long-term Care, 2012a, n.p.). A total of \$600 million was invested in the FHT model (Smitherman, 2004, June 3). In 2007, the government initiated the implementation of 25 nurse-practitioner led clinics, to be completed by 2012; these are in various stages of development (Ontario. Ministry of Health and Long-term Care, 2012b, n.p.). A total of \$38 million was invested in this model (Arthurs, 2008, April 4). Additionally, since 2004, the province has invested \$300 million (Naqvi, 2008, March 18) to revive and expand an existing model of team-based primary care, Community Health Centres (CHCs)². To this end, the government implemented 21 new CHCs and 28 CHC satellites (Association of Ontario Health Centres, 2013, n.p.).

These three models of interdisciplinary primary care team are the focus of this study³. All three models are explicitly defined and structured as interdisciplinary teams that include physicians, nurses and/or nurse practitioners, and other health professionals (Health Force Ontario, 2007, pp. 48-49). However, these models vary from each other in several important ways. First, they vary in the composition of their governing boards, where decisions about the overall operation of the entity are made. CHCs are governed by members of the local community (ibid, p. 49). FHTs may be governed entirely by physicians (physician-led), entirely by community members (CFHTs), or by both

² As of 1995, there were 56 CHCs (Suschnigg, 2001, p. 96). In 1995, the Progressive Conservatives froze CHC funding (ibid, p. 98). This freeze remained in place until 1999, when they lifted it to create 2 new CHCs and 3 satellites (Association of Ontario Health Centres, 2011, n.p.), bringing the number of CHCs/CHC satellites in 1999 to 61. No further expansions are noted in the literature until 2004.

³ Ontario has had a multiplicity of primary care reform models since the 1970s. Health Force Ontario (a branch of the Ontario Ministry of Health and Long-Term Care) identified ten models, most of which involve physicians working with nurses or nurse practitioners, and some that include nurses and other health care professionals (Health Force Ontario, 2007, pp. 47-49).

physicians and community members (mixed board); the majority of FHTs are physician-led (Rosser et al, 2011, p. 167). NPLCs are governed by a mixed board consisting of 51% nurse practitioners and 49% community members (Heale, 2012, p. 1).

The models also vary by modes of professional compensation. In CHCs, all the health professionals, including physicians, are paid by salary (Health Force Ontario, 2007, p. 49). This system of professional compensation is considered more egalitarian than other models. In other models, physicians are typically paid through mechanisms different than their non-physician colleagues, which provide physicians with more flexibility and/or ability to control income based on volume (e.g., fee-for-service or capitation⁴). In the case of the FHT model, physicians are compensated mainly by capitation funding, and supplemented by salary. However, physicians in the CFHT model are paid on a salary basis (Health Force Ontario, 2007, p. 48). Non-physician health professionals working in FHTs are compensated by sessional payments, salary, or contracts (ibid, pp. 48-49). In the NPLC model, all health care professionals are paid by salary, except the consulting physicians, whose consulting fees are paid by the Ministry of Health and Long Term Care (Heale & Butcher, 2010, p. 21).

These models also vary by the kinds of populations served. CHCs, for example, have had an historical mandate to serve marginalized populations such as impoverished communities, racial or ethnic minorities, gay/lesbian/bisexual/transgender people, and/or geographically isolated populations (Suschnigg, 2001, p.97; Johnston, 1999, p.ii).

⁴ Fee-for-service payment of physicians means that physicians receive payment for each kind of treatment provided. This method of payment, preferred by many physicians (Hutchinson et al., 2001, p. 127), is criticized as encouraging physicians to provide needless treatments, to favor expensive treatments, and to overbook patients (Suschnigg, 2001, p. 93). Capitation funding is when health care organizations receive a set fee each year from the provincial government based on how many patients are enrolled to receive services; the number or type of services given to an individual patient does not factor into the fee (Suschnigg, 2001, p. 93), making this physician payment model attractive to governments.

According to Ontario's Ministry of Health and Long Term Care, NPLCs "...provide comprehensive, accessible, and coordinated family health care services to populations who do not have access to a primary care provider" (Ontario. Ministry of Health and Long-term Care, 2012b, n.p.). FHTs are described by Ontario's Ministry of Health and Long Term Care as expanding on the foundations of physician care by including elements of primary health care in physician services, such as prevention and health promotion (Ontario. Ministry of Health and Long-term Care, 2012c, n.p.). In contrast to the CHC model and NPLC model, there is no specific mandate to serve particular populations. The Ministry does state, however, that "[d]iverse populations in Ontario mean that there are different needs for different communities. As a result the composition of a Family Health Team will be different from place to place" (ibid).

The structure of clinical leadership and the working relationship between health professions varies by model. Historically, CHCs have sought to promote a sense of equality between health professions on the team (Johnston, 1999, p.ii; Suschnigg, 2001, p. 92); outwardly, there is no clear clinical leader in this model. FHTs are a physician-based model "[d]esigned to give doctors support from other complementary professionals," such as nurses, nurse practitioners, dietitians and pharmacists (Ontario. Ministry of Health and Long-term Care, 2012c, n.p.). Physicians remain the clinical leaders in this model (Rosser et al., 2011, p. 167). In NPLCs, nurse practitioners are the clinical leaders and main providers of primary health care, and work collaboratively with "Registered Nurses, Registered Practical Nurses, collaborating family physicians, and other health care professionals" (Ontario. Ministry of Health and Long-term Care, 2012b, n.p.). In this model, family physicians act as consultants on cases where patient issues fall outside of the scope of practice of nurse practitioners (Heale & Butcher, 2010, p. 22).

Finally, these entities also vary in terms of whether, and how, patients are registered to receive services. In the FHT model, patients are required to register to a physician (or a group of physicians) within the entity (Rosser et al., 2011, p. 167). The central role played by the family physician in this model “...fosters patients’ perceptions that they are patients of the physician and team rather than patients of the clinic” (ibid)⁵. In the CHC model, registration of patients is not mandatory; however, when patients do register, they are registered to the CHC itself, rather than a physician within (Interview 003; Interview 009). In the NPLC model, registration is mandatory, though patients are considered registered with the NPLC itself, rather than a particular nurse practitioner or physician (Heale, 2012, p.5). Patients see a nurse practitioner first, who decides which other health professionals the patient needs to see (ibid). This is done to ensure that patients continue to receive care if a health professional leaves the entity, and “helps to eliminate silos of care within an institution and to promote an interprofessional team approach” (ibid). Table 1 (below) summarizes the characteristics discussed above.

⁵ With FHTs, this process is called “rostering”. Rostering is explored in more detail in Chapter Five.

Table 1: Characteristics of the Models of Focus

Characteristic	Team Model		
	Family Health Team	Community Health Centre	Nurse Practitioner-led Clinic
Governance model	Three possible models: Physician-led (most common); mix of community and physicians (next most common); community-led (least common)	Community-led	Mix of community and nurse practitioners.
Compensation model	Physicians paid mainly by capitation with some salary* Non-physicians paid by salary or sessional payments.	All professionals paid by salary.	All non-physician professionals paid by salary. Physicians paid as consultants.
Population emphasis	Mainly mainstream populations	Mainly marginalized or isolated populations	Mainly isolated populations or populations with no access to a primary care provider
Clinical leadership	Physician-led	More egalitarian	Nurse Practitioner-led**
Registration of Patient	Mandatory; patient registers to a physician within the FHT	Voluntary; patient registers to the CHC	Mandatory; patient registers to the NPLC

*Except in the Community FHT model, where all professionals are paid by salary.

**Nurse practitioner refers to an on-site physician in matters exceeding their scope of practice.

Research Questions

My research questions included: When and how did the concept of interdisciplinary primary health care teams gain popularity in Ontario? How do the state and health professions position themselves and their interests in relation to the three models of interdisciplinary team-based care? What interests are shared and what interests are divergent? How are ideas about interdisciplinary care articulated in relation to each of the three models of interdisciplinary primary health care teams in Ontario? What actions are taken by these groups toward each model, and for what reasons? How are interdisciplinary care teams influenced by these groups? What do I think the public should know about interdisciplinary care teams?

Situational Analysis as Method and Theoretical Framework

To answer my questions, I drew on components of situational analysis. Situational analysis, a “theory/methods package” (Clarke, 2005, p. xxiii), is based on the principles and methods of grounded theory, social worlds/arena analysis, and post-modern scholarship as synthesized by Adele Clarke (2005). It is ideally suited to the task of analyzing a complex phenomenon such as interdisciplinary care delivery systems, while at the same time accommodating issues of importance from a sociology of professions perspective. In this mode of inquiry, a situation in its entirety is the unit of analysis (ibid, p. 19). This mode of inquiry incorporates grounded theory’s reliance on empirical data to identify basic social processes; social worlds/arena analysis’ attention to identifying collective actors, their commitments to action, and debate and negotiation among these regarding a particular issue; post-modern concerns to account for the influence of discourse and history; and feminist post-modernists’ concern with marginalized voices

(ibid, pp. 64; 110; 113; 261). Complexity, contingency, conflict, negotiation, and multiplicity of perspectives and discourses are all assumed in situational analysis (ibid, p. xxiv).

Clarke's inclusion of post-modern concerns was helpful in this project. In particular, the approach encourages the researcher to account for the influence of historical conditions delimiting the situation by investigating "conditions of possibility," that is, the "...constellation of constraints, opportunities, resources and other elements in the situation at hand" (2005, p. 56). Social worlds/arena analysis examines the production and negotiation of discourses surrounding a particular issue under these historically specific conditions (ibid, p.59). The concern with history overcomes the noted shortcomings of traditional grounded theory studies in accounting for structure, discourse, or history and how these delimit collective action (ibid, p. 53). The basic question posed by this reckoning with historical influences is "where CAN things go from here?" (ibid, p. 56, my emphasis) —i.e., what actions and modes of thinking are possible, given the conditions? This was especially helpful for correcting for the tendency in the interdisciplinary teams literature to ignore historical contexts.

Tenets of social worlds/arena analysis, as part of situational analysis, were also useful for my project. Social worlds are "...groups with shared commitments to certain activities sharing resources of many kinds to achieve their goals and building shared ideologies about how to go about their business" (Clarke, 2005, p. 45-46). Thus, the groups of immediate interest to me (the state and health professions) may be understood as social worlds. An arena is a discursive site

...characterized by multiple, complex, layered discourses that interpolate and combine old(er) and new(er) elements in ongoing, contingent, and inflected practices. Further, because perspectives and commitments differ,

arenas are usually sites of contestation and controversy, especially good for analyzing both heterogeneous perspectives/positions on key elements and to see power in action (ibid, p.38).

In my project, articulations of interdisciplinary teams may be conceptualized as an arena, where certain aspects or ideas about interdisciplinary teams and the forms they should take are negotiated and contested by different social worlds or segments within those worlds. Given that my main interests are in how interdisciplinary care became possible in the first place, and in how different groups have attempted to use or mold the idea, my research focuses first on examining the conditions of possibility allowing and promoting interdisciplinary teams, then focuses on the arena of interdisciplinary teams, where groups within the political and professional social worlds attempt to define and promote their particular vision of interdisciplinary teams.

A second helpful element of social world/arena analysis is that social worlds, as loosely bound wholes, are assumed to be complex enough to be composed of various segments, subworlds, or subdivisions that shift "...as patterns of commitment alter, reorganize and realign" (Clarke, 2005, p. 48). This assumption is particularly helpful for putting some boundaries around the problem of the fragmented nature of professions. Professions are social worlds, in that each has fundamentally shared goals, technologies, training, and world views that make them recognizable as professions. However, professions are also divided by specialty and levels of power; segments within professional social worlds sometimes vary in their orientations to interdisciplinary teams or issues surrounding these. This is particularly relevant for the medical profession, given changes to patterns of medical organization and dominance that have in the past allowed the medical profession greater cohesion (Blisshen, 1991, p. 75). This method of investigation thus allows me to talk about a given professional world as a whole, while

also understanding it as inherently fragmented. This assumption will help to account for differences within all the social worlds examined herein.

Given that much of the project focuses on the professions, any of the well-known sociology of professions theories might have been used. However, upon closer examination, I found these too confining for my project. Theories of medical dominance (e.g., Freidson, 1970; Willis, 1989) make the medical profession the centre of the analysis; other groups in the situation are only seen in relation to medicine, eliminating the possibility of examining relationships between other groups on their own terms. Approaches focusing on the activities of groups to attain professional status, like Larson's (1977) focus on professionalization, are helpful in understanding the collective activities of professions, but tend to focus on the path of one profession at a time, rather than professions in relation to each other, an analytical focus that I felt was very important. Abbott's (1988) theory of the system of professions is more promising in that it sees professions in relation to each other. However, his conception of the system of professions is insular; interdisciplinary teams would necessarily be conceptualized as a "system disturbance," (an external source of change to the system) (ibid., p. 91), making it secondary to the analysis, rather than as an interesting concept worthy of extensive examination in its own right. As with theories of medical dominance, other groups, such as government, would be peripheral rather than integral to the analysis.

Situational analysis offered distinct analytical and methodological advantages over these competing theoretical frameworks. It does not impose a pre-conceived set of concepts on the investigation, allowing the researcher to identify important emergent concepts, and assumes that varied and multiple groups and concepts may be important in the investigation. The professions, government, and the very idea of interdisciplinary

teams are on equal footing in the analysis. The use of grounded theory techniques in situational analysis allows important findings to emerge without subsequently having to make these fit into the conceptual and explanatory bounds set by extant theoretical frameworks. Finally, the focus on discourse analysis as an important method in situational analysis closely matched my goal to learn more about how each of the groups in the situation contend with, and contribute to, the discourse of interdisciplinary teams.

Central Thesis and Chapter Outline

Throughout the dissertation I argue that while the groups in the study state that interdisciplinary primary care teams are beneficial and necessary, they all also talk about teams in ways intended to advance their particular interests.

Chapter Two consists of two parts. In Part One, I review the literature regarding interdisciplinary teams in health care. I identify three broad genres in the literature about teams (positivist, contextual, and critical), examining the contributions and limits of each, and situating my work and its contributions as fitting into both the contextual and critical genres. In Part Two, I explore historical and political conditions in Canada and Ontario that shaped the possibilities for interdisciplinary teams leading up to the timeframe covered in this dissertation (2004 to 2011). These include: the persistence of two early conceptions of team models; concerns over efficiency and cost that peaked in the 1980s and 1990s; the rise of primary health care philosophies and their influence on health system reform; and changes in the health professions that saw the decrease of the medical profession's influence and the expansion of the scopes of practice of several non-medical health professions.

Chapter Three further outlines details about the methodology, guiding theoretical framework, and data sources used in this study, which consist of textual data (n=383 documents) and fifteen key informant interviews. I address the methodological and ethical challenges I encountered during the research and how I dealt with these. I also outline my past research and work experiences in relation to the topic of interdisciplinary teams.

Chapters Four, Five, and Six comprise the analysis chapters of this dissertation. Chapter Four presents findings from the political social world data. Although there is agreement among all parties of the importance and necessity of teams, there are disagreements about the forms teams should take, and a struggle to be seen as the party behind the original or best version of interdisciplinary primary care team. I begin the chapter by outlining the ways there is all-party agreement on interdisciplinary teams. I follow with an examination of the Liberals' strategies for implementing teams starting in 2004, and the issues, debates, and controversies that played out in legislative debates. I then focus on claims made by the Liberal government regarding communities, the broader Ontario public, and teams. I outline the ways that interdisciplinary teams were used by the Liberal government to justify decisions made in other areas of health care, including de-listing services and levying a health care premium. I end the chapter with some reflections on the findings, and outline some implications of the Liberals' emphasis on the Family Health Team model.

Chapter Five presents findings from the medical social world data. First, I provide an overview of the medical organizations and data used in the chapter. Then, I examine how these organizations acknowledge the need for primary care reform and interdisciplinary teams. I then outline the array of discursive strategies employed in their

attempt to maintain the dominant position of the medical profession in the midst of health care reform and the formation of interdisciplinary teams in Ontario. An important part of the profession's overall strategy is to explicitly support the Family Health Team model, while speaking out against the Nurse Practitioner-led Clinic model, and marginalizing the Community Health Centre model. The chapter concludes with a discussion addressing two main areas. First, I address the findings in relation to two important concepts in the sociology of professions: professional autonomy and medical dominance. Second, I address how the findings from this chapter might be of interest to the broader public.

Chapter Six presents findings from the social worlds of the non-medical professions, consisting in this study of the nurse practitioner, dietetic, and chiropractic professions. After providing an overview of the organizations and data used, I examine the broad agreements of these professions with the need for primary care reform and interdisciplinary teams, and their commitments to these. In contrast to the medical profession, these professions do not clearly favour one model of interdisciplinary primary care team over another. I then delve into issues and controversies surrounding interdisciplinary teams specific to each of these professions, and the discursive strategies used by each to advance their profession's interests in relation to teams. The chapter ends with further discussion of how the findings build on existing literature about these professions.

Chapter Seven concludes the dissertation. I outline the major contributions made by my work to the substantive area of interdisciplinary primary care teams and to sociology of professions theory, and the insights gained from using situational analysis. Throughout, I note areas in need of further empirical study.

Notes about Terminology

A notable trend in literature about interdisciplinary teamwork in health care is the wide variety of terms used to describe the phenomenon of different health professions working together to provide patient care. The multiplicity of terms is addressed in Part One of Chapter Two. My study does not seek to define or clarify these terms. Rather, my focus is on how interdisciplinary teams are articulated and used by the various groups to promote their interests. While I tend to use the phrase interdisciplinary team, as this was the phrase most in use at the start of my project, I am flexible in my terminology throughout, particularly when discussing findings where other terms are used.

Chapter Two

Literature Review and Historical Context

Introduction

This chapter consists of two parts. In Part One, I outline and assess three major approaches utilized in the literature about interdisciplinary teams: positivist, contextual, and critical. At the end of Part One I outline how my study contributes to the extant literature. In Part Two, I provide a brief history of conditions in Ontario that have allowed or influenced the development of interdisciplinary primary care teams.

Part One: Interdisciplinary Care Literature

Positivist Approaches

The majority of the literature on interdisciplinary care may be described as positivist in terms of methods employed and assumptions held. Positivism has had different meanings and criteria throughout history (Halfpenny, 1982, p. 115; Gartrell & Gartrell, 1996, p. 145). For my purposes here, positivism is understood broadly as a scientific tradition that: believes scientifically generated knowledge promotes social progress and benefits humanity; believes science is unified, or ought to be unified, in terms of its semantics; believes that science consists of “a corpus of causal laws on the basis of which phenomena are explained or predicted”; and believes that knowledge is based on empirical data, whether experimental, quantitative (statistics) or qualitative (observation) (Halfpenny, 1982, p. 18, 19; p. 114, 115). Below, I elaborate further on the positivist tendencies evident in the literature that I have reviewed for this project.

In line with the positivist tradition of seeking unity in the semantics of science, many authors express concern over the “terminological quagmire” (Reeves et al., 2011, p. 168) surrounding interdisciplinary teams (Zwarenstein et al., 2009, p. 3; Cote et al., 2008, p. 449; EICP, 2005, p. 2; Xyrichis & Lowton, 2008, p. 142; Barker et al., 2005, p. 169; Goldman et al., 2009, p. 151). Examples include “interdisciplinary team” (D’Amour et al., 2005, p. 120; Hall & Weaver, 2001, p. 868), “multidisciplinary team” (D’Amour et al., 2005, p. 120; Hall & Weaver, 2001, p. 868), “interdisciplinary collaboration” (EICP, 2005), “interprofessional practice” (Lahey & Currie, 2005), “interprofessional care” (Cote et al., 2008; Health Force Ontario, 2007), “interprofessional collaboration” (Gaboury et al., 2009; Zwarenstein & Reeves, 2006), and “collaborative practice” (Soklaridis et al., 2007; Hall, 2005). Some have expressed concern that this multitude of terms (often used interchangeably) for describing a similar phenomenon has created confusion about whether everyone is talking about the same thing (Reeves et al., 2011, p. 168; Goldman et al., 2009, p. 151; Soklaridis et al., 2007, p. e.2; EICP, 2005, p. 1). Goldman et al. (2009) argue: “...the interprofessional field is characterized by a conceptual and semantic confusion that limits our ability to understand key elements and the relationship between education and practice activities and positive health or system outcomes” (p. 151).

These concerns have prompted calls for clearly distinguishing and standardizing terms (e.g., Barker et al., 2005, p. 166; EICP, 2005, p.1; McPherson et al., 2001, p. ii47; Goldman et al., 2009, p. 151; Reeves et al., 2011, p. 168). They have also sparked theoretical and empirical pieces seeking to clarify concepts and terms. D’Amour and Oandasan proposed “interprofessionality” as a concept to be distinguished from interdisciplinarity in health care, and outlined a theoretical framework to be used as a

basis for future empirical study. They propose interprofessionality focuses on the field of practice rather than knowledge (2005, pp.8-9), and argue the necessity of this distinction: They assert that: “[t]he fact that no term currently exists to capture this particular phenomenon is symptomatic of the state of the knowledge in this area (D’Amour & Oandasan, 2005, p. 9). Similarly, Goldman et al. (2009) conducted a scoping review of literature in order to map the current use and understanding of interprofessional collaboration and education, with the ultimate hope of constructing a conceptual framework to guide future research (ibid, p. 152). Further, they argue that “...conceptual clarity could optimize health professional buy-in for improving IPC [interprofessional collaboration]” (ibid, p. 154).

The same research team published a second paper in 2011 based on updated results of their initial study (Reeves et al., 2011). They again argue that the “...lack of clarity impedes the development of a robust evidence base for the effects of IPE [interprofessional education] and IPC [interprofessional collaboration]” (Reeves et al., 2011, p. 168). Their updated results distinguished three interprofessional categories: interprofessional education interventions (two or more professions learn interactively to improve collaboration), interprofessional practice interventions (activities or procedures incorporated into regular practice to improve collaboration), and interprofessional organization interventions (changes at the organizational level to enhance collaboration) (Reeves et al., 2011, p. 169). Their hope is that others will adopt their clarified concepts, which will “... allow for more direct comparison of research findings and ultimately help to better understand how interprofessional interventions affect outcomes at different levels” (ibid, p. 172). The belief in a unified language around teams is thus a clear focal point for the positivist genre of interdisciplinary team literature.

Another feature of the literature is that interdisciplinary teams are seen as a cure-all solution to commonly cited problems in the health system, broadly reflecting the positivist beliefs in progress through science and its promise of benefitting humanity. It is argued that interdisciplinary teams will improve the quality and continuity of care (Gaboury et al., 2009, p. 707), and patients will have better access to the “right professional at the right time” for their health care needs (Herbert, 2005, p. 1). Literature also suggests that interdisciplinary teams will ease the burdens caused by the increasing complexity of health problems due to an aging population (Hall & Weaver, 2001, p. 872; D’Amour et al., 2005, p. 116) and the increase in chronic illness (Willison, 2008, p. 343). It is argued that interdisciplinary teams will improve patient outcomes (Sargeant et al., 2008, p. 228; Hall, 2005, p. 192; D’Amour & Oandasan, 2005, p. 10; Begley, 2009, p. 276), and may reduce errors in care (Willison, 2008, p.343; Xyrichis & Lowton, 2008, p. 141) or result in improved health behaviours and cognition among patients about their health issues (Willison, 2008, p. 344). It is argued further that interdisciplinary teamwork may improve professional satisfaction (Health Force Ontario, 2007, p. 15; D’Amour et al., 2005, p. 128; Hall, 2005, p. 194; Willison, 2008, p. 344), an important factor in addressing problems of recruitment and retention of health care professionals (Willison, 2008, p. 344). The implementation of effective teams is equated with progress and reform of the health system.

It is important to note, however, that the language used to describe these benefits is often predictive (as in “can,” “will have,” and “may”), rather than conclusive. This may be due to the fact that the evidence for the effectiveness of interdisciplinary team based care is limited, despite the proliferation of research on the topic. Some assert evidence of effectiveness of interdisciplinary teamwork is building (Cote et al., 2008, p. 456;

McPherson et al., 2001, p. ii46). There is some evidence, for example, of the positive effects on user satisfaction (Willison, 2008, p. 344; Sarma et al., 2012, p. 1812), quality of care (EICP 2005, pp. 15-17), improved access to care, better coordination of care, improved chronic disease management, more efficient use of health services, and increased professional satisfaction (Sarma et al., 2012, p. 1812; Gaboury et al., 2009, p. 712). However, others note that there is little evidence showing the efficacy of interdisciplinary teams in terms of patient health outcomes (Sarma et al., 2012, p. 1812; Jansen, 2008, p. 221; Zwarenstein & Reeves, 2006, p. 48; EICP 2005, pp. 15-16; Hutchison et al., 2001, p. 125-6). Some authors suggest that the lack of standardized terms is the likely reason that conclusive evidence about the effect of interdisciplinary team approaches on patient outcomes is elusive (Reeves et al., 2011, p. 167; Xyrichis & Lowton, 2008, p. 142; EICP, 2005, p. 15). Others blame a lack of good research design. Zwarenstein et al. (2009) note that there are very few systematic studies of interprofessional collaboration that allow "...generalisable inferences about the key elements of IPC [interprofessional collaboration] and its effectiveness" and that more rigorous study (evidence based or in the form of randomized trials) is needed (p. 2).

There is significant focus on understanding and improving the mechanics of team function in the literature reviewed for this dissertation. This focus reflects the positivist assumption that, with proper research techniques, the universal causal laws governing successful teamwork may be uncovered and used to benefit the populace. Often, this genre of literature uses the language of "barriers and facilitators" (or some variant thereof) when discussing mechanical problems and solutions in teamwork, respectively (e.g., Brown et al., 2011; Howard et al., 2011; Goldman et al., 2010; Ragaz et al., 2010; Price et al., 2009; Xyrichis & Lowton, 2008; Solheim et al., 2007).

A number of problems surrounding teamwork function have been identified. Professional culture is a commonly cited reason for difficulties encountered in team-based care, or the failure of interdisciplinary teamwork to become widely popular among health care professionals. Specific problems cited include the insular nature of professions (sometimes called “professional silos”) (Willison, 2008, p. 348; Zwarenstein & Reeves, 2006, p. 47; D’Amour et al., 2005, p. 117; Hall, 2005, p. 194; Herbert, 2005, p. 1; Long, 1999, p. 86); the negative effects of persistent professional hierarchies (Brown et al., 2011, p. 7; Howard et al., 2011, p. e190; Ragaz et al., 2010, p. 42; Rice et al., 2010, p. 358; Jansen, 2008, p. 222 ; Kvarnström , 2008, p. 196; Xyrichis & Lowton, 2008, p. 151) which may include turf battles or upset with encroachment into professional boundaries (Brown et al., 2011, p. 6; Kvarnström ,2008, p. 195; Murray et al., 2008 p. 76; Barker et al., 2005, p. 174; Herbert, 2005, p. 3; Long, 1999, p. 86; Jansen, 2008, p. 222); a fear of losing one’s own professional identity in the context of teamwork (Jansen, 2008, p. 221); and negative stereotypes held by professions toward other professions (Begley, 2009, p. 278). A very commonly cited problem is unfamiliarity with, or lack of appreciation of, other professionals’ abilities and roles (Brown et al., 2011, p. 6; Jansen, 2008, p. 221; Xyrichis & Lowton, 2008, p. 150; Murray et al., 2008, p. 76; Soklaridis et al., 2007, p. e.2; Solheim et al., 2007, p. 625; Minore & Boone, 2002, p. 139; Ateah et al., 2011, p. 209). Conversely, Bateman et al. (2003) noted that difficulty applying one’s own professional role in an interdisciplinary setting can also be problematic (p. 144). Communication problems between team members are also a commonly cited issue hindering interdisciplinary teamwork (e.g., Deneckere et al., 2012, p.265; Brown et al., 2011, p.7; Kvarnström, 2008, p. 196; Hall & Weaver, 2001, p. 867).

The proposed solutions to deficiencies in team function are often mirror images of the problems listed, and focus primarily on changing individual behaviour or organizational policy. Proposed solutions include those that would counter the negative effects of professional cultures, such as: respect and appreciation of the abilities of other professions (Howard et al., 2011, p. e190; Xyrichis & Lowton, 2008, p. 149; Willison, 2008, p. 347; Minore & Boone, 2002, p. 139; Bateman et al., 2003, p. 144); understanding of other professions' scope of practice (e.g., Ragaz et al., 2010, p. 40; Jansen, 2008, p. 224; Solheim et al., 2007, p. 625); and clarity and/or agreement on roles to be played by various professionals (Ragaz et al., 2010, p. 42; Xyrichis & Lowton, 2008, p. 149; Soklaridis 2007, p. e4; Solheim et al., 2007, p. 625). Consistent or better communication between team members is also an oft-proposed solution (e.g., Brown et al., 2011, p. 8; Ragaz et al., 2010, p. 41; Xyrichis & Lowton, 2008, p. 149; Murray et al., 2008 p.76; Solheim et al., 2007, p. 631; Whitehead, 2007, p. 1014; Minore & Boone, 2002, p. 139; Bateman et al., 2003, p. 144). Ragaz et al. (2010) recommend that teams select integrated health professionals (i.e., non-physician team members) based on individual characteristics, specifically, those comfortable with ambiguity, willing to be flexible, and willingness to take leadership⁶ (Ragaz et al., 2010, p. 42). They note, too, that the physicians on the team must also be willing to be educated about the role of the other health professionals, and to be willing to adapt to the changes in their practice (ibid).

Solutions for improving team function at the level of organizations have also been proposed. Both Brown et al. (2011, p. 8) and Ragaz et al. (2010, p.42) suggest that human

⁶ It is unclear whether this means willing to be lead by leaders, or to be leaders themselves.

resource policies and organizational protocols might be used to enhance understanding of roles and deal with problems arising from professional hierarchies. Begley (2009) has suggested the use of trained facilitators to resolve issues between team members (p. 279). The role of organizational leadership on team function has also been examined. Using survey data to assess correlations between organizational factors and a climate positive to interdisciplinary teamwork, Howard et al. (2011) found that strong organizational leadership and a less hierarchical group structure were better predictors of a positive climate than focusing on variations in team size, governance structure, and team composition (pp. e-189-e190).

Interprofessional education is perhaps the most commonly discussed strategy to successfully transition toward teamwork. Typically, interprofessional education is described as health professional students learning about and working with other health professionals, with the ultimate hope of improving interdisciplinary primary care team function and patient outcomes (e.g., Reeves et al., 2011, p. 167; Ateah et al., 2011, p. 209; Gaboury et al., 2009, p. 710; Goldman et al., 2009, p. 151; Cote et al., 2008, p. 450; Jansen, 2008, p. 224; Willison, 2008, p. 343; Xyrichis & Lowton, 2008, p. 151; Soklaridis et al., 2007, p. e.1; Hall, 2005, p. 194; Minore & Boone, 2002, p. 140). While much of the emphasis is on pre-licensure training, the importance of post-licensure interprofessional education is also acknowledged in the literature, particularly for physicians (Murray et al., 2008, p.77; Goldman et al., 2009, p. 154; Price et al., 2009, p. 901e.2). Hall and Weaver (2001) note that there has been a longstanding debate about whether it is better to introduce interprofessional education before licensure before profession-specific attitudes become solidified, or after licensure, when one fully

understands their own profession enough to know how other professions might contribute to team efforts (p. 869).

Optimism for the future of interdisciplinary teams is also a marked trait of the positivist literature. Despite the lack of agreement about the evidence for the effectiveness of interdisciplinary teams and education, great faith is placed in their promise by policymakers and prominent authors in the field. For example, Carol Herbert, then Dean of Medicine at the University of Western Ontario, states:

While many of us are “true believers” in inter-professional practice...the available literature...is thin. Now we know that “no evidence of benefit” does not equate to “evidence of no benefit”, so what we need is excellent educational research to help us to define evidence-based best practices and to discard those approaches that do not work. Any and all projects must have carefully designed evaluation components (2005, p. 3).

For Herbert, if the literature is weak, the scientific body of knowledge required *will be* produced to make interdisciplinary teams work. Similarly, Cote et al. (2008) state:

...there is active promotion and networking, concrete frameworks and funds [for interprofessional education and interprofessional collaboration] but few published results regarding the efficacy of implementing IPC [interprofessional collaboration] in health care organizations. As experience with the approach accumulates, evidence on the effective implementation of IPC [interprofessional collaboration] in health care should grow (p. 457).

The optimism in these passages that interdisciplinary teams and education can and will be successfully enacted once the scientific knowledge base is further established reflects the positivist belief in the inevitable progress of science, and its benefit for social life.

In sum, much of the literature about interdisciplinary teams to date reflects positivist beliefs and assumptions. In this literature, teamwork in health care is an unquestioned goal, and there is an underlying optimism that the conditions for successful teamwork can (and will) be discovered through agreement on terms and concepts, and

rigorous empirical study of enablers and barriers. While it is possible that this genre of study may indeed eventually produce some of the much-sought evidence for the efficacy of teams, and the optimal conditions to produce teamwork in health care, it suffers from limitations that may prevent this goal. In its quest to uncover the universal laws of teams, authors in this genre tend to ignore the significant effects of specific historical, social, and political factors in their analyses. The assumption that teams are governed by universal laws fails to account for how teams are created by varied groups of people living in particular contexts, with competing interests. This genre will likely continue to suffer the frustration of being unable to universally define and accurately measure teams and teamwork, which are created in conditions that are not generalizable.

Contextual Approaches

Fewer studies have examined the effects of specific historical and/or political contexts on interdisciplinary primary care teams, though focus on these macro-level influences adds important insights. Hutchison et al. (2001; 2011), for example, discuss the role played by policy legacies in shaping the Canadian health care system and the potential for system reform toward primary care teams. Medicare is one such legacy; the “founding bargain” made between the federal government and the medical profession has entrenched a “...formidable policy legacy of physicians’ autonomy” (Hutchison et al., 2011, p. 262). In exchange for agreeing to participate in a publicly funded system that limited their entrepreneurial discretion, physicians were allowed to retain their fee-for-service method of payment, to maintain their status as autonomous professionals, and to define the services that are medically necessary and thus covered under Medicare (Hutchison et al., 2001, p. 118; Hutchison et al., 2011, p. 257). A trajectory was set, whereby “...federal and provincial policymakers have been hesitant to challenge this

accommodation for fear of jeopardizing the medical profession's allegiance to Medicare" (ibid).

Several authors have noted how the accommodation of physician interests has influenced the way interdisciplinary teams have played out in Canada. First, physicians have never been required to work in interdisciplinary teams; they have only ever been invited to do so by governments (Hutchison et al., 2011, p. 262; Muldoon et al., 2006, p. 21). Further, they have had considerable latitude in choosing models of teams that suit them or ignoring those that do not (Muldoon et al., 2006, p. 22). Suschnigg (2001) highlights how the Community Health Centre (CHC) model, introduced by the provincial government in 1982, was largely ignored by physicians in Ontario during the 1980s because it would have made them employees of a lay board (limiting their clinical autonomy) and salaried rather than working on a fee-for-service basis (limiting their financial autonomy) (pp.93-94). Physicians were more apt to choose the other available model of interdisciplinary care, the Health Service Organization (HSO), which utilized capitation payment for physicians and allowed them to maintain clinical leadership (Suschnigg, 2001, p. 93; Hutchison et al., 2001, p. 120). The HSO model quickly proved more expensive and easily manipulated by physicians to maximize their income. However, the CHC model was not further pushed because of the tension between the provincial government and physicians over the issue of extra-billing making any pressure on physicians to agree with widespread implementation of the CHC model a politically inexpedient move for the provincial government (Suschnigg, 2001, p. 94)⁷. The CHC

⁷ Prior to the passing of the Canada Health Act in 1984, some physicians charged patients beyond the amounts set in the provincial fee schedule, referred to as extra-billing (Suschnigg, 2001, p. 94). The Canada Health Act established financial punishments for provinces allowing extra-billing; believing the Act violated the Charter of Rights and Freedoms, the Ontario Medical Association attempted to overturn the law (ibid). When this was unsuccessful, physicians in Ontario went on strike for 25 days in 1986 (ibid).

model has remained unpopular with physicians (Muldoon et al., 2006, p. 20). Similarly, Tuohy (2002) outlined how, in the 1990s, physicians in Ontario resisted the implementation of interdisciplinary teams because the government wanted to fund the new models from the physicians' global budget (p. 43), a clear threat to physicians' autonomy. Bourgeault and Mulvale (2006) note that Medicare's exclusive focus on payment of physicians has impeded interdisciplinary primary care teams, as there is no mechanism for paying non-physician providers outside of hospital settings (p.486).

Authors have noted the effects of other policy decisions by governments that have limited the widespread implementation of interdisciplinary teams. Jansen (2008) notes that the health care reforms of the 1990s displaced a significant portion of the Canadian health care workforce through job loss, early retirement, and employee layoff provisions, with adverse effects on the team milieu (p. 219). Team initiatives that suffered loss of health care personnel failed (ibid). She further argues that low and inconsistent government funding contributed to the failure of interdisciplinary teams to take hold in Canada (ibid, p. 219). Muldoon et al. (2006) assert that the Ontario government's failure to evaluate the efficacy of the various interdisciplinary primary care team models introduced over the years has made physicians wary of investing the time and money to change their practices into possibly ineffective team structures (p. 21). Bourgeault & Mulvale (2006) assert that the exclusive scope of practice model regulating health professions in some Canadian provinces is a barrier to collaborative care, in contrast to the overlapping scope of practice model first developed in Ontario, and adopted in other provinces starting in the 1990s (p. 485).

The above discussion of Medicare as a policy legacy alluded to the influence of the medical profession on interdisciplinary teams. Other authors have also highlighted the

important effects of the health professions in general on interdisciplinary teams in health care. San Martin Rodriguez et al. (2005) assert the professional system affects collaborative practice, as "...the process of professionalization is characterized by the achievement of domination, autonomy and control, rather than collegiality and trust" (pp. 136-137). Consequently, "...the dynamics of professionalization lead to a differentiation of professionals and to territorial behaviors within the team" (ibid, p. 137). Further, professionals are socialized during their education to adhere to their profession's philosophies, values, and theories; these may clash with those of other professions on the team, causing conflict and hindering collaborative practice (ibid, p. 137). Similarly, Jansen (2008) asserts that the professional education system has traditionally been discipline-specific, contributing to "ethnocentrism" within health professions and hindering effective teamwork (p. 221). Finally, Jansen (2008) notes the importance of studying the professional associations' potential role in limiting the implementation of teams, given their traditional role of protecting the political interests of their members (ibid, p. 220).

Empirical studies have documented the influence of the professions on interdisciplinary teams. Kvarnström (2008) asserts that in her study of four interprofessional health care teams in Sweden, health care workers struggled to balance the competing agendas of their interprofessional team and their respective professions (p. 199). Further, she argues that a hierarchy of knowledge was evident; some team members' suggestions for patient care were not valued and not put to use⁸ (ibid, p. 195-196). Drawing broadly on a sociology of professions perspective, she asserts that "the

⁸ The specifics of which professions were undervalued and which undervalued the other professions were not provided.

varied status of the professions may have an impact on how and whether knowledge contributions are put to use” (ibid, p. 199). In their examination of an interprofessional mental health team in Canada, Salhani and Coulter (2009) studied the effect of professional projects on the dynamic of interdisciplinary teams. They argue that the professions are in a continuous process of pursuing their “professional projects” by demarcating, expanding, or maintaining their state-sanctioned scope of practice and right to self-governance (Salhani & Coulter, 2009, p. 1221). For healthcare workers, professional projects “...advance claims of practical therapeutic efficacy blended with strategies for the advancement of the profession’s social–economic and professional goals” (ibid, p. 1222). These professional projects are in direct tension with the permeable and flexible professional roles implied in interprofessional work (ibid, p. 1221). Their investigation focused on how professional projects were actively pursued by nurses in this interprofessional setting, concluding that “...political discourse and practices were an integral part of understanding, working and thriving/surviving for participants in this health organization” (ibid, p. 1227). In their study of interdisciplinary clinics specializing in integrative healthcare⁹ throughout Canada, Gaboury et al. (2009) demonstrated how restrictions were imposed on physicians by their respective provincial colleges, limiting how physicians could work collaboratively with complementary/alternative health care practitioners (p. 711). These studies highlight the role played by professional politics at the micro-level of teams; however, more empirical work is needed to understand the origins of the political forces that come to play out in teams. My study undertakes this task.

⁹ Integrative health care is the combination of biomedical practice with various complementary and alternative medicine therapies (Gaboury et al., 2009, p. 707).

In sum, contextual studies expand our understanding of interdisciplinary teams beyond the limits of the positivist literature's focus on perfecting team mechanics. Contextual studies correct for the positivist tendency to generalize by focusing on how possibilities and limits for teams are set in particular jurisdictions by historical events and political influence. Here, the causality and complexity of teams are linked to specific times and places, rather than to underlying universal laws. This necessitates comparative analysis of teams, rather than attempting to generalize them.

Critical Approaches

The past few years have seen the genesis of empirical studies utilizing social scientific theories and methods to study interdisciplinary teams critically. The authors in this emerging genre of literature openly question the importance placed on teams. Further, these studies are conducted without the explicit goal of improving team function; rather, they focus on what other insights may be gained by studying interdisciplinary teamwork. This is in contrast to the unquestioning acceptance of the importance of interdisciplinary teams characterizing the positivist literature, and to the neutral tone of the contextual studies regarding the value of teams. Further, critical approaches thus far have focused primarily on studying micro-level team settings, whereas contextual studies tend to focus on macro-level historical and political factors.

Several of these more recent studies utilize ethnographic techniques combined with hitherto unused theoretical approaches from the social sciences. Nugus et al.'s (2010) study is an example of research concentrating on observing teams without attempting an intervention to promote interdisciplinary work or learning. Their study combined ethnographic approaches with negotiated order (a symbolic interactionist theoretical approach first used by Anselm Strauss) in order to investigate how health care

professionals exercise various forms of power in their interactions in a variety of team-based health care settings in an Australian state (Nugus et al., 2010, p. 898). Questioning the simplistic view of power proposed in theories of medical dominance as competitive and zero-sum, they sought to "...account for the possible co-existence of agency and structural influences" by conceiving of two types of power: competitive and cooperative (ibid, p. 899). Competitive power consists of instances when one profession dominates another in a given situation (ibid, p. 907), whereas collaborative power consists of instances of interdependent participation and decision-making (ibid). They found that both types of power existed in the interprofessional clinical settings they studied (ibid). However, the level of each was mediated by the level of acuity in patient care: in settings where the patient care needs were less acute, nurses and allied health professionals were able to assert their own role, and more collaborative power was exercised by all team members (ibid, p. 908). Conversely, the more acute the care required, the more prominent was physician exercise of competitive power, including the circumscription of the roles of the nurse and allied health professionals (ibid, p. 908). Finally, while physicians were not the only profession to exercise competitive power, the authors conclude that there continues to be "...a ubiquity in the actualized and potential domination by doctors across various care settings, [reinforced by] cultural and institutional currency" granted to physicians (ibid).

Arguing that normative discourses of teams and teamwork are rarely examined or critiqued in relation to the everyday organization and maintenance of interprofessional practice, Lewin and Reeves (2011) used ethnographic techniques and a modified form of Goffman's theory of impression management to examine how "...teamwork is negotiated and enacted between different professional groups in different clinical contexts" (p.

1596). They examined the interactions of physicians, nurses, and allied health professions in two general medical wards in a large UK hospital, paying particular attention to planned team-based interactions (rounds, scheduled team meetings) and ad-hoc interprofessional interactions (Lewin & Reeves, 2011, p. 1598). They also considered whether the interactions (planned or ad-hoc) occurred in front of patients (termed front stage) or in the absence of patients (ibid). They found that planned front stage interactions (rounds) tended to reinforce traditional professional roles (p. 1599); ad-hoc front stage interactions tended to be short-lived and opportunistic, and were "...largely task-oriented and terse" with limited sharing of information between team members (ibid). Planned backstage activities (team meetings) were poorly attended by physicians and nurses due to time constraints; ad-hoc backstage interactions allowed the various professionals to quickly re-connect and briefly discuss issues from their front stage interactions, to relay messages to colleagues that were absent from front stage interactions, or to emotionally process front stage activities (ibid, p. 1600). However, advanced teamwork around patient care was not typically achieved in these settings (ibid, p. 1601). The authors conclude that "...the notion of teamwork, as a form of regular interaction and with a shared team identity, may have little relevance in a general medicine context" (ibid).

In their study, Finn et al. (2010) sought to present interdisciplinary teamwork in a manner distinct from "its normative, evangelistic promotion within much management and health policy writing" (p.1148). They combined Giddens' concept of identity work with critical organization theory to examine "...the mobilization of teamwork discourse in construction of occupational identities" in two hospitals in the UK (Finn et al., 2010, p. 1150). They examined the ways teamwork discourse was used consciously in the identity

work (the construction of the self using socially sanctioned discursive resources) of health professionals, while also paying attention to the ways teamwork discourse also operates insidiously to reinforce managerial agendas (ibid, p. 1150). Teamwork, from a managerial perspective, holds "...the promise of uniting various groups of employees around a common identity – a set of goals and values that maximises their contribution towards management objectives" (ibid, p. 1150). Further, focusing on teamwork "...tends to write out other available ideas about organization," particularly professional interests such as clinical autonomy or material reward (ibid, p. 1153), and has the further benefit for managerial interests in not appearing to support any one professional group's interests, nor in calling for any major structural changes to be made (ibid, p. 1152).

Finn and colleagues found that, while the health professionals in the study used teamwork discourse as a resource for self-description, they also used it for other purposes that varied by profession type. Surgeons and anaesthetists drew on "instrumental" and "technical" discursive resources about teamwork to legitimate their privileged position; these emphasized the efficiency of teamwork, the necessity of certain attitudes and skills to achieve teamwork, and the assumption that teams were in place to assist surgeons and anaesthetists (ibid, p. 1152). Conversely, nurses and operating department practitioners used team discourse to challenge medical privilege, by drawing on "relational" discursive resources that emphasized teamwork in terms of courtesy, respect, and appreciation (ibid). The strategic use of teamwork discourse by the health professionals reinforced, rather than broke down, professional divisions, implying the failure of the discourse to serve managerial purposes of unifying the professions to work together harmoniously (ibid, p. 1153). However, the strategic use of teamwork discourse by the health professionals kept the focus on "teamwork" at the micro-level, rather than on other

concerns, such as “occupational integration at more fundamental, structural levels, the redistribution of material reward for team-based incentives, efforts to counter the negative effects of efficiency drives on team formation and stability, or more fundamental challenges to power inequalities for enhanced communication and engagement” (ibid). In highlighting teams as a discursive entity that can be used strategically by actors, while also having effects on them, the authors assert their work is “...a counterpoint to the uncritical adoption of corporate management discourses often seen in contemporary healthcare” (ibid, p.1151).

Critical discourse analysis is another method only starting to be used to examine the concept of teams critically. Asserting that interprofessional collaboration has “...grown in popularity to the point of being accepted as ‘common sense,’” Haddara and Lingard (2013) conducted a Foucauldian critical discourse analysis of literature about interdisciplinary collaboration in order to probe beyond common sense meanings of interprofessional collaboration and teams (p. 2). They examined 188 documents about interprofessional collaboration between nurses and physicians since 1960, including empirical studies, editorials, and professional conference proceedings. The authors examined these for themes, truth statements about interprofessional collaboration, the type of language used, irregularities, ruptures, and transformations, “...until a stable description of the various discourses emerged” (ibid, pp 1-2). They identified two main discourses: a utilitarian discourse, and an emancipatory discourse. They assert that the utilitarian discourse is marked by two truth statements: first, interprofessional collaboration is necessary because it produces better patient care and improves patient outcomes; second, that “...the utility of interprofessional collaboration can and should be demonstrated through positivist, experimental research” (ibid, p. 3). Its language is

focused on determining the components, mechanics, associations, and causal paths of successful interprofessional collaboration, as well as emphasizing measurement, validity, rigour, and evidence (ibid). The authors assert the truth statement of the emancipatory discourse is that interprofessional collaboration is necessary to diminish medical dominance, which is seen as an ongoing impediment to effective health care delivery (ibid, p. 4). The language of this discourse is less unitary, ranging from “opinion pieces and editorials that employ imperative, exclamatory, and confrontational language to papers that use empiricist approaches, nonconfrontational [sic] language, and a more covert positioning of the power-leveling agenda” (p. 5). The authors concede that these two discourses are not necessarily mutually exclusive; some documents in their sample invoke both (ibid, p. 3).

Thus, in moving beyond the assumption of teams as an imperative, critical studies have created a space where other important social processes surrounding teams are examined. These studies highlight the less idealistic aspects and effects of teams. For example, as noted above, teamwork discourse may serve managerial purposes more than enabling fundamental changes (Finn et al., 2010), discourse about teams may be used by some groups strategically (ibid), and different groups have different goals with regard to teams (Haddara & Lingard, 2013). Critical studies, in purposely not focusing on making teams work, can (somewhat ironically) highlight factors impeding teamwork that may have solutions. Acknowledgement of these factors and their effects may be the first step in rectifying them.

My study combines critical and contextual approaches. It contributes to the literature by looking beyond teams as an imperative or inherent social good, and focusing on the political context of teams at the macro level, a neglected area in the literature

(Salhani & Coulter, 2009, p. 1222; Bourgeault & Mulvale, 2006, p. 491; San Martin Rodriguez, 2005, p. 144). Having outlined the contours of the literature on interdisciplinary teams, I now examine the historical context and conditions that have influenced the development of interdisciplinary teams in Ontario.

Part Two: Health Care Reform in Canada and Ontario

Cost and Efficiency: Early Talk of Teams

The cost and efficient provision of health care services have been longstanding concerns in Canada, both before and after the introduction of publicly funded medical care. Team models of care have been suggested by two national reports. The Hall Report (Canada, 1964) discussed physician group practices as the most efficient model for provision of health care outside of hospitals. Framed as maximizing a health care division of labour, group practices, it was argued, would employ nurses, technicians, and administrative staff, so that physicians could devote more time to medical matters (Canada, 1964, p. 544). The Hastings Report (1973) advocated multidisciplinary health care teams (defined as including a variety of health and other types of personnel) in Community Health Centre settings as a means of improving service and containing growing costs, especially compared to expensive hospital-based care (Canada. Health and Welfare Canada, 1973, p. ii; p.3). In contrast to the Hall Report, the Hastings Report advocated greater equality among team members as a means of improving efficiency (ibid, p. 3). This tension between models featuring a more traditional physician-centered division of labour versus a more egalitarian working relationship among team members continues today, and is examined in more detail in this dissertation.

Concerns about the cost and efficiency of health services in Ontario prompted provincial-level commissions starting in the early 1970s. In 1970, the Committee on

Healing Arts proposed to rationalize health care services by granting twenty health professions overlapping scopes of practice to counter the rigidity and perceived inefficiencies of the medically dominated division of labour (Coburn, 1993, p. 134; O'Reilly, 2000, p. 64). This never came to pass due to strong resistance from physicians and dentists (Coburn, 1993, p. 134). The idea, however, resurfaced a decade later, in the 1982 Ontario Health Professions Legislative Review. The Review proposed that the existing scope of practice monopolies could be changed to increase equality and cooperation among health professions. It also proposed changes to laws preventing hospitals and community health centers from using a combination of health professionals that would provide the best service at the lowest cost (Schwartz, 1989, p. 14; O'Reilly, 2000, p. 71). The recommendations of this review were implemented in the *Regulated Health Professions Act* (RHPA) of 1991 (O'Reilly, 2000, p. 70). This Act eliminated exclusive scopes of practice in favor of a system of 13 controlled acts¹⁰. Professions were granted or denied access to each of the controlled acts based on their training. This allowed the possibility of more than one health profession to perform a given controlled act, depending on adequate training (Health Force Ontario, 2007, p.4; deWitt & Ploeg, 2005, p. 126; Coburn et al., 1997, p. 12). According to O'Reilly (2000), the RHPA succeeded in fulfilling several of the state's goals: it broke the monopolistic model of professional practice that had been the norm since the late 1800s; allowed for greater coordination of health professional labour; allowed greater cooperation and

¹⁰ Controlled acts are those outlining activities or procedures that involve some level of risk to the patient if not performed by someone with adequate training. In 2007, a fourteenth controlled act (psychotherapy) was added to the list of controlled acts via Bill 171, the Health Systems Improvement Act, which amended the Regulated Health Professions Act (http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=519&detailPage=bills_detail_about), accessed November 16, 2013.

egalitarianism among health professions; and re-aligned professional self-regulation with the political, economic, and judicial standards of the day (pp. 88, 174, 199).

While talk of health care teams as efficient and cost-effective were not new in Canada, the post-recession era that started in the 1980s brought a new sense of urgency concerning the cost and efficiency of publicly funded services. The role of the welfare state was in question, and interest in markets as providers of public services grew (Coburn, 2006, p. 436). Starting in 1984, federal ministries were restructured with the goal of achieving greater efficiency. The restructuring was guided by the New Public Management—business-inspired models of lean production designed to counter wasteful and ineffective government bureaucracies. Greater responsibility for organization of services was devolved to the provinces (Aucoin, 1995, p. 9, p.127; Savoie, 1994, p.150), and greater accountability to the public was promised (Aucoin, 1995, p.9). In 1995, the Liberal government's introduction of the Canada Health and Social Transfer combined federal health funding with funding for other social programs, and the overall amount of transfer payments was significantly reduced (McBride & McNutt, 2006, p. 186; deWitt & Ploeg, 2005, p. 127; Baines, 2004, p. 8). As a result, provincial governments were placed in an unfortunate financial position.

In response, provincial governments adopted similar mindsets and approaches. In Ontario, the rhetoric of fiscal crisis and the need to contain health care costs peaked in the 1990s (Angus & Bourgeault, 1998, p. 66; Coburn et al., 1997, p. 9), and coincided with a recession and reduced government revenues in that decade (ibid). Attempts to rein in

health care costs included caps on physician spending¹¹ in the early 1990s (deWitt and Ploeg, 2005, p. 127; Angus & Bourgeault, 1998, p. 75; Coburn et al., 1997, p. 9), lowering the physician-population ratio (and thus the overall number of billing physicians) by lowering medical school enrolments and limiting post-graduate training placements (ibid, p. 8), and hospital rationalization, including closures and consolidation into “mega-hospitals” (Suschnigg, 2001, p. 98).

Primary Health Care, System Reform, and the Health Professions

Overlapping and intertwining with concerns about cost and efficiency of health care services were assertions that health services needed to be reorganized to incorporate primary health care philosophies and practices. The literature generally describes primary health care’s concerns as: broadening the definition of health and health care beyond the curative model of medicine (i.e., defining health as encompassing not just the absence of illness or injury but total physical, mental and emotional health) (Angus & Bourgeault, 1998, p. 61); acknowledging social causes of poor health and the need to address these (Suschnigg, 2001, p. 95); promoting preventive approaches to health at both the individual and community levels (such as public sanitation) (Angus & Bourgeault, 1998, p. 66; Suschnigg, 2001, p. 92); encouraging individuals to become involved in and responsible for protecting their health and the health of their communities (Angus & Bourgeault, 1998, p. 66; Chamberlain & Beckingham, 1987, p. 158); encouraging all health professionals to work together as “a team”¹² (Félix-Bortolotti, 2009, p. 863); and

¹¹ This included introducing limits on the overall amount that the profession as a whole could charge in a given year, as well as limits on what individual physicians could charge in a given year (Coburn et al., 1997, pp. 8-9).

¹² The original World Health Organization-sponsored Alma Ata Declaration of 1978 regarding primary health care reads: “...[primary health care] relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional

implicating expansion of non-medical health professional roles (Suschnigg, 2001, p. 92). These concerns permeate discussions of primary health care in the academic and grey literatures.

Both in Ontario and nationwide, primary health care has been promoted by researchers and policy advisors since the early 1970s, but did not become central to government health policy until the 1990s (Hutchison et al., 2001, p. 120; Angus & Bourgeault, 1998, p. 65). The early 2000s saw several major events concerning health care reform at the federal level. These included a Royal Commission into the future of health care, lead by Roy Romanow (Romanow, 2002), two First Ministers' Meetings (in 2001 and 2004), and two First Ministers' Health Accords (in 2003 and 2004). In the course of these events, a number of policy priorities about primary health care were set. Primary health care would ensure Canadians receive the "most appropriate care, by the most appropriate providers, in the most appropriate settings" (Cote et al., 2008, p. 450); such care would be "patient centered" (Canada. Health Canada, 2006); interprofessional and collaborative health education for health professionals would be improved (ibid); by 2011 "50 percent of Canadians would have access to a multi-disciplinary team of health providers, 24 hours a day, 7 days a week" (Bourgeault & Mulvale, 2006, p. 485); and Health Human Resources management would be a priority (Cote et al., 2008, p. 450). Referencing the Royal Commission's final report, which recommended team-based collaborative care, and the First Ministers' Accords firm commitment to this end, the Ontario government released a *Blueprint for Action* document in 2007 with recommendations to facilitate interprofessional care, including another legislative review

practitioners as needed, suitably trained socially and technically *to work as a health team* and to respond to the expressed health needs of the community" (emphasis added) (World Health Organization, 1978).

(Cote et al., 2008, p. 451). Team-based health care thus became an official policy goal of the federal and provincial governments during this time.

The tenets of primary health care intertwine with the interests of both the state and non-medical health professions. Primary care's emphasis on improving access to the health system via primary care providers creates a need to either expand the number of physicians or allow non-medical health professionals to become points of entry into the health system. Both state bureaucrats and the public have come to see the medicine-dominated division of health care labour as unnecessarily rigid and complicated, and a hindrance to effectiveness and cost efficiency (deWitt & Ploeg, 2005, p. 127; O'Reilly, 2000, p. 64; Coburn, 1993, p. 132). Thus considerable attention has been paid to improving so-called "skill mixes" in health care settings, and providing opportunities for substituting less expensive health care workers with similar abilities for more expensive health care workers, where safety allows, to alleviate costs (Angus & Bourgeault, 1998, p. 66).

For certain health professional groups, especially those that have for some time been trying to escape from "under the thumb of medicine" (Coburn, 1993, p. 133) or gain official recognition from the state as a health profession (ibid), the government's and public's interest in delivery of primary care via non-medical health personnel was beneficial to their professionalization process. This has been the case, for example, with primary care nurse practitioners in Ontario, who have promoted themselves as a viable alternative to physicians as an entry point into the health system and, in gaining some legislative rights to limited prescribing, as a direct substitute for the care of a physician (deWitt & Ploeg, 2005, p. 126). As well, partly through the influence of the feminist movement, the profession has promoted its emphasis on what Angus and Bourgeault

(1998, p. 60) call the “care-ative” aspects of health (i.e., an emphasis on prevention and health promotion, also emphasized in conceptions of primary health care), as opposed to the curative approach of medicine (Adams & Bourgeault, 2003, p. 79). The emphasis on the caring aspects of nursing, combined with the willingness and ability of nurse practitioners to work in multidisciplinary team structures in Ontario (e.g., Community Health Centres) (ibid, p. 70), further makes nurse practitioners an attractive alternative to physicians. Both of these strategies are nicely in line with the tenets of primary health care and the goals of the state.

The medical profession in Ontario has also seen its relationship with the state and other health professions change significantly with system reform toward primary health care. Historically, the medical profession in Ontario has held a dominant position in the system of health professions. This holds in other contexts, and has been studied by sociologists in the U.S. (Freidson, 1970), Australia (Willis, 1989), and Canada (Blisshen, 1991). The concept of medical dominance, first used by Freidson in 1970 and later expanded and modified by others, refers to the ability of the medical profession to assert its control over its own work, its clients, the work of other health occupations, and the broader context of health care (Willis, 1989, p. 2; Blisshen, 1991, p. 5; Coburn et al., 1997, p. 2; Angus & Bourgeault, 1998, p. 56).

Coburn (1993, p. 130) describes three phases in the historical relationship between the state and the medical profession in Ontario, with the first two phases clearly indicating the profession’s privileged status. In the first phase, starting in the latter nineteenth century, the state supported the well-organized medical profession’s bid for a monopoly of practice through legislation (ibid). This legislation saw the limitation, exclusion or subordination of chiropractic, midwifery, dentistry, pharmacy, and nursing

from medicine's domain (ibid, p. 131). The second phase, comprising most of the twentieth century, saw a more intimate and permeable relationship develop between the state and the medical profession; the state granted more responsibilities to the medical profession and granted it control over the emergent health division of labour, closely adhered to the advice and views of the leaders of the profession, and often granted members of the medical profession high-ranking positions in provincial health ministries, directly writing health policy (ibid, p.131). The early political action and involvement of the medical profession thus had a profound impact on the early organization of health care in Ontario.

More recent decades, however, have seen a decline in medical dominance, with implications for the expansion of the interdisciplinary care ethos in Ontario. Coburn's third phase of state-medical profession relations is characterized by the infiltration of the state and the public into the organizational structures of the medical profession, often in the name of rationalizing the health system to alleviate high costs (1993, pp. 132, 136). In particular, the state has become much more involved in controlling medical education (via publicly funded universities and medical schools) than in the past, when it was the responsibility of the College of Physicians and Surgeons of Ontario (CPSO) (ibid). The CPSO lost further influence with the passing of the *Regulated Health Professions Act* (RHPA) of 1991, which gave ultimate control over the health professions in Ontario to the Minister of Health. Under the RHPA, the Minister has the authority to direct any health professional College to carry out designated activities (Coburn et al., 1997, p. 13). Previously, the Minister only had the power to *ask* Colleges to carry out certain activities (Coburn, 1993, p. 136). As well, the RHPA required 40-49% lay representation on College boards for medicine and other health professions, compared to 25% in 1974 and

0% before that (deWitt and Ploeg, 2005, p. 126; Coburn et al., 1997, p. 13; Coburn, 1993, p. 136). The RHPA also ordered the creation of the Health Professions Regulatory Advisory Council, a 100% layperson-run board that advises the provincial government on which health professions should be regulated, and what each profession ought to be able to do (deWitt and Ploeg, 2005, p. 126; Angus & Bourgeault, 1998, p. 65; Coburn, 1993, p. 135). Thus, the medical profession was made more accountable to, and influenced by, both the public and the state through these manoeuvres; the ability of the medical profession to resist these was weakened.

Medical authority over other health professions has also weakened in the last two decades in Ontario. Midwives, excluded from the health care system in the early twentieth century due to the political efforts of the medical profession, were reintroduced formally to the Ontario health care system in 1991 by the Ontario government (Adams & Bourgeault, 2003, p. 86). The medical profession was excluded from this process (Angus & Bourgeault, 1998, p. 75). The introduction of nurse practitioners to the Ontario health care system in the early 1970s, initially supported by the Canadian Medical Association and the Ontario College of Family Physicians, was effectively halted in 1983 (a time of perceived physician oversupply and therefore increased competition to provide services) because physicians lobbied the government to discontinue nurse practitioner education programs (deWitt & Ploeg, 2005, pp. 122-123; Angus & Bourgeault, 1998, pp. 62-63). However, this profession too was reintroduced by the Ontario government in 1998, despite considerable opposition from the Ontario Medical Association, The College of Family Physicians of Ontario, and the College of Physicians and Surgeons of Ontario (Angus & Bourgeault, 1998, pp. 71-73). As with the re-introduction of midwives, organized medicine was excluded from the planning and policy development process that

led to the reintroduction of nurse practitioners (Angus & Bourgeault, 1998, p. 75). The College of Family Physicians of Ontario resorted to legal action in an attempt to slow the re-introduction of nurse practitioners, but to no avail (ibid, pp. 71-72).

Legislative changes in Ontario have considerably weakened medicine's control over the work of other health professions. As noted above, the Regulated Health Professions Act restructured legislation from an exclusionary to an overlapping scope of practice model. The further changes of 2009 to the *Regulated Health Professions Statute Law Amendment Act* have expanded the role of nurse practitioners, pharmacists, physiotherapists and midwives (Ontario. Ministry of Health and Long-term Care, 2009) into territory once closely guarded by physicians: diagnosis and prescribing (Torrance, 1998, p. 8).

Despite these trends that have weakened the considerable power of the medical profession to control its own work, the work of others, and the general health care context, some effects of medical dominance still remain, with implications for interdisciplinary primary health care teams. The fee-for-service system set in place during the implementation of Medicare in Canada continues to be the dominant method of payment of physicians throughout much of Canada (Bourgeault & Mulvale, 2006, p. 486; Hutchison et al., 2001, p. 117). Public insurance systems based on fee-for-service cannot pay non-physician providers outside of hospitals, providing structural and administrative disincentives for physicians to invite other health professionals to work in their practices (Bourgeault & Mulvale, 2006, p. 486; Gaboury, 2009, p. 711). However, physicians in Ontario willing to switch to a Family Health Team model are able to take advantage of flexible funding and payment options that blend fee-for-service, capitation, lump sum payments, or special allowances in order to pay non-physician providers (Bourgeault &

Mulvale, 2006, p. 486). Government policies regarding the structure of some forms of interdisciplinary teams may place physicians as *de facto* leaders of such teams; in Ontario, Family Health Teams are required to have a physician (ibid, p. 487). Bourgeault and Mulvale (2006) call this persistence of conditions which privilege the medical profession in systems of health expenditure and health service organization “the structural embeddedness of medical dominance” (p. 482). Thus, while medical dominance has waned, it has not disappeared. Further, it has influenced how teams have played out to date in Ontario.

In Part Two, I have outlined both changes and persistent conditions that have influenced the development of interdisciplinary primary care teams in Ontario. Concern over the high cost of medical services and the inefficiencies caused by the unnecessarily rigid hierarchy in the health division of labour presented the impetus to conceive of new ways of delivering health care services, with multi-professional arrangements as one option. Changes in economic conditions and in the philosophy of the government’s role in public service provision led the provinces to take more responsibility for the costs and design of health care services. Ontario was the first jurisdiction in Canada (and possibly the world) to implement a system of overlapping scopes of practice (O’Reilly, 2000, p. 3), providing a starting place for reorganizing services into team structures on a broad scale. The move toward primary health care reform in Ontario, with its focus on prevention, the social determinants of health, and the belief in the superiority of team-based care has provided a possible alternative to the hierarchical, biomedically-driven system of health care delivery that has dominated Ontario since the late 1800s. Though the influence of the medical profession over the state and other health professions has recently weakened, limiting its resistance toward interdisciplinary teams, entrenched

patterns of physician appeasement have continued to shape the structure of teams.

Overall, the conditions have overwhelmingly favored the formation of interdisciplinary primary care teams in Ontario.

Chapter Three

Methods

Situating the Researcher

Acknowledging the existing knowledge and experience of the researcher is an important part of conducting situational analyses (Clarke, 2005, p. 75; p.85). Clarke differentiates situational analysis from classic grounded theory techniques that assume the researcher begins the project with no knowledge or assumptions about the substantive area, by positing that researchers in situational analysis likely already know something about their projects, whether through experience or through readings of literature, and thus come to their projects already sensitized to some issues and concepts (Clarke, 2005, p. 184; p.75). Situating oneself in relation to one's data is an important reflexive exercise done as a means of acknowledging that data is never read neutrally (ibid; Gavey, 1989, p. 468). Therefore, I will outline how my previous research and work experiences affected my project.

My interest in interdisciplinary primary health care delivery systems originated in my work on a research project in Ottawa as a research associate on a Primary Health Care Transition Fund Project between 2004 and 2006, called the Integrating family Medicine and Pharmacy to Advance primary Care Therapeutics (IMPACT) project. In this project, pharmacists were integrated into existing family physician group practices as clinic team members to conduct medication assessments of patients and work with physicians to resolve patient medication-related issues. It was while working on this research project that I first learned of the Ontario provincial government's intention to create Family Health Teams. This announcement generated a great deal of excitement among my

colleagues on the research team, as it meant that their research could contribute to this process, and showed further support for their strong belief in the potential benefits of interdisciplinary primary care teams.

My work experience on the IMPACT project proved very valuable in doing this project as I have some familiarity with the structure of FHTs and have contributed to several research articles outlining some of the issues encountered in their implementation, as well as the challenges and successes in developing interprofessional working relationships within these entities (e.g., Pottie et al., 2009; Pottie et al., 2008; Farrell et al., 2008). While this work experience gave me insight into issues occurring at the level of individual health practitioners and two family medicine practices that eventually became FHTs, I found myself very curious about the bigger picture. I was interested in several questions: What higher level political processes were behind the decision to introduce Family Health Teams, in particular, as a model of interdisciplinary primary care? Were the tensions I witnessed between professional viewpoints with regard to teams at the more immediate level of my work experience reflected at the political level of the professions? These questions informed my research foci and analysis. Thus, my statuses as an experienced research worker in the area of primary care transformation in Ontario, and as a sociologist with an interest in professions have shaped my interpretations of the data. Finally, the extensive literature reviews I have done on this topic for my comprehensive exams and this dissertation will have had a similar effect.

Modified/Limited Situational Analysis

As noted in Chapter One, I executed this study drawing on the techniques and assumptions of situational analysis, an approach developed by Adele Clarke (2005). I

noted how this approach, with its emphasis on grounded theory techniques, on identifying collective actors (who comprise a social world) and debates among these, and attention to the effects of history and discourse was well suited to the task of explicating complex situations, such as the development of interdisciplinary primary care teams in Ontario. However, the strengths of situational analysis are also weaknesses. Treating the situation of interest as the unit of analysis, the use of grounded techniques, and the focus on explicating complexities and multiple viewpoints, can easily allow projects to become too large, a problem that Clarke herself acknowledges (2005, p. 111). Given limited time and funding, I had to set limits right from the start. First, Clarke says one should identify *all* social worlds important to the situation before embarking on analysis, lest an unobserved but powerful social world be left out (2005, p. 112). While I watched for these, I stayed focused on two social worlds: the provincial government and health professions. In studying these, I account for two of the most influential social worlds in this situation.

Further, I had to set limitations within social worlds. Within my examination of the health professional social world, I chose to focus on particular professions and, in some cases, specialties within professions. These were family medicine, nurse practitioners, dietetics, and chiropractic. My choice of these was guided by both theoretical and practical reasons. I chose family medicine because this would be the branch of medicine most affected by primary care reform, and because I was curious about the effect of the movement toward interdisciplinary teams on medical dominance. I chose nurse practitioners because of that profession's long struggle to be recognized by the government. I chose dietetics because it was one of the original professions approved by the government to be part of FHTs. Finally, I chose chiropractic because it was not one of the professions originally approved by the government for FHTs, and because of

its historically contentious relationship with the medical profession (Coburn & Biggs, 1986). Further, because of the lack of literature studying interdisciplinary teams at the macro-level, I decided to focus on the professional associations and regulatory bodies of these professions.

In addition to focusing on collective actors pertinent to a given situation, Clarke (2005) also provides a framework for identifying other potentially important elements. These include influential individuals; political and economic elements, temporal and spatial elements; major issues/debates; non-human elements; silent/implicated actors; sociocultural/symbolic elements; and discourses (Clarke, 2005, p. 90). Given my interests and time constraints, I chose to focus on some situational elements more than others. While I noted influential individuals, temporal and spatial elements, non-human elements, and sociocultural/symbolic elements, and how these tied into the situation, my main situational elements of interest for this project were political and economic elements, major issues/debates, silent/implicated actors, and, most importantly, discourses.

In addition to setting limits on which elements to study, I modified Clarke's recommended procedures for conducting analysis, particularly the mapping-on-paper exercises. Instead of mapping elements of the situation and relations among these on paper, I used a qualitative data analysis program, MaxQDA, to code my data for situational elements and relations among these. This was aided by the program's memo function, which allowed me to make notes about codes (this is where I wrote about relationships to other codes) and the option to label codes by colour, which helped to easily identify certain codes as constituting a particular type of element (for example, the black code signified discourses and discursive strategies). I consider my open coding

process in MaxQDA for my various datasets as my “messy maps”. While this approach does not reflect Clarke’s ideal of representing the situation cartographically in a literal sense (Clarke, 2005, p. 25), I nonetheless followed her advice about purposely delineating the complexity and inherent messiness in the situation. My open coding procedures reflected these goals, in that I did not pursue the usual grounded theory approach of coding to reduce data with the ultimate goal of outlining one coherent social process (Clarke, 2005, p. 25; Holton, 2010, p. 277). Rather, I coded segments of text in order to note differences in viewpoints in the data (as per Clarke, 2005, p. 128); my goal was to ensure that the variation and complexity in talk about interdisciplinary primary care teams in the data was easily identifiable and retrievable for further analysis. However, I was also careful to note how some groups agreed upon, or used the same discourses. While this resulted in many codes, I found these very useful for subsequent discourse analysis, which focuses on explicating variation in the data, and for noting how some discourses are used by everyone.

Data Sources

I used two primary sources of data to do this project: existing texts and interviews.

Textual Data Collection

Textual data comprise the bulk of the data used for this project. Three-hundred eighty three texts were analyzed. The search for textual data was conducted online, as the provincial government, professional associations, and regulatory bodies of the professions I studied had well-developed websites that included news releases, newsletters/communiqués, frequently-asked-questions, policy documents, and position statements. These data were helpful in analyzing discourse produced at the organization level and used in a non-interactive setting (i.e., when only one group is speaking about or

producing text about interdisciplinary primary care teams). Textual data also included provincial legislative debates and legislative committee minutes, in order to examine how discourses about interdisciplinary primary care teams work in a more interactive setting where multiple groups discussing them are present. These two broad approaches to data collection allowed me to examine how the provincial government and health professions produce their particular discursive versions of interdisciplinary primary care teams, as well as seeing how those discourses play out in social interaction, two approaches to discourse analysis outlined by Clarke (2005, p. 155).

Wherever possible, and wherever the amount of potential data sources for a particular entity (e.g., the provincial government) proved very large, I identified and collected textual data employing systematic searches for texts containing relevant keywords. Using systematic keyword searches helped to ensure both efficiency and comprehensiveness in my search for relevant texts. The keywords I used in my searches included: interdisciplinary, inter-disciplinary, multidisciplinary, multi-disciplinary, interprofessional, inter-professional, family health team, community health centre, and nurse practitioner-led. The first six terms reflect the terms used in the literature to refer to the phenomenon of different professions working together to provide care (as noted in Chapter Two). The last three are the team models of interest in this project. The terms collaboration and collaborative were also used at first, but were dropped because the term produced too many unrelated results, and where results were relevant to my topic, these were already associated with the terms interprofessional or interdisciplinary anyway. Where data sources were smaller and not searchable, materials were reviewed for their relevance.

Though I used this systematic approach for locating texts, I did not use every returned result, as one would do in performing a quantitative content analysis (Neuendorf, 2002, p. 14; Potter & Wetherell, 1994, p. 52). Rather, I employed a purposive sampling strategy of the search results appropriate to my research goals and to qualitative analysis. I reviewed each resultant text to determine how the search terms were being used. I then selected texts for their relevance in helping me to make meaningful comparisons and to help me answer my research questions (Mason, 1996, p. 94, 96). This approach provided me with both a wide variety of views about, and an in-depth understanding of, interdisciplinary primary care teams (Clarke 2005, p. 186). I excluded texts that used the search terms simply in passing or in a way not relevant to my project¹³.

Textual data collection and analysis was conducted over a series of months. I kept a diary of the textual data collection and analytical process, which tracked the date searches were done, where I searched for data, what search terms I used, and decisions I made along the way to include or not include particular avenues of investigation or particular texts. The iterative nature of this process allowed me to develop a complex understanding of the situation; as the data accumulated, areas of my dataset that required further development became clear, prompting me to sample further in areas not previously explored. While some of these sampling processes led to dead ends, others proved useful. The diary also served as a reflexive research tool; I made notes about breakthroughs, uncertainties, questions raised by the process, and how the data I was collecting was expanding on my existing knowledge of the topic.

¹³ In legislative debates, for example, using these search terms sometimes brought up results that were related not to health care, but to another area of concern, such as provincial infrastructure.

Textual Data Analysis

The textual data were analysed in three different ways, relating to the goals of my project and following broad guidelines suggested by Clarke (2005) for conducting a situational analysis. First, texts were analysed for basic information that helped me further understand and situate interdisciplinary team-based care in Ontario. As outlined earlier, I identified situational elements of interest, focusing mainly on political and economic elements, major issues/debates, silent/implicated actors, and discourses. Identifying these basic elements helped to determine who and what the major components of the situation were, and to consider potential relationships between elements (Clarke, 2005, p. 87).

Second, along the lines of Clarke's suggestion for social worlds/arena analysis, I analysed the texts for evidence of how the groups of interest oriented themselves toward interdisciplinary primary care teams, what sorts of action they took toward these, and how they committed themselves to this form of health care. Evidence of commitment and/or action included things such as statements of commitment (as in "we are committed to/we approve of/we believe in") or evidence of an organization's participation in an activity promoting teams, such as writing policy manuals outlining how interdisciplinary care teams could operate in Ontario.

Finally, I analyzed how discourses were used by each group, and across groups, within these texts to discuss, shape, and justify the various forms interdisciplinary primary care teams take, or should take. This was done using a form of discourse analysis that matched my theoretical understandings of discourse. I understand discourses as systems consisting of statements, symbols, images, or other forms of communication that cohere to produce meaning and knowledge about a given topic (Gavey 1989, p. 464;

Clarke, 2005, p. 148). Discourses both constitute individual subjectivity and order social life (hierarchically), including its material aspects (Jaworski & Coupland, 1999, p. 3; Potter & Wetherell, 1994, p. 47; Gavey, 1989, p. 464). Discourses delimit what is possible to know, think, or act in regards to a given topic (Clarke, 2005, p. 54; p. 160). Some discourses may be dominant, in that they are far reaching, "...constitut[ing] the subjectivity of most people most of the time (in a given place and time)" (Gavey, 1989, p. 464), and produced and perpetuated through institutional systems such as law, media, and education (Clarke, 2005, p. 54). According to Gavey (1989), dominant discourses "...seem 'natural', denying their own partiality and gaining their authority by appealing to common sense" (p. 464). However, alternate discourses are possible, and compete with dominant discourses (Gavey, 1989, p. 464; Lawes, 1999, p. 18).

Experts in discourse analysis generally agree that there are no standardized procedures for its execution (Potter & Wetherell, 1994, p.55; Wood & Kroger, 1995, p.88; Gavey 1989, p. 467). However, there are some basic techniques commonly used as starting points. Techniques I used for recognizing discourses at work included watching for variations in definitions of, descriptions of, or variety of meanings associated with interdisciplinary primary care teams, to determine the full range of views of this form of health care for comparison with each other (following Potter & Wetherell, 1994, p. 48, and Gavey, 1989, p. 467; and Clarke, 2005, p. 150). As well, I read texts closely for categories (of people or things) being constructed and used by the speakers (Potter & Wetherell, 1994, p. 58; Elizabeth, 2000, p. 93). As well, following Potter and Wetherell, I noted incidences of contradiction or inconsistency in texts, as these are often sites of multiple (and competing) discourses at work in one location (1994, p. 55) that can subsequently be analysed.

I also watched for common patterns indicating dominant discourses, or discourses competing for dominance. These included watching for claims to truth, or true forms of interdisciplinary primary care teams (or related items) (following Clarke, 2005, p. 262, p.151), and for the ways that dominant discourses attempt to naturalize their conception of a phenomenon by making appeals to common sense, fairness, objectivity, or the naturalness of that particular view (Gavey, 1989, p. 464; Potter & Wetherell, 1994, p. 60). Similarly, given my interest in the debates about interdisciplinary primary care teams between groups with diverse and competing interests (particularly the various health professions involved), I also employed a technique similar to Potter and Wetherell's (1994) approach. This entailed watching for rhetorical techniques used by people to construct a discursive version of a topic designed to be persuasive and to successfully compete with an alternative (Potter & Wetherell, p. 48). I paid attention to how a discourse is "organized to make argumentative cases and for the way it is designed to undermine alternative cases" (ibid, p. 59), and how it might bring to the fore "... a particular terrain for dispute into existence and ignore or eliminate other potential terrains (ibid, p. 63)."

Interview Data

Interviews with key informants were conducted to supplement textual data analysis. As with the textual data, interviews were analysed for general information contributing to my understanding of interdisciplinary primary care teams in Ontario, for outlining perspectives from the point of view of particular social worlds, and for how discourses about this phenomenon are used. Interviews were especially useful for gaining deeper insight into the perspectives of a given social world, contentious issues in the situation, and for garnering both practical details and interesting insider insights not

available from the textual data about “how things work” in the Ontario health care system with regard to interdisciplinary primary care teams.

Interview Participant Recruitment Procedures and Challenges

Potential participants were approached based on their position and/or membership in the government or professional social worlds, and for their knowledge of or involvement in interdisciplinary primary care teams and/or primary care reform in Ontario. Recruitment efforts focused mainly on professional organization leaders and government officials/high-ranking bureaucrats. Focusing on leaders was a strategic move in order to ensure maximum insider knowledge, experience, and clarity on organization viewpoints. However, given difficulties in the recruitment process (explained below), I also took opportunities to interview other types of people involved in (or knowledgeable about) the interdisciplinary primary care scene as they arose. These included: front line workers involved in interdisciplinary care teams, some of whom were pioneers in their professions in this type of work; a representative of a citizen’s health coalition; and a worker from an umbrella organization representing one of the three models of interest in this project. Participants were located using a number of techniques, all of them non-random and purposive, including: the results of the textual analysis; searches of the websites of relevant organizations; referrals from my personal contacts; attendance at an international Community Health Centre conference in June 2011 in Toronto; and referral from other participants.

There were some difficulties with recruitment of interview participants. Given that I was focusing on organizational leaders in government and health professions, some of these difficulties undoubtedly owed to the special challenges of studying elites. Many potential participants I contacted simply did not respond, despite multiple attempts

through both telephone and email. This is possibly a function of issues in studies of elite populations that have been noted in the literature, such as extremely hectic schedules (Thomas, 1995, p. 27) and wariness of, or lack of interest in, social research (Dexter, 1970, p. 113; p. 136; Hirsch, 1995, p. 77; Gamson, 1995, pp. 88-89).

Interviewee Characteristics

I conducted a total of fifteen interviews. At the start of each interview, I asked participants basic questions about their background and experience, both to ease into the interview and to gain a better understanding of how they fit into the broader context. Educational attainment varied from no formal training related to their role (1), to undergraduate degrees (2) to professional/graduate degrees (12). Disciplines/areas of study included: law (2), public administration (1), business administration (1), medicine (2), political science (2), dietetics (3), pharmacy (1), and nursing (2). Amount of experience in/with the Ontario health care system ranged from less than 5 years to more than 20 years. Participants' roles in the system varied, and included policy analysts or advisors in organizations (4), organization leaders or executive staff (7), and currently practicing front line professionals involved in some aspect of interdisciplinary primary care teams (6). Some held more than one of these roles concurrently, while others had held them separately over time, which explains why these latter numbers do not add up to 15.

Interview Techniques

Interviews were conducted exclusively by telephone, in order to prevent the problems cited in literature about interviewing elite participants in person, namely that interviews were frequently interrupted by their telephones ringing, or their attempts to multitask while being interviewed (Odendahl & Shaw, 2002, p.305; Conti & O'Neil,

2007, pp. 71-72). As well, telephone interviews allowed for flexible scheduling. Possible limitations in my using telephone interviews include missing out on body language cues, and limiting the opportunity to build a sense of trust and rapport that might more easily occur in a face to face interview.

Participants were not interviewed as individuals for their personal views and opinions (though these were occasionally offered, with their caveats), but rather as members of their respective social worlds, representing its collective views, opinions and positions about interdisciplinary primary care teams. Interviewees were very cognizant of their positions, and were very careful to distinguish any individual opinions they had from those of held collectively in their respective social worlds. Interview guides specific to each social world were used during the interview. Questions common to all participants included elaboration of their experience, role, or involvement with interdisciplinary care teams in Ontario; descriptions of processes related to the development of teams; the agreements and contentious issues they witnessed or had knowledge of with regard to teams, and their organization's perspectives regarding Family Health Teams, Community Health Centres, and Nurse Practitioner-led Clinics. Opportunities to pursue interesting points were taken.

The interviews ranged in duration, with the shortest being 34 minutes and the longest 65 minutes long, and the majority (8 out of 15) being 45 minutes or longer. All participants agreed to their interview being digitally recorded. I transcribed all of the interviews from the digital recordings verbatim. Transcripts were reviewed by those requesting it, and clarifications to unclear parts (due to poor sound quality or telephone line interruptions) were made by the participants. The interviews were analysed in

MaxQDA as one dataset, using the coding and memo functions. Similar analytical techniques to those outlined for the textual analysis were used.

Ethical Concerns

Despite the high-ranking positions of many of the interviewees, some expressed concern about being identified. One participant, for example, stressed to me that the health care sector in Ontario was actually quite “a small world.” Another participant joked with me during the consent process that they were not worried about any consequences of the interview, except for losing their job. There was also considerable concern about how I might use the data, especially direct quotations, in the dissertation. Concerns were expressed about being quoted in a manner that would be offensive to those in other organizations or professions, or that might “get them into trouble” with their own organization. Some of the most interesting, controversial, and/or poignant points made in the interviews were, much to my disappointment, immediately followed by the words “please don’t quote me on that.” Another technique participants used to defuse controversial statements was to clarify when they were speaking personally, rather than from the perspective of their organization or profession. Given these concerns, I had to be very careful in how I used direct quotes and in how I described speakers so as to not make my participants identifiable. I have done all I can to prevent identification, and to use the interview data in a way that honors my promises to my participants.

Chapter Four

Government Social World

“...because health care, that most human of endeavours, is best when it's delivered by a team.” (George Smitherman, Minister of Health and Long-term Care, Ontario Legislature, February 15, 2005¹⁴).

Introduction

In this chapter I focus on the talk, the claims made, and the actions taken toward interdisciplinary primary care teams in the provincial government social world, which in this study consists of members of the ruling party (Liberals) and opposition parties (the Progressive Conservatives and New Democratic Party). The data sources for this chapter are legislative debates and telephone interviews with key informants. My data indicate two basic points of agreement among all parties: the need for primary care reform, with interdisciplinary teams seen as part of that reform; and the expansion of non-physician health professional roles as a necessary action to achieve reform. However, there is considerable disagreement about team composition and structure, about the governance of teams, and about actions taken by the Liberal government to implement their particular vision of primary care reform and teams. It is through the discussion of various team models that ideas about teams, communities, and the public are created, clarified, or limited; these are examined in this chapter. Also evident in the data is the struggle of all parties to claim a legacy in primary care reform and establishment of teams. In this social world, Family Health Teams (FHTs) are the most contentious model, Nurse Practitioner-led Clinics (NPLCs) are the least contentious model, and the Community Health Centre

¹⁴ Smitherman, 2005, February 15. See Appendix A for a full list of ministers and opposition critics for the Ministry of Health and Long-term Care spanning 2003 to 2011.

(CHC) model becomes increasingly marginalized and limited in its potential in the discourse on interdisciplinary primary care teams.

First, I provide some background about the Ontario political milieu leading up to and including the period of focus. Then, I outline the basic structure of the discourse around primary care reform in the Ontario Legislature, and investigate the points of agreement among all the parties. After a brief overview of the strategies employed by the Liberals for implementing teams as part of primary care reform, I delve into the details of each set of strategies, examining the main issues raised and points of interest with regard to teams. I also examine claims about communities and the public in the discourse about implementing interdisciplinary primary care teams, and how teams are used as a justification for certain actions taken in the Liberals' plan for primary care reform. I finish with a brief discussion of some key findings and their implications, particularly with regard to the most contentious model, the FHT.

Primer on Ontario Politics

Governments and Leaders (2003-2011)

On October 2, 2003, Dalton McGuinty's Liberals formed a majority government, winning 72 of Ontario's 103 seats and unseating the Progressive Conservative Party which had held the majority since 1995 (Ontario. Elections Ontario, n.d., "Composition of Legislature"). The Progressive Conservatives, under Ernie Eves, formed the official opposition with 24 seats (ibid). The New Democratic Party, with Howard Hampton as leader, held 7 seats (ibid). The Liberal Party continued to hold a majority of seats in the 2007 election, but was reduced to a minority government in 2011 (ibid). The Liberals had one leadership change in 2011, when Dalton McGuinty resigned and minister of agriculture Kathleen Wynne became premier (Ontario. Legislative Assembly of Ontario,

n.d., “Kathleen O. Wynne”). The Progressive Conservative Party has been the official opposition since 2003, and have had three leaders since Ernie Eves resigned in 2004: Bob Runciman (2004-2005 and 2007-2009), John Tory (2005-2007), and Tim Hudak (2009 onward) (Ontario. Legislative Assembly of Ontario, n.d., “Robert (Bob) Runciman”; *ibid*, “John Tory”; *ibid*, “Tim Hudak”). The NDP maintained third party status, and changed leadership in 2007, from Howard Hampton to Andrea Horwath (*ibid*, “Howard Hampton”; *ibid*, “Andrea Horwath”).

Previous Government Approaches (1990-2003)

As will be shown in this chapter, the parties share in common a commitment to enacting primary care reform and better utilizing health human resources. However, there are some distinctly partisan approaches to interdisciplinary teams and primary care reform from two previous governments worth noting, as these reflect in their critiques of the Liberals’ approaches subsequently described in this chapter.

The NDP, in power from 1990 to 1995 under Bob Rae’s leadership, favoured the CHC model during their tenure, nearly doubling the number of CHCs in the province from 29 to 56 (Suschnigg, 2001, p. 96; Johnston, 1999, p. 59). Community governance and involvement was seen by the government as an important feature of the model (Johnston, 1999, p. 58). They also froze funding for Health Service Organizations, a capitation-based and physician-governed model of primary care team introduced by the Progressive Conservatives in 1982¹⁵, as these were less focused on client empowerment, community development, utilizing non-physician professionals, and less cost effective than CHCs (Suschnigg, 2001, p. 95; Johnston, 1999, p. 61). There was also a marked

¹⁵The Health Service Organization model was introduced alongside the CHC model in 1982 by Progressive Conservative health minister Larry Grossman (Suschnigg, 2001, p. 92).

shift in this period toward government appreciation of the effects of broader social factors such as unsafe working conditions, poverty, racism and sexism on health (Suschnigg, 2001, p. 95). Faced with a recession and the need to reign in health care costs, the NDP introduced caps on physician spending, set limits on medical student seats in universities in the province, and limited postgraduate medical training placements (Coburn et al, 1997, pp. 9-10). In sum, the NDP's approach during the recession years of the early 1990s consisted of cost-containment strategies focusing on rationalizing physician care, focusing on community-governed primary care teams, and increasing focus on the social determinants of health.

The Progressive Conservatives, in power from 1995 to 2003, under the leadership of Mike Harris until 2002, and Ernie Eves until 2003, also faced pressures to reign in health care costs. A significant part of their strategy was to rationalize health care services through hospital closures and consolidation (Suschnigg, 2001, p. 98). The PCs also made two major moves regarding interdisciplinary teams. First, they froze funding for CHCs between 1996 and 1999, eliminated funding for the Association of Health Centres of Ontario (the CHC advocacy organization), cut the budgets of CHCs by 5%, and initiated a review of CHCs for cost-effectiveness (Association of Ontario Health Centres, n.d., "Our History"; Johnston, 1999, p.64). Second, they developed their own models of primary care team. These included the Family Health Network (FHN) model, a capitation-based model of physician group practice, and the Family Health Group Model (FHG), a fee-for-service physician group practice model (Health Force Ontario, 2007, pp.46-47)¹⁶. The development of these models was done with extensive consultation

¹⁶ Please see Appendix B for the differences between the Family Health Network, Family Health Group, and Family Health Team models.

between the OMA and the government (Ontario Medical Association, 2001, n.p.), in contrast to the expansion of CHCs during the 1990s. Finally, it is worth noting that the PC government tended to focus on promoted preventive health measures that focused on modifying individual behaviours and preventive screening for diseases, rather than on broader social factors (Suschnigg, 2001, p. 98). In sum, the Progressive Conservatives favored team models and approaches that maintained physician control of resources, and preventive approaches that focused more on modifying individual behaviour, rather than social conditions.

Agreement on Primary Care Reform, Teams, and Role Expansion

The discussion of interdisciplinary primary care teams in this social world is closely intertwined with discussions of primary care reform¹⁷. My data indicate that all the political parties in the legislature during the McGuinty era (starting in 2004) agreed on the need for primary care reform in Ontario. Statements supporting primary care reform came from all parties, and in the 209 sessions of legislative debate I reviewed, there were no instances of speaking out against the basic idea of reform.

Discussions of primary care reform in my data contained repetitive terms and catch phrases used by members of provincial parliament (MPPs) from all parties, suggesting that certain elements in discourse around primary care reform in Ontario had become well established. These generally focus on elements related to increasing efficiency, effectiveness, or availability of primary care services. For example, primary care should be available “24/7” or “around the clock” (Witmer, 1998, May 26;

¹⁷ The first archived use of the term “primary care reform” in the Ontario Legislature is June 19, 1994, by NDP Member of Provincial Parliament Robert Frankford. Digitally archived records of legislative debates in Ontario date back to 1986 (my searches of legislative debate data cover the period 1986-2010).

McGuinty, 2000, April 3; DeFaria, 2000, April 10; Leal, 2004, June 7; Martel, 2004, December 6). Primary care should be available “close to home” or “in the community” (Smitherman, 2004, October 14; Martel, 2005, November 24; Harris, 2000, April 4). It should expand services toward preventive as well as curative care (Martel, 2000, December 12; *ibid*, 2000, December 6; Barrett, 2002, May 23; Smitherman, 2004, June 9). Finally, it was noted that primary care could be provided by more than one type of health care professional (Boyd, 1998, May 26; Elliot, 2000, April 10; Smitherman, 2004, June 1), reflected in catch phrases such as “the right care in the right place at the right time” (Wilson, 1997, April 30), and “...the right number and mix of ...health care practitioners in the right place at the right time” (Balkissoon, 2009, May 25)¹⁸.

Some of these phrases in this broader discourse implicate interdisciplinary teams as part of primary care reform. For instance, the phrases about time imply the need for more than one professional working in a particular service delivery entity or geographic area in order to continuously cover a 24 hour period, 7 days a week (conditions that would be impossible for one provider to provide). The phrasing related to the possibility of more than one type of professional (as in the right care, the right mix of professionals) implies that some aspects of health care do not require a physician (the implied reference category), allowing other professionals to provide care. These two conditions, combined, implicate interdisciplinary teams as part of the conditions considered necessary for primary care reform.

¹⁸ The Liberal MPPs in this paragraph include: Dalton McGuinty, George Smitherman, Jeff Leal, and Bas Balkissoon. Progressive Conservative MPPs include: Elizabeth Witmer, Carl DeFaria, Michael Harris, Toby Barrett, Christine Elliot, and Jim Wilson. NDP MPPs include: Shelley Martel and Marion Boyd.

The discourse on primary care reform from the data in this social world not only implicates teams, but further paints the superiority of an interdisciplinary team approach compared to non-team approaches. Two examples follow:

More and more, best practice for dealing with chronic disease, more and more, best practice for dealing with most of the common elements of primary care, is better done in a group setting, called an interdisciplinary team, where all of the different providers work together to provide quality care (Gélinas, 2008, November 17).

Ontario's health human resources strategy... supports team-based care and interprofessional collaboration. Evidence shows that the benefits of this kind of approach are undeniable. They include improved patient outcomes, improved access to care, increased caregiver satisfaction and decreased turnover, and are a more effective use of our precious health care resources (Balkissoon, 2009, May 25).

In these passages, the speakers emphasize the increase in efficiency, effectiveness and access afforded by teams. There were no negative responses by any party about the perceived importance or benefit of team approaches to primary care.

Another long-standing point of agreement among all parties in the Ontario legislature relating to teams and to primary care reform was that non-medical health professionals were under-utilized. As shown in Chapter Two, discussions of the more effective use of non-medical health professionals precede the term primary care reform. These early discussions culminated in the Registered Health Professions Act (RHPA) in 1993, which gave 25 health occupations professional status in the eyes of the state, and removed exclusive scopes of practice by establishing thirteen controlled acts, many of which could now be performed by more than one qualified profession (Coburn et al., 1997, p. 12). In 1997, NDP member Frances Lankin described the history of passing the RHPA, which took considerable time and effort on the part of all parties in the legislature:

I remember one of the first challenges I had as Minister of Health was to deal with the regulated health professions legislation [the RHPA]. That was a package of statutes...that amended how certain health services, health providers are regulated, things like the College of Physicians and Surgeons and the College of Nurses and a whole range of other health care providers. That package of legislation saw three different governments working on trying to arrive at a consensus out in the field among all of the professions, three different governments and eight different Ministers of Health. That's how many it took to get the job done... There may have been a couple of crises that were left that had to be sorted out between certain groups or professions around scopes of practice, but by and large, the work had been done over years by previous governments: by Tory governments, by Liberal governments and finishing up by our own [NDP] government (Lankin, 1997, June 19).

It is thus not surprising that there was all-party agreement about overlapping scopes of practice, given that so much time and effort on the part of all parties was needed to achieve the goal.

The idea that non-medical role expansion might specifically promote collaboration between health professionals also preceded the tenure of the McGuinty Liberal government. In 1997, when the Progressive Conservative (PC) government sought to pass legislation expanding the role of nurse practitioners, Health Minister Jim Wilson stated:

Today's initiative is just one example and just one part of our vision for health care reform. Once passed, the Expanded Nursing Services for Patients Act will legally recognize nurse practitioners and will enable them to practise [sic] to their full potential within a multidisciplinary health team. Nurses play a valuable role in our health care system, and this legislation recognizes their contribution in providing care to patients... We believe our actions will lead to better collaboration between nurse practitioners, family physicians and other health providers, which means better all-round care and enhanced services for more patients. This will support our government's vision for quality health care in Ontario, providing the right care in the right place at the right time (Wilson, 1997, April 30).

This hope continued into the tenure of the McGuinty Liberal government. Statements from all parties about the need to better utilize the skills of a variety of health practitioners continued. For example, NDP MPP Gilles Bisson stated:

We need to constantly try to figure out ways of making the system work better. I think one of the ways we do that is to challenge the people within the system and we here in the Legislature to really think about how we can deliver services in a more effective manner and at the best possible price... We need to do a better job of figuring out how to use all the people in the health care system as part of the solution to provide people the services we need -- everybody from pharmacists to nurses to nurse practitioners to physiotherapists, all of them. All have a role to play with doctors to provide that service (Bisson, 2007, March 21).

Role expansion for non-medical health professions was thus a long agreed upon course of action to improve access to care and to enhance the consensual goal of increased collaboration among health professionals.

However, action toward continued expansion of non-medical professional roles came in 2009, well after the Liberal government introduced 224 interdisciplinary primary care teams in the form of 150 FHTs in 2004, 49 CHC/CHC satellites¹⁹ in 2005, and 25 NPLCs in 2007. Role expansion was achieved primarily through Bill 179, the Regulated Health Professions Amendment Act. Among the many changes to existing legislation wrought by this bill, the most relevant here are that it expanded the scopes of practice of six regulated health professions in Ontario to include access to controlled acts previously not held by those professions (Ontario. Ministry of Health and Long-term Care, 2012d²⁰, n.p.); removed restrictions for administering, prescribing, dispensing, selling and using drugs in practice for nine regulated health professions (ibid)²¹; allowed x-rays to be

¹⁹ First introduced by the Progressive Conservative government in 1999, a CHC satellite is an outpost of an established CHC (Association of Ontario Health Centres (Association of Ontario Health Centres, n.d. a, "Our History"),

²⁰ These were nurse practitioners, pharmacists, physiotherapists, dietitians, midwives and medical radiation technologists.

²¹ These were chiropodists and podiatrists, dental hygienists, dentists, midwives, nurse practitioners, pharmacists, physiotherapists and respiratory therapists.

ordered by nurse practitioners and physiotherapists (under certain conditions) (ibid); removed all restrictions for nurse practitioners with regard to prescribing (College of Nurses of Ontario, n.d., “FAQ: Bill 179”), and stipulated that all regulated health professionals carry liability insurance (Ontario. Ministry of Health and Long-term Care, 2012d). Further, the legislation stipulated that the “[q]uality assurance programs [of the professional Regulatory Colleges] would be strengthened by adding a mandatory component for continuing education and professional development related to interprofessional collaboration” (Balkissoon, 2009, May 25).

Bill 179 was presented by the Liberal government in Legislature specifically as a means of promoting teamwork, among other claims:

Our proposed legislation would increase access to care for Ontarians. It would allow for more efficient health care services, more providers working together in teams and an enhanced regulatory system that would increase patient safety (Balkissoon, 2009, May 25).

All the parties agreed on the need for Bill 179²², continuing the historical precedent set with regard to role expansion.

Despite this overall agreement, some concerns about the bill were raised. PC member of provincial parliament (MPP) John O’Toole wondered if the expansion of roles of non-medical health professionals working in team settings (including FHTs) would necessitate billing codes through the Ontario Health Insurance Plan, and cited this as a potentially significant source of conflict between nurse practitioners and physicians:

²² Endorsement of the bill by the PCs was voiced in Legislature by Elizabeth Witmer (Witmer, 2009, May 25) and John O’Toole (O’Toole, 2009, May 25). NDP endorsement was voiced by France Gélinas (Gélinas, 2009, May 25) and Paul Miller (Miller, 2009, May 25).

...all three parties have the same objectives, of working towards collaborative health. The problem is, who gets the money? In other words, if you don't give a billing code to the nurse practitioner, if you want the nurse practitioner to work in a subordinate role to the doctor, you're going to have a problem here, Houston, because it's all power and control, and it comes down to the money; it really does. If they get part of the OHIP piece, the \$8 billion or \$9 billion in the OHIP fund-it must flow through the doctors' group (O'Toole, 2009, May 25).

Sylvia Jones, another PC MPP, expressed concern that the emphasis on role expansion for non-physician health professionals would detract attention from the need to hire more physicians in the province (Jones, 2009, May 25). As well, concern over patient safety in the wake of role expansion was expressed by PC MPP Elizabeth Witmer (Witmer, 2009, May 25). Both NDP MPPs (France G linas and Paul Miller) and PC MPPs (Elizabeth Witmer and John O'Toole) raised concerns in the Legislature that the bill did not cover some regulated health professions that had appealed over the years to have their scope of practice expanded or to be allowed to work in primary care teams (G linas, 2009, May 25; Miller, 2009, May 25; Witmer, 2009, May 25; O'Toole, 2009, May 25). However, only the exclusion of chiropractic was mentioned specifically (Miller, 2009, May 25).

The repetitive phrases in discussions of primary care reform in this social world allowed me to identify the explicitly agreed upon conditions of primary care to be met, and an approved means for meeting them through teams and non-medical role expansion. However, I came to realize that what was missing in the commonly used discourse about primary care reform was just as important, and could account for many of the disagreements I saw in the data for this social world. There were no agreements about which health professionals should minimally comprise teams, how the labour of teams should be organized, how they should be implemented, or who should govern teams. It is in these less defined spaces in the discourse about primary care reform that controversy,

disagreement, and new possibilities for specific forms of teams arise. These are examined in the remainder of the chapter.

The Liberals' Strategies for Implementing Teams: An Overview

Since coming to power in October 2003, the Liberal government made three major investments in interdisciplinary primary care teams as part of their broader plan for primary care reform²³. These were: the introduction of 150 Family Health Teams (FHTs), announced in the Throne Speech of November 2003; a major expansion of the already existing Community Health Centre (CHC) model starting in 2005, and the introduction of Nurse Practitioner-led Clinics starting in 2007.

The financial investment in these models by the government varied, with the FHT model receiving the most financial resources overall. While the Liberals' \$300 million expansion of CHCs by a total of 49 entities (21 full CHCs and 28 satellites) constituted the single largest investment in CHCs in Ontario's history (Association of Ontario Health Centres, n.d., "Our History"), it paled in comparison to their \$600 million investment in 150 FHTs. NPLCs received \$38 million for a total of 25 entities (Arthurs, 2008, April 7). So, while the Liberals invested in a variety of team models, the FHT model benefitted most.

Introduction of FHTs

"Our Model"

In addition to devoting more material resources into the FHT model, the Liberals also invested in them heavily in a discursive sense, using a number of speaking strategies.

²³ The other investments they claim to have made at the community level are: long-term care, home care, public health, and mental health/addictions (Smitherman, 2004, June 3).

One strategy was to make FHTs the apparent flagship of their primary care reform efforts. FHTs were described by Liberal MPP Pat Hoy as the “...signature piece of our government's comprehensive plan to improve health care in Ontario” (Hoy, 2005, April 27). Similarly, Minister of Health and Long-term Care George Smitherman described FHTs as his party's “signature investment” (Smitherman, 2005, May 16; 2006, October 18) in primary care reform, and as “our model” of primary care reform (ibid, 2005, March 30; 2004, November 17), clearly demarcating FHTs as the Liberals' special brand of interdisciplinary primary care team.

Second, FHTs were explicitly linked to a commitment made by the Liberals in their first throne speech, delivered by Lieutenant Governor James Bartleman, to maintain the publicly funded health care system and to enacting primary care reform in Ontario. He stated:

Your new government understands that money alone will not save medicare. Nor will legislation alone. Real, positive reform is needed, starting with primary health care. It will keep its commitment to improve primary health care through the creation of family health teams, made up of health care professionals who will protect and promote the health of Ontarians. These teams will ensure patients get care closer to home and health care dollars are wisely spent. Your new government understands that promoting good health is as important as treating illness (Bartleman, 2003, November 20).

Here, the main elements of primary care reform are addressed: team-based care, with both curative and preventive approaches, and the care located close to users' homes. The commitment to these elements is further touted as “real” and “positive” reform, implying past efforts were insufficient.

As well, the Liberals also explicitly linked the FHT model with Roy Romanow, the commissioner of the oft-cited 2002 Royal Commission entitled *Building on Values: The Future of Health Care in Canada* (commonly known as the “Romanow Report”). As

noted in Chapter Two, the Romanow Report recommended interdisciplinary teams as a way of strengthening health care systems. An example follows of the Liberals explicitly linking FHTs to the Romanow Report:

I want to tell you briefly about our Plan for Change, a bold four-year plan to transform health care in Ontario. It is inspired by the idea advanced by *Roy Romanow and many others* that health care is the most essential public service. Our Plan for Change puts Romanow's key ideas into action. What we are building in Ontario is a responsive, accountable, accessible health care system that serves the needs of all Ontarians... Our strategy is to drive vital health resources down into communities where they can do the most good. Over four years, we will create 150 family health teams, where doctors work alongside nurses, nurse practitioners and other primary care providers to deliver front-line care as close to people's homes as possible (Smitherman, 2004, June 9, my emphasis).

In presenting Roy Romanow (and others like him) as experts with valuable opinions, this speaking strategy was employed to lend extra credence to the Liberals' early claims around FHTs and primary care reform. This technique was also employed by the Liberals for other actions regarding teams, including their expansion of the CHC model, explored later in this chapter. This strategy was also used by the NDP to promote CHCs. I called this strategy in my coding "invoking health care giants"²⁴. In sum, employing the strategies outlined in this section, the Ontario Liberals are attempting to claim a significant legacy in primary care reform and interdisciplinary teams.

FHTs as Physician-centered Models

On balance, my data suggest that the Liberals intended FHTs to be a physician-centered model in terms of the division of labour and clinical leadership. At times,

²⁴ The Liberals invoked Roy Romanow, Monique Begin, Pierre Trudeau's "Just Society", Lester Pearson, and even Tommy Douglas. The NDP invoked Tommy Douglas and Stephen Lewis. The Conservatives did not invoke giants (there are fewer names to invoke from that party), but rather depended on their not inconsiderable track record on primary care reform starting in the late 1990s and into the 2000s to make claims regarding their contribution to primary care reform.

references to FHTs by the Liberals did not suggest any particular hierarchy in the team structure, as in this example:

What we're looking to do in communities is take a family doc, a nurse, a nurse practitioner, a pharmacist and other health care providers to work together and provide a team approach to individual Ontarians who are seeking out primary care (Smitherman, 2004, June 17).

More frequently in the data, however, the language is much more explicit about the role to be played by non-physician health professionals as “helping” physicians, as outlined in the examples below:

The beauty in this idea [Family Health Teams] is that doctors working in sole [sic] practice have limitations in terms of the number of patients they see. Doctors working in team practices with other helpers, like nurses, nurse practitioners and other health care professionals, benefit the patients by being able to see fully 52% more patients... (Smitherman, 2005, April 14).

Family health teams can actually help a doctor see up to 50% more patients, because they use the resources of nurse practitioners, nutritionists and other professionals within the family health team. So the doctor can make the diagnosis and then refer the patient to the appropriate medical professional in the family health team, thereby freeing himself or herself to see the next patient (Mossop, 2006, November 1).

The latter passage further shows that the major decision making process (diagnosis) remains firmly with the physician, who then delegates care to what they feel are the appropriate team member or members.

Issues raised in responses to the FHT model

FHTs are Just Rebranded PC Models

Responses from the opposition parties toward the Liberals' announcement of the FHT model were complex. They often contained a mix of praise for the efforts toward primary care reform and teams, and criticism of the FHT model or the manner in which these were implemented. Sometimes they also included their own claims to being the first

party to implement primary care reform. For instance, the Progressive Conservatives (PCs) argued a number of times over a five year period that the FHT model was nothing more than a “rebranding” of Family Health Networks (FHNs) and Family Health Groups (FHGs), primary care entities that were established in the late 1990s and early 2000s when they were the government:

I'm very pleased that the Liberal government has seen fit to build upon the vision and the foundation for increasing access to medical care that our government put in place. As the Minister of Health [George Smitherman] knows, but doesn't want to acknowledge, it was our government that appointed the expert panel to undertake long-term planning to address Ontario's physician shortage. In fact, I'm very pleased to say that it was our government that introduced primary care reform -- the first province in Canada. This government continues to rebrand the same PC program, but I have to tell you that by the time September 2003 rolled around, we actually had 3,000 physicians in this province who had joined primary care models serving three million patients... So thank you for building on our model. If you want to give it another name, that's fine. We're just glad you're doing what you can to improve access (Witmer, 2005, May 16).

I just want to remind the government, because I saw a few people on the other side make a few comments, that it was our government, the Progressive Conservative government, that established multidisciplinary family health networks in collaboration with the Ontario Medical Association in 1998. These teams were part of our overall plan to improve access to care and to provide a continuum of care that began with health promotion and disease prevention... We also, by 2001, had established 12 family health networks in Ontario. They were rebranded "family health teams" by this [the Liberal] government in 2003 (Witmer, 2009, May 25).

PC MPPs also went so far as to appropriate²⁵ the term “family health team” from the Liberals when describing their own previous efforts at primary care reform (called Family Health Networks and Family Health Groups):

²⁵ A lexical search of my data indicates, however, that the earliest use of the term “family health teams” occurs for the first time June 19, 2002, when then Health Minister Tony Clement ridiculed Dalton McGuinty about the Liberals’ proposed family health team model (Clement, 2002, June 19). A search of the Hansard database for the term “family health teams” confirms this date as the earliest use of the term. The PCs’ claim that they established family health teams first is inaccurate (at least, in the most literal sense).

Of course, we have been advocating for interprofessional collaboration ever since we set up the family health teams, beginning back in 1997-98. Despite the fact that the government tries to take credit for the family health teams, it was our government that first established those. I can remember the first pilot projects that we set up—five to seven—around the province of Ontario, where we encouraged the doctors to start to work in collaboration with other professionals. We're pleased to see that this government did move forward with that approach. I think at the end of the day it helps to provide better access to care in the province of Ontario (Witmer, 2009, May 25).

The NDP also questioned whether FHTs were distinct entities from the PCs' primary care models (FHNs and FHGs), and further pointed out what they saw as the failure of the PC models to improve access to primary care, predicting the same fate for FHTs:

How many of the family health teams announced today are actually reincarnations of existing family health groups or family health networks that were established and funded under the previous Conservative government? **How many, in fact, are only conversions from FHGs and FHNs that were already in existence and that will essentially fail to provide any more care to any more people, because they have a similar structure?** How many of the ones announced today are actually physician groupings that were already in place? I raise this because in April 2005, when the government announced its first wave of family health teams, the minister had to admit to Canadian Press that, "Half of the first wave of family health teams will involve docs already working in group practices [i.e., FHNs and FHGs] switching over to a new model" (Martel, 2006, April 6, my emphasis).

While she does not overtly say it here, Ms. Martel's question (in bold, above), reflects a critique of FHNs and FHGs brought up in other instances of legislative debate and in one of my interviews (Interview 003): that FHNs and FHGs were never very "team-like", in that they mainly consisted of physicians and nurses only, with very little in the way of other health professionals²⁶ (Martel, 2001, December 12; Smitherman, 2006, April 6).

²⁶ This may be due to the fact that neither the FHN nor the FHG model provides any funding for compensating non-medical health professionals (as per Health Force Ontario, 2007, pp. 46-47), even though the model was intended to encourage physicians to work with other health professionals (Ontario Medical Association, 2001, n.p.).

There was validity to the accusation that some of the new FHTs were based on conversions of the PC models. Some already existing FHNs had indeed applied to become FHTs; NDP MPP Shelley Martel noted in legislature that fourteen FHTs were in fact FHNs that switched over (Martel, 2006, April 6). This is because the Liberal government decided to fund the FHT model in two parts (Interview 005; Interview 007; Interview 012). The first part of the funding deals strictly with physician compensation, and the second part is a funding envelope that pays for the remaining health care providers (ibid). To become a FHT, there must first be a physician group practice model based on a capitation model of payment, such as a FHN²⁷, in place in order to apply for FHT status which would consequently provide the funding envelope for the non-medical health professionals (ibid). This split payment structure between physicians and the remaining interdisciplinary providers is confirmed in the Health Force Ontario *Health Human Resources Toolkit* (2007, p. 48). The exception is the community FHT model (CFHT), where physicians and non-physicians alike are paid on a salary basis (Association of Ontario Health Centres, n.d., “Community Family Health Teams”).

Interestingly, the fact that FHTs are based on physician group practice structures, including FHNs, does not appear to be addressed by the Liberal party in the legislative debate data. Rather, in response to the critique that FHTs were no different from FHNs or FHGs, Liberal MPPs counter-argued that FHTs were definitely unique from those models. Their two main strategies were to claim a more interdisciplinary model than the FHN and FHG models, and to claim that communities would be able to choose the

²⁷ The other eligible group practice model is the Family Health Organization (FHO), which was introduced by the Liberal government in 2006, when it transformed 48 Health Service Organizations (HSOs) and 12 Primary Care Networks into physician group practices (Health Force Ontario, 2007, p. 48). Prior to this, HSOs could consist of solo practice physicians, a form of physician practice that both the PC and Liberal governments of the past 20 years have attempted to reform into group practice for the cost savings it brings.

services, depending on the need (however, as I will demonstrate later, this claim is often ambiguous and in some instances even contradicted by the Liberals themselves). For example:

The honourable member from Simcoe-Grey [Jim Wilson, PC] is pretending that he's the father or the grandfather of family health teams, but nothing could be further from the truth. Our model is distinct, because it's going to provide communities with the opportunity to tailor a team of health care professionals to meet the population needs that are found in those communities (Smitherman, 2004, June 17).

The argument that FHTs were just a rebranding of FHNs and FHGs was used by opposition parties as late as 2009, well after the first FHTs were established. One Liberal MPP finally distinguished the two entities by name in 2009, highlighting the greater degree of interdisciplinarity of FHT teams compared to FHNs and FHGs.

I just want to add to comments [earlier this session] by the member from Durham [John O'Toole, PC] and clarify something, because it was mentioned by many of the previous speakers: this comparison between family health networks and family health teams. Family health networks existed when the Conservative government was in power, and I'll tell you what a family health network is: A family health network is a group of physicians who work as a network, along with a nurse-staffed after-hours telephone advisory service, to provide primary care for their patients 24 hours a day, seven days a week. The networks emphasize illness prevention and comprehensive care for patients. Let me tell you what this government's proposal for a family health team is. Family health teams are groups of health care professionals, such as physicians, nurse practitioners, nurses, social workers and dietitians, who work together to provide primary care for a group of patients. They provide a wide range of services, including health promotion, treatment services, chronic disease management, and prevention, rehabilitation and palliative care. They are available nights and weekends to provide health advice and care, so that their patients do not have to go to a busy hospital emergency department for non-emergency care. They also help their patients navigate their way through other parts of the health care system to receive the best possible care. As you can see, this government's proposal and strategy on the health care system is more complex and extensive compared to what was there before (Balkissoon, 2009, May 25).

This argument thus distinguished FHTs as a form of team beyond physicians and nurses (as was mostly the case with FHNs and FHGs), and highlights the assumption underpinning the term “team” implying more than two types of health professionals.

Why Not CHCs?

The NDP issued another challenge to the Liberals with regard to the introduction of the FHT model, in asking why the long-established CHC model was not pursued as the main model of interdisciplinary primary care team:

For the life of me, I don't understand why the government doesn't use a model that has been effective, that has worked, and just expand the number of community health centres in Ontario in order to respond to community needs. That would make sense... What's interesting is that about four years ago, the Ministry of Health did an internal review of community health centres to determine how they were functioning in the province. I can tell you that the results of that review were very positive. This was done by the Ministry of Health itself. On every level, the ministry concluded that community health centres do respond effectively and fully to the primary health care needs of Ontarians. Why on earth, in the face of a review that is now four years old and that clearly shows how important and effective CHCs are as a model for primary health care reform, would the government be looking to now another model to deliver primary health care in the province? It makes no sense (Martel, 2004, December 6).

Here, Ms. Martel drew on evidence of past effectiveness of the CHC model as demonstrated by government research. The possibility of the CHC model being a widespread primary care model to meet the primary health care needs of “Ontarians” in general, and communities in general, was presented as an option. She also made an appeal to “sense,” positioning CHCs as the sensible option, and contrasted that to the unknown, untested FHT model, making these seem like a gamble or a bad investment (a nonsensical approach). Unfortunately, there was no response from the Liberals, as the Legislature moved on to new business.

In a similar strategy to the PCs, the NDP emphasized their claim to being the first to implement “real” primary care reform via interdisciplinary teams in Ontario by reminding the legislature that they were the first party to make a large investment²⁸ in CHCs:

I am pleased to respond on behalf of the NDP to the statement by the Minister of Health [of \$1.6 million to CHCs for diagnostic equipment]. The minister said in his press release, "Community health centres perform a unique and critically important function in our health care system." I wonder why he was at Regent Park Community Health Centre this morning and didn't announce a major expansion of community health centres in Ontario as the way to really push primary health care reform. I don't understand why this government continues to refuse to look at CHCs as a positive model to bring more doctors and health care professionals into the health care system to provide primary health care to Ontarians who need it. We know that community health centres are a proven model. They've been in existence in Ontario for over 30 years. I was pleased to be part of a government that created 23 new community health centres and 10 Aboriginal community health centres when we were the government, as a sign of the commitment by New Democrats to community health centres (Martel, 2005, February 15).

Again, Ms. Martel presents the long history and proven track record of the CHC model (the FHN, FHG, and FHT models had no such assessment to draw on at the time). She makes allusions to the CHC model being a model of “real” reform twice, though she does not elaborate how or why in this instance. Finally, she attempts to highlight the legacy of the NDP toward primary care reform in Ontario using their heavy investment in the CHC model as evidence. Again, there was no opportunity for the Liberals to respond, as the Legislature turned to new business in the agenda.

FHTs as Substitute for CHC Requests?

During this phase, the Liberals were asked by MPPs about specific requests for CHCs from their respective constituencies. While the Liberals announced their intention

²⁸ CHCs were first supported by a provincial government in 1982, under the PCs. And, prior to November 2005, the NDP was the party that had made the most significant investment in CHCs in Ontario's history.

to introduce 10 CHC satellites in November 2004 (Ontario. Ministry of Health and Long-term Care, 2004), the demand for CHCs was far greater. As a solution, Health Minister George Smitherman offered to give those communities that had requested a CHC first priority to be considered for a FHT instead:

The challenge we face, of course, is that 140 or so communities in Ontario are underserved from the standpoint of physicians. There are about 100 communities or so that have made application for either an expansion of their existing CHCs in the form of satellites or for new community health centres. I cannot confirm for the honourable member [Shelley Martel, NDP] that Sudbury will be on that list, but what I can tell the honourable member is that our commitment around family health teams will see the first 45 family health teams launched in fiscal year 2004-05, and that what we are seeking to do in the first class of applicants, if you will, is to reach out to those communities that have made application for community health centres, because we really want to, in a certain sense, reward the community effort that's gone into the development of those proposals. So I do think there is hopeful news out there for communities that have long been waiting for more access to primary care at the community level (Smitherman, 2004, October 26).

On several occasions, the Liberals tried to emphasize what they saw as the important similarities between the FHT and CHC models. When asked by John Baird (PC) why a CHC application had been denied for the Nepean area, George Smitherman replied:

...All the community health centres in Ottawa, like all other community health centres in Ontario, got a substantial increase [\$21 million] to their budgets. But way more than that, what we're in the midst of, as a government, is bringing forward family health teams, which find their roots in the interdisciplinary way that community health centres operate. In Ontario, before the end of this fiscal year, 45 additional communities will receive family health teams, and those that will have the first shot at these are the very same communities that have made application for community health centres. That's our commitment to meaningful primary care (Smitherman, 2004, November 15).

Instead of making any specific commitment to the Nepean area, Mr. Smitherman focused on the overall investment in CHCs to date by the Liberals. Subsequently, he emphasized

the significant investment in the FHT model (“way more than that”), claimed that the FHT model had “roots” in the interdisciplinary nature of the CHC model, and promised again that communities applying for a CHC would be first to be considered for a FHT.

Below, Minister Smitherman makes an even bolder statement, stating that FHTs and CHCs have the same “ideological roots”:

The honourable member [Howard Hampton, NDP] obviously has a difficult time grasping that family health teams find their ideological roots in the community health centre movement ... and that community health centres have helped to inform family health teams, which will be interdisciplinary (Smitherman, 2004, November 22b).

Again, Mr. Smitherman focuses on the interdisciplinary aspect as a key shared trait between the two models. However, his claim that the two models were born of the same social movement, is much weaker. CHCs, as Suschnigg (2001) notes, were partially the result of the feminist and labour social movements of the 1960s and 1970s. I found no evidence of promotion of the FHT model by feminist, labour or any other social movements beyond the expressed desire of specific communities for health care services. It is thus unclear exactly which “ideological roots” are shared between the FHT and CHC models.

Challenges to Claims about the Interdisciplinarity of FHTs

The Liberals had thus invested heavily in emphasizing the interdisciplinary aspect of FHTs. However, concerns were raised over the years in the legislature by the opposition parties that, despite these claims, FHTs were not “really” interdisciplinary teams in their structure. The PCs noted problems with the speed of implementing the non-physician components of the FHTs:

It's great to have made a promise to establish 150 family health teams. It's great to talk about collaboration. However, according to your own statistics, as of December 31, 2008, only 32 of the 150 family health teams had hired

their full complement of staff²⁹, such as nurses, nurse practitioners, doctors and dietitians. I think a lot of people will find this quite shocking, considering that the McGuinty government has now had six years to get these teams fully staffed. I urge the government to develop a timeline to finally develop a plan in order that you can fully staff these 150 family health teams that you talk about as quickly as possible (Witmer, 2009, May 25).

The NDP also noted the imbalance between physician and non-physician practitioners:

... the minister's much-lauded family health team, which he touted as being a model of interdisciplinary practice, in fact is overwhelmingly comprised of physicians as opposed to a balance with other health professionals. There are roughly eight physicians for every nurse practitioner; 18 physicians for every one dietitian. Basically, there are 72 dietitians in the whole system, which leaves at least 70-some family health teams with none. There are 366 physicians for every chiropodist, which means that we have all of four chiropodists working in family health teams right now. That's 146 family health teams with none at all-not much of a team there (Gélinas, 2008, June 16).

Ontario's promise of interprofessional care provided through family health teams has been by and large a disappointment. The fact of the matter is that family health teams are not representative of the entirety of health professionals. They continue to be a primary health care model that sees physicians dominate, and other complementary forms of care, such as nurses and nurse practitioners, continue to be grossly underrepresented. To give you an example, for 1,000 physicians, you can find one pharmacist; I would not call this a team. There is yet to be a single physiotherapist hired by a family health team. Family health teams are basically physicians working together, which is a step in the right direction, with a few nurses, a few nurse practitioners, sometimes a dietitian and sometimes a social worker. But that's about where it ends-not exactly the type of interdisciplinary care that Ontario needs (Gélinas, 2009, May 25).

Later, the NDP also questioned the interdisciplinary spirit of the FHT model:

We have this family health teams model that is supposed to be the end-all of it all, but basically what we have with the family health teams is a whole bunch of physicians on an alternate payment plan with one or two what they call staff members-not exactly my idea of interdisciplinary care, where everybody works as part of a team and is a colleague (Gélinas, 2010, May 11).

²⁹ No updated information could be located.

Other MPPs noted that the Liberals' original proposed team composition did not come to pass:

One of the things the government has said about a role for pharmacists was that they hoped pharmacists would become more involved, or become involved, in family health teams. I remember the government saying this very thing about eye doctors when they delisted eye exams. In response to a question at the time, the minister said, "We expect optometrists to be part of the family health team." I don't expect there's any family health team right now that has an optometrist as a partner; as well, I'd be very surprised if we ever see the day when pharmacists are partners in family health teams. I say to the government, don't hold out the false hope to either pharmacists or the public that one of the new roles of pharmacists is going to be as members of family health teams. I doubt very much that that's going to happen. It certainly didn't happen in the case of optometrists even though well over a year ago the minister said in this House that that was his objective and that's what he wanted to see. I'll bet you there isn't one family health team that has an optometrist on it, and I don't expect that there's ever going to be a pharmacist on a family health team either (Martel, 2006, April 25).

Ms. Martel's prediction about pharmacists did not happen; over 100 pharmacists now work in FHTs (Dolovich, 2012). However, optometrists have not yet been approved by the Ministry of Health and Long-term Care to become employees of FHTs. Version 3.2 of the Ministry of Health and Long-term Care's *Guide to Interdisciplinary Provider Compensation* stated that the "...integration of chiropractors, midwives, optometrists, physiotherapists, and speech therapists into the Family Health Team model is currently under review" (Ontario. Ministry of Health and Long-term Care, 2010, p. 6). Of these, only chiropractic and physiotherapy have become approved interdisciplinary providers³⁰ for FHTs (Ontario. Ministry of Health and Long-term Care, 2013a, p.6). Thus, the government has considerable influence over which health professions work in FHTs, setting limits on the interdisciplinary character of FHTs. This is an important observation

³⁰ Approved interdisciplinary providers include: case worker/manager, chiropodist/podiatrist, chiropractor, counsellor, health educator/promoter, nurse practitioner, occupational therapist, pharmacist, physician assistant, physiotherapist, psychologist, registered dietitian, registered nurse, registered practical nurse, and social worker/mental health worker (Ontario. Ministry of Health and Long-term Care, 2013a, p.6).

to bear in mind; later in this chapter, I examine the Liberal government's claim that communities would determine the complement of professionals in interdisciplinary teams.

Back Room Deals with Doctors?

Issues related to FHTs were also raised during the Liberal government's negotiations with the Ontario Medical Association (OMA) in 2004. On October 14, 2004, the Liberals announced in the Legislature that an agreement had been reached with the negotiating team for the OMA. During their announcement, the Liberals made explicit links between the OMA negotiations, primary care reform, and FHTs:

This deal is different from any agreements that have been negotiated with doctors in this province or in any other province. That is because this agreement fuels meaningful change in the delivery of health care, consistent with our transformation agenda. It will bring more doctors to communities across this province. It will compensate and reward doctors to practice in new ways. It will improve the ability to provide care to their patients... It will do this by compensating doctors to provide more comprehensive care and work as part of a team to deliver care 24/7 to people in their communities... If they want to work as part of a family health team or other primary care model providing around-the-clock care close to where people live, this agreement will provide more resources for them to do just that. This agreement will finally give life to the much-touted phrase "primary care reform." Some doctors will choose to continue to practise in traditional fee-for-service models or in walk-in clinics. That will continue to be their choice, but this agreement rewards doctors who want to provide more care and operate in new models of care (Smitherman, 2004, October 14).

The difference from past dealings refers to the fact that for the first time, there were no across-the-board increases in physician compensation (ibid). Rather, as the quote suggests, increases were targeted to specific areas or ways of practicing (i.e., working on a system other than fee-for-service) that would enhance primary or comprehensive care (ibid.). The replies from the opposition that day focused mainly on inquiries about the cost of the agreement.

However, the opposition had more to say after the OMA membership rejected the deal in late November 2004. The PCs characterized the Liberals' failure at negotiations as the result of them "bullying" physicians (Baird, 2004, December 6), and contrasted the Liberals' performance in negotiations with the OMA to their own during their tenure in government:

Premier, the difference between your government and our government is, we went immediately back to the table with the OMA because we knew the right thing to do for patients was to make sure that doctors were relatively happy in this province, able to deliver the services and not impeded by government and the lack of agreement and being distracted with all the legalities of that. Your health minister failed to go out during the time of this agreement and explain to all the local OMA branches what his transformation agenda was and what this agreement was about. He failed to go out and sell the agreement. He sat silent on a secret agreement. For a month and a half he sat on this agreement. He failed to sell it. He failed to explain it. He failed to get the confidence of the people of Ontario (Wilson, 2004, November 23).

The NDP also criticized the Liberal government for being secretive about the details of the proposed deal with physicians. In contrast to the PCs' concern for physicians, the NDP characterized the negotiations as "back room deals" with physician leaders. Further, they criticized the Liberals for not including other professions in the planning of FHTs to the same degree that seemed to occur with the physicians in the OMA negotiations. For two days in the Legislature, NDP leader Howard Hampton grilled the Liberals about these matters; the Liberal response was to assure that all professions were involved in FHT development, and to remind the House that interdisciplinarity was a key feature of FHTs, in terms of both their structure and in the planning process. An example from one of those days follows:

Mr Howard Hampton (Kenora-Rainy River) [NDP]: Your doctors' deal has been voted down by the doctors themselves and, as a result, your plans for primary care reform in Ontario are stalled. We say that you need to get all of our health care partners, like nurses and nurse practitioners, on board to

drive the primary care reform agenda. But so far, your government's plan B looks identical to your failed plan A: Go back for more meetings in the backroom with physicians and exclude everyone else. What is your plan B if it's not simply a repetition of the failed plan A?

Hon Dalton McGuinty (Premier, Minister of Intergovernmental Affairs): I obviously don't agree with the leader of the third party's characterization of what has happened so far and where we're going. First of all, part of this very agreement that has been rejected by Ontario's doctors provided for new funding for nurse practitioners, just so you know what we counted on in that part. Secondly, our goal is to establish 150 family health teams... These are full, interdisciplinary teams, including nurse practitioners, other physicians and other members who want to get involved in the delivery of primary health care in Ontario. So we are moving ahead on that front, notwithstanding any arrangement that we can or cannot obtain with Ontario doctors.

Mr Hampton: Premier, it was a very specific question: What is your plan B? Is it simply going back and meeting with the same physicians in a backroom or do you have a plan to bring all of the health care providers together? Let me tell you what one self-described expert said. He said, "You know, if we're going to move this agenda forward, at that table should be nurse practitioners, nurses, other health care professionals and representatives of the patient community." This self-described expert goes on: "It is simply impossible to move primary care reform forward [by just talking to the doctors]." Do you know who that was? It was Dalton McGuinty, a mere four years ago. But now we see you adopting the very plan you used to criticize the Conservatives for. You used to be critical of them for talking only to the doctors of the OMA. So I ask you, Premier: Do you have a plan B to include all of the health care providers involved in primary care reform or is it simply a repetition of plan A: Go back and talk to the doctors in a backroom?

Hon Mr McGuinty: I want to assure, reassure and confirm for the leader of the NDP that we are in fact working with all of our health care partners when it comes to defining the kind of family health team we want to have in Ontario. The Minister of Health just spoke at the annual general meeting of nurse practitioners a couple of weeks ago and I understand he got a two-thirds standing ovation, and in these days, that's not bad. We will take that. We are bound and determined to proceed with these family health teams in a way that proves to be effective. By their very nature, they have to be interdisciplinary in order to ensure that we've got a good working model. You can't construct that without the advice and support of the other partners, and that's exactly what we're doing (Hampton & McGuinty, 2004, November 23).

Despite the Premier's claims that other professions were being consulted about FHTs, there was no discussion of how non-medical professions would be paid to work in

them, in contrast to the attention given to this matter in discussions of the OMA negotiations. In fact, the issue of how non-medical professionals would be paid in the FHTs did not seem to be addressed outright in discussions of FHTs. Rather, the issue appears to have been brought up only once by PC MPP John O'Toole (2009, May 25)³¹, in the context of debating Bill 179 (described earlier this chapter), which expanded the scope of practice of several non-medical health professionals. In sum, discussions of the OMA negotiations of 2004 suggest that there was a great deal of emphasis on the consideration of physician payment in order to implement FHTs, and much less, if any, on the non-medical professions.

Expansion of Community Health Centres

On November 10, 2005, the Liberal government issued a news release announcing a \$74 million investment in the expansion of the CHC model by 22 full CHCs and 17 satellites, constituting the largest one-time expansion of CHCs in Ontario's history (Ontario. Ministry of Health and Long-term Care, 2005, n.p.). In the Legislature several days later, Minister Smitherman repeated the announcement, reiterating the key features of CHCs:

Mr. Speaker, as you and many members of this House know, community health centres are a tremendously effective and important part of this government's efforts to reform primary health care. They offer an interdisciplinary approach to health care and healthy living through a team of health care professionals working together. They provide both front-line primary health care services as well as community health programs. They're community-focused and cost-effective, and they are particularly oriented toward those who face barriers such as poverty, homelessness or language

³¹ The reader is reminded that in his comments about the bill that day, he wondered whether non-medical professionals working in teams would want to have billing codes like physicians, and whether this would become an issue of contention. These concerns were not addressed by the Liberals in those discussions; rather, they focused on how the bill would open the scope of practice of non-medical health professionals to facilitate teamwork.

barriers. In short, they're one of the most effective tools we have to address health issues. By "health issues" we don't just mean treating people when they're sick; we mean the entire range of factors that contribute to healthy lives and healthy communities (Smitherman, 2005, November 14).

As with the reaction to FHTs in 2004, the opposition's reaction to the expansion of CHCs was mixed. Both the PC and NDP MPPs responded with statements of approval of the CHC model, some form of criticism, and a reminder to Legislature of their respective governments' past commitment to CHCs. The PCs' response to the announcement began with Elizabeth Witmer stating: "I am pleased to be able to respond to the statement in regard to community health centres today. I have always -- as has our [former PC] government -- certainly supported health centres" (2005, November 14). This was immediately followed by a long string of critiques, including an accusation that the announcement was made to coincide with a by-election in a riding receiving a CHC, a lack of clarity about how much of the money promised would go to help existing CHCs, the absence of a clear timeline for implementation, the poor record of implementation of the 150 FHTs to date, and criticism of the delisting of chiropractic and optometry from the provincial health insurance plan, the health premium levied by the Liberal government, and the firing of over 700 nurses by the Liberal government (*ibid*).

The NDP's response was also critical, while also clearly establishing their record of support for the CHC model:

In response to the statement made by the Minister of Health, the question is, how long have New Democrats been urging this government to fund CHCs? The answer is: For two long years since this government was elected, every time the minister got up and talked about primary care reform, I said in response, why doesn't the government move forward on this effective model of primary care? That's what our government did. We recognized that it was a good idea to have health care providers on salary, that it was a very good idea to have a full range of health care providers -- doctors, nurses, nurse practitioners, mental health workers, social workers -- providing care to

patients, that it was a good idea that the focus shouldn't just be on illness, prevention or treatment but on health promotion initiatives as well keeping people healthy longer, and that it was a very good idea to have local boards determine what the direction of those CHCs would be so that they could be responding to the health care needs in those communities. That's why our government funded 21 new CHCs and nine aboriginal health and wellness centres in the depths of a recession (Martel, 2005, November 14).

CHCs are known for their successful track record in addressing the health needs of vulnerable, marginal, and isolated populations (Russell et al., 2009; Dahrouge et al., 2010). However, prior to the arrival of the FHT model, the CHC model was also promoted in the legislature as an alternative to fee-for-service for the delivery of primary care in Ontario for the population in general. For example, Frances Lankin, a former Health Minister during the Rae administration (1990-1995), spoke of how the NDP government funded CHCs as a means of broadly improving population health:

When we [the NDP government] began looking at the need to restructure the health care system, to look at how you move the resources -- because a lot of people have said that there were significant resources being expended and that those resources could be applied in a better way that would promote a healthier population -- we started looking at how that shift could take place, that shift from illness treatment to health promotion, to illness prevention. We started to look at how important it was that government, in its other areas of expenditure, have the room to invest in what are referred to as the determinants of health, those things which keep people healthy in the first place: good nutrition, important emphasis on child nutrition; a good education; a clean environment; clean, safe housing; safety in our streets -- all those things that build a healthy population. The healthier your population is, of course, the better you can use your resources overall in the province and in the health care system... I'm pleased that during years where we were facing tremendous fiscal challenges in the government through the recession and we saw restraint beginning on government expenditures in a large number of areas, we were able within the health envelope to continue to expand, even in those very difficult times, the investment in community health centres... I believe that it is a critical point of entry for people to the health system in their community and that the community health centres have an opportunity to provide a multidisciplinary team approach to the delivery of health care services (Lankin, 1997, June 19).

Ms. Lankin's references to the population are generic, rather than specific to especially access-challenged populations.

However, several factors occurring in the McGuinty era may have changed the marketability of CHCs as a model of primary care reform for the general population. The Liberals' talk of the expansion of the CHC model frequently included the CHC model's success in dealing with vulnerable and/or hard-to-serve populations, and was promoted as the Liberals' strategy for dealing with these:

Community health centres perform a unique and critically important function in our health care system. They offer services to people who otherwise might have difficulty receiving health care, people who face barriers such as language, culture, physical disabilities, homelessness, poverty or geographic isolation (Smitherman, 2005, February 15).

The single, most important and effective tool we can put in place to address the inequities to be found in health care -- and admittedly some exist; we inherited those -- is a community health centre... These are specifically aimed at communities that are having trouble accessing health systems, whether those be our First Nations communities or lower-income communities. We even have some new ones which are specifically targeting youth in Ontario, another group that traditionally has been hard to reach (McGuinty, 2006, April 27).

Whether intentional or not, the frequent association of CHCs with vulnerable populations, combined with the more significant and more widespread investment in the FHT model as a community-level model and alternative to a fee-for-service structure, and the Liberals' unabashed enthusiasm for the FHT model as their "signature" on primary care reform, may have limited CHCs in Ontario to being reserved for vulnerable populations only³². These may have limited the potential of the CHC model to become a more widespread form of interdisciplinary primary care team.

³² In fact, this issue made the agenda of a primary care forum hosted by the Association of Ontario Health Centres I attended in Toronto, Ontario in June 2011, where those present discussed whether this more

Another factor in the political social world that serves to limit the potential of the CHC model to become a more widespread model of primary care for the general population is the perception in the political social world that CHCs, though highly effective, are expensive. This point was raised in several interviews (001, 009, and 010).

One interviewee noted:

[009]: We do have, uh, there are research organizations in Ontario—the Bruyère Institute in Ottawa did actually look at the cost effectiveness of all of our models, and they did conclude that the CHC you know, had the healthiest patients on the outcomes that they could measure

[SH]: Mm-hmm

[009]: but it was at a much higher cost

[SH]: Right

[009]: and I think that's really the debate - how much more do you want to pay for that?

Another commented on this perception as an outsider to the political social world:

[001]: and I don't know the facts on this one but I also know that there was lots —like many, many, many people in government in particular said the community health center model is too expensive to roll out to society at large

[SH]: Okay

[001]: I mean how I interpret that is because so many of the services are very much support services for people who need those extra types of support

[SH]: right

limited mandate should be pursued, versus also promoting the CHC model as model for all populations. One of my interviewees from the government social world (009) also noted the current debate in the CHC world of whether to continue presenting CHCs as for specialized populations only, or for all populations.

[001]: and for the broad middle class who don't need that kind of thing it's you know—there really wasn't the budget nor, um, the driving need to replicate that for everybody

This perception has the potential to thwart the widespread implementation of the CHC model. However, researchers from the Bruyère Institute (mentioned by my respondent above) stress that much more research is needed, particularly with regard to the treatment of various types of chronic diseases, to determine the overall cost effectiveness of each model in the system (e.g., Liddy et al, 2011, p. 124; Milliken et al, 2011, p. 102). Thus, the door may not yet be entirely shut on the more widespread implementation of CHCs.

Introduction of Nurse Practitioner-led Clinics (NPLCs)

Given their more recent appearance, there is less information overall about Nurse Practitioner-led Clinics (NPLCs) in my data compared to the other two models. However, there are several points about NPLCs worth exploring. The first is that the NPLC model originated from a different process than the FHT model. The NPLC model originated in Sudbury in 2007 through the actions of local nurse practitioners and, eventually, the Registered Nurses' Association of Ontario (RNAO); this was brought to my attention through a key informant interview. After a series of rejections in applying to the government for funding for a clinic, the small group of nurse practitioners “kind of got angry about it,” (Interview 003), writing letters to politicians and to the Registered Nurses' Association of Ontario (RNAO), which subsequently also began to lobby the government. The Ministry of Health and Long Term Care responded with interest, but offered the group a FHT instead, with a limit of two NPs on staff (ibid). This offer did not sit well with the group, who refused and continued to pursue a nurse practitioner-led

model with the Ministry (ibid). Within a few months, the Ministry and Premier's office agreed to fund the nurse practitioner-led clinic in Sudbury, which opened in the summer of 2007 (Sudbury District Nurse Practitioner Clinics, n.d., "About Us"). The group was initially told they would be a "one-off", but with support from then Minister of Health and Long Term Care George Smitherman, and after several rounds of evaluation and proving themselves, they successfully lobbied the government to put out the call for applications for more NPLCs (Interview 003).

Patterns in the legislative debate data corroborate these events. The first mention of the NPLC model in the legislative debate records came not from the ruling Liberals, but from the NDP. In October 2006, the MPP for the area, Shelley Martel, told the legislature about the struggle to get the Sudbury clinic off the ground, and appealed to the Health Minister (George Smitherman) to consider funding the proposed clinic:

In Ontario today, there are far too many unemployed and underemployed nurse practitioners. Their scope of practice now allows them to provide many primary health care services that patients need. Applying these skills and expertise benefits all Ontarians, but if nurse practitioners aren't able to work, that's a huge waste of talent, energy and skills in the health care system. Over nine months ago, I supported an application to establish a nurse practitioner-led clinic for the city of greater Sudbury. In a city with over 20,000 orphaned patients, you'd think the McGuinty Liberal government would be interested in supporting this proposal, especially as the nurse practitioners were going to focus their work in the outlying communities, where primary health care needs are the greatest. This excellent proposal was turned down. There's been no change in the number of orphaned patients. The outlying communities are still underserved. Local nurse practitioners can't get work in their field. There's something wrong with this picture (Martel, 2006, October 5).

The next mention of the NPLC model in the legislature was in the 2007 Throne Speech, where the Liberal government committed to funding 25 NPLCs (Onley, 2007, Nov. 29).

Also of interest is how NPLCs were described, as the wording reflects what was seen as unique about them, and the challenges they faced. The descriptions of NPLCs in

legislature by members of all parties continued to reflect the same emphasis as those for FHTs and CHCs, particularly on their ability to increase access to primary health care services (Matthews, 2010, May 11; Oraziotti, 2009, March 3; Brown, 2008, November 19) and to relieve strain on hospitals (Dunlop, 2010, September 27; Caplan, 2009, February 23; Oraziotti, 2009, March 3), their mandate to address local health needs (Caplan, 2009 March 4; *ibid*, 2009, May 12), and their interdisciplinary or team-based structure (Matthews, 2010, May 3; Caplan, 2009, March 4; Gélinas, 2008, September 23; Mauro, 2009, March 11). Descriptions of their proposed team complement included nurse practitioners, nurses, dietitians, pharmacists, social workers, and physicians (Caplan, 2009, March 4; Oraziotti, 2009, March 4; *ibid*, 2009, March 3), with the nurse practitioners serving as the clinical leads, rather than physicians.

However, the descriptions also contained new catch phrases that reflected some of the unique features of the model. The NPLC model was often described by Liberal MPPs as a “first” for both Canada and North America (McGuinty, 2010, May 12; *ibid*, 2009, October 7; Arthurs, 2010, March 30; Oraziotti, 2009, March 3; Caplan, 2008, November 19). The term “innovation” was also frequently used in descriptions of the NPLC model (Caplan, 2008, November 19; Matthews, 2010, May 3; Gélinas, 2010, May 11). The explicit mandate of the clinics to manage chronic disease was also emphasized (Caplan, 2008, November 19; Matthews, 2010, May 11; Gélinas, 2009, May 25; *ibid*, 2010, May 11). Though chronic disease management is also likely an activity that occurs in FHTs, it is not an explicit part of that model’s mandate³³.

³³ In the government’s basic information page about the FHT model (Ontario. Ministry of Health and Long-term Care, 2012a) and in a Q & A page about the FHT model (*ibid*, 2012c) there is no mention of chronic disease management. There is, however, explicit mention of chronic disease management as a priority of the NPLC model in the government’s information webpage about that model (Ontario. Ministry of Health and Long-term Care, 2013d, n.p.).

The uniqueness of nurse practitioner leadership was also promoted. Health Minister Deborah Matthews noted that, through NPLCs, “...we will be able to provide care that has a slightly different nuance to it” (2010, May 3). NDP health critic France Gélinas also noted that NPLCs have a different feel to them, owing to the clinic structure being nurse-led:

... the nurse practitioners' clinic in Sudbury, the first, is something to be proud of. It is a very innovative model, and they do really good work. I would say that people who have the opportunity to receive their care from nurse practitioners are always very satisfied and in awe. Nurse practitioners at the basis are nurses. They teach like a nurse; they communicate like a nurse; they are nurses, and people really appreciate the type of care that those health care professionals deliver (Gélinas, 2010, May 11).

To “communicate like a nurse” and “teach like a nurse” is posited as something very positive; the fact that patients are “in awe” due to nurse practitioner communication and teaching styles suggests that there is something special about this style of care. Though the exact intention of the speaker is not clear, the fact that they felt compelled to point this difference out is interesting.

Another set of catch phrases associated with NPLCs were focused on presenting NPLCs an acceptable way to receive primary health care. One such catch phrase was that NPLCs provide “excellent” or “high quality” care. Another new feature of the discourse around this model was a brief explanation of what nurse practitioners can do (such an equivalent for the physicians in FHTs, or any of the other professionals mentioned, were not apparent in the data about FHTs or CHCs). Descriptions also noted that physicians would be part of the clinic team, though it is important to note that, unlike the FHT structure, physicians are not the clinical leaders (the nurse practitioners are), and they play a consultative role for issues outside the nurse practitioner scope of practice. Examples of these sets of catch phrases within the descriptions follow:

Nurse-practitioner-led clinics are an innovative way to improve access to high-quality care. Nurse practitioners are able to treat common illnesses and injuries, and they can write prescriptions and order lab tests and X-rays, among other things. Through collaboration with physicians and other health care partners, these new clinics will focus on chronic disease management and prevention, as well as health promotion (Caplan, 2008, November 19).

I'm very happy to have the opportunity to talk about a new innovation in Ontario: the nurse-practitioner-led clinic... Nurse practitioners can offer excellent primary health care. All nurse-practitioner-led clinics are affiliated with a family doctor so that there is a continuity of care (Matthews, 2010, May 3).

Recently, I had the privilege of announcing that our government is creating a new nurse practitioner clinic at Sault College. The clinic will benefit thousands of local residents, who will now have greater access to primary health care, as nurse practitioners are able to treat common illnesses and injuries and order lab tests, X-rays and other diagnostic tests. The Sault College clinic will include nurse practitioners, on-site physicians, consultative physicians and other health care professionals, who could include pharmacists, dietitians and social workers (Oraziatti, 2009, March 3).

The repetitive inclusion of the term “excellent” or “high quality” care, along with short statements of the abilities of nurse practitioners, and the constant reminder of the presence of physicians in the clinics appear to be addressing an unspoken concern about the scope of practice of nurse practitioners, and whether they are a safe form of primary care. The public’s concern and curiosity was brought up at least once in legislature (below, by Liberal MPP Bruce Crozier), though notably, it was also apparent that the people from this particular constituency were certainly interested in nurse practitioners:

Mr. Bruce Crozier: ...My constituents, for example, are encouraged by the recent announcement of a nurse-practitioner-led clinic in the riding of Essex. I know that this is a new way of delivering health care, and one that has seen a lot of success in Sudbury, for example. My constituents are pleased to have access to more primary health care, but are seeking clarification about the role that a nurse practitioner can play in the community. I also understand that yesterday, Minister, you made an announcement that would expand on the range of things that nurse practitioners can do for patients. Please tell the House your vision for nurse practitioners in Ontario, and why you think it's important to give them an extended role.

Hon. David Caplan [Minister of Health and Long Term Care]: The member from Essex asks another excellent question, and I want to thank him for an important question about our hard-working nurses. We've committed to creating 25 nurse-practitioner-led clinics around this province, making Ontario a leader in Canada. Nurse-practitioner-led clinics are locally driven, primary health care delivery organizations. They include registered nurses, family physicians and a range of other health care professionals committed to providing comprehensive, accessible, coordinated family health care services (Crozier & Caplan, 2009, May 12).

The question of the efficacy of NPLCs was also brought up in legislature (from a Liberal member). The Minister of Health and Long Term Care assured the member that NPLCs would be evaluated:

Mr. Michael A. Brown: I'm glad to hear that the Sudbury clinic has increased access to health care for Ontarians in need. Still, I'm hoping that the Minister of Health will be able to elaborate further on the effectiveness of nurse-practitioner-led clinics. Some say that these clinics reduce the likelihood of further investment in the province's family health teams. I ask the Minister of Health to address these concerns. How can he be sure that nurse-practitioner-led clinics are effectively delivering health care to Ontarians?

Hon. David Caplan: That is an excellent question. First of all, I would like to say that I'm extremely proud of what our first nurse-practitioner-led clinic has accomplished in Sudbury. I know that members from the Sudbury area share that view. Moving forward, we will evaluate the clinics' performance to find the best practices and identify ways that we can improve the model. But I'm sure of this: Nurse practitioners deliver high-quality care and effective quality care for Ontarians. They are an integral part of our vision for the health care of Ontarians (Brown & Caplan, 2008, November 19).

Unfortunately, there is no further context to Mr. Brown's comment that would tell the reader exactly whom he is referring to when he says "[s]ome say that these clinics reduce the likelihood of further investment in the province's family health teams." It does, suggest, though, that some people may be upset with the thought of funding being diverted from FHTs in favour of NPLCs.

There appeared to be general agreement among the opposition parties that NPLCs were a good idea; there were no negative comments about the idea behind the model. The only criticisms from the opposition had to do with implementation issues; no issues were raised about team composition. One PC member, for example, criticized the Liberal government for twice rejecting a well-supported application for an NPLC in his riding:

I'd like this House and the people of Ontario to know that for the second time the city of Orillia and area has been denied a nurse-practitioner-led clinic. I tell you that the community is extremely disappointed with this government. The submission was accompanied by significant community support, including an endorsement from city council, myself and the Orillia Soldiers' Memorial Hospital. The establishment of a nurse practitioner clinic would reduce the demand on the emergency room department that sees approximately 50,000 visits per year, and therefore would reduce wait times.....I ask the Ministry of Health to explain to myself and the citizens of Orillia and area why they were refused this important service for the second time (Dunlop, 2010, September 27).

No response was offered, due to the order of legislative business that day. The only noticeable criticism from the NDP (in addition to the already mentioned rejection of a clinic in Sudbury in 2006) was on the slow pace of implementation of NPLCs (Horwath, 2010, May 3).

Unlike the data for the FHTs, the opposition parties did not attempt to make any legacy claims to this model, though it is noteworthy that both NDP and PC members openly stated contributing to the NPLC application process in their areas, as noted in the examples above featuring Garfield Dunlop (PC) and France G  linas (NDP).

Claims about Communities, the Ontario Public, and Teams

Public Demand for Teams: Textual vs. Interview Data

Claims about the public demand for interdisciplinary primary care teams were made in legislature. Certainly, there are instances in the legislative procedures I analysed

that indicate that specific communities had applied to the provincial government for CHCs even before the McGuinty Liberals came to power and well before the announcement of FHTs. NDP health critic Shelley Martel reminded the PC government in 2001 that 80 communities had applied to the Ministry of Health for a CHC (2001, April 23), and gave the Liberal government the same reminder in 2004 and 2005 (2004, December 6 and 2005, November 14, respectively). She further highlighted the team approach of CHCs as one of the features the communities in question found attractive about the model:

Communities know that they will be able to keep not only their doctors but nurse practitioners and others in the community if they can work together in a team approach, if they can bill by salary, if they can have some kind of quality time with their families, and they will because they work in a team (Martel, 2001, April 23).

Brock Township petitioned the Legislature a minimum of four times in my data³⁴, with the petitions also highlighting the appeal to this specific community of the team aspect of care. For example:

“...Whereas a CHC in Brock township could provide a range of community-based health and social services provided by a multidisciplinary team including physicians, nurse practitioners, nutritionists, health promotion coordinators, social workers, counsellors and other health professionals needed in our local community; We, the undersigned, petition the Legislative Assembly of Ontario as follows: That the Brock CHC proposal submitted on February 27, 2003, be funded as recommended by the district health council” (Scott, 2004, June 9).

The announcement of the FHT model also garnered significant interest from specific communities for that model of interdisciplinary primary care team. In 2004, Minister Smitherman noted that following the announcement of 150 Family Health

³⁴ Scott, 2004, June 9; Scott, 2005; May 10; Scott, 2005, May12; Delaney, 2005, June 13.

Teams, that “[a]lready, 90 communities in Ontario have said, “[w]e want to be part of this action” (Smitherman, 2004, November 22b). By 2005, 213 Ontario communities applied for FHTs:

There's ample evidence [of primary care reform] in the province of Ontario, found in at least 213 communities which on February 15 submitted applications to be part of our government's model of primary care reform, and that is family health teams. That's well-known to the honourable member and to honourable members in all parties, because communities all across the province of Ontario have asked to be part of an interdisciplinary method of practice that brings together our doctors, nurses, nurse practitioners and dietitians to provide the kind of comprehensive care that is at the heart of our model of primary care (Smitherman, 2005, March 30).

In the next passage, the Minister uses those 213 communities as a springboard to make a larger claim that approval of FHTs was “almost universal” in the province:

The 55 family health teams that we announced [in the first wave of implementation]... were selected from 213 applicants, representing 1,300 doctors and 2,600 other health care professionals from communities that want a family health team of their own -- 213 applications. It seems that people understand instinctively that this is a great idea. Our government shares a vision of health care with Ontarians. It is a vision of a system that helps keep people healthy, delivers good care to them when they need it and that will be there for generations to come... family health teams represent the future of health care. They are that rare example of an idea that is almost universally seen to be great. Patients, providers, political leaders and academic experts all agree: Family health teams are a huge step on the road that is taking Ontario to a better health care system... (Smitherman, 2005, April 18).

In addition to recounting the numbers, Minister Smitherman implies that the desire of these communities for a FHT can be taken as evidence of a much broader approval of FHTs among the population, a “shared vision” between “Ontarians” and the government. While the word “Ontarians” could mean the specific people from those communities, the term “universally seen to be great” does suggest that the Minister is extrapolating to the rest of the population. Further, the statement that people “instinctively” think FHTs are a

good idea is a naturalizing statement that makes FHTs seem logical and indisputable, something that everyone could agree on.

Data from my interviews contradict these claims. Where the language of Minister Smitherman in the legislative debates describes interdisciplinary primary care teams as something widely desired by Ontarians, the majority of my interview data suggests Ontarians are a less informed public with regard to teams, and even to primary care reform in general, than is alluded to in the legislative debate data.

First, my interview data suggests that the broader Ontario public still equate their health care with physician care, rather than with interdisciplinary teams. One government social world interviewee claimed that while this view is changing, it will take time for the public at large to see their medical care in terms of interdisciplinary teams:

[SH]: [skipped material] So in your experience, is the general public aware of or interested in interdisciplinary team-based primary care? So in your dealings has it ever been an issue typically on the minds of the groups of the people that you are trying to engage?

[010]: Yeah, I mean, I think people still – people still generally speaking have a very traditional view of what medical care means, and it means a doctor

[SH]: Mm-hmm

[010]: uh, and uh, I think that's starting to change – I think the family health team model has been – I mean I think it's been a big paradigm shift in the province of Ontario, there is a – a big move forward

[SH]: Mm-hmm

[010]: um, now there's a big variety of FHT's, and some of them are not that multidisciplinary

[SH]: Hmm. Mm-hmm.

[010]: but – but um, I think that is-- that is a simple case of seeing is believing

[SH]: Mm-hmm

[010]: and as people benefit from that kind of care and as people get used to it, it will mold their expectations

[SH]: Okay

[010]: um, but you know, that's a cultural shift, and that will take awhile...

Similarly, another interviewee noted:

[SH]: Okay. Do you think the public in general is becoming more aware of um...of...well I guess of these family health teams, or of these new—this new way of doing things? Um, do you think it's picking up, from a public perspective?

[002]: I think it's picking up. I think it's still a slow process, I think people still—to me it appears people still like to have that personal family physician, for instance

[SH]: Mm-hmm

[002]: because they know them, in quotation marks, you know

[SH]: Mm-hmm

[002]: type of thing, but then on the other hand, I think the shortage of family physicians and um, the people who have been without one, and now there seems to be uh, more, you know, uh—more uh, places for patients—for instance, in our town, we've opened a big clinic and they're advertising for patients, so

[SH]: Mm-hmm

[002]: I think the ones that had gone without physicians for so long [laughs] they're actually in a—in an odd way, you know, are much more—are much more accepting of this type of an arrangement, because at least they've got a doctor now, or they've got access to... a medical facility now

Secondly, another interviewee (from one of Ontario's fifteen health coalitions) spoke about the knowledge gap between policy elites and the broader public about the structure of the health care system in general:

[SH]: Uh, now, I'd like to go into just a little bit about public awareness and interest in interdisciplinary primary care teams in Ontario. Now, in your experience, has the movement toward interdisciplinary primary care teams been an issue of importance, do you think to the general public, and what were the indicators of that, if that was the case?

[014]: No, I don't-- unfortunately, I don't think it is an interest to the general public-- I don't think it's, um, it has sort of jumped the wall between the kind of chattering class of the policy elites, and the general public.

[SH]: Okay

[014]: I don't think -- I think the barriers are, um, language-- I don't think the public knows what primary care is, secondary care, tertiary care

[SH]: Okay

[014]: you know, I don't think they understand those terms -- in fact I know the public doesn't understand those terms. I know because we do, um, town hall meetings all over the province all the time, and you know, I probably speak with amounting to more than 20,000 [people] each year, and I know the public doesn't know what that means...

The same respondent also noted the same gap with regard to FHTs, and surmised its cause:

...family health teams were kind of just announced by the government, they probably were in the works in the bureaucracy for quite some time, but they didn't consult on them, and then there was no-- you know, they weren't created by some popular movement or anything, they came out of the bureaucracy (Interview 014).

Finally, one interviewee pointed out another possible limitation in the Ontario public's knowledge of interdisciplinary primary care teams, in that most would not have

an opportunity to experience being both a client of a CHC and a FHT (Interview 010). This is likely the case, given that some areas would not have both types of entities, the fact that CHCs typically focus on hard-to-serve populations, and that FHTs require patients to roster to a physician. This limitation in the experience of different styles of team-based primary care could limit the public's knowledge about the advantages and disadvantages of various model types, further limiting their participation in discussions of what teams could or should look like in Ontario. Overall, my interview data point to limits on the claim that Ontarians universally want or approve of interdisciplinary primary care teams.

Determining Community Needs

Another interesting claim related to communities is how community needs would be defined and met through interdisciplinary primary care teams. The data for FHTs regarding this topic is particularly interesting, due to ambiguities in the claims made by the Liberals for how this would occur, and in who would be determining the needs. For example:

Our family health team proposal provides the opportunity for health care providers to come together and offer an array of services that meet the needs of those populations. That means that if those populations dictate that optometry, physiotherapy or chiropractic are their priorities, they'll be able to work those into their family health teams (Smitherman, 2004, June 3).

On one hand, Minister Smitherman says the health providers are coming together to “offer” an array of services that meet the needs of those populations, suggesting that it is the providers deciding what to put on offer. His next statement says that the populations will dictate the services; however, this wording has two possible interpretations. On one hand, it could mean that it is the health conditions of the populations that will dictate what is needed, as seen from the perspective of the providers gathering to offer services,

with “they’ll” and “their” referring to those providers; the other possible meaning is that members of the population are dictating to the providers what is needed, from their perspective.

Another passage describing how health needs of communities served by FHTs would be determined is again vague on who is determining those needs:

...family health teams are coming to life in the province of Ontario in a variety of different ways... We have determined that it's appropriate not to be overly prescriptive but rather to allow family health teams to emerge depending on the population health basis. In some cases, that will mean that they're targeted toward seniors who need this array of services; in other cases, maybe toward younger families where a midwife might more appropriately be part and parcel of the team (Smitherman, 2005, November 17).

There is no indication who is analyzing the population health basis, or who is doing the targeting of services.

Conversely, at times the Minister Smitherman’s language more straightforwardly suggests that the FHT model works “on behalf” of the patients in the area (seemingly removing the onus for planning from the community and putting it with the health care providers):

Our model will bring health practitioners of a variety of sorts together so that there is a team environment working on behalf of the patients in that area. This stands out as one of the most essential elements of our government's strategy to transform health care by driving it down to communities and making family doctors available again in communities, after years and years of the absence of any commitment in that regard from two parties while in government (ibid, 2004, November 17).

The same day, however, Liberal MPP Pat Hoy blended the responsibility for determining community health needs between the community itself, and other unstated entities: “Across my riding, family health teams are being designed for communities and by communities” (Hoy, 2004, November 17), again making it

difficult to know exactly the mechanism for determining community needs, or who is making those decisions.

Despite repetitive claims made by the Liberals that FHTs would respond to specific community needs and “drive resources down to the community” (Smitherman, 2004, June 3; *ibid*, 2004, November 17; *ibid*, 2005, February 15), concerns were raised early in the implementation of FHTs regarding their proposed governance structures and whether these would be “truly” responsive to community needs. NDP health critic Shelley Martel asked specifically about whether FHTs would allow for community governance:

I wonder if the family health teams that the government is going to put in place will have community-run, local boards. That is key to the effective running of community health centres. We know that local control means that boards can respond effectively and in a timely fashion to the needs that come from the community. Those needs can be very diverse, can be very different, can be linguistic needs that need to be responded to, can be the needs of very difficult populations that people have to respond to -- HIV/AIDS clients, for example. Community boards can do that, and it will be interesting to see if the government will use what has been an effective strategy from CHCs and implement those with the family health teams, namely the community boards (Martel, 2004, December 6).

For this MPP, community needs are best defined by the community itself, and community governance of health care facilities is posited as the “true” way to address those needs. She presents these as “known” and “effective” strategies for meeting local needs. The language in legislature about who determines community needs in the CHC model is less ambiguous; the community-based board of directors are consistently claimed to be the main influence in determining the community’s needs (e.g., Martel,

2004, December 6; Gélinas, 2008, April 8). Whether this is the case empirically is another matter³⁵.

In fact, community-based (i.e., community-governed) FHTs (CFHTs) did become available as a governance option; there are 26 CFHTs in Ontario (Association of Ontario Health Centres, 2009). However, my data suggest that this option was not originally part of the plan for FHTs. For instance, on the Association of Health Centres of Ontario's (AOHC's) website, their historical timeline indicates that “[a]fter successful advocacy by AOHC, the Ministry recognize[d] community-governed FHTs” (Association of Ontario Health Centres, n.d., “Our History”). As well, for all the emphasis that they placed on FHTs meeting community needs, the Liberals were surprisingly silent about community-based FHTs in the legislative debate data, and about the issue of governance overall. My dataset showed that only the NDP made specific references to the CFHT model, and even then, only twice, by France Gélinas (2008, March 18, and 2010, May 4). In my dataset of over 200 legislative debate days, using a variety of lexical searches, I found no further references. I confirmed this with a search of the Hansard database for CFHTs³⁶ (and all variants of the term I could think of), which produced the same two results as those in my sample.

In addition to this silence in the data about this particular model, a report by the Association of Health Centres of Ontario (the advocacy organization for CFHTs)

³⁵ Johnston's case study of an urban CHC (1999) found that the involvement of community members on the CHC board of directors was low and subordinated to the interests of the health professionals working in the centres, particularly physicians (p. 71, p.97). This highlights the need for more empirical investigation of these dynamics at the micro-level in CHCs to test the claim that community members on the boards are the main decision-makers in these entities.

³⁶I used the search engine provided by the Office of the Legislative Assembly of Ontario, located at: <http://hansardindex.ontla.on.ca/> on December 5, 2012.

indicated that since their inception CFHTs have encountered difficulties in their interactions with the Ministry. This includes an allegation that CFHTs were encouraged by their Ministry contacts to drop the community governance model:

Those communities and groups that submitted successful IRFs [Information Request Forms], many of which had begun as CHC applicant groups, were all told at some time in their early development to abandon the community governance model. Ministry staff at various levels, site coordinators, consultants, Primary Care Team, repeatedly advised CFHT steering committee and boards to get physicians on their boards, contract with a FHN or FHO and forget community governance. In some cases, physicians who were already employees of CFHTs on the Blended Salary Model were encouraged by Site Co-ordinators to form FHOs [a capitation model] (Association of Ontario Health Centres, 2009, p. 7)

There are no further reports updating these findings. Overall, the findings from the legislative debate data, along with this report, suggest very strongly that community governance in the FHT model was never a priority for the Liberal government.

Justifying Actions with Teams

In their efforts to implement their agenda for changes to the health care system in Ontario, the McGuinty Liberals made controversial changes to the health system that were decried in legislature. These included levying a health premium, as well as de-listing chiropractic services, eye examinations, and some physiotherapy services from the Ontario Health Insurance Plan (OHIP) in May 2004 (Ontario. Ministry of Finance, 2004). The Liberals justified these moves with the promise of FHTs and CHCs, portraying their actions as the result of having to make “tough choices” that were necessary to implement their vision of primary care reform, which included introducing FHTs and expanding the number of CHCs. Sometimes, the Liberals also made a point of vilifying the actions of past governments that they claimed forced their hand, particularly with allegations of the

PC's record of cutting health care funding (Smitherman, 2004, November 22a; *ibid*, 2005, February 15) and leaving a severe deficit (Wynne, 2005, Apr. 18; Duguid, 2004, Oct. 14; Flynn, 2004, October 14), as well as allegations against the NDP for reducing medical school seats (Smitherman, 2004, June 2; *ibid*, 2004, June 9), a factor they claimed contributed to the physician shortage in Ontario. Examples of justifying delisting of services follow:

Example 1

Ms. Laurie Scott (Haliburton-Victoria-Brock) [PC]: My question is for the Minister of Health and Long-Term Care. Like most members of the Legislature, I've been hearing from my constituents about your government's budget and the impact it's going to have on them and their families. Although people are concerned with many aspects of the budget, the biggest issue I'm hearing about, and the most vocally, is the decision to delist health care services. This decision will have a direct impact on the residents of my riding, and they have been very clear about their lack of support for this measure. I will ask the minister: Will you please reconsider your decision to delist chiropractic, optometry and physiotherapy services?

Hon. George Smitherman (Minister of Health and Long-Term Care) [LIB]: By now I know the member has had a chance to hear, on a few cases, that we recognize the difficulty of this decision, and, frankly, the response is understandable and predictable. But the fact of the matter remains that as a government we face the challenge of adequately funding medically necessary services, and that's what we've done in our budget. In a statement earlier in the House, this member was very keen to acknowledge, as an example, that her community desires to have community health centres. I'm proud to say that as a result of the prioritization in this budget, there is \$111 million for new primary care initiatives, including \$14 million targeted specifically at community health centres (Scott & Smitherman, 2004, June 3).

Example 2 (re: delisting optometrists):

Ms Shelley Martel (Nickel Belt): I have a question to the Premier. Premier, your decision to delist eye exams from OHIP makes no sense, but what makes even less sense is the suggestion by the Minister of Health that a patient might need a referral from a family doctor in order to get an OHIP-covered eye exam. A diabetic whose eye care is already being monitored by an optometrist shouldn't have to go to a doctor in order to get a referral to that optometrist. Thousands and thousands of Ontarians don't have a family

doctor, so you're going to force them to go to an after-hours clinic or an emergency ward to get a referral to see an optometrist. Look, optometrists are highly qualified primary care providers. They ensure good, direct access for patients to eye care, and there is no need to impede that access by forcing them to see a doctor to get a referral first. Premier, why don't you just do the right thing and announce that all eye exams will be covered under OHIP?

Hon Mr. McGuinty: The Minister of Health.

Hon Mr Smitherman: The member, in her question, makes a point of the fact that too many Ontarians are struggling with access to a family doctor. I wonder why that is, I ask the member of the New Democratic Party and their government, that when they were in government, they cut the number of spots in medical schools that caused the problem of shortages of doctors in this province. Secondly, she obviously misses the point, which is that these medically necessary services for people with diabetes, as an example, will continue to be covered. But she misses one other important point as well: We have a different plan around family health teams and around the provision of primary care. It is that instead of one silo here and one silo there, which she continues to be a proponent of, we'll bring together interdisciplinary teams of health care providers working in a complementary fashion. It isn't all about a doctor over here and an optometrist over here and a nurse or a nurse practitioner over here and over there. It is about a vision for primary health care.

Ms Martel: May I remind the minister that his plan for family health teams doesn't even include optometrists, so who is he trying to kid? This move is going to do nothing to improve primary health care. In fact, it's going to increase the burden on doctors who are already overworked. It's going to decrease the legitimate role of optometrists in the health care system. ...I say to the minister, optometrists are primary health care providers. They have an important role in the system. Patients should have direct access to them, and that access should be paid by OHIP. Reverse your decision.

Hon. Mr Smitherman: The longer the honourable member talks, the more she makes my point. Optometrists and other providers ought to be part of a primary health care delivery team, and we're moving forward on a team approach (Martel & Smitherman, 2004, June 2).

It was not until October 2013 that the Liberal government integrated chiropractic and physiotherapy services into FHTs (Ontario. Ministry of Health and Long-term Care, 2013a, p.6). However, optometry has yet to be integrated into FHTs, despite Minister

Smitherman's assertion in the latter quote that optometrists should be part of a primary care team.

Discussion

Several points arising from the analysis of this data are worthy of further comment. First are some reflections about the nature of the interactions in the political social world with regard to teams, and more broadly, primary care reform. As one might expect, the language and style of interaction are at times highly "political," complete with attacks on the logic or governmental track records of other parties and touting the accomplishments of one's own party toward teams and primary care reform. As well, there are some obvious partisan stances evident in this data. For example, the NDP regularly take stances supporting community governance and greater equality between professionals within interdisciplinary teams; such stances are absent in the discourse from both the PCs and the Liberals. The PC members seem more concerned with physician autonomy than the other parties, based on their critiques of the OMA negotiations which denigrated the Liberals for not working more closely with the OMA. These stances continue basic patterns that I noted in my introduction to Ontario politics at the start of the chapter. However, the data also indicate significant instances of all-party agreement with regard to teams and primary care reform, including the need for role expansion of non-physician health professionals, to the need for interdisciplinary teams, and, ultimately, a commitment to the publicly funded health care system.

Second, it is worth reiterating some of the discursive patterns in the data with regard to teams and primary care reform. In the course of the debates about the introduction of FHTs, it became apparent that the structure of this new form of team brought several issues to the fore that resulted in both some clarifications and new paths

toward what could or should constitute a primary care team. For instance, debates over whether FHTs were unique from FHNs and FHGs clarified that both the Liberals and the NDP disagreed with the mainly physician-nurse only team structure enacted by the PCs. Thus, it was clarified in the House that the majority agreed that “teams” should consist of more than two profession types working together; teams must be, in the truest sense, *multidisciplinary* in their composition. However, the NDP took the Liberals to task several times for what they saw as a shortcoming in the FHT model, that is, the physician-centered division of labour, which they contrasted to the CHC model, “where everybody works as part of a team and is a colleague” (Gélinas, 2010, May 11). For the NDP, real teams are those that are, like CHCs, more horizontally structured, with the physician not necessarily being the centre of the care process, and with all professions on the same payment scheme (salary). The Liberals, however, were just as apt to claim FHTs as “real teams” in their physician-centered multidisciplinary structure.

Similarly, discussions of the FHT model also brought to the fore and clarified the possible meanings of “real” primary care reform. In addition to real reform being judged by the degree of interdisciplinarity of team structures, real reform was also defined by how resources were directed to and/or held at the local level. The Liberals claimed they were implementing real primary care reform in driving resources “down to the community level” (Smitherman, 2004, June 3). However, the NDP’s challenge to the Liberals in asking whether FHTs would be community governed differentiates between having resources allocated to the community level and having resources owned at the community level. Real reform was also judged by the NDP for its potential to change the hierarchical relationship between physicians and non-physician health professions.

While focusing on the discussion of FHTs showed how new or refined meanings of terms such as teams and reform occurred in the context of the political debates, insight is also obtained from focusing on the limits or silences of the discourse around teams and reform in this social world. The broader discourse of primary care reform in Canada as outlined in the Romanow Report and the First Ministers Meetings of 2003 and 2004 is very general in its requirements with regard to space, time, and who should provide the care, while at the same time implying interdisciplinary teams. However, the discourse is silent about exactly how the teams ought to be organized and silent on issues of governance. Further, the silence of the Liberals with regard to the option of community governance of the FHT model, coupled with the ambiguous language about who would determine community health needs in the FHT model, allowed for the much touted “flexibility” in governance structures of the Liberals’ model. This flexibility (or alternately, an absence of stated commitment to community governance by the Liberals) allows for the option of physician governance of FHTs, while also loosely promising that communities would be involved in some way in planning FHT services. More empirical research into the FHT development process as it occurred at the community level could help determine which community members were involved (and more deeply, what interests were being represented). Physician governance of FHTs might have been a logical choice, for several reasons. First, the pre-existing group practice structure of FHNs (i.e., physician-governed entities) would have saved the Liberals some work in setting up FHTs. Another possibility is that the conditions of the time (a severe shortage of physicians) might have demanded a model appealing to physicians (turn-key operations). Finally, the historical dislike of CHCs by physicians in Ontario (Lomas,

1985) may have also influenced the decision to allow FHTs the option of physician governance.

The comparison, blending, and appropriation of team names and types by the different parties is also worthy of further consideration. The attempts by the PCs to blend FHTs into their previous model of primary care (the FHN) by denying the uniqueness of the FHT model, and their appropriation of the term FHT could be seen straightforwardly as an attempt to keep their claim to a legacy of primary care reform in Ontario at the fore. The NDP was also suspicious of the Liberals' claim to the uniqueness of FHTs, and also questioned how FHTs were unique from FHNs. In doing this, the NDP is blending the strategies of the Liberals and PCs together, perhaps in an effort to highlight the NDP's uniqueness in relation to these two parties.

Given that the Liberals invested considerable effort in touting the FHT model as their claim to a legacy of reforming primary care, their discursive strategy of attempting to blend or match the characteristics of FHTs to CHCs (as in comparing their interdisciplinary team structure and community-level focus) warrants further examination. It is possible that this strategy was used in order to placate communities that had requested CHCs with FHTs instead, perhaps a more desirable option from a government standpoint, given that my data suggests CHCs are seen as the more expensive model. In promoting the shared interdisciplinary and community-level aspects of FHTs and CHCs, and remaining relatively silent about the difference in governance structures between the two models, the Liberals may have hoped for a simple substitution of models. More empirical research is needed to determine if those communities that had requested a CHC received a FHT or a CHC, to determine whether the substitution occurred, and, if it did, whether the FHT was felt to have met the community's needs.

This would help to untangle the factors seen as important to communities in their attempts to improve primary care services. Being *community-based* may not translate into knowing community needs as well as being *community-governed*. My findings highlight the need for vigilance about how the term community is used in the discourse about primary care reform; governments may claim that their models are meeting community needs by relocating services to the community level, but this does not necessarily equate to community control over those resources and decision-making processes.

In tension with (and opposition to) the discursive blending of FHTs with CHCs by the Liberals is the equation of CHCs with marginalized populations. As mentioned earlier, this manoeuvre, intentional or not, sets up the CHC model as a model with limited purpose, and seems to pave the way for the FHT model to become the flexible model of primary care for “the rest” of the population. It is difficult to predict the effect of this limitation. On one hand, it is promising to see governments acknowledge that some populations do have a harder time accessing health care, and need the “something extra” provided by the CHC model, particularly the increased provision of social services and mental health care. On the other hand, the superior performance of CHCs in chronic disease management (compared to physician-centered models) (Russell et al., 2009; Milliken et al., 2011) will be denied to the remainder of the population in an effort to save money. The FHT is still the unproven model in this regard, and could indeed prove to be a “bad investment”. If CHCs are forever relegated to the margins, the broader public may be unaware of the effectiveness of the model, and the possibility of community governance of their primary care system. While we can assume that some geographic areas contain higher levels of hard-to-serve populations, this is not to say that

those fitting the hard-to-serve category are not dispersed throughout areas seen as less in need of this type of interdisciplinary primary care team.

Overall, discursive strategies about teams have been found in this data that blend models in order to maintain political legacies and to make substitutions of one model for another, that keep silent about issues that might be of interest to Ontarians in general, but not to the government, that remain vague about other issues in order to maximize flexibility of future action, and that set limits on the mandate of the CHC model.

A third point of reflection is on the centrality of physicians in the Liberals' FHT model. The fact that the FHT is based on a group physician practice model with a separate funding envelope for the interdisciplinary team component speaks volumes about the priorities of the Liberal government with regard to the FHT model. Further, physicians negotiate their funding with the government, whereas the government sets the guidelines for how the remainder of the team should be paid (i.e., the *Guide to Interdisciplinary Provider Compensation*); there is no negotiation with the government by these workers regarding their remuneration. The lion's share of the funding goes toward physicians, given that physicians outnumber the non-physician professionals. Thus, the distribution of financial and decision-making power in the FHT model is highly skewed in the favor of physicians, helping to maintain the traditional hierarchy between physicians and non-physicians.

As well, the physician-centeredness of the FHT model represents a gamble on the part of the Liberals, who have put their faith and the bulk of their financial resources into changing physician practice to be more interdisciplinary in order to solve the problem of deficient primary care services. Less emphasis went into trying other strategies believed in the past to be successful in primary care reform, namely, in community governance of

health services and in less physician-centered team arrangements. While the Conference Board of Canada is currently conducting a 5-year review of FHTs (Conference Board of Canada, 2014), future empirical work could focus on aspects of FHTs not covered by the review, to assess the success of the Liberal strategy of focusing on enhancing physician-centered care with interdisciplinary “helpers” to improve primary care services.

Finally, there are two points from the data regarding Ontario communities and the Ontario public, which are worth further consideration. First, my findings suggest that there is a conflation of community and the broader public occurring in the debates, where interest expressed by specific communities is extended to represent the interest in interdisciplinary primary care teams by the public as a whole. These findings are contradicted by my interview data, which suggest that the public is for the most part unaware of not only interdisciplinary primary care teams, but also primary care reform. These suggest that there is a need for more empirical study to determine the level of knowledge of the public with regard to primary care reform and to interdisciplinary primary care teams, including its knowledge about the variety of team models available, how those teams are structured, how the labour is divided, and how they are governed, and what public preferences would be regarding each of these aspects. The broader public’s preferences might be different than those of politicians, of community leaders, and of health professionals, and knowledge of those preferences might help to improve the design, appeal, and utility of teams meant to serve them.

Second is a consideration of the power of the public in this situation. There is a considerable amount of talk in the legislative debates about the Ontario public with regard to teams and primary care reform. However, there seems to be little evidence of the broader public’s voice in this particular social world. These two factors combined

make the public what Clarke (2005) calls an implicated actor, a person or a group of people who are invoked in discourse, but for whatever reason, remain silent in the situation. It is surprising and regrettable (from a public interest perspective) that there was not a consultation by the government with the broader public about the implementation of interdisciplinary primary care teams during the McGuinty era, and the broader public's voice does not appear to be present in this particular social world.

However, I would argue the public is not without some power in this situation, though I would caution that it might best be described as a latent power. Just as it is an implicated actor, my data suggest that the public in this situation is also an implicated audience. The Legislature, though dominated by politicians, is a public institution, with its records (Hansard Reports) available to the public, and whose procedures are broadcast on television. The political parties constantly battle in Legislature to be seen or remembered as the party that implemented the truest, most extensive, or best primary care reform in the name of saving the publicly funded health care system; these verbal battles are displays aimed at the public, who ultimately vote a given party into power. The claims of each party to a legacy of commitment and action toward primary care reform are an important cue for Ontarians to take their own action with regard to interdisciplinary primary care teams.

Chapter Five

Medical Professional Social World

Introduction

In this chapter I focus on the talk, the claims made, and the actions taken toward interdisciplinary primary care teams in the Ontario medical professional social world. I focus on organizations representing both the medical profession as a whole [the Ontario Medical Association (OMA) and the College of Physicians and Surgeons of Ontario (CPSO)], and the sub-world of family medicine, the segment of the medical profession most involved in and affected by primary care reform [represented by the Ontario College of Family Physicians (OCFP)]. Data for this chapter derive from medical organization policy papers, news releases, position statements, and other types of communiqués publicly available from their respective websites³⁷. The data range in date from 1996 to 2011. The data mainly reflect the views of the leadership of the medical profession, though the data also occasionally allude to the views of front line physicians, which sometimes differ from those of the medical organizations. Furthermore, the data point to some disagreements between the OMA and the OCFP about how interdisciplinary primary care teams should work.

My data suggest that, overall, interdisciplinary primary care teams are viewed positively by the medical organizations in my study. However, this support is highly conditional, in that they only actively endorse team models that maintain the dominant position of the medical profession vis-à-vis other health professions, and maintain the

³⁷ While there were interviewees from this social world, most preferred to not be quoted directly, and the greater focus on specific organizations in this chapter made it difficult to integrate interview materials without the chance of identifying participants. For this reason, this chapter relies on textual data.

financial autonomy of physicians. In this social world, Family Health Teams (FHTs) are the model of least contention, and Nurse Practitioner-led Clinics (NPLCs) are the model of greatest contention. The Community Health Centre (CHC) model is rarely mentioned in these data; when they are discussed, they are largely seen as a specialized model that focuses on marginalized populations. Though the FHT model is the most favored form of government-funded team currently available to physicians, physician organizations call on the provincial government to allow other models of interdisciplinary primary care teams, particularly those that allow physicians more choice in payment structure.

After briefly introducing the medical organizations included in this study, I examine the medical organizations' views of the broader primary care reform movement. I then outline an array of strategies used by the medical profession to keep their dominant position in the midst of the development and implementation of interdisciplinary primary care teams, including how they construct and use discourses about teams and collaboration to justify their positions. Finally, I consider some of the implications of my findings.

Primer on Physician Organizations

Each of the organizations included in this study has a unique mandate regarding physicians and interdisciplinary primary care teams in Ontario. The Ontario Medical Association (henceforth OMA) "...represents the political, clinical and economic interests of the province's medical profession" (Ontario Medical Association, 2013). The OMA has existed since 1880; however, changes in the relationship between the state and medical profession wrought by cost containment initiatives in the 1990s led to the OMA agreeing to become the official collective bargaining agent for all Ontario physicians

(including family physicians) in 1991 (Coburn et al., 1997, p. 8). The OMA has played a significant role in the evolution of primary care reform in Ontario, starting with their involvement in the development of Family Health Networks, a pre-cursor of Family Health Teams, through their continued role as bargaining agent for physician compensation in team settings, and in formulating policy suggestions for interdisciplinary primary care teams.

The original mandate of the Ontario College of Family Physicians (henceforth OCFP) since its foundation in 1954 was to provide continuing medical education for family physicians (Rosser & Kasperski, 2010, p. 1). Changes to the health care system in Ontario during the 1990s that were seen by the OCFP as threatening to the long-term viability of family medicine prompted their expansion of mandate into the areas of research and public policy, in order to help “...establish family medicine as the cornerstone of our transformed healthcare system in Ontario” (ibid). The OCFP has made progress in their expanded mandate, producing over 50 documents in policy and research as of 2006 (Ontario College of Family Physicians, 2006, Spring, Appendix A), securing over \$35 million in Primary Health Care Transition Funds to do research in primary care reform from the family physician perspective (ibid, 2008, October, p. 5), and advising both government and the OMA on policy issues pertaining to family medicine broadly and interdisciplinary primary care teams specifically (Ontario College of Family Physicians, 2006, Spring, p. 5). The OCFP has distinguished its views from those of the OMA regarding primary care reform on at least two occasions³⁸. The OCFP

³⁸ The OCFP, for example, has openly disagreed with the OMA on physician reimbursement for providing comprehensive primary care services (including the provision of preventive care) in supporting the blended payment model when OMA rejected it in 1994 (Rosser & Kasperski, 2010, p. 2). The OCFP also distanced itself from a 2009 OMA advertising campaign that openly questioned scope of practice expansion of nurse

has increased its presence and influence in the primary care reform milieu in Ontario and serves as a prominent advocate of family medicine in Ontario.

The College of Physicians and Surgeons of Ontario (henceforth CPSO) is “...the body that regulates the practice of medicine to protect and serve the public interest” (College of Physicians and Surgeons of Ontario, n.d., “About the College”). The duties of the CPSO include “...issuing certificates of registration to doctors to allow them to practise medicine [;] monitoring and maintaining standards of practice through peer assessment and remediation[;] investigating complaints about doctors on behalf of the public, and conducting discipline hearings when doctors may have committed an act of professional misconduct or may be incompetent” (College of Physicians and Surgeons of Ontario, n.d., “About the College”, n.p.). My use of data from the CPSO is less frequent compared to that from the OCFP and the OMA. The CPSO’s comments about interdisciplinary primary care teams are limited mostly to acknowledging the necessity of primary care reform and interdisciplinary teams, and to concerns around the expansion of scope of practice of non-physician health professionals. The most relevant materials from CPSO are included in this chapter.

Acknowledging the Need for Primary Care Reform and Teams

As with the data from the political world, discussion of interdisciplinary care teams in the medical social world in Ontario is intertwined with discussion of primary care reform. There is broad agreement with the political world, in that data from the medical social world also posit primary care reform in Ontario as necessary to resolve

practitioner and pharmacists. While the OCFP also questioned scope expansion, they disagreed with the negative tone of the OMA’s campaign (Ontario College of Family Physicians, 2009, October, p. 2).

cost, efficiency, and human resource issues in the existing system, and ultimately, to protect the publicly funded health care system. Documents in this social world note a need to move primary care from expensive hospital settings into community settings to save costs (Ontario College of Family Physicians, 2011, p. 6) and to make primary care more efficient and less wasteful (Ontario College of Family Physicians, 1998b, p. 2). Both the Ontario Medical Association and the Ontario College of Family Physicians firmly state their commitment to maintaining the publicly funded system (Ontario College of Family Physicians, 1996, p. 1; Ontario Medical Association, 2005, n.p.).

More specific to the medical social world, primary care reform is also portrayed in the data as necessary to help physicians with changes affecting the knowledge base and everyday practice of medicine. Tremendous growth of medical knowledge and technologies (Ontario College of Family Physicians, 2005, December 5, p.1; Ontario College of Family Physicians, 2005a, p. 6), the aging population, and increasing rates of chronic disease are making patient care more complex than in the past and adding significantly to the everyday workload of physicians (ibid, 2005b, p. 16; ibid, 2000b, p. 2). The extra workload for Ontario's family physicians due to the physician shortage is also highlighted in the data (ibid; ibid, 2004, p.8). The need for family medicine to practice more preventive care in addition to acute care (ibid, 2002, p. 3; ibid, 2004, p. 6), to pay more attention to treating mental health issues (Ontario Medical Association, 1998, n.p.; Ontario College of Family Physicians, 1999, p. 15), and to strive to address issues of access to health services for marginalized populations in their everyday practice (ibid, p. 16; ibid, 1998a, p.2) are also discussed.

Interdisciplinary primary care teams are presented by medical organizations in Ontario as part of the solution to these issues, with specific references to the need for

teams appearing as early as 1996 (Ontario College of Family Physicians, 1996, p. 22). Teams are seen as a way to improve clinical outcomes, including the quality of patient care and patient satisfaction (Hanna, 2007, p.5) and as a way to reduce referrals to specialists and emergency department use (Rosser & Kasperski, 2010, pp. 2-3). Teams are also presented as a way to revitalize family medicine³⁹ in that teams will offer a better work/life balance by reducing physician workloads (Ontario College of Family Physicians, 2008a, p. 4; *ibid*, 2005, May 31, p. 5), and more generally, will attract graduating physicians to practice in family medicine (*ibid*).

The recognition of changing conditions and the acceptance of interdisciplinary primary care teams as a solution are tempered by warnings from medical professional organizations of the limits of teams. The OCFP noted in 2005 that “[g]overnments across Canada seem to view collaborative interdisciplinary teams as a panacea... policy has been built entirely on the hope that team work will make a difference” (Ontario College of Family Physicians, 2005b, p. 31). Similarly, the OMA noted in its policy paper on interprofessional care that “... while improvements in interprofessional care are welcomed, they will not solve all of the problems in our health-care system” (Hanna, 2007, p.1). Physician organizations assert that addressing Ontario’s acute shortage of physicians⁴⁰ is also an important strategy to resolve the problems of the system:

As we look to the potential our current primary care initiative [the development of the FHN and FHG models, precursors to the FHT model] provides, we also cannot afford to have unrealistic expectations. It would be naïve to assume that primary care reform can and will meet all of the

³⁹ The data for the OCFP presents family medicine as being “in crisis” (Ontario College of Family Physicians, 2005, May 31, p. 2; *ibid*, 2008, July 15, p. 1). Elements of the crisis include low enrolment compared to medical specialties (*ibid*, 2005, October 25, p.2) being viewed with disdain by the broader medical world (*ibid*, 2005, May 31, p. 4), and suffering low morale (*ibid*, 2008, July 15, p. 1).

⁴⁰ The shortage has since been slowly reversing (Interview 007; Interview 012; Interview 013).

challenges we face throughout the health-care system. Ontario has a problem of both physician supply and distribution. More physicians are required to provide sufficient care. Primary care reform may help make the way primary care is delivered more effective, but it will not be able to address the problem of physician shortage (Ontario Medical Association, 2000, n.p.).

The physician shortage is thus seen as the most pressing issue to be resolved and as a problem that is separate from, and not cured by, primary care reform.

Taking Charge of Primary Care Reform and Teams

The discourse on primary care reform in the medical social world further focuses on attempting to keep the dominant position of the medical profession in the changing structure of primary care in Ontario at the fore of discussion and action. The medical organizations I studied employ a number of discursive strategies to do this: they highlight their political involvement and leadership in primary care reform; they attempt to define primary care as based on first contact with physicians and as distinct from primary health care; they assert the fundamental importance of the patient-physician relationship to the health care system; and they make recommendations about how primary care reform should work with regard to the pace and tone of reform, the role of non-physician health professionals, and the need to expand beyond capitated and salaried payment models for physicians. Each of these is examined in more detail below.

Highlighting Political Leadership in Primary Care Reform

Medical organizations recognized early in the primary care reform process that physicians needed to be politically involved. As early as 1996, the OCFP expressed their view of the importance of having family physicians become politically involved within the Ministry of Health during the reform planning process:

In order to implement such reforms [primary care reform], it is very important that the health professionals who form the foundation of our

primary health care system be represented within the Ministry of Health...In Ontario, if family physicians are to participate effectively in the development of policies affecting primary care, they must have a voice in the planning process within the Ministry, as does the nursing profession. Participation rather than reaction is the goal; more importantly, participation is the means to effective health reform (Ontario College of Family Physicians, 1996, p. 10).

The phrase “participation rather than reaction” is particularly interesting, because it reflects Coburn et al.’s (1997, p.8) assertion that medical organizations in Ontario have increasingly relied on negotiation with the state and becoming involved in health policy planning rather than on job action, as they had in the past⁴¹. Throughout the primary care reform process in Ontario, members of the medical profession have become deeply involved in primary care reform planning at the Ministry level, either through appointments to special committees⁴², or through becoming high-ranking civil servants in the Ministry⁴³.

The OMA and the OCFP also sought to become politically involved in the primary care reform process, from outside the Ministry. Their respective views of reform did not always match, however. Further, there was a power differential between these two organizations. The OMA was in a better position to influence policy early compared to

⁴¹ The last instance of physician job action in Ontario was in 1986, when physicians went on a three-week strike over the issue of extra-billing. The strike failed to gain the support of the public, the media, and even members of the medical profession to the point that the OMA called off the strike without making any gains in their fight to extra-bill (Coburn et al., 1997, p. 8).

⁴² For example, Ruth Wilson, a family physician, served as chair on both the Progressive Conservatives’ Ontario Family Health Network (OFHN) to implement the FHN model and on the Liberals’ Family Health Team Action Group to implement the FHT model (Smitherman, 2004, December 6). Jim McLean, a family physician, led the primary care branch of the Liberals’ Health Results Team, and was responsible for informing communities in Ontario about how to set up Family Health Teams (Smitherman, 2004, December 6).

⁴³ Joshua Tepper, a family physician, served at the rank of Assistant Deputy Minister in Ontario’s Ministry of Health and Long-term Care in the Division of Health Human Resources (Ontario College of Family Physicians, 2009, December 16, p. 2).

the OCFP, as it had become the official bargaining agent for all physicians in Ontario, a prerogative granted to them by the provincial government in 1990 (Coburn et al., 1997, p. 8). During the beginnings of reform, the OCFP was still only starting to expand its mandate to include research and policy work; however, it would eventually claim its success in influencing primary care reform policy. The differences of opinion between the two entities in the early days of reform, as found in my data, are examined for the way these shaped reform, and ultimately, interdisciplinary primary care teams in Ontario.

OCFP Claims to Leadership in Primary Care Reform

Data from the OCFP discuss the differences of opinion held between the OMA and the OCFP with regard to primary care reform. Further, the OCFP portrays these disagreements as the spark that prompted the OCFP to propose two models of primary care, the Family Health Network (FHN) and an un-named progenitor of the FHT. According to the OCFP, one source of disagreement between the two entities was based on the work of five academic chairs of departments of medicine in Ontario⁴⁴, who proposed that Ontario primary care physicians should be paid on a blended payment model (a combination of capitation, salary, and fee-for-service payments) in order to provide physicians with incentives to provide a consistent and wider variety of primary care services (Rosser & Kasperski, 2010, pp.1-2; Forster et al., 1994, p. 1524). The OCFP alleged that the OMA dismissed the blended payment plan “...as having come from ‘ivory tower academics with little connection to the real world’” (Rosser & Kasperski 2010, pp.1-2). In contrast, the OCFP Board of Directors agreed with the changes proposed by the academic chairs (ibid, p. 2). There are no references in the OMA

⁴⁴ The chairs were: John Forster (University of Ottawa), Walter Rosser (University of Toronto), Brian Hennen (Western Ontario), Ron McAuley (McMaster University), and Ruth Wilson (Queen’s University) (Forster et al., 1994, p. 1523).

data about its initial rejection of the blended payment model or its rebuking of OCFP for developing policy, nor could I locate any outside of my data to corroborate the OCFP's claims.

The second point of contention concerned the standardized basket of fifteen primary care services outlined by the Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) in 1996⁴⁵ as constituting the minimum range of primary care services that should be provided by physicians to their patients. The OCFP agreed with PCCCAR's assessment. The OCFP alleged that the OMA failed to incorporate the full PCCCAR basket into its Primary Care Network model, a model developed in conjunction with the Ontario government in 1998 as an early experiment in primary care reform (Rosser & Kasperski, 2010, p. 2).

The disagreement over the blended salary model prompted the OCFP to take measures to expand its mandate into research and policy development. When the OCFP had released its first research-based policy paper introducing a "new model" of primary care in 1997, it alleged the OMA "...took issue with the OCFP for developing public policies, stating that the OMA had sole responsibility in that regard"(Rosser & Kasperski, 2010, p.2). The OCFP nonetheless continued to work on the "new" (but not named) model and held a conference in 1999 to present it to the government, the opposition

⁴⁵ I could not locate any original document(s) released by the Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR). The work is cited in other government documents. One such document (Report of the Provincial Working Group: Alternative Funding Plans for Academic Health Science Centres, available at http://www.health.gov.on.ca/en/common/ministry/publications/reports/ahsc_fund.pdf, accessed April 1, 2013) states that the PCCCAR papers were unpublished, despite being widely cited (p.3). My search was further complicated by the fact that the OCFP mistakenly deciphered the acronym as the Primary Care Committee on Community and Academic Relations in my source document. I have included the information on PCCCAR here because of the important effect it had on spurring change on the part of the OCFP.

parties, and the larger medical community (ibid). The OCFP's story of its "new model" then becomes vaguer:

The first Family Medicine Forum/Think Tank in September 1999 resulted in a decision to move the [OCFP's] model forward. The 2000 OMA/MOHLTC [Ministry of Health and Long-term Care] negotiations were anchored in strong support for family doctors and resulted in a commitment to develop a blended funding model for the family physicians of the province. The Ontario Family Health Network Agency was established to assist physicians to develop Family Health Networks [FHNs]. Further recommendations resulted in the development of the Family Health Group (a blended funding model weighted towards fee-for-service) and Family Health Organizations (weighted towards pure capitation) in 2003 (Rosser & Kasperski, 2010, p.2).

The OCFP does not make a direct claim that the resultant FHN model is "their model", but it is implied that their model somehow influenced the developments leading to the FHN. In the very next sentence of the next paragraph in their narrative, however, the OCFP makes a direct claim that the Liberal party adopted "their model", giving rise to the FHT: "In 2002, the newly elected Liberal Party adopted the OCFP's' [sic] model and established 150 FHTs with another 50 to be announced in the near future" (ibid, 2010, p. 2).

OMA Claims to Leadership in Primary Care Reform

The OMA also highlights their leadership role in primary care reform. As already noted, the OMA's first experiment with primary care reform was to negotiate Primary Care Networks with the Ontario government:

Many components of health care are undergoing change or review. As front-line providers, physicians of Ontario experience the stresses on our health-care system and witness the resulting impact on patients everyday. That is why we [the OMA] are actively exploring different ways of improving our health-care system for the better. We know that one potential area for change is in primary care, which is why the OMA is leading the way, with the government, in exploring a new model of providing primary care to patients. Our goal for this project, ultimately, is to determine whether the [Primary Care Network] model can improve the quality of patient care, to see whether

it can provide a greater continuum of care and if it can assist in the prevention of disease (Ontario Medical Association, 2000, n.p.).

The OMA's language concerning the introduction of the FHN model (the physician group practice model on which FHTs are based⁴⁶) also suggests their considerable influence as the official bargaining agent of physicians in Ontario in shaping primary care reform:

The Ontario Medical Association (OMA) voted today to allow a new provincial initiative to be offered to Ontario's family doctors, a key step in paving the way toward voluntary province-wide primary health care reform. As the implementation arm of primary care reform, the Ontario Family Health Network (OFHN) will be offering this new contract to family physicians who choose to form a Family Health Network. "Today's decision is another step in the evolution of primary care in Ontario. Physicians who voluntarily wish to enter into a Family Health Network now have the means to do so," says OMA President, Dr. Kenneth Sky. "Building on the 1999 MOHLTC/OMA agreement, this agreement on primary care reform represents the desire of the Ontario Medical Association and Government of Ontario to provide quality health-care for the patients of this province. The OMA looks forward to developing future PCR [primary care reform] policy and working with OFHN [sic] to implement further reform." It is intended in [sic] that the Family Health Network (FHN) model doctors work in teams with other health care professionals to provide accessible, continuous care to their patients (Ontario Medical Association, 2001, n.p.).

Of particular interest here is the language depicting the relationship between the OMA and the provincial government. While the OMA is careful to state that their involvement in this particular part of reform is in conjunction with the Government of Ontario, the wording stating that it is "allowing" the government to "offer" physicians a deal clearly positions the OMA as the gatekeeper to Ontario's physicians. It is also clear that the OMA intends to continue their involvement in reform with the government. Finally, the

⁴⁶ The FHN model was originally supposed to be a model that would encourage involvement of non-physician health professionals in the provision of care. As I noted in Chapter Four, the model has generally been seen in both the legislative debate data and my interviews as unsuccessful in that regard.

language clearly suggests the voluntary nature of this change, leaving the decision to pursue team-based models in the hands of front line physicians.

Overall, the language and actions of these two medical organizations suggest a strong commitment of the medical establishment to be not only involved in primary care reform, but also to ensure that the changes match physician interests and are voluntary for physicians.

Distinguishing Primary Care from Primary Health Care

Another strategy used by physician organizations to maintain physicians' favorable position during primary care reform in Ontario was to claim the term "primary care" as physician care. My data suggest that the history of this strategy varied between the OMA and OCFP; each of these is examined in turn.

Prior to 2000, the OMA's definition of primary care matched that of the provincial government. In 1998, the Ontario Progressive Conservative government defined primary care as "...a term that refers to a person's first point of contact with a health provider" (Government of Ontario, 1998, May 26). The generic term "provider" is not specified here or throughout the remainder of that document. An OMA document, also from 1998, uses a very similar definition:

Primary care is frequently perceived as the point of first contact with the health-care system. This could involve an assessment by a physician, chiropractor, optometrist and others at a separate facility (Ontario Medical Association, 1998, n.p.).

In the same document, the OMA promotes a definition of primary care that allows for the creation of teams of various health professionals:

Primary care is perhaps usefully seen as, "an approach to providing primary care rather than a set of specific services, with its practitioners or facilities judged on a degree to which they implement this approach." Focusing on the

approach to primary care allows for different types of practitioners, nurses, physicians, and others, to function as teams competing for the designated provision of primary care services (Ontario Medical Association, 1998, n.p.).

Further, OMA documents from this period appear to use the terms “primary care” and “primary health care” interchangeably and indiscriminately. An example follows, with the relevant terms bolded to highlight their interchangeable use:

The Definition of **Primary Care** [:] There have been a number of definitions of **primary care**. The World Health Organization used over 100 words to describe **primary care** in its 1978 Alma Ata Declaration, an excerpt of which appears below: "**Primary Health Care** is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health care system of which it is the nucleus and of the overall social and economic development of the community...It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process...**Primary Health Care** addresses the main health problems in the community, providing promotive, preventive, curative, supportive and rehabilitative services accordingly" (Ontario Medical Association, 1998, n.p., emphases added).

Thus, during this period, the OMA suggests that primary care may occur with any type of health care professional, and sees the terms primary care and primary health care as interchangeable.

However, starting in 2000, the OMA's definition of primary care changes, from any health care practitioner as the first point of contact to physicians as the first point of contact:

The need for effective primary care is important because primary care is the first point of contact a patient has with a family physician. Patients know from experience that their family doctor provides a wide range of services, whether it's providing treatment or care in his or her office, or referring to a specialist or another provider and monitoring their progress. Since primary care is a crucial component of the overall health-care system, fundamentally altering it would have a major impact on the 11 million people living in

Ontario and the 10,000 general practitioners who care for them (Ontario Medical Association, 2000, n.p.).

Here, the OMA explicitly defines primary care as first contact with a family physician, and subsequently constructs what patients “know” about the abilities of physicians. The last statement in the example continues to imply that primary care is physician care, in stating that altering primary care will affect millions of patients and thousands of physicians. At this point, it is difficult to tell whether the OMA’s equating primary care with physician care was perfunctory, or an intentional defense of physician territory vis-à-vis other health practitioners. However, a paragraph further in the original text clarifies that physicians see primary care as physician care that may be *assisted* with other health care providers:

Many health professionals can be part of the new primary care network. For example, nurse practitioners, under the supervision of a physician, can be a positive complement to the expertise physicians offer and can provide many services including disease prevention and health education. Physicians in Ontario welcome the important role nurse practitioners and other health care providers can play in primary care teams (Ontario Medical Association, 2000, n.p.).

The assertion that physicians in Ontario “welcome” the role of nurse practitioners in primary care teams suggests that nurse practitioners are being invited to be *part* of primary care, which they have already established is physician care. The statement that nurse practitioners would be providing care in a complementary fashion and under the supervision of a physician insinuates their placement into an already assumed hierarchy. As presented in this text, primary care is physician care that may be assisted with other health care providers.

Starting in 2007, the OMA carefully distinguishes primary care from primary health care, in contrast to its 1998 document that used the terms without distinction. In its

policy paper *Comprehensive Primary Care*, the OMA introduces the term “primary medical care” to further distinguish between “primary care” and “primary health care”:

In articulating a vision of an ideal model of primary care, it is important to define the topic in clear terms. Although primary medical care and primary health care are used interchangeably in much of the literature, it is important to distinguish between the two and recognize the unique role of the comprehensive primary care physician and medical care within the primary care system. The OMA supports the following definitions of primary medical care and primary health care... *Primary medical care draws on the unique skill-set of the comprehensive primary care physician, coupling the diagnosis, treatment and management of health problems with the provision of illness prevention and health promotion services... Primary health care incorporates primary medical care, but places a greater emphasis on the broader determinants of health, including population health, sickness prevention and health promotion, with services provided by comprehensive primary care physicians and other providers, often in group practice and multi-disciplinary teams* (Ontario Medical Association, 2007, p.1, italics in original).

The OMA thus defines primary health care in terms relative to primary medical care (“incorporates primary medical care”) and places comprehensive primary care physicians first in a dichotomy (physician vs. “other providers”). It asserts the unique skills of the physician in the traditional areas of diagnosis, treatment and patient management. Further, they assert that the location of primary health care “often” occurs in physician group practice, with multidisciplinary teams listed second. The language throughout this passage acts to emphasize the physician role and make it central to both primary medical care and primary health care. The OMA thus makes a clear distinction between primary care and primary health care, and subsequently attempts to make primary care the central concept that subsequently encompasses primary health care.

The strategy of distinguishing primary care as physician care is slightly different in the data from the OCFP. It should be noted first, though, that as with the pre-2000 OMA data, OCFP makes no distinction between the terms primary care and primary

health care from the 1990s until 2005. Even its 2004 policy document dealing with primary care (Ontario College of Family Physicians, 2004) uses both terms throughout the document with no distinction between them.

However, starting in October 2005, distinctions are clearly made in the OCFP data between the terms primary care and primary health care. The term primary care becomes explicitly associated with physician care; coupled with this clear link are the OCFP's claims about the efficacy of primary care that is supported both by scientific evidence and the long-standing confidence of the public in family physicians. These are contrasted to the term primary health care, which is portrayed as an unclear concept, as lacking evidence of efficacy, and as potentially upsetting or confusing the general public. The OCFP clearly criticizes literature that treats the two terms as interchangeable (despite following the same pattern in their writing up to that point). Examples of these manoeuvres follow. In this first example, the OCFP portrays primary care as evidence-based, and contrasts primary health care as having a weak evidence base.

As governments all across Canada begin to implement strategies to enhance their primary care system, they tend to use the terms primary care and primary health care as if they are interchangeable. While there is clarity on the meaning of primary care [this is not specified until the next page in the original document, where primary care is explicitly linked to physician care], consensus on the meaning of primary health care has yet to be established. In spite of several attempts to impress upon the public the value of a primary health care system, the reference to "primary care providers" confuses the public whose main interest is in having a family doctor. The discipline of family medicine is evidence-based and the benefits of a strong patient/physician relationship are well documented; however, primary health care strategies are being developed and implemented in an iterative fashion without the benefit of a strong evidence base. In many instances, this is due, in part, to the fact that this is ground-breaking work (Ontario College of Family Physicians, 2005b, p. 5).

Their assertion that the term "primary care providers" is confusing the public is also interesting; coupled with the insinuation in the two lines that primary health care is being

implemented hurriedly (“implemented in an iterative fashion without the benefit of a strong evidence base” and “ground-breaking work”), it gives one the sense that OCFP sees primary health care as a fad, distracting the public which would prefer a family doctor to another arrangement. Primary care is portrayed as solid and dependable, while primary health care is portrayed as confusing and weak in its evidence base.

The next example focuses on equating the term “primary care” with physician care, arguing its efficacy, and presents “primary health care” as having little evidence of efficacy:

Our review of the literature strongly supports our position to move forward with investments in primary care; however, while there is a wealth of evidence to support major investments in our primary care system, there is a paucity of evidence regarding strategies being promoted as key to the implementation of a primary health care system. Research conducted both within and between countries points to better effectiveness of the healthcare system at lower costs when primary care (i.e. primary care physician supply and receipt of care from primary care physicians) is adequate and easy to access (Ontario College of Family Physicians, 2005b, pp. 5-6).

In this next example, the OCFP addresses the concept of interdisciplinary care teams in relation to its distinction between “primary care” and “primary health care”. The equation of “primary care” with physician care and the known efficacy of primary care are reiterated. However, rather than contrasting primary health care as untested and unknown in terms of its efficacy, the discourse instead focuses on concerns about governments’ tendency to treat primary care (i.e., physicians) and primary health care (“other”, non-physician health professionals) as though they were interchangeable. The OCFP also voices its concern that funding will be diverted from family practices to “something other than traditional family practice”:

While there is support for interdisciplinary teams, there is little clarity on what we want them to do. The evidence is strong for investing in primary care services (i.e. family physician supply and family practice services) in

Canada; however, government documents refer to investing in primary health care, often using primary care and primary health care (i.e. access to a broad range of health, healthcare and social services delivered by dentists, chiropractors, psychologists, public health nurses, social workers, dietitians, pharmacists, rehabilitation professionals, nurse practitioners, etc.) as if they were interchangeable. Physicians are struggling to deliver the comprehensive primary care services identified by the Provincial Committee on Community and Academic Health Centre Relations (PCCCAR) in the 1990s, in addition to secondary & tertiary services (such as hospital and emergency care, obstetrics, home visits, palliative care, care for the elderly at home and in long term care facilities, etc.) and want help to do so. The language of primary health care and interdisciplinary collaborative teams suggests that government is planning to fund something other than traditional family practice services, and the lack of clarity about what that something is, has caused confusion, mistrust and even resistance (Ontario College of Family Physicians, 2005b, p. 23).

While the OCFP clearly wants interdisciplinary teams, they are also clear about wanting those teams to be based on family physician practices. These examples show the development of a clear binary for the OCFP with regard to these terms. Where the OMA simply attempted to co-opt primary health care by defining it as an extension of primary medical care, the OCFP takes a slightly different approach, in trying to invalidate primary health care as unclear and unproven and to contrast it to the tried and true primary care (physician care), which desperately requires funding for a particular kind of interdisciplinary approach (one based on family physician practice).

The considerable attention given to distinguishing the terms “primary care” and “primary health care,” as well as its rather abrupt appearance in the data compared to documents even a year earlier, piqued my curiosity. Why was the OCFP suddenly compelled to make this distinction? Re-examining my data, I came across a potential reason, in the form of an advertising campaign by the federal government intended to educate the Canadian public about potential changes to the health care system. The campaign is first mentioned in the proceedings of the sixth Family Medicine Forum,

hosted by the OCFP on September 24, 2005, where keynote speaker Dr. Carolyn Bennett spoke of the campaign. The proceedings state:

Dr. Bennett began her address by presenting to the participants a television advertisement designed to introduce the public to the key concepts of primary health care. The message emphasizes teams, healthy living, information sharing and telehealth. The message delivered by Dr. Bennett was that the key role family doctors play in our healthcare system is not recognized in the messaging (Ontario College of Family Physicians, 2005d, p. 12).

Nothing more about the campaign is mentioned in these proceedings. However, it appears that the OCFP picked up on this almost immediately, with the Light at the End of the Tunnel document suddenly distinguishing primary care from primary health care less than two weeks later, as outlined above.

However, the advertising campaign is directly addressed by OCFP's then-president Cheryl Levitt in a March 2006 membership communiqué:

In September 2005, federal Health Minister Ujjal Dosanjh and the Honourable John Nilson, Saskatchewan Minister of Health, announced the launch of the National Primary Health Care Awareness Strategy's campaign to provide Canadians with a better understanding of primary health care. The ads were run in November⁴⁷ and again in February and March. The campaign proposes that there are "Four Pillars" of "Primary Health Care": "teams, information, access and healthy living". It's not that I don't agree that we need better team approaches, enhanced information technology, improved access and the promotion of healthy living. Properly implemented in a collaborative way with family physicians, these initiatives would go a long way to improving health care in Canada. But these ads imply, by omission, that it is national policy that the primary health care teams envisaged by governments right across Canada are somehow going to supplant or replace family doctors. Many millions, the overwhelming majority, of Canadians have a family physician, and 94% believe is important to have a family physician who delivers the majority of the care [she cites an unspecified Decima Poll]. Those that don't have a family physician are clamouring to get one. People fortunate enough to have a family doctor have better access to services and are more satisfied with every sector of the system. So where are the family physicians in this federal-provincial-territorial campaign? The ads and website identify many partners,

⁴⁷ This suggests that the commercial had not aired prior to the September 2005 Family Medicine Forum, but that Dr. Carolyn Bennett had somehow known about their content prior to their airing.

pharmacists, nurses, dietitians, dental hygienists, etc. -- but not family physician partners...The Health Council and the federal, provincial and territorial governments should immediately assure Canadians that the eventual deconstruction of our effective and almost universal family physician workforce is not a central, unarticulated component of the current governmental “primary health care” strategy. Without doubt, the present advertising discourse gives good reason for Ontarians and other Canadians to fear that it is (Ontario College of Family Physicians, 2006, March 27, pp. 1-2).

A couple of noteworthy points derive from the above passage. First, the OCFP President is careful to state her agreement with interdisciplinary teams, as long as they are implemented “properly,” and with the appropriate spirit of collaboration. Proper collaboration and proper teams are defined as occurring only with family physicians present. This discourse thus attempts to nullify the possibility of non-physician-centered health teams as “proper”. Second, the term “primary health care” is associated with non-physician teams, and is demonized as an unspoken plot to “deconstruct” the central place of family medicine in the health care system, a move the OCFP asserts will frighten Ontarians and Canadians. The OCFP has thus constructed a clear binary between primary care and primary health care in order to provoke concern for the profession of family medicine, to warn the public, and to define the proper configuration of interdisciplinary teams as always containing a physician.

Subsequently, the OCFP added a component to its strategic plan in 2007 specifically to promote the image of family physicians as integral and necessary to interdisciplinary primary care teams. Further, the strategy entails further distinguishing family physicians and family medicine from non-physician health care providers and the

term “primary health care”. Objective Two⁴⁸, Sub-point 4 of their 2007 strategic plan states:

Promoting the Role of Family Doctors throughout the Healthcare System...is critical to countering the trend to minimize the role of the family doctor in providing frontline care while enhancing the role of other health professionals. We are working on developing a process to “brand” the image of the family doctor as the key member of a patient’s healthcare team where and wherever that care is delivered. In addition, the role of the family doctor in hospitals and as team leaders must be emphasized. Building on previous PHCTF [Primary Health Care Transition Fund⁴⁹] projects we are seeking to develop avenues to disseminate research and policy that clearly emphasizes family doctors and family medicine vs. primary care providers and primary healthcare (Ontario College of Family Physicians, 2007, September 4, p. 2).

Again, as in the other examples, the discourse and action invoked are to construct teams as always containing physicians, making non-physician teams impossible.

Overall, the strategies employed by the OMA and the OCFP to define primary care as physician care, and to distinguish it from primary health care, serve to bolster the position of physicians in team settings. The strategy makes physicians the center of the system and by extension of teams, whether through the co-optation of primary health care by primary care (the OMA strategy), or by clearly dichotomizing primary care and primary health care, and demonizing the latter as a bad gamble that goes against the spirit of collaboration and the public’s interest (the OFCP strategy).

⁴⁸ Objective 2 of the OCFP’s 2007 strategic plan is “[t]o ensure the highest quality of healthcare for the people of Ontario by promoting and encouraging the highest standards in the practice of family medicine in Ontario” (Ontario College of Family Physicians, 2007, September 4, p. 1).

⁴⁹ The Primary Health Care Transition Fund (2000-2006) was a federal initiative whose purpose was to promote research into improving primary care throughout Canada, with particular emphasis on multidisciplinary teams (Canada. Health Canada, 2007).

Maintaining the Primacy of the Patient-Physician Relationship

A third discursive strategy employed by the medical organizations for maintaining the position of physicians in the midst of health care reform in Ontario is to establish and promote the primacy of the patient-physician relationship. Documents from both the OCFP and OMA posit the patient-physician relationship as the central feature of the health care system. They portray the introduction of interdisciplinary primary care teams as a potential intrusion into this relationship, requiring careful planning and implementation to minimize possible negative outcomes. Physician organizations promote physician leadership of interdisciplinary primary care teams as the best way to minimize disruption. These strategies are examined in more detail below.

The primacy of the patient-physician relationship is established through several discursive strategies. One of these is to appeal to the emotional aspects of the patient-physician relationship. This is a strategy used exclusively by the OCFP, who present this fundamental relationship as rooted in “trust” between the patient and family physician:

As federal and provincial governments attempt to address the perceived deficiency in the current healthcare system, efforts must be made to ensure that planned changes do not compromise the long-term sustainability of the system. Faced with a growing and aging population, governments across Canada are taking a positive step forward by developing plans to further strengthen the cornerstone of our Canadian healthcare system – Family Medicine. **At the heart of Family Medicine is the trusting relationship between physician and patient.** Family Doctors are able to provide **patients with a sense of security and well-being.** Through these **human interactions**, the patient becomes confident that their physician has expert medical knowledge and is able to access specialist and other healthcare resources, as required. **The sense of well-being is enhanced by the fact that patients begin to believe that someone truly cares about them on a personal level and will be an advocate for them throughout the system.** Patients and physicians have a unique opportunity to share experiences through the tangible assistance of the Family Doctor at events such as the birth of a baby, the cure of a sick child, and the death of a loved one. The tangible and emotional support provided by **Family Physicians at key points throughout the life cycle leads to a level of confidence in the doctor that**

is vitally important to the healthcare system in general. The effect of confidence in Family Physicians across a patient population is enormous. It is safe to say that the psychological and economic health of our medical care system is dependent upon trust in the patient-physician relationship. The breakdown of trust in physicians, or trust in the system in general, creates situations in which patients demand multiple opinions and costly investigations. As system changes are being introduced, it is important that their potential impact on trust in the patient-physician relationship be reviewed (Ontario College of Family Physicians, 2000a, p. 2, my emphasis).

This passage portrays the patient-physician relationship using a very specific narrative.

The narrative starts with a series of encounters through which the patient's trust of their physician develops. An emotional bond forms between them throughout the life cycle of the patient; the patient's sense of trust grows with presumably successful treatment by the physician. The use of the term "human interactions" resulting from the physician providing "security and well-being" further frames the relationship as deeply fundamental and natural. References to the physician being present throughout the life cycle, providing emotional support through good and bad times, imply an unbroken, long-term relationship. The relationship is thus supposed to be emotionally satisfying, and life-long; the joys and struggles experienced together are the things that will make the patient trust their physician, and ultimately, the health care system. Any threat to this relationship is seen as potentially damaging to the whole health care system, precariously balanced on this important (but also seemingly fragile) relationship. This highly specified narrative excludes other health professionals from forming the same intense bond with patients; it excludes the possibility of patients and physicians not forming this kind of bond at all; it predicts that patients will see teams as an intrusion into this relationship; and it necessitates very careful management of the way teams are implemented to minimize damage.

Below, the OCFP argues for the necessity of the family physician's involvement in team-based care (whether in conjunction with non-physician health professionals or with medical specialists):

Patients greatly appreciate the team approach to care but efforts need to be made to ensure that team approaches do not interfere with the patient-physician relationship. Trust is not built in a day. Trust develops from encounters over the course of time and will be less likely to develop in a system that triages only the sickest patients to the Family Doctor. The economy of "wait and see" processes is lost in inexperienced and less skillful hands. It is for this reason that collaborative/shared-care⁵⁰ models need to be developed as the focus of care delivery between Family Doctors and team members, and between Family Doctors and their Specialist colleagues (Ontario College of Family Physicians, 2000a, p.10).

This bolsters the position of family physicians not only vis-à-vis non-physician professionals in a team setting, but also vis-à-vis medical specialists. The family physician and the patient-physician relationship become the foundations of the team.

The OCFP also appeals to the long history of the trusting patient-physician relationship as further justification for the need to minimize the disruption caused by changes to the health care system:

The Hippocratic oath [sic] is as important today as it was 2,400 years ago. Just as it was all those years ago, trust in the doctor-patient relationship remains vitally important for effective healthcare... Models of care need to recognize the historic importance of the patient-physician relationship and facilitate those changes that further strengthen the establishment of a trusting patient-physician relationship (Ontario College of Family Physicians, 2000a, pp.2-3).

This appeal to history further romanticizes the view of the patient-physician relationship and again assumes that the patient-physician relationship was based on trust in ancient times, with no substantiation.

⁵⁰ The OCFP uses the term collaborative care to describe the working relationship between family physicians and non-physician health professionals, whereas the term shared care describes the working relationship between family physicians and medical specialists.

Aside from the emotional appeals made regarding the patient-physician relationship, physician organizations bolster the importance of this relationship with two other strategies. One is to cite evidence of the efficacy and/or desirability of the relationship. For example, an OMA policy paper draws directly on research literature to assert that a strong patient-physician relationship leads to improved outcomes in health service utilization, efficiencies in health spending, and high levels of patient satisfaction:

International research demonstrates that countries with a strong primary care orientation achieve better health and satisfaction levels at lower costs [3 citations]. The availability of comprehensive primary care physicians and the delivery of patient centred care (built on a strong patient-physician relationship), are considered central features of a strong primary care system. World Health Organization research further confirms this relationship, finding that the strength of the primary care system and the supply of primary care physicians impacts heavily on rates of expenditure and on mortality and morbidity [1 citation]. In the North American context, significant evidence demonstrates that a strong patient-physician relationship and primary care system improves the management of health and disease while decreasing referrals to specialists and test ordering [1 citation], emergency department visits and hospitalizations [2 citations]. Furthermore, patients consistently report high levels of satisfaction with the care they receive from their physician (Ontario Medical Association, 2007, p. 2).

Another strategy is to cite evidence that patients value the patient-physician relationship and do not wish to have it unduly disturbed by interdisciplinary team members. Earlier documents from the OCFP cite research positing patients as wary of teams and wanting their family physician to be the main provider of their health care. For example:

Research [a Decima study commissioned by OCFP] indicates that patients will accept team-based care, but want reassurances regarding the maintenance of the patient-physician relationship. In rostering patients to FHNs & FHGs, the only question that patients ask is if their own family doctor will still remain front and centre of their care delivery (Ontario College of Family Physicians, 2005b, p. 33).

A document from the OMA acknowledges that patients in Ontario are interested in receiving care from teams, but continue to assert the patient-physician relationship as the fundamental basis of health care. Indeed, the patient-physician relationship comes to form the basis of the team in this discourse, with the physician portrayed as the natural or best choice for leader of the team:

...the pivotal role of the patient-physician relationship within the team, and the role of the physician as the clinical lead, should be clearly defined and understood. The comprehensive primary care physician is a natural clinical lead on any primary health care team since the physician maintains both the largest scope of practice and a comprehensive knowledge of the patient. Moreover, this arrangement meets the desires of patients, who, while amicable to the idea of team-based practice, want assurances that they will have access to their physician when required (Ontario Medical Association, 2007, p. 3).

While these statements are presented as factual by the OMA, they are not supported with references to the research literature. Thus, according to physician organizations, evidence (whether provided or not) suggests that patients are open to interdisciplinary primary care teams, but want to maintain the patient-physician relationship and to have their physician be the leader of the team.

Until now, I have focused on the ways that physician organization discourses outline the patient-physician relationship as natural, enduring, emotional, and logical (in that physician care is shown through research to be, or is simply stated to be, the most economical and effective choice). The relationship appears to be voluntary and based on ideals. However, in reality, the implementation of primary health care models (including FHNs, FHGs, and FHTs) has changed the nature of the patient-physician relationship from one that is less formally documented and voluntary to one that is formalized and regulated by the state. In order to receive the full services of a FHT (in other words, from both their physician and the non-physician members of the team), a patient must

officially register to receive care from a particular physician within the FHT. When a patient signs on to a FHT [a process called “rostering” (Ontario Medical Association, 2000, n.p.) or “enrolment” (Hanna, 2007, p.4)], it is expected that they receive their medical care only from their FHT physician, or another of the FHT’s physicians if their own physician is unavailable (Ontario. Ministry of Health and Long-term Care, 2012c, n.p.). The need for rostering is based on the fact that the FHT model is based mainly on capitation payment of the physicians in the FHT⁵¹. Patients must enrol so that the provincial government knows how much to pay the physicians, and how much additional funding is required for the non-physician providers in the FHT.

The OMA and the OCFP have slightly different ways of talking about rostering. The OMA’s representation of rostering is focused on the mutual obligations of patient and physician in this arrangement:

When a patient rosters with a comprehensive primary care physician there is a mutual commitment between the parties. The physician commits to providing timely access to comprehensive care, while the patient commits to utilizing the physician as their main, and where possible, first point of entry to the health-care system. Both groups should be accountable to this commitment. As stated on the patient enrolment form: *By enrolling, you agree that, except in the case of an emergency or when you are travelling away from home, you will first contact your family doctor, the Family Health Network to which your family doctor belongs or the [Family Health] Network’s Telephone Health Answering (if available), whenever you or your enrolled family members need primary care medical advice or treatment* (Ontario Medical Association, 2007, p. 4, italics in original).

The OMA asserts that this form of patient accountability is necessary, because when patients do not fulfill their obligation, the physician is financially penalized (ibid). It

⁵¹ The reader is reminded that the FHT model consists of two parts: the underlying physician group (Family Health Network or Family Health Organization) which is paid mainly on a capitation basis, and a funding envelope that is given to the physicians that allows the physicians to hire non-physician professionals to work in the FHT, making it a FHT.

further implies that patients may not roster to a non-physician provider in an interdisciplinary primary care team setting:

In interprofessional care teams that involve patient enrolled models of care, the OMA believes that patients must be rostered with a physician or group of physicians in order to ensure appropriate accountability for the services delivered to the rostered patients. OMA Principle [:] The physician or group of physicians should be the only health-care providers to whom patients roster (Hanna, 2007, p. 4).

This matches the OMA's view that patients new to a particular primary care entity must be seen by a physician first, prior to seeing any other health care professionals in the team (ibid). These assertions (a patient must roster with a physician or group of physicians, they must not roster with any other health care providers, and they must be seen first by a physician before they see other health care professionals on the team) serve to keep patients in a relationship with a particular physician or group practice, and in the context of interdisciplinary primary care teams, maintain the primacy of the patient-physician relationship.

Early in discussions of primary care reform, the OCFP also discusses the probable need for patients to formally enrol with a group of primary care providers to receive a full range of primary care. Like the OMA, there is some language focused on the mutual responsibilities involved in rostering. However, the OCFP talks about the responsibilities of the patient and the health network, rather than the physician:

It is very unlikely that a single physician could provide all of these [primary care] services. Our expectation is that the chosen physician would be part of a health care provider network which includes physicians, nurses, midwives, physiotherapists, and others best suited to provide for the patient's needs...The most significant change for the patient would be that their basic, or primary, care would be provided through one organization. The patient's responsibility would be to agree to receive all their care from one provider network; the healthcare network's responsibility would be to provide a full range of services both efficiently and effectively (Ontario College of Family Physicians, 1998b, p.3).

However, an OCFP document produced five years later takes a different approach, one that puts the emphasis back on the patient-physician relationship, using appeals to both emotion and logic. In its 2002 submission to the Romanow Commission, the OCFP makes a distinction between the term “rostering”, which they argue implies a physician-government relationship for the purposes of physician reimbursement, and the terms “enrolment” and “covenant”, which keep the focus on the trusting, voluntary relationship between patients and their physician:

The enrolment of patients is a process that formalizes the patient-physician relationship (I choose you to be my doctor). This is a far different concept than “rostering” for the purpose of implementing a capitation based funding model. It involves a covenant between patient and physician – not a contract between government and the physician. “I will do everything in my power for you. [sic] Rather than, I will provide the services in my contract and no more”. Since family physicians are the healthcare professionals with a scope of practice broad enough to co-ordinate care throughout the system, the enrollment of patients needs to be with their family physician (Ontario College of Family Physicians, 2002, p. 6).

This language is another example of the OCFP’s portrayal of the patient-physician relationship in emotional terms. The word “covenant” implies a strong, enduring, and even sacred bond. The voluntary nature of the relationship is also kept intact (“I choose you to be my doctor”), and de-emphasizes the mandatory nature of rostering with a physician, which might seem onerous to members of the public. In the final sentence, they also appeal to logic, arguing that the physician’s broader scope of practice makes enrolling with the family physician the best choice, rather than enrolling with a non-physician health care provider.

The rules of rostering as outlined by physician organizations, whether in logical or emotional terms, ultimately serve to keep the focus of discussion and action on the

patient-physician relationship, and away from the possibility of rostering with a non-physician health care provider.

Calling for Evolutionary, Not Revolutionary, Change

Physician organizations assert that changes to the health care system, including the development of interdisciplinary primary care teams, will be successful only if introduced to physicians on a gradual and voluntary basis. Physician organizations often use the catch phrase “evolution, not revolution” to make this point; this idiom appears to be directed at policy-makers. The OCFP, for example, states:

The fundamental importance of stability combined with innovation has been the hallmark of successful changes in our healthcare system. Therefore, the partners [health care leaders including the OCFP⁵² participating in a provincial government-sponsored consultation process] are calling for evolutionary, not revolutionary, changes since radical changes run the risks of exacerbating existing pressures on already severely stressed providers, at least in the short-term (Ontario College of Family Physicians, 2004, p. 4).

A variant of the catch phrase “evolution, not revolution” is used again in the same document, this time with specific reference to interdisciplinary primary care teams:

Participants [as noted in the last quote] not only supported the concept of scaling up primary care but saw the development of interdisciplinary teams of primary care providers as key to the establishment of a truly integrated system, but the change must be evolutionary, not revolutionary (ibid, 2004, p. 15).

A document from the OMA, while not using the catch phrase, nonetheless has the same message about recommended speed and tone of implementation of teams: “For established physicians, the change from working as an independent practitioner to

⁵² These were: The Ontario College of Family Physicians (OCFP), The Association of District Health Councils of Ontario (ADHCO), The Ontario Association of Community Care Access Centres (OACCAO), The Ontario Family Health Network (OFHN) and The Ontario Hospital Association (OHA) (Ontario College of Family Physicians, 2004, p. 4)

working as a team member may be better achieved if it is perceived as a process that occurs over time, rather than a singular event” (Hanna, 2007, p.6).

The following passage from an OCFP document aptly illustrates some of the assumptions operating behind the term evolutionary change, from the perspective of the medical profession, as well as a hint in the first line of the greater acceptance of reform among the physician leadership compared to their front line counterparts:

Many of us in leadership positions [in family medicine] saw the changes [primary care reform] as simply a process of evolution in family medicine. Much like the diversification of species this, by definition, should be a gradual process which will result eventually in a model of family practice that is simply the best and most supportive system for the provision of primary care services by family physicians and other primary care providers. This takes time, and unfortunately, trial and error. But the time lines of an elected government are not always compatible with an evolutionary process. Although I [Peter Deimling, President of OCFP in 2004] have found the government agenda frustrating in its insistence on tight timelines, I recognize that the alternative is revolutionary change in the system. The potential for harm in this alternative path is, I believe, greater and so I have focused on finding ways to make evolutionary change possible (Ontario College of Family Physicians, 2005c, p. 5).

In addition to the usual suggestion of allowing gradual change, the evolutionary argument for change also suggests that experimentation must be allowed to create the best result, much like evolutionary theory suggests that certain mutations will eventually prove the most effective in a particular environment. It is noteworthy too, that the “best result” is defined in terms of improvement to existing family medical practice, rather than any other type of primary care. The focus is kept on maintaining control and the derivation of any benefit from the primary care reform process, as much as possible, in the hands of physicians.

While the meaning of evolution is explained in a more direct fashion from the quote above, the meaning of revolution is less directly addressed. Presumably, some of

the meaning of revolution reflects the opposite of the requirements of evolution (a short timeline and forced changes). Other possible meanings of what constitutes revolution may be derived from examining physician concerns about what changes would be forced in the primary care reform process. One of these is the fear of changing the physician payment structure from fee-for-service to salary:

Although some viewed these models [Primary Care Networks, Family Health Networks and Family Health Groups] as “a plot to put all doctors on salary and work them around the clock”, I [Peter Deimling, President of OCFP in 2004] viewed them as options for family physicians providing flexibility in payment method while offering improved infrastructure support (Ontario College of Family Physicians, 2005c, p. 5).

The fear of being forced onto a salaried model of payment is also reflected in this quote from an OCFP communiqué questioning whether the community-owned Family Health Team model, where physicians are employees paid on a salary basis rather than a fee-for-service basis (where they are self-employed practitioners) would be accepted by physicians: “Since most physicians cherish their independent practices, will physicians agree to work as salaried employees reporting to a CEO in a community-driven FHT⁵³?” (Ontario College of Family Physicians, 2005b, p. 33).

One OCFP document from 2002 suggests that, in the early stages of primary care reform, the capitation model of payment for physicians sought by the Ontario Ministry of Health and Long-Term Care was also viewed with suspicion by physicians:

Fears and misconceptions regarding PCR [primary care reform] are rampant across the country... For many doctors, PCR has come to be synonymous with “rostering and capitation” – that is, code words for “HMOs, managed care, big brother (i.e. government) looking over their shoulders telling them

⁵³ OCFP uses the term “community-driven FHT” to describe what is more widely known in Ontario as the Community-based FHT model (CFHT). In this model, the governing board consists mostly or completely of community members rather than physicians, and physicians are paid on a salary basis, rather than by capitation or fee-for-service.

how to practice medicine” (Ontario College of Family Physicians, 2002, pp.3-4).

Thus, rapid changes toward new payment structures that are seen as threatening to physician independence from government likely constitute part of the definition of the “revolution” portion of the idiom.

The same document provides yet another possibility for the meaning of “revolution” from the perspective of the medical social world, this being the introduction of nurse practitioners as independent practitioners in team settings. It states:

“Government promotion of ‘interdisciplinary team work’ is seen [by physicians] as a thinly veiled plan to address the acute shortage of family doctors by using nurse practitioners as ‘physician substitutes’ (ibid, p. 4).” The handling of this issue by physician organizations is addressed later in the chapter; for now, it suffices as possible insight into what physician organizations mean in their call to policymakers to avoid “revolutionary” changes.

The suspicions and fears of front line physicians insinuated in the “evolution, not revolution” discourse are related to discourse that posits the necessity of obtaining the “buy-in” of front line physicians to primary care reform and interdisciplinary primary care teams. Physician organizations warn that failure to do so will inevitably result in the complete failure of primary care reform. The OMA simply states that, in order for the switch from solo or physician group practice models to an interprofessional model “[t]o be successful, physicians must be in favour of the change” (Hanna, 2007, p.5). The OCFP is more detailed in their assessment of the power of the front line physicians to thwart progress toward primary care reform:

None of the strategies being proposed to enhance our primary care system will be successful unless special attention is paid to the concerns of the major providers of primary care, family doctors. Wise governments have been focusing on strategies to recruit and retain family physicians to comprehensive primary care practices. They recognize that little progress can be made without physician buy-in. Physicians are being asked to join group practices, work collaboratively with other disciplines, change the way that they are paid, organize extended hours and 24/7 on-call for telehealth, and adapt their practices to incorporate information technology...[they] need evidence that moving forward will enhance patient care and will do so without negative impacts on their income or lifestyle. At the very least, they need time to build a consensus amongst themselves that the changes are appropriate. If barriers are placed in the way just as consensus is being built, any forward momentum will be halted (Ontario College of Family Physicians, 2005b, p. 18).

The language throughout the passage attempts to portray physicians as ultimately controlling the outcome of primary care reform: physicians are the major providers that must be listened to, and wise governments recognize the power of physicians to derail primary care reform if the changes are not to their liking.

The OCFP further points out how physician buy-in may be achieved by focusing on how the working lives of physicians may be improved:

Buy-in does not come easily...Family physicians are asking for assistance to increase their numbers and to manage the complexity that has arisen in their practices – not a major top-down change in the way they practice medicine or in their scope of practice. Interdisciplinary teams supports [sic], information technology and integration activities in local communities should be clearly focused on how to remove the burdens of care for family doctors as key to quality improvements throughout the system (Ontario College of Family Physicians, 2005b, p. 18).

Like other discursive strategies already discussed, this is yet another used to establish the impossibility of primary care reform or of interdisciplinary teams without physician presence or approval. Overall, the “evolution, not revolution” discourse works to ensure that primary care reform and the implementation of teams proceeds at a pace and tone acceptable to front-line physicians, who might otherwise foil reform efforts.

Prescriptions and Proscriptions: the Role of Non-medical Health Professionals

The medical profession's perspective on the proper role of non-physician health professionals in interdisciplinary primary care teams is given considerable attention in the medical social world data. Suggestions from Ontario's medical organizations to policy-makers regarding the role of non-physician health professionals in interdisciplinary primary care teams set limits on the mandate, scope of practice expansion, and ability of these professionals to work independently in domains of practice that have traditionally belonged only to physicians, particularly diagnosis and prescribing. These circumscriptions are examined below, as well as how discourses about collaboration and teamwork are used to justify these proposed limitations.

The OCFP, for example, clearly sees the role of non-medical health professionals in interdisciplinary primary care teams as helping family physicians with their increased workloads and with the increasingly complex care required by their patients. The discourse typically states or implies that the family physician is the leader in the patient's care. For example:

Allied healthcare providers would greatly enhance the ability of Family Doctors to provide comprehensive services; however, only Family Doctors can provide the continuity of care that patients want and need. Collaborative practice models that support the trusting patient-physician relationship need to be developed and tested (Ontario College of Family Physicians, 2000b, p. 3).

The data for the OMA do not appear to reflect the same sort of portrayal of non-physician health professionals as existing in a team environment just to assist physicians with their work. Their documents tend to be more generic in outlining the purpose of teams as improving patient care. For example, Janice Willet, President of the OMA (2008) wrote:

As our health-care system faces growing pressures, quality care will depend on health-care professionals working together as part of the same team, with the ultimate goal of giving our patients the best possible care. We should build on the existing team based-models that include doctors and health professionals such as nurses, dieticians and physiotherapists working together to provide patients with comprehensive care by the right professional when they need it (Willet, 2008, January 22).

However, as noted earlier, the OMA has clearly stated its view that physicians are “natural” clinical leads of interdisciplinary primary care teams (Ontario Medical Association, 2007, p. 3).

While the OMA and OCFP differ in their approach to defining the purpose of interdisciplinary primary care teams in Ontario, they are both against the “independent practice” of non-physician health professionals in any setting. The OCFP, for example, asserted in a 1999 policy paper that:

The Ontario College and its members are fully supportive of the expanded role of nurse practitioners. Some of our members have been working for some time in collaborative working relationships with a nurse practitioner or a Family Practice nurse. Seventy percent (70%) of the members surveyed would welcome the opportunity to work collaboratively with publicly funded nurse practitioners to provide enhanced care within their scope of practice. Eighty-five percent (85%) of our members reject the model of independent free-standing practice for nurses and midwives (Ontario College of Family Physicians, 1999, p.21).

The OCFP’s stance against independent non-physician practitioners has continued (Ontario College of Family Physicians, 2009, January 22). The OMA also has spoken out against the independent practice of non-physician health professionals. These views are explored in more detail in the discussion below.

While the meaning of independent practice by non-physician health professionals is not explicitly defined in either the OCFP or OMA data, a number of specific types of work activity appear to provoke physicians to speak out in concern, particularly prescribing, diagnosis and patient management. The OMA, for example, expresses

concern over inefficiencies that would be created if nurse practitioners were allowed to have their own panel of patients (that they would independently review, diagnose, treat and for whom they would oversee care plans) in a team setting:

It is the OMA's understanding that in many instances, the RN(EC)⁵⁴ wishes to have his or her own "practice," yet maintain a collaborative relationship with a physician. The OMA believes that there should be only one panel of patients so that when the patient must come under the care of the physician, this does not result in double-charting and reduced co-ordination of care [OMA Task Force on the Working Relationship between Physicians and Registered Nurses (Extended Class), 2002, p. 2].

The OMA's view that non-physician professionals should not care for patients independently is further confirmed in their policy paper on interprofessional care, where they assert that physicians ought to be the first professionals to review new patients and delegate tasks to non-physician professionals as needed:

Physician Review

All new patients should be reviewed by a physician. The physician may then decide, as part of the treatment plan, to have the patient seen by other health-care providers, or to refer the patient to other members of the health-care team. Patients who are in ongoing care may be seen by the appropriate non-physician providers and triaged according to need. Patients who require episodic care may be seen by their physician or by the appropriate non-physician provider, depending on need, with the understanding that physician review, consultation or transfer will occur if necessary (Hanna, 2007, p. 4)

This policy effectively eliminates the possibility of any independent assessment or management of the patient's care by a non-physician practitioner.

Expanded prescribing powers for non-physician health professionals also prompt response from physician organizations, and further help us to understand what is meant by "independent" practice. The following passage from an OMA press release highlights concern by physicians over expanded prescribing powers for nurse practitioners and

⁵⁴ RN(EC) stands for Registered Nurse, Extended Class, and is the technical term for Nurse Practitioners in Ontario (Nurse Practitioners' Association of Ontario, 2007b, p. 1). However, the term Nurse Practitioner is the far more familiar term used throughout the data.

pharmacists proposed in Bill 179, The Regulated Health Professions Statute Law Amendment Act, which proposed to give pharmacists increased scope to independently make changes to prescriptions, and to remove all prescribing restrictions for nurse practitioners:

Dr. Mark MacLeod, President-Elect of the OMA will raise some concerns at the hearing about several proposals within the legislation. Specifically, with respect to pharmacists being granted the ability to "adjust, adapt or extend" a prescription, Dr. MacLeod pointed out that this may create separate practice silos between a prescribing physician and a pharmacist and this type of fragmented treatment may diminish the quality of patient care. Dr. MacLeod reiterated the OMA's long standing position that collaboration among health professionals results in a more comprehensive level of care being delivered to patients. The OMA strongly believes that if nurse practitioners are able to prescribe, dispense, sell, or compound drugs, then their prescribing power must be carefully regulated (Ontario Medical Association, 2009, September 29, n.p.).

In sum, non-physician practitioners assessing, diagnosing, managing patient care, or prescribing in isolation from physicians constitutes "independent practice" in the eyes of physician organizations. Allowing non-physician health professionals to do these activities, and receive government funding to do them, is referred to in the medical social world as "physician substitution."

Physician organizations use the ideals of collaboration and teamwork to justify their stances about what they see as the proper role of non-physician professionals in interdisciplinary primary care teams, and to counter the threats of scope expansion, independent practice of non-physician health professionals, and physician substitution. The OMA, the College of Physicians and Surgeons of Ontario, and the OCFP all portray scope of practice expansion for non-physician professionals through legislation as potentially interfering with "true" collaboration.

The OMA, for example, portrays scope of practice expansion as unnecessary and even contradictory to the spirit of teamwork:

The expansion of scopes of practice is related only peripherally to interprofessional care. Collaborative care is not dependent on members of a team expanding their independent scopes of practice and, indeed, may be anti-thetical [sic] to the team concept. More important than scope is the need for clear delineation of roles from the outset and mutual confidence in the competence of team members in the provision of care within their respective roles. This confidence comes from the knowledge that health-care providers share a fundamental educational base through training in the *medical model* and is supported by personal experience. Over time, as competencies become evident, the responsibilities of various team members may expand (Hanna, 2007, p. 4, italics in original).

Role expansion is made secondary to the central goal of collaboration.

Several other points from this passage are noteworthy for the way they enforce medical dominance. First, the emphasis on the “medical model” sets the medical paradigm as the legitimate knowledge base against which the competence of health professionals is judged. Second is the question of who is judging competence, and who is being judged. While one sentence suggests that role delineation allows for “mutual confidence” in the competence of team members, the language of the last sentence implies that it is the physician who is judging competence. Presumably, if the medical model is the standard, then the physician is by definition the best judge, even though the other practitioners might share the same knowledge base. Physicians alone would be the ones to best judge whether competencies become evident through observation over time. Alternate criteria are not being applied to make judgements, again suggesting that the physician is not the one being judged. As well, the phrase suggesting that “...as competencies become evident, the responsibilities of various team members may expand” is talking implicitly about non-physician health professionals, given that the discourse sets up the medical model as the standard and the physician as the logical choice of

judge. It is also nonsensical to think of the responsibility of the physician being “allowed” to expand. Finally, the supremacy of the medical profession is argued here through the assertion that physician observations and judgements of competence outweigh legislative scopes of practice. Overall, these statements attempt to reinforce the medical profession’s dominance in matters of knowledge.

The OCFP argues that scope expansion only serves to create independent non-physician practitioners, rather than improving collaboration:

HPRAC [Health Professions Regulatory Advisory Council⁵⁵] is currently reviewing the scopes of practice of a number of healthcare professionals (nurse practitioners, midwives, pharmacists, physiotherapists, dieticians etc). A message being delivered by many of the professional associations is that their members need increased scopes of practice for them to work in collaboration with physicians and other professionals. Our Board Chair, Dr. Robert Algie writes: “It is interesting to talk about collaboration and how enhancing scopes of practice might somehow improve collaboration. Scopes of practice have little to do with collaboration. Expansion of scope can sometimes interfere with collaboration. What we have seen as physicians is that enhancing scope of practice can foster independence rather than interdependence and collaboration. Expanding the scopes of practice of various allied health personnel doesn’t necessarily enhance collaboration. Systems of care and organizations enhance collaboration, not legislated scope of practice” (Ontario College of Family Physicians, 2008, July 15, p.2).

In this next example, the OCFP subverts scope of practice expansion for non-physician health professionals to the greater goals of teamwork, patient safety, and quality of care:

The ultimate focus should be on interprofessional teams, actively working together in the joint care of the patient producing synergistic results, with team functioning that is anchored in the principles of collaboration, cooperation, open communication and mutual respect and trust. Working in an interprofessional model of care should be the goal. Supporting various disciplines to work towards their full scope of practice or towards

⁵⁵ The Health Professions Regulatory Advisory Council (HRPAC) is an Ontario provincial government-appointed entity consisting of a layperson board “...with a statutory duty to advise the Minister on health professions regulatory matters in Ontario” (http://hprac.org/en/about/mandate.asp?_mid_=2247, accessed March 7, 2013). This includes advice on whether unregulated professions should be regulated and amendments to the Regulated Health Professions Act of 1991.

an increased scope of practice is a minor secondary goal. Safety and quality of patient care should always be our first consideration (Ontario College of Family Physicians, 2008a, p. 5).

The language used in the above passage is highly idealized, appealing to the values of collaboration, cooperation, respect and trust. The patient is made the focus of the professionals' collective efforts. Indeed, scope expansion of non-physician professionals could seem like a selfish goal, let alone a secondary goal, when couched in these terms.

In this passage, the OCFP again draws on language that subverts scope expansion to “true” collaboration. Further, an appeal is made to create conditions that would maximize the unique knowledge base of nurses to complement the work of physicians, rather than to foster independence of nurse practitioners:

In working with RN(EC)s, [nurse practitioners] physicians do not believe that scope of practice is the main issue that needs to be addressed. The underlying issue facing primary care/family practices is the lack of support for establishing true collaborative, interprofessional team approaches to care with our nursing colleagues. We need to work on providing those facilitators that are known to make a difference; namely, a process to identify areas of practice such as health promotion and prevention that make best use of the unique nursing expertise of RN(EC)s that would augment the work already being done in the offices of family physicians across the province... (Ontario College of Family Physicians, 2008b, p. 13).

A suggestion is being made that a particular division of labour among physicians and nurse practitioners has already been established; nurse practitioners are presented here and elsewhere in the document (*ibid*, p. 5) as excelling in the areas of health promotion and preventive care. The proper role of nurse practitioners in an interdisciplinary primary care team is thus articulated in relation to physicians and to “true” collaboration.

Compared to the OMA and the OCFP, the language of the CPSO is more outwardly supportive of scope of practice expansion. The more positive tone is gleaned

in a generic statement of support for scope expansion in its submission to the Ontario Ministry of Health and Long-term Care regarding Bill 179:

In general, the CPSO supports expansions for other scope for other regulated health professionals, as long as these expansions are:

- consistent with the knowledge, skill and judgment of the professionals involved;
- subject to a rigorous regulatory structure;
- supportive of a truly collaborative, team-based approach to care as opposed to parallel care (i.e. professions working independently without appropriate interprofessional interaction (i.e. parallel care));
- safe for patients; and
- accompanied by educational initiatives for both the public and health care providers to ensure that people understand the changes that are being made (College of Physicians and Surgeons of Ontario, 2009b, p. 8, bulleted format and error with parenthesis in third bullet in original).

While the tone is positive overall, scope expansion is nonetheless circumscribed. Scope expansions may be made only if they allow activities to be done in the context of a “truly collaborative, team-based approach” and consider the effects of such changes on patient safety. As well, the language suggests the CPSO does not support parallel (independent) practice of non-physician health professionals. Immediately after the above passage, the CPSO expresses doubts about the rapid pace and unreflective manner in which scope expansion through Bill 179 was occurring:

We are concerned...that in the rush to expand scopes to facilitate access [to care] ensuring that the expansion is kept within the parameters of the profession’s knowledge, skills and judgement may not be receiving the rigorous analysis required. There is a significant difference between competence to do individual procedures or controlled acts and the ability to manage a patient’s care in its entirety, especially if care is not provided in a collaborative fashion (ibid, p. 8).

Also of particular interest in the above passage is the CPSO’s reservation about allowing non-physician practitioners to be sole managers of the patient’s care, especially in the absence of collaboration; while it is not stated outright, it is implied that collaboration means collaboration with a physician.

A more specific example of CPSO's conditional acceptance of scope expansion comes from their submission to the Ministry regarding HPRAC's recommendations about scope changes for nurse practitioners. The CPSO begins with a statement that demonstrates their underlying preference for nurse practitioners to work through medical directives (physician directives that allow non-physicians to perform certain acts with the physician's approval), followed by their conditional acceptance of scope expansion if certain conditions are met. Again, these focus on ensuring patient safety and a regulatory structure. Further, they warn that scope expansion must not result in physician substitution, and must be used only in the context of an interprofessional model:

The CPSO recognizes that NPs are currently able to safely and effectively perform many of the CNO's proposed acts by way of delegated authority from physicians through medical directives. However, in the interest of public safety, the CPSO also acknowledges that some of the proposed acts must be subject to clear standards for safe and effective care before NPs are granted the authority to independently perform them. In general, the CPSO supports expanding NP's scope of practice to facilitate access to care. However, we caution that NPs should not be authorized to bypass the role of family physicians, as this would create a parallel, rather than collaborative, care model. Our support is contingent on the changes being: consistent with NPs' knowledge, skill and judgment; subject to a rigorous regulatory structure; and implemented within a context of IPC [interprofessional collaboration] (College of Physicians and Surgeons of Ontario, 2009a, p. 3).

The expansion of nurse practitioners' scope of practice is made contingent on the ideals of collaboration. The CPSO is implying that nurse practitioners must always work with a physician, by proscribing independent practice for nurse practitioners and by appealing to the "real" goal of a collaborative model. While scope expansion might be tolerated by the CPSO, collaboration without a physician is ruled out in this discourse.

Similarly, the CPSO conditionally accepts scope expansion for non-physician professions with regard to prescribing medications, but not without first outlining the conditions under which this should occur:

prescribing can only occur safely when it is undertaken *in collaboration* with a health professional who has the range of controlled acts that are essential to seeing “the whole picture”....As well, the CPSO is of the view that stringent educational requirements must be put in place by regulatory colleges to ensure that all health professionals have the necessary knowledge, skill and judgment to effectively and safely prescribe the drugs designated in their respective regulations. With appropriate training, prescribing can be a useful component of non-physician health care, provided that this is done within a collaborative context (College of Physicians and Surgeons of Ontario, 2009b, p.9, my emphasis).

Two areas of the text are especially noteworthy. First is the condition of prescribing “...*in collaboration* with a health professional who has the range of controlled acts that are essential to seeing ‘the whole picture’.” In Ontario, the profession of medicine has the most solid claim to the broadest range of controlled acts in Ontario (medicine has the authority to perform all of the controlled acts as outlined in the Regulated Health Professions Act, with the exception of fitting or dispensing dental, orthodontic or periodontal appliances⁵⁶). Without stating it outright, the CPSO designates medicine as the profession with whom other health professions should be collaborating with regard to prescribing. Second, even if stringent regulations and education are set up to train non-physicians to prescribe as set out in their allowed scopes of practice, the end statement in the passage again circumscribes the act of prescribing by making it conditional on collaboration, presumably with a physician.

Talk about teams and collaboration by medical organizations is also used in an attempt not only to shape the work of non-physician health professions in a practical, regulatory sense, but also to shape their mindset. The OCFP uses the term “interdependence” to prescribe the proper thinking pattern among non-health professionals in order to promote the ideal of collaboration:

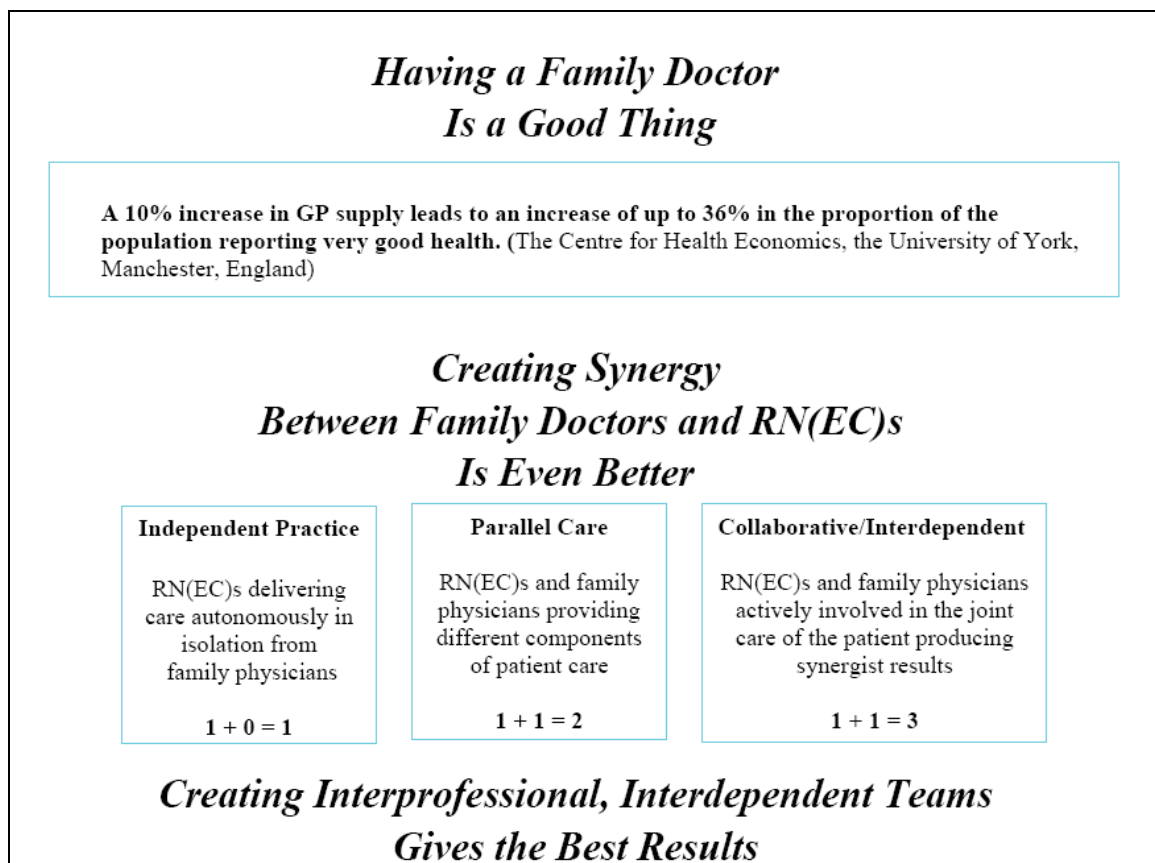
⁵⁶ As per the Regulated Health Professions Act, available at: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm , accessed April 11, 2014.

When it comes to collaboration, it is important that health professionals move their thinking and actions from independence to interdependence ... Practitioners such as nurse practitioners and pharmacists should be moving from dependence on the physician (I will write the order and you will do it) to independence (I will write the order and I will do it myself) to interdependence ([i]t is in the best interest of patients if we do it together) (Ontario College of Family Physicians, 2009, October 5, p. 2).

The term “collaboration” here, as in previous examples, takes on the very specific value of interaction with a physician. There is no mention or conception of collaboration occurring, for example, between a pharmacist and nurse practitioner. The use of the term interdependence by the OCFP is beneficial for family physicians on two levels: it allows physicians to receive help from non-physician professionals to manage increasingly complex patients and heavy workloads while also circumscribing any ambitions that non-physician health professionals might have in the areas of prescribing, diagnosis and patient management—activities that physicians see as their jurisdiction and label as “independent” behaviour in non-physician health professionals.

The OCFP also draws on the idea of “synergy” to promote its vision of collaboration. In their submission to HPRAC about the proposed expansion of nurse practitioners’ scope of practice (Ontario College of Family Physicians, 2008b, p.6), the OCFP presents their argument for having nurse practitioners work with physicians, rather than independently, in the following figure:

Figure 1: Ontario College of Family Physicians' Proposed Interprofessional Relationship between Family Physicians and Nurse Practitioners.



Source: Ontario College of Family Physicians, 2008b, p. 6.

Independent practice is again defined only in terms of the nurse practitioner working alone, while having a family physician (alone—no other professionals are mentioned at first) is “a good thing” (Ontario College of Family Physicians 2008b, p. 6). The nurse practitioner-only scenario is equated with the lowest number, while an interdependent relationship between a nurse practitioner and physician results in a value greater than the sum of its parts (a dictionary definition of synergy). While an equation is not provided for the last statement about teams (presumably containing a greater variety of health professionals), the assumption is that interdependent practice among the health

professionals within these will result in even greater synergy. In the same document, the OCFP touts the synergistic power of “the” (interdependent) healthcare team:

... those patients who have chosen to be cared for by RN(EC)s [nurse practitioners] are satisfied with the care they are receiving. We believe that even better results will occur when physicians, nurses, nurse practitioners, pharmacists, social workers, dietitians and other health professionals work in a collaborative, interdependent team. Patients deserve to receive care that flows from the synergistic efforts of all members of the healthcare team (Ontario College of Family Physicians 2008b, p. 6).

The definition of a synergistic team starts with physicians and runs through the remaining list of professionals. Again, there is no definition considered for any combination of the remaining professionals in the list producing synergistic results for the patient without a physician present.

The reaction of physician organizations to the development of nurse practitioner-led clinics in Ontario further shows how interdisciplinary primary care teams are viewed in very specific terms by physician organizations, and further shows how the language of teamwork is used in an attempt to keep focus and resources on physician-led team models (i.e., FHTs). In 2007, the McGuinty Liberal administration introduced 25 Nurse Practitioner-led Clinics (NPLCs) in their budget (Onley, 2007, November 29). These clinics are a form of interdisciplinary primary care team. As their name suggests, these entities feature nurse practitioners as clinical leaders. The remainder of the team consists of non-physician health professionals and at least one physician onsite or otherwise available to act as a consultant for cases that fall outside the scope of the nurse

practitioners; this latter point is required by law⁵⁷ (Ontario College of Family Physicians, 2009, December 16, p.2).

Despite the fact that a physician is required to be part of the NPLC model, and despite the fact that NPLCs feature an array of health care professionals working as a team, physician organizations spoke out against the model, drawing on the language of teamwork and collaboration to augment their arguments. The NPLC is presented as an untested, un-collaborative model, and contrasted to the FHT model, portrayed as a proven, collaborative interdisciplinary team model. Intertwined with these arguments are concerns over the NPLCs creating competition for FHTs (which are typically physician-led entities) for scarce resources. The example below demonstrates the dichotomies created between the FHT model and the NPLC model:

... the OMA is disappointed the government plans to also move ahead with [a series of more] independent Nurse Practitioner Clinics. “At a time when health profession resources are stretched thin, it is puzzling why the government would create competition within the health care system for these resources rather than promoting collaboration,” said Dr. Ken Arnold, President of the OMA. “Family Health Teams are a highly effective and tested collaborative care model that provides a comprehensive level of care to patients and adding more FHT’s to the system is good news for patients and Ontario’s doctors.” Ontario’s doctors have long advocated for collaborative health care teams such as FHTs, where various health professionals work together under one roof to provide care to a large number of patients. By comparison, independent nurse practitioner clinics run directly counter to these integrated care models. In addition, according to the Registered Nurses Association of Ontario, there is a shortage of 9,000 nurses in the province. Over the past four years, collaborative health care teams have helped take on an additional 630,000 patients who previously didn’t have a family doctor. Specifically, the Blue Sky Family Health Team in North Bay serves 30,000 patients, up from 18,000 when it was established in 2005. Comparatively speaking, the Nurse Practitioner Clinic in Sudbury has taken on a mere 1,900 patients since it opened its doors in 2007 (Ontario Medical Association, 2009, January 22, n.p.).

⁵⁷ Thus, as Dr. Joshua Tepper, a civil servant trained as a physician and working in the MOHLTC pointed out, NPLCs are not completely autonomous operations (Ontario College of Family Physicians, 2009, December 16, p.2).

FHTs are portrayed as collaborative, tested models. NPLCs are simply said to “run directly counter” to the FHT model; though they do not state directly that NPLCs are non-collaborative or untested in this passage, the turn of phrase run directly counter to leaves little room for another interpretation. Finally, a quantitative comparison is made between the models, with the OMA claiming that “collaborative health care teams” (equated directly with a FHT in the example they give) serve far more patients than the NPLC model, implying the inferiority of the NPLC model in this regard.

The OCFP also attempts to dichotomize FHTs and NPLCs using the language of collaboration. In the passage below, the FHT is portrayed as the “original” form of collaborative interdisciplinary primary care team model, and the NPLC model as an incomplete FHT.

When the first Nurse-led Clinic was announced in Sudbury, the OMA and the OCFP were reassured that it was a “Provider-led FHT⁵⁸” and the nurses would be required to prove that they could operate a FHT within a year. FHTs are anchored in family practice (i.e. one FTE family physician per one FTE other healthcare professional). A FHT with 10 family physicians would be allocated 10 FTEs and might end up with 2 NPs, 4 RNs, 2 social workers, 1 dietician and 1 pharmacist for example. The Sudbury Nurse-led Clinic has never fulfilled its obligations to become a FHT. As a result, it has been referred to as a “Nurse Only” Clinic⁵⁹. With all due respect to our nursing colleagues, the Nurse-led Clinic model is the exact opposite of the collaborative practice model envisioned by government when it created FHTs (Ontario College of Family Physicians, 2009, January 22, p. 1).

The term “Nurse Only’ Clinic” is interesting, in that it again implies that nurses are the only health professionals on the premises. As already noted, all NPLCs from the start

⁵⁸ The term “provider-led” in this milieu generally means “physician-led.”

⁵⁹ Nowhere in my government references has the NPLC ever been referred to as a “Nurse Only” clinic (as revealed by conducting lexical searches of my datasets from all remaining social worlds). This would appear to be a designation given by the OCFP, though a lexical search of my OCFP data reveals that the usage in the above passage was the only time OCFP used the term.

have required a physician onsite to consult on cases outside of the nurse practitioners' scope of practice. It seems the fact that the model is nurse-led, rather than a physician-led group practice model, is what is raising the ire of the OCFP, rather than whether the model is collaborative or not.

Like the OMA, the OCFP expressed concern that the NPLC model created competition for scarce health care resources. It states:

The main concern is that RN(EC)s clinics [NPLCs] will fail to attract family doctors and the RN(EC)s will be required to refer patients to specialists for care when needs are beyond the narrow scope of practice of RN(EC)s. The other alternative is to simply send patients to emergency departments for care. The specialist referral system is currently overwhelmed and will simply grind to a halt in the absence of family doctors and the impact on our clogged emergency departments is of grave concern (Ontario College of Family Physicians, 2008b, p. 12).

Despite the efforts of physician organizations to discredit the NPLC model using the language of collaboration and teams, the NPLC model remains in place in Ontario.

Beyond FHTs and CHCs: Prescriptions for Other Team Models

The above discussion about the introduction of the NPLC model and the reaction of the physician organizations shows the clear preference of physician organizations for the FHT model. However, another area of concern for physician organizations regarding interdisciplinary primary care teams is their limited number and availability to physicians and to the Ontario public. Though there are now 200 Family Health Teams in Ontario, only 3 million (25%) of Ontario's 12 million people are served by this model (Ontario Ministry of Health and Long-term Care, 2013b, n.p.). Even when other models are factored in, the majority of Ontarians do not have access to interdisciplinary primary care teams; CHCs serve 500,000 (4%) of Ontarians (Association of Ontario Health Centres,

n.d., “CHC Factsheet”, n.p.), and NPLCs serve 32, 900 (less than 1%) (Ontario. Ministry of Health and Long-term Care, 2013c, n.p.). Physician organizations argue that the lack of access to interdisciplinary primary care team models is due not just to the limited resources put toward the FHT model, but also to discrimination by the government against physicians that work in solo practice (and thus on a fee-for-service payment model), or a group practice that operates on a fee-for-service model (i.e., the Family Health Group model). The OMA presents this as discrimination against fee-for-service models that subsequently results in unequal access to interdisciplinary primary care teams for the public:

Unfortunately, a very small percentage of Ontario’s patient population can benefit from current interprofessional care arrangements in primary care. The majority of physicians, and their patients, are denied access to such programs strictly because of the physician’s funding model. This discrimination takes place despite the absence of research demonstrating the superiority of any one physician remuneration model. Given the distorting effect that the current allocation of resources has on our health-care system, and the critical need to improve access to comprehensive primary care physicians, funding for collaboration must be extended to fee for service physicians (Ontario Medical Association, 2007, p. 2).

The OCFP also observes that relatively few FHTs have been established, alleges exclusion of fee-for-service models in the Liberal government’s plans for interdisciplinary teams, and calls the resulting system “two-tiered”:

FHTs appear to be yet another pilot project. This time, we appear to be testing whether interdisciplinary teams can provide quality services to more Ontarians... FHTs will be implemented only in some settings, in some communities. Furthermore, they are being established only in settings where the physicians are willing to change from a fee-for-service model to a capitation model, although no evidence exists showing the superiority of one funding model over another. This creates a two-tier system.... It is estimated that 150 FHTs will only include approximately 1300/6500 family doctors caring for 2.5 million patients. What is the plan for the other 9.5 million Ontarians who are not included in this pilot (Ontario College of Family Physicians, 2005a, pp. 3-4)?

The OCFP further argues that the resulting two-tiered system of access to interdisciplinary primary care teams based on physician choice of payment scheme violates the spirit of health equity underpinning the Canadian health care system:

...the bulk of funding in the primary care systems for interprofessional team based care has been directed towards physicians in salaries [sic] or capitation funding models. the OCFP has repeatedly identified the fact that the healthcare system was established on the basis of the value of “equity” (i.e. the most care for those most in need). Basing access to care on physician payment models and thereby creating inequitable access to care has been referred to as “two tiered” medicine. If the goal is effective healthcare and IPC [interprofessional collaboration⁶⁰] is a tool towards that goal, as we argue is the case, then policy and funding changes are required to reduce the inequitable access to funding support, which in the end, creates inequitable access for patients: patients are being penalized based on their physician’s choice of physician payment models, although no evidence exists showing the superiority of one funding model over another in terms of improving quality of care, achieving better patient outcomes or achieving successful IPC (Ontario College of Family Physicians, 2008a, pp. 5-6).

Thus the OCFP borrowed some of the language and terms used in other discussions about health care policy in Canada. Though the OCFP claims that “basing access to care on physician payment models...has been referred to as ‘two tiered’ medicine,” the use of the term “two-tiered” for that purpose appears to be limited to the OCFP (as above), the OMA, and Progressive Conservative MPPs for the purpose of challenging the FHT model in the Ontario legislature⁶¹. More commonly, the term “two-tiered” in the Canadian health care context refers to the inequitable system of health care that would

⁶⁰ IPC is identified as interprofessional collaboration in that particular document (Ontario College of Family Physicians, 2008a, p. 3).

⁶¹ In legislature, Progressive Conservative MPP Elizabeth Witmer, in challenging the Liberal government about the “imbalance” in the care made available to Ontarians, quoted then-president of the OMA, Greg Flynn, as calling FHTs a form of two-tiered health system where patients enrolled to FHTs had access to free services such as physiotherapy and diabetes care, when 12 million other Ontarians did not. George Smitherman chastised Ms. Witmer’s use of the term “two-tiered”, saying that “...referencing any differential in care that might be available to Ontarians as [‘]two-tier,[‘] when the phrase was invented to describe the idea that those with additional resources would pay for access on a different basis, is a misappropriation of the phrase” (Witmer & Smitherman, 2006, April 6).

result if individuals were allowed to pay money to gain faster access or better care outside of the publicly funded system (e.g., Cukier & Thomlinson, 2005), and is used in discussions of the dangers of privatization. In much the same way, in the above passage, the concept of health equity is being applied in a way that differs from its usual use (a focus on marginalized populations that have difficulty accessing health services based on characteristics such as their class position, citizenship status, race, ethnicity, gender identity, and/or sexual orientation).

The OCFP further criticizes the government's discrimination against fee-for-service physicians by portraying it as “ideology”:

The focus on salary or capitation-based funding models seems to be based on ideology rather than evidence and is a major deterrent in FHT development. Many comprehensive family doctors wish to remain in a blended or straight fee-for-service but are being told that they must be in a capitation or salary funding model to move forward with FHT development... Well- established physicians are finding it difficult to understand why a government that seems convinced that primary care teams will provide higher quality care is intent to make them off-limits to physicians who do not wish to change the way that they are paid. Evidence would support their request for a continued fee-for-service option and blended funding models like FHGs [Family Health Groups], if they so wish (Ontario College of Family Physicians, 2005b, p.34).

Further, the OCFP has attempted to create a binary by suggesting its arguments are based on evidence and logic, while the government’s reliance on “ideology” to make decisions about funding is illogical by comparison.

The OCFP further advocates “flexibility” in design and implementation of interdisciplinary care models, with physicians developing interdisciplinary primary care team models according to their “practice style”:

Research shows that by emphasizing flexibility in model design and implementation, practice groups will be able to adapt the structure and function of successful collaborative practice in a manner that preserves the characteristics of the partners’ preferred practice styles and respects the needs

of the patient population and any geographical variations or limitations. Structures that are supportive of new ways of working together, provide administrative support, time and space for interaction, supportive leadership and culture, change management, information and communication technologies (Ontario College of Family Physicians, 2008a, p.9).

This appeal to flexibility, and the reference to research showing the efficacy of this approach for promoting the adoption of interdisciplinary primary care teams by physicians, is another way that physicians attempt to maintain their financial autonomy in the changing conditions of primary care delivery in Ontario.

The above data have demonstrated how physician organizations promote the fee-for-service model as a viable alternative to providing interdisciplinary primary care to the mainly capitation-based model preferred by the government. Further, it shows how the physician organizations have framed this in terms of physician financial autonomy (physician choice of payment); fee-for-service has long been the preferred payment method for physicians in Ontario. Conversely, salaried models of physician reimbursement have not enjoyed much favour with physicians in Ontario (Muldoon et al., 2006), as being salaried is associated with compromised financial autonomy⁶² (Interview 001; Interview 004). This might explain why neither the CHC nor CFHT (community-based FHT) models are promoted by the OMA or the OCFP in my data as alternate forms of interdisciplinary primary care teams to the FHT model; both are salaried models. The CFHT model is not mentioned at all in the OMA data⁶³. The CFHT model is mentioned only twice in the OCFP data, though they are called “community-driven FHTs”. In both

⁶² The concept of physician financial autonomy is addressed in the discussion at the end of this chapter.

⁶³ I did not come across CFHTs in my coding process. Further, I conducted text searches of my OMA data using MAXQDA, my data analysis program, which is capable of executing lexical searches of imported data. I searched for the terms “CFHT”, “C-FHT”, “community-based FHT” and “community” and “FHT” within two paragraphs, with no results.

instances, the model is mentioned in passing (Ontario College of Family Physicians, 2006, pp. 12-13; *ibid*, 2005b, p. 33). In one of these sources, the CFHT model's potential attractiveness for physicians is questioned, due to its salaried payment system and the implication that the physician is an employee of the CFHT (Ontario College of Family Physicians, 2005b, p. 33).

The CHC model also receives relatively little attention in the OMA data. As I only found two passages about the model in the data, I conducted a more thorough lexical search of my OMA materials, resulting in 14 hits in 5 documents⁶⁴. Most of the references are in passing or are incidental to other topics (Ontario Medical Association, 2004, January 22; Ontario Medical Association, 2009, p. 2; Ontario. Ministry of Health and Long-term Care, 2008, p. 9). In one document, the fee-for-service model is compared to CHCs; the result suggests that there is no difference in the efficiency of preventive care between the two models (Ontario Medical Association, 1998). In another document, the CHC model is mentioned as a form of interdisciplinary primary care team that has been around for decades, but has been superseded by the FHT model, Ontario's "...first broad implementation of multidisciplinary care in the community [setting]" (Hanna, 2007, p. 2). There is no deeper discussion of the CHC model beyond these references in my OMA textual data.

The OCFP devotes more attention to the CHC model than the OMA. Throughout the OCFP data, the CHC model is recognized as a form of interdisciplinary primary care team particularly suited to providing care to marginalized populations:

⁶⁴ The search terms were for "CHC" or "community health centre". My two coded segments are included in these results.

The Community Health Centre model emerged in Ontario in the 1970s and was based on the governing principles of community control and health promotion. CHCs are multidisciplinary centres that offer integrated, coordinated, and accessible primary health and social services, crisis intervention, and social supports at the local level...Centres focus particularly on making health and social services accessible for hard-to-serve groups such as recent immigrants, Canadians from different cultural groups, and the homeless (Ontario College of Family Physicians, 2004, p. 68).

However, in one OCFP research paper, that recognition is followed by concern about the cost of the CHC model, which is believed to be higher than other forms of interdisciplinary primary care team. For this reason, CHCs were viewed by the expert participants in that paper⁶⁵ as being reserved for marginalized populations: “Given the cost of the model, CHC’s should be implemented in those areas of the province where their unique model of care can best meets [sic] the needs of Ontario’s most vulnerable populations (Ontario College of Family Physicians, 2004, pp. 25-26).” However, in that same document, the OCFP gives an alternative view to the expert participants, stating that the CHC model could be extended to serve non-marginalized populations as well:

...when assessing the cost-effectiveness of the CHC model, it is important to recognize that the needs of the socially disadvantaged have resulted in the inclusion of a multitude of support services that are not strictly speaking “health”-related in the traditional sense. Housing, language, peer support, legal, welfare and integration services are often found under a CHC’s roof in addition to health services. As a result, the cost of delivering care through CHCs is increased. Since many of these services do not have the same pertinence for the population as a whole, the average cost of the bundle of services offered per patient would decrease. This also connotes the possibility that CHCs in communities not geared to underprivileged populations can funnel more capital and human resources into family medicine, mental health and health promotion. Despite the historical marginalization of CHCs to very

⁶⁵ This research paper was based on extensive consultations of the OCFP with members of The Association of District Health Councils of Ontario (ADHCO), The Ontario Association of Community Care Access Centres (OACCAO), The Ontario Family Health Network (OFHN), The Ontario Hospital Association (OHA), and Miltom Consulting. Consultations were held in seven districts in Ontario (Hamilton, Barrie, Windsor, Sudbury, Ottawa, Thunder Bay and Toronto) with approximately 280 expert participants, between April and June of 2004 (Ontario College of Family Physicians, 2004, p. 10).

specific population groups, Community Health Centres continue to be an excellent mechanism for primary care delivery to the socially disadvantaged, and opportunities exist to expand them to the rest of the Ontario's population (Ontario College of Family Physicians, 2004, p. 68).

However, the view that CHCs could be expanded to serve the general Ontario population does not appear again in the remainder of my OCFP data. Instead, after 2004, the talk seems to switch into the discussions of “two-tiered medicine” outlined above, where concern is focused on the exclusion of fee-for-service physicians from the FHT model. The OCFP's shift away from presenting CHCs as a viable model for the general population, whether intentional or not, maintains the marginal status of the model. While the language of the OCFP toward CHCs in my data is respectful, it appears to be bounded in its enthusiasm by concerns about the financial viability of broad application of the model. Arguably, there are other, less obvious constraints on the enthusiasm for CHCs by the OCFP, particularly the elements of the CHC model that clash with physician autonomy, such as the community governance aspect, physicians as salaried employees, and the flatter hierarchy of health care professionals.

Further, the OCFP's stated commitments to improving care for marginalized populations might inadvertently create competition for the CHC model. The OCFP has sought to make family physicians more aware of health issues facing marginalized populations, to make family medicine more adept at serving those populations, and to be more aware of the need to consider marginalized populations in planning health services. In the following example, the OCFP outlines the need for family medicine in Ontario to adopt a “team approach” with other health professions to address the health needs of marginalized populations:

A co-ordinated team-approach is essential to facilitate access to care for marginalized groups and individuals who have multiple health and social

needs. Understanding each health provider's role and responsibility is essential in establishing better working relationships and providing a more effective and appropriate health care in these instances. THEREFORE, it is recommended that coalitions with other health professionals be developed to facilitate on-going communication and working relationships among the health disciplines (Ontario College of Family Physicians, 1998a, p. 8, all caps in original).

The above passage invokes family medicine to take action toward a team approach, but a model for doing this is not specified. Rather, appeals are made again, as in other discussions highlighted in this chapter, to mutual understanding of roles as the starting point for providing care⁶⁶. This generic talk allows for new team models of interdisciplinary primary care for marginalized populations.

In sum, physician organizations assert that interdisciplinary primary care team models must expand beyond the capitation- and salary-based models of the FHT and CHC, respectively, in order for interdisciplinary care to be available to more Ontarians. These appeals, couched in terms of "flexibility", tend to focus on allowing fee-for-service physicians to access funds to provide interdisciplinary care.

Discussion

Overall, the data suggest that the medical social world in Ontario, as represented by the organizations studied herein, are *conditionally* positive toward primary care reform and to interdisciplinary primary care teams. My data suggest that in the medical social world, there is an acknowledged need for reform and for teams. However, my data also indicate that these organizations aim to maintain and ensure physicians' dominant position in the health care system amidst reform and the movement toward

⁶⁶ The reader is reminded that earlier, I showed how appeals to role understanding in physician organization data imply a physician-led team. While there is insufficient evidence in this particular passage to imply the same, it is nonetheless a possible interpretation.

interdisciplinary primary care teams. As well, physician organizations have spoken out against reforms and team models that threaten their professional autonomy and/or dominance, further evidence of the medical profession's limited acceptance of interdisciplinary primary care teams. This is different than the political social world, where teams are universally viewed positively.

Some of the data from the medical social world about primary care reform and interdisciplinary primary care teams straightforwardly reflect longstanding medical professional concerns about autonomy and dominance. The reader is first reminded of the important contours of these two concepts. Professional autonomy is the ability of a profession to control the content and conditions of its own work (Randall & Williams, 2009, p. 53). Further, literature suggests that professional autonomy is multidimensional, including economic autonomy (control over prices and incomes) and clinical autonomy (control over clinical decision-making) (Randall & Williams, 2009, p. 55). Dominance is the ability of a profession to control the work of others (Willis, 2006, p. 422; Coburn, 2006, p. 433), to control clients and access to clients (Coburn, 2006, p. 433), and to control the broader social context that creates the terms and conditions of professional work, including the policy context (Coburn, 2006, p. 433; Bourgeault & Mulvale, 2006, p. 483). In their discourses about teams, one can discern physician organizations' attempts to protect their economic autonomy in their arguments that fee-for-service physicians should be free to choose their payment system but still receive financial support to create interdisciplinary teams, and in the OMA's argument that physicians should be paid extra for leading interdisciplinary primary care teams. Obvious attempts to protect physicians' clinical autonomy in team practice include appeals to grant the physician the first right of

clinical review of new patients and subsequently to delegate aspects of the patient's care to non-medical professionals on the team.

Some of the data also reflect overt examples of the protection of medical dominance. One example of an attempt to maintain physician control over access to clients is the OMA's statement that patients may only roster with a physician, and not a non-physician professional, in teams that use the patient enrolment model (e.g., the FHT model). Statements from the OMA, OCFP, and the CPSO speaking out directly against the independent practice of non-physicians, particularly in the areas of prescribing, diagnosis, and patient management, constitute overt attempts to control the work of other professions, as do the statements from the OMA and OCFP against the NPLC model. There is still some utility, then, to the concepts of dominance and autonomy as they can still help to make sense of some of what is being said in the medical social world about actions undertaken in primary care reform and the movement toward interdisciplinary primary care teams.

At other times, my analysis reveals discursive patterns regarding interdisciplinary primary care teams that are not as transparently related to issues of autonomy and dominance, but are arguably about those very issues. For example, the binary constructed between primary care (as physician care and proven efficacy) and primary health care (as potentially excluding physicians altogether and lacking evidence of efficacy) by the OCFP serves to keep physicians as the safe and logical point of first contact in the health system. If it is successful in this bid to convince policy-makers to invest in primary care, the OCFP would maintain both clinical and economic autonomy for physicians, by keeping both the locus of care and provincial funding with physicians. The appeals to the emotional aspects of the patient-physician relationship and its potential

disruption by teams are a less direct way of controlling access to clients, by emphasizing this relationship and excluding the possibility of such a bond forming between patients and other professionals. Drawing on ideals about teams and interprofessional collaboration to subvert scope expansion by non-physician professionals is a subtle way of attempting to control the content of work done by other professionals and is arguably an attempt to maintain medical dominance through this discourse.

My analysis thus adds a new dimension in understanding discursive processes in the talk about interdisciplinary primary care teams: as methods for attempting to defend medical autonomy and dominance. This analysis can help non-professional audiences, such as the broader public, to understand some of the nuances of the discourse about interdisciplinary primary care teams, and to what ends some of the talk is being put by physician organizations, as the lessons might also apply to other provinces. At the very least, the public can now be aware of some of the purpose of this talk, and be better prepared to speak out about, or make choices about, the culture of their health care.

My choice of the word “attempt” in my description of the discursive manoeuvres by physician organizations throughout this chapter is purposeful. I cannot claim a direct causal link between what medical organizations are saying about teams and the outcomes of the changes to the medical profession wrought by primary care reform and the introduction of interdisciplinary primary care models.

However, I am able to use the concepts of autonomy and dominance to assess the gains and losses to the medical profession in Ontario that result from the establishment of interdisciplinary primary care teams. The medical profession has gained most in economic autonomy, though I would characterize this as a *net* gain. Physicians lost ground in losing the battle to have a fee-for-service-based FHT (interdisciplinary) model,

a blow to their choice of payment model. However, as noted by Rosser et al. (2011), physicians that have switched into the FHT model⁶⁷ have increased their income by 40% compared to fee-for-service physicians (p. 170), a considerable financial gain. Finally, given that the most significant investments to date in interdisciplinary primary care teams has been in the FHT model, which are mainly physician-led, rather than in the CHC or NPLC models, the medical profession continues to garner the most government funding for interdisciplinary primary care teams.

Physicians also appear to have maintained their clinical autonomy overall, at least in that the FHT model is the most common form of interdisciplinary primary care team. Patients must enrol with a physician who is responsible for coordinating their care as they see fit; the point is that the control still lies with the physician, who decides what and to whom to delegate aspects of the patient's care. Thus, the fact that patients must roster with physicians in the FHT model allows for a culture of care where the physician is still in charge. Although models of interdisciplinary primary care teams in which nurse practitioners independently see patients (as in the CHC model and the NPLC model, or even in FHTs that allow it⁶⁸) would represent a loss to physician autonomy at the political level, one interviewee noted that it is the physician's *choice* to enter non-physician-led models (Interview 013).

⁶⁷ The FHT model may be based either on the FHN or FHO model, which are both capitation-based systems of payment for the physicians therein.

⁶⁸ The OCFP noted in its submission to HPRAC regarding the role of nurse practitioners in 2008 that, in some FHTs, nurse practitioners would see patients with minor ailments while physicians handled the more complicated patients, suggesting a more independent form of practice for nurse practitioners in those settings (Ontario College of Family Physicians, 2008b, p. 5). While no indication was given about how many FHTs engaged in this practice, the connotation was that it was not very many. As well, the OCFP was quick to note immediately after that sentence that “[m]ore successful collaborative practices seem to recognize that the entire practice population has the potential of benefiting from the combined skills of family physicians, registered nurses, nurse practitioners and other healthcare providers” (ibid.).

The greatest losses for the medical profession come in some areas of control over the work of other health professionals, despite the medical profession's success in negotiating a largely physician-led model of interdisciplinary primary care with the FHT. While the medical profession was able to make submissions to HPRAC about their concerns over the scope of practice expansion for some non-physician health professionals, they were unable to stop scope expansion wrought by Bill 179. They were also unable to stop the Ontario government from implementing 25 NPLCs, whose nurse-led culture threatens medicine's traditional leadership role in the health care system. These failures stand in contrast to past examples in Ontario of medical dominance over non-medical professions: the successful blocking of midwives from practising in the provincial health system in the early twentieth century (Adams & Bourgeault, 2003, p. 86); and the effective blocking of nurse practitioners due to successful physician lobbying to discontinue nurse practitioner education programs in the early 1980s (deWitt & Ploeg, 2005, pp. 122-123; Angus & Bourgeault, 1998, pp. 62-63). In the post-1990s era, however, the Ontario medical profession was simply not strong enough to overcome the long-standing interest and desire of the political apparatus in Ontario to make better use of non-physician health professionals.

Finally, I address here some points arising from this chapter that might be of interest to the public. The public is at once in an advantaged and disadvantaged position in terms of primary care reform and the movement toward interdisciplinary primary care teams. Based on my data in this project, they are disadvantaged in two respects: first, as noted in Chapter Four, the public appears to have limited knowledge of primary care reform and its consequences. Second, as I also noted in Chapter Four, the public still largely associates their primary care with their family physician. Thus, the discourse of

the medical organizations might be quite influential in public opinion about interdisciplinary primary care teams. If the FHT model is presented to the public by the medical profession (as well as the provincial government) as “the” model of interdisciplinary primary care team, the public might not know of other options in team models, or of the distinct cultures of each model. There is thus a danger of the public not recognizing non-FHT models as viable models of their primary care, even though those models might be better for them, or could be found with future research to be more effective at providing interdisciplinary primary care (alternately, of course, it could also turn out the FHT is a highly effective model for everyone). The pending Conference Board of Canada assessment of the FHT model may tell the public more about its efficacy. However, the Conference Board’s evaluation criteria will have to be closely scrutinized for whether it is evaluated on measures of potential interest to the public.

However, I would also reiterate the contention I made in Chapter Four: the public holds a considerable but latent influence in policy decisions in health care. I think this also applies to the public’s relationship to the medical profession. Both Abbott (1988, p. 59) and Freidson (1970, p. 188) note that professions seek legitimacy not just from the state, but from the public as well. This could account for some of the findings herein; the emotional appeals to the patient-physician relationship and the dangers posed by teams, the warnings about the untested and unproven primary health care model compared to the solid reputation of primary care, and the dangers posed by physician substitution for public safety are all appeals to the public to put their trust in the medical profession in the matter of teams. Recent history also suggests that public opinion matters. The abject failure of the OMA’s 1986 strike to garner public support and the consequent turnaround in attitude by the OMA toward greater cooperation with the state is a reminder of the

latent power of the public in relation to the medical profession and to health care policy.

It is my hope that my research could be used to inform the public about the nuances in the talk about teams such that it would have a greater ability to judge the claims of the medical profession about interdisciplinary primary care teams, and subsequently be able to participate in the wider discussion about primary care reform in a more informed way.

It would be a mistake, however, to paint the interests of the public and the medical profession as completely antithetical to each other. For example, the public may want to follow the medical profession's example of a more cautious optimism about the potential of interdisciplinary primary care teams to improve care, rather than the political social world's view of teams as a panacea. They may also want to support the medical profession's contention that while teams might be beneficial, there may still be need of more physicians in the province of Ontario. The public might also adopt some of the medical organizations' skepticism toward expanded scopes of practice for non-medical health professions into the areas of diagnosis and prescribing, particularly if these are areas with which a given profession has no extensive prior knowledge base or that may threaten patient safety. The public has some opportunities to make their views on these matters known. For example, members of the public are allowed to present their views on relevant legislation to legislative committees. Given that HPRAC's mandate is to represent the lay perspective in regulating the health professions in Ontario, members of the public might make their views or concerns known to that body as well. Overall, more scholarly empirical research would have to be conducted to learn more about the public's view of these matters, as well as their perceptions of the role to be played by physicians on teams, and their understanding of teams and primary care reform more broadly,

beyond the studies of the public commissioned by the OCFP⁶⁹ and executed by Harris-Decima.

Finally, I think the public should be aware that the FHT model may have limited potential to effect the transformation of the health care system envisioned by policy-makers. The majority of the FHTs in Ontario are physician-led⁷⁰. This means that the character and culture of FHTs could still end up being physician dominated, though more empirical study would be needed to test this hypothesis. Continued physician domination of the culture of care potentially means that certain areas of primary care in which physicians have been less successful, such as preventive care (Russell, 2005, p. 105) and chronic disease management (Katz et al., 2006, p.2239), may continue to suffer in the FHT model, despite the presence of non-physician health professionals; more research would be needed to test this hypothesis as well. While data from the OCFP indicated that family medicine is becoming more aware of the need to address health inequities, recent empirical studies from Ontario suggest that various family physician-led group practice models (including the FHN model on which FHTs are now based) were less successful than the CHC model at chronic disease management (Russell et al., 2009, p. 312), community outreach activities (such as home visits), and knowing the health needs of the

⁶⁹ In my data for the OCFP I have identified 3 such studies of public opinion relating to interdisciplinary primary care teams commissioned by OCFP in my data, conducted in 2010, 2008, and 2005. One of these was referenced earlier in the chapter, in the section entitled *Maintaining the primacy of the patient-physician relationship*.

⁷⁰ This term applies in two senses: first, as I already noted in this chapter, in the FHT model the coordination of care lay largely with the physician with aspects of care delegated to other health professionals on the team. Second, the majority of FHTs have physician-based governance structures, which make decisions about how the entity is run and what services are offered. Personal correspondence with the executive director (Angie Heydon) of the Association of Family Health Teams of Ontario (AFHTO) revealed that, of 168 FHTs that responded to AFHTO's request for information (of a total of 186 FHTs), 84 (50%) were physician-only governed, 56 (33%) were of mixed community and physician governance, and 28 (17%) were community governed (personal communication, September 30, 2012).

communities served (Muldoon et al., 2010, p.679). Again, the pending Conference Board of Canada FHT evaluation may be able to provide information about whether the FHT model will improve physician group practice in the areas of preventive care and increasing access to health care for access-challenged populations compared to FHNs and to CHCs. If the Conference Board of Canada's evaluation does not include these areas, then these would prove a valuable area of future research.

Chapter Six

Non-medical Professional Social Worlds

Introduction

In this chapter I focus on the talk, the claims made, and the actions taken toward interdisciplinary primary care teams by the nurse practitioner, dietetic, and chiropractic professions in Ontario. The data for this chapter derive from the professional associations and colleges of each profession, and interviews with key informants involved in each of these professional social worlds. Textual data sources include organization webpages, communiqués, submissions to government, position statements, and policy documents. Data range in date from 2003 to 2011 for the nurse practitioner data, 2006 to 2011 for the dietetic data, and 2002 to 2011 for the chiropractic data; the variation is due to the differences in the availability of data for each profession.

Each of these three professions views primary care reform and interdisciplinary primary care teams positively. Further, there is no particular emphasis on any one of the three team models by any of these professions, though in the early days of reform the nurse practitioner profession attempted to shape the FHT model to be more egalitarian in its governance structure, and proposed a nurse practitioner-led version. Each of these professions uses discourses about teams and teamwork to advance their interests. After briefly introducing the organizations studied, I examine the broad agreement of these three professions with the basic tenets of primary care reform and teams. I then examine team-related issues and controversies specific to the nursing, chiropractic, and dietetic professions in Ontario, and how discourses about teams and collaboration are used by each in an effort to enhance their respective positions in the health care system. I

conclude the chapter with a discussion contextualizing the findings vis-à-vis the literature, as well as implications and future areas of study.

Primer on the Organizations

Nurse Practitioner

The College of Nurses of Ontario (CNO) is the governing body for all nurses in the province, including nurse practitioners (College of Nurses of Ontario, 2012a, n.p.). The CNO sets standards for practice and entry to the profession, and ensures that members adhere to standards of practice and ethical conduct (ibid). Nurse practitioners must be a member of CNO to legally practice in Ontario (ibid, 2012b, n.p.). Nurse practitioners must pass the entry requirements and become members of the College's Extended Class to legally practice (ibid, 2013, n.p.).

The Nurse Practitioners' Association of Ontario (NPAO) was established in 1973 by graduates of the nurse practitioner programs at the University of Toronto and McMaster University (Nurse Practitioners' Association of Ontario, n.d, "NPAO Vision, Mission and Values", n.p.). The NPAO's original mandate was to represent the interests of nurse practitioners working in primary care, though this mandate now also covers nurse practitioners in secondary and tertiary care (ibid). In 1985, the NPAO became affiliated with the Registered Nurses' Association of Ontario (RNAO, the professional association of registered nurses) by becoming an RNAO expert sub-group⁷¹ (ibid). This

⁷¹ The Registered Nurses' Association of Ontario (RNAO) calls such groups "interest groups"; RNAO currently has 31 interest groups (Registered Nurses' Association of Ontario, n.d., "Interest Groups"). Each group "...represents a unique specialty or population within the nursing spectrum. Interest groups have access to RNAO resources and group leaders attend RNAO's Annual Assembly (ibid; Registered Nurses' Association of Ontario, n.d., "Why become an RNAO interest group?"). Examples of RNAO interest groups (aside from the one for nurse practitioners) include mental health nursing, family practice nursing, pediatric nursing, gerontological nursing, and nursing research.

entitled NPAO to RNAO resources, as well as representation and the opportunity to contribute to policy discussions at the RNAO's Annual Assembly (Registered Nurses' Association of Ontario, n.d., "Why become an RNAO interest group?", n.p.) The NPAO is run by a voluntary board elected by its membership (ibid). The NPAO hosts its own annual conference, provides educational funding and continuing education programs for nurse practitioners, and has made submissions to government and the Health Professions Regulatory Advisory Council (HPRAC) about the role of nurse practitioners in Ontario's health care system (Nurse Practitioners' Association of Ontario, n.d., "NPAO Vision", n.p.). Membership in the NPAO (and the RNAO) is voluntary. I did not collect data from the RNAO because of the NPAO's existing affiliation as a subgroup of the RNAO, and because the NPAO had much more data specific to nurse practitioners and their concerns about teams.

Dietetic

The College of Dietitians of Ontario (CDO) was established in 1991 via the Regulated Health Professions Act (College of Dietitians of Ontario, n.d., "College of Dietitians of Ontario", n.p.). The CDO is the regulatory body for registered dietitians in Ontario, and is responsible for setting and enforcing the practice and ethical standards of the profession, ensuring the continued competence of its members, supporting its members, and ensuring public safety (ibid; ibid, n.d., "College Responsibilities", n.p.). CDO made a joint submission with Dietitians of Canada to HPRAC regarding Bill 179 (the Regulated Health Professions Amendment Act) proposing legislative changes to expand dietetic scope of practice to enhance teamwork (Dietitians of Canada, n.d., "Accreditation", n.p.), and presented to the Standing Committee on Social Policy regarding Bill 179 (Gignac, 2009, October 5).

In contrast to the nursing and chiropractic professions, the dietetic profession in Ontario does not have a provincial professional association. However, Dietitians of Canada (DC), the professional association representing dietitians at the national, provincial and local levels, has three regional representatives for Ontario (Dietitians of Canada, n.d., “Key contacts”, n.p.); half of Canada’s 6000 dietitians are located in Ontario (Whittington-Carter, 2009, September 29, n.p.). DC’s stated activities include educating the public about dietetics, providing leadership in developing nutrition policy at all levels, developing standards and resources (including professional development), accrediting education and training programs for dietitians, and promoting dietitians as “...valuable members of the health team” (Dietitians of Canada, n.d., “What we do”, n.p.). DC has conducted research about the role of dietitians in interdisciplinary primary care teams in Ontario (e.g., Davidson et al., 2005; Ciliska et al., 2006; Davidson et al., 2006; Brauer et al., 2006; Davidson et al., 2007). In addition to its joint submission with CDO to HPRAC regarding Bill 179, DC made a presentation to the Standing Committee on Social Policy regarding the Bill (Whittington-Carter, 2009, September 29, n.p.).

Chiropractic

The College of Chiropractors of Ontario (CCO) is “...the governing body established by the provincial government to regulate chiropractors in Ontario” (College of Chiropractors of Ontario, n.d., “About CCO”, n.p.). Chiropractors must be members of the College to practice legally in Ontario (ibid). The College sets practice standards and guidelines as well as entry requirements for the profession, monitors competence through a quality assurance program, and disciplines members who have committed acts of professional misconduct (ibid, n.d., “How CCO Protects the Public Interest”, n.p.). The

CCO was established via the Regulated Health Professions Act in 1991 (Coburn, 1994, p. 135).

The Ontario Chiropractic Association (OCA) is "... a voluntary professional association whose purpose is to serve our members and the public by advancing the understanding and use of chiropractic care" (Ontario Chiropractic Association, n.d., "Ontario Chiropractic Association", n.p.). The OCA has existed since 1929 (ibid, n.d., "What we do", n.p.). The OCA outlines its activities as supporting its members and chiropractic research, educating the public about chiropractic (Ontario Chiropractic Association, n.d., "What we do", n.p.), strengthening the profession's involvement in the health care system, and enacting health policy developed by the provincial government (Ontario Chiropractic Association, n.d., "Health policy", n.p.), including interprofessional collaboration (ibid, n.d., "Interprofessional collaboration",n.p.).

Agreements and Commitments to Primary Care Reform and Teams

Each of the nursing, chiropractic, and dietetic professions in Ontario view primary care reform, interdisciplinary care, and the movement toward teams positively. Similar to government and the medical profession, these three professions view teams as an integral part of primary care reform. Teams are said to improve patient outcomes (e.g., Nurse Practitioners' Association of Ontario, 2011, p. 6; Dietitians of Canada, 2009, p. 14; College of Chiropractors of Ontario, 2008a, p.11) and to improve health care system efficiencies and/or lower costs (e.g., Dietitians of Canada, 2009, p. 14; Ontario Chiropractic Association, 2004, p. 13; Nurse Practitioners' Association of Ontario, 2007a, p. 1).

The organizations from each of these professions stated or actively demonstrated their commitment to interdisciplinary care. The CNO, for example, stated that “CNO supports interprofessional practice by all health providers and believes that interprofessional collaboration is an essential prerequisite for effective and efficient patient and family-centered care” (College of Nurses of Ontario, 2008a, p. 3). The NPAO’s commitment to interdisciplinary care is stated in the official list of its organizational values: “[c]ollaborative and autonomous Nurse Practitioner practice fostering interprofessional care” (Nurse Practitioners’ Association of Ontario, n.d., “Vision, Mission, Values, Goals”, n.p.). Its commitment was further reflected in its 2006 consensus building project for its members. The project, entitled *Development of an Accord on the Nurse Practitioner Role in Ontario: Developing Models of Interdisciplinary Practice that Enhance Patient Care*, sought to “...increase the impact of the NP role and its relevance to health system transformation...and how it can best be positioned and advanced within interprofessional collaborative team practice” (van Soeren et al., 2007, p. 2).

Similarly, dietetic organizations signaled their support for interdisciplinary care. DC stated: “[p]rimary health care reform presents new opportunities for Registered Dietitians to contribute to health promotion, disease prevention and treatment in interdisciplinary and collaborative primary health care settings” (Ciliska et al., 2006, p. 7). The CDO’s statement reads:

Interprofessional care and collaborative scopes of practice are emphasized in Ontario's healthcare transformation. RDs [registered dietitians] are strongly supportive of interprofessional care, and believe that the patient's best interests are served when healthcare teams work collaboratively and maximize the expertise of all professions (College of Dietitians of Ontario, 2008, Summer, p. 7).

Finally, organizations representing chiropractors demonstrated support for teams. The CCO stated “[i]nterprofessional collaboration on all fronts leads to increased health for all concerned. Our commitment to improving patient outcomes and promoting collaborative patient care is paramount if our patients are to experience higher levels of health” (College of Chiropractors of Ontario, 2008b, p.1). The OCA incorporated interdisciplinary collaboration into its code of ethics in 2002 (Ontario Chiropractic Association, 2002, p.1). In its 2009 Pathways to Practice professional development day for its membership, the OCA featured a workshop on “...developing a collaborative model for delivering chiropractic care within a Family Health Team” (ibid, 2009, n.p.). Thus, each of the organizations for these professions in this study has clearly committed in some way to engaging in and promoting interdisciplinary care or interdisciplinary primary care teams.

Another noteworthy similarity is that none of these three professions promote one model of team over other models. This is in contrast to the medical profession, where the FHT model was actively promoted as the best model, the NPLC model was denounced as not collaborative, and the CHC model relegated to a niche role serving marginalized populations. In the texts from the dietetic and chiropractic social worlds, discussion was limited to CHCs and FHTs, with no mention whatsoever of the NPLC model. Discussion of the CHC and FHT models by these two professions focused on members of the profession working in these models (Brauer et al., 2006, pp. 6-7; College of Dietitians of Ontario & Dietitians of Canada, 2008, p.1; College of Dietitians of Ontario, 2011) or to the role or potential role played by each profession in CHCs and FHTs (e.g., Brauer & Dietrich, 2006; Ontario Chiropractic Association, 2009). Interview participants from

dietetics (008) and chiropractic (005) confirmed that members of their professions work in both of these models, and opined that there is no preferred model of team in their professions.

Data from nurse practitioner sources presents a somewhat different pattern from that of dietetics and chiropractic. The NPAO in particular engaged in a more in-depth discussion of the FHT model in a 2005 document discussing the potential role of nurse practitioners. While agreeing with the FHT model overall, the NPAO sought to expand the possible forms they might take to include more egalitarian forms (eventually, these alternate visions of FHTs were realized in the NPLC model). In that document, the NPAO refers to the First Ministers' 2003 Accord on Health Care, reiterating the First Ministers' assertion that primary health care should be delivered by interdisciplinary teams, and that the benefits of this approach would be:

[t]imely access to a team to address health problems and ensure they receive information, advice and services needed to prevent avoidable illnesses and stay healthy; [g]reater focus on health promotion and better support for individuals to make health choices to maintain and improve their health; [and] [s]upportive work environments for health care providers that enhance both professional satisfaction and their own ability to make healthy choices (Nurse Practitioners' Association of Ontario, 2005a, p.1).

The NPAO then acknowledges the Ontario government's considerable efforts to realize these objectives through the widespread implementation of the FHT model (ibid).

However, it subsequently argues that:

If the Family Health Team model is to be effective in meeting the objectives of the [First Ministers'] Health Care Accord, and notwithstanding the key role of family physicians in primary health care, it is imperative that Nurse Practitioners are recognized as essential members of the health care team. A shift in power and decision-making from a physician dominant structure to one that is more egalitarian and democratic is necessary to achieve this objective. Through utilization of different models of governance to guide

delivery of care, ensuring participation by team members in decision making, new thinking in the approach to funding and innovation in developing models for remuneration, NPAO is confident that the goals of primary health care can and will be achieved (Nurse Practitioners' Association of Ontario, 2005a, p. 2).

The NPAO thus strategically drew on the First Ministers' Accord in order to link Ontario's FHTs to the goals of primary care reform as set by the Accord. These goals include health promotion (a claimed specialty of nurse practitioners) and a supportive work environment for health practitioners, specifically defined by NPAO as one that redistributes decision-making more equitably among a team of health care professionals.

NPAO's approach of suggesting new governance structures within the FHT model is also noteworthy, as it allows for nurse practitioners' participation in governance:

NPAO supports a variety of governance models for Family Health Teams. NPAO supports options in provider-led governance models whereby Nurse Practitioners participate as full members of the governance structure. Regardless of the governance model, NPAO expects that Family Health Teams will incorporate processes and procedures that include participation by all members of the interdisciplinary team, including Nurse Practitioners, in operational, fiscal and clinical program decision-making (Nurse Practitioners' Association of Ontario, 2005a, p. 2).

This strategy of working for change within the FHT model also allowed the NPAO to propose a nurse practitioner-led FHT form in the same document, and to warn of the consequences of not allowing this innovation:

NPAO supports new and innovative approaches to governance for Family Health Teams. Refer to Appendix 1 for an example of a Nurse Practitioner managed FHT⁷². Innovative thinking in the implementation of Ontario's

⁷² That Appendix outlines a fictional scenario as an example of how a nurse practitioner managed FHT could benefit a given area where large numbers of people have no access to primary care; outlines how community needs would be identified, how the team's composition would be determined based on the community's needs; and outlines four phases of tasks in order to implement that particular model (Nurse Practitioners' Association of Ontario, 2005a, p.8).

approach to improving access to primary health has the potential to fully realize the goals set out by the First Ministers in the Health Care Accord. In the absence of opportunities for Nurses [sic] Practitioners – and other health care professionals – to participate in a more active way in governance of Family Health Teams, NPAO believes that Ontario will simply be adding another acronym to the health care system and will miss the opportunity to take bold steps to improve access to primary health care for Ontarians (Nurse Practitioners' Association of Ontario, 2005a, p. 3).

The NPAO is thus attempting to claim that “true” or “complete” health system transformation will occur only if the governance of teams is shared more equitably among the professions working in them.

This is the extent of the critique of the FHT model that I encountered in the nurse practitioner data. The NPAO makes no in depth comment about the FHT model in subsequent documents; comments about the model are limited to acknowledging that FHTs are places where nurse practitioners work (Nurse Practitioners' Association of Ontario, 2007b p. 3). The CNO's comments on FHTs are limited; they note FHTs are places where nurse practitioners work, and that the model will enhance understanding of the nurse practitioner role in the primary care system (e.g., College of Nurses of Ontario, 2007, p. 24).

The NPLC model is discussed only by the NPAO; surprisingly, there were no documents by the CNO addressing this model. The NPAO's discussion of NPLCs is not extensive, comprising only a page in their website (Nurse Practitioners' Association of Ontario, 2010, October 18). That page focuses on the structure of the model and how patients may register for services, while also emphasizing the unique character of the model due to its leadership by nurse practitioners (*ibid*). The latter point is examined in more detail in the next section of this chapter. Here, I would emphasize that while the

language of the NPAO's description of the NPLC model is positive, there is no suggestion that the NPAO promotes NPLCs over FHTs or CHCs.

Finally, the nurse practitioner data do not offer any in-depth discussion of the CHC model. As in the dietetic and chiropractic professions, CHCs are mentioned only as places where nurse practitioners work (e.g., College of Nurses of Ontario, 2007, p. 45). In its 2005 document discussing the potential role of nurse practitioners in the FHT model, the NPAO briefly mentions a community governed model "...similar to existing community health centres" as its preferred model of governance for FHTs (Nurse Practitioners' Association of Ontario, 2005a, p. 3). However, it is important to note that the NPAO also sees other models of governance as acceptable possibilities.

Overall, the nurse practitioner, dietetic, and chiropractic professions agree with the oft used tenets of primary care reform, and see teams as an important part of primary care reform. There are no stated preferences by any of the three professions for one of the three team models over another, though nurse practitioner organizations argued for more egalitarian forms of governance for the FHT model, and proposed to expand the variety of FHT forms by proposing a nurse practitioner-led version of the FHT.

Having examined the professions' broad agreement with primary care reform and interdisciplinary teams, I now address issues of importance specific to each profession.

Nurse Practitioner Profession

In this section, I focus on three main issues identified in my data from the nurse practitioner social world. First, I examine how the nurse practitioner profession (specifically, the NPAO) frames primary care reform and the movement toward interdisciplinary primary care teams as the new health care world, and its attempt to posit

nurse practitioners as leaders in the new world. Second, I examine how scope expansion is sought by nurse practitioners in the name of advancing interdisciplinary primary care teams. Finally, I examine how ideals about teams are used by the nurse practitioner profession to highlight inequities among health care professions working in interdisciplinary primary care teams. Throughout, I show how interdisciplinary primary care teams are used in an attempt to advance the position of nurse practitioners in Ontario. However, I will also highlight instances where the profession is careful to set boundaries on some of its claims.

The New Health Care World: an Opportunity for Nurse Practitioners

In the NPAO data, primary care reform is presented as creating momentous changes in health care conditions in Ontario. The nature of the changes, as well as the new opportunities for nursing leadership and practice within this new milieu are articulated throughout the talk of the changes. For example:

In 2006, during the NPAO Accord project⁷³, nurse practitioners advanced that the new model that would help transform health care (i.e. the second curve of health care in the 21st century) focused on person-centred care that supports Ontarians to live intact meaningful lives using strong interprofessional collaboration as a key success factor in the delivery of health care services. Equipped with that perspective on health care in the future, nurse practitioners will continue their efforts to be leaders within a transformed health care system (Nurse Practitioners' Association of Ontario, 2007b p.18).

The portrayal of the shift toward “person-centered care...” as “the second curve of health care in the 21st century” reflects the widespread belief in this social world (and others in

⁷³ This was the *Development of an Accord on the Nurse Practitioner Role in Ontario: Developing Models of Interdisciplinary Practice that Enhance Patient Care* project, initiated by NPAO and funded by the Primary Health Care Transition Fund via the Ontario Ministry of Health and Long-Term Care (van Soeren et al., p.1).

this study) of the need for the modernization and transformation of the health care system; interdisciplinary teams are mentioned as an important part of that transformation, though not in any specific way. Nurse practitioners are presented as leaders with the skills and knowledge to transform the system.

In the passage below, also from NPAO, changes to the Ontario health care system are characterized as “the new health care world”:

We must effectively challenge the historical comparison of the nurse practitioner role to that of physicians and the alignment of the role as an augmentation or replacement for physicians during times of shortages. It will become increasingly clear in the new health care world that this misconception is based on a focus of tasks that nurse practitioners and physicians perform (e.g., prescribing treatment and diagnosing disease). This role overlap merely reflects overlap of some competencies necessary to deliver care, but the core education, in this case medicine versus nursing, indicates different approaches in care delivery will be used. Each approach uniquely reflects what the discipline brings to the interaction... The use of comparisons serves to create a competitive approach that undermines the ability to create interactive teams in the new world that will deliver future health care (Nurse Practitioners’ Association of Ontario, 2007b pp. 17-18).

The NPAO makes several interesting assertions against the backdrop of this new health care world. First, it implies that care delivery in the new health care world, whether by physicians or nurses, requires skill in diagnosis and prescribing (this is described as an overlap of required competencies in the new health care world for these two particular professions, rather than usurpation of traditional physician territory). This claim serves to naturalize diagnosis and prescribing by nurse practitioners as normal activities in the new world of health care (an attempt to expand the jurisdiction of nurse practitioners). At the same time, the uniqueness of nurse practitioners’ and physicians’ professional ethos and knowledge base is emphasized, and reassurance is provided that nurse practitioners are

not attempting to replace physicians. These at once assuage stated concerns of the medical profession (as noted in the previous chapter) of physician substitution, while also allowing nurse practitioners to maintain their uniqueness as nurse practitioners, and to play an expanded role in the new environment.

While the profession's leadership emphasized that nurse practitioners were not physician substitutes, there was also no mistaking that it was intent on ensuring that the traditional domination of nursing by physicians would not occur in the new health care world, at least for nurse practitioners. This would occur through active nurse practitioner leadership:

... the NP role is at risk to remain framed within the old model of care delivery. Leadership [by nurse practitioners] within practice sites and support for change is required. New approaches to meet the needs of patients and families, identified through dialogue with conference participants [nurse practitioners], included the need for... intentional design of systems and teams (van Soeren et al., 2007, p. 2).

The introduction of the Nurse Practitioner-led Clinic (NPLC) model in Ontario in 2007 provided a unique opportunity for nurse practitioners to exercise nursing leadership in an interdisciplinary team-based primary care setting. The NPAO stress the unique aspects of nursing leadership and perspective imbued in the NPLC structure and philosophy, while also emphasizing that the care provided is as comprehensive as other (i.e., physician-led) models:

One of the unique aspects of the [NPLC] model is the incorporation of nursing leadership within an interprofessional team...NPLCs provide the same comprehensive family health-care services as other family practice models. The key difference is that nurse practitioner leadership at all levels of the organization (e.g., governance, clinical practice and day to day operations) is embedded into the structure of the organization and patient care. This brings the comprehensive perspective of nurses, especially the focus on wellbeing, health promotion and disease prevention, to the day-to-

day delivery of care for patients. In this model, nurse practitioners and registered nurses work to their full scope of practice (Nurse Practitioners' Association of Ontario, 2010, October 18, n.p.).

However, it is important to note that the nurse practitioner profession does not portray the NPLC model as a replacement of physician services or physician-based teams. Rather, it posits the model as filling a gap in areas where people have no access to health care services (ibid). In the same webpage describing the NPLC model, the NPAO emphasizes the unique benefits that nurse practitioners can bring to a community where many do not have access to a primary care provider: "...nurse practitioners are experts in community health care needs assessment and program planning, implementation and evaluation. These programs are targeted to specific health care needs identified in collaboration with their communities" (Nurse Practitioners' Association of Ontario, 2010, October 18, n.p). In promoting the NPLC model this way, the nurse practitioner profession is relying on a more inclusive approach to promoting a nurse-led model (i.e., one that does not exclude physician-based models) compared to the more explicitly exclusionary strategy used by the medical profession to promote physician-led models and denounce nurse practitioner-led models of interdisciplinary primary care teams.

Defining and Defending Nurse Practitioner Scope Expansion in the Name of Teams

Another common topic in the data is the advancement of teams through the expansion of nurse practitioner scope of practice. Here, my analysis focuses on scope of practice expansion discussions for nurse practitioners from 2005 to 2009. During this timeframe, there were four events pertaining to scope expansion for nurse practitioners. These were the health minister's request for advice from the Health Professions Regulatory Advisory Council (HPRAC) in 2005 regarding the following: the currency of

its 2001 report which reviewed scopes of practice statements and access to controlled acts outlined in the Regulated Health Professions Act) (Health Professions Regulatory Advisory Council, 2006, pp. 20-21); the possibilities for the expansion of scope of practice for nurse practitioners in June 2007 (Health Professions Regulatory Advisory Council, 2008a, p. 7); the possibilities for non-physician prescribing in June 2007 (Health Professions Regulatory Advisory Council, 2009, p.1); and the introduction of Bill 179 (the Regulated Health Professions Amendment Act) in 2009. The first event prompted submissions to HPRAC by both CNO and NPAO⁷⁴, the next two events resulted in submissions to both HPRAC and the minister commenting on HPRAC's recommendations from both the CNO and NPAO, and the latter event resulted in each association directly submitting to the Standing Committee on Social Policy, the multi-party legislative committee responsible for amending the bill.

Scope expansions pertaining to controlled acts that were sought through these years included: removing existing limits on communicating a diagnosis (College of Nurses of Ontario, 2007, p. 5); dispense, sell, and compound a medication (ibid; ibid, 2008b p.7; Nurse Practitioners' Association of Ontario, 2005b, p. 2); apply a form of energy (College of Nurses of Ontario, 2007, p. 5); setting or casting a fracture of a bone or a dislocation of a joint (Nurse Practitioners' Association of Ontario, 2005b, p. 2; College of Nurses of Ontario, 2007 p. 5); open prescribing/removing limitations on prescribing (ibid; Nurse Practitioners' Association of Ontario, 2005b, p. 2); order a broader range of diagnostic tests (ibid); and removing limits on administering a substance by injection or inhalation (College of Nurses of Ontario, 2007, p. 5).

⁷⁴ Unfortunately, a copy of CNO's response could not be obtained.

Throughout their submissions to HPRAC, the minister of health, and legislative committees, nursing organizations argue the need for changes to legislation that they view as restricting nursing practice and, ultimately, interdisciplinary teamwork. Accompanying these arguments is the assertion that nurse practitioners are trained to do more than they are legally allowed to perform. The proposed changes that would allow nurse practitioners to do work that matches the full extent of their training is called “working to full scope of practice”, or a variant thereof. The NPAO, for example, argued: “It is time to take the significant steps that are necessary to address the legislative, regulatory and policy barriers that restrict the capacity of Ontario’s nurse practitioners to work to their full scope of practice and reduce the effectiveness of interprofessional teams” (Nurse Practitioners’ Association of Ontario, 2009, p.1). Similarly, the CNO asserted in their submission to HPRAC in 2007 regarding scope expansion that:

According to recently commissioned federal papers on the topic of interprofessional care, restrictive scopes of practice are impediments to interprofessional collaboration: “the fact that scopes of practice have become overlapping does not prevent (them) from being a barrier to the development and full deployment of certain professions to broader inter-professional practice”... NPs, like all professionals, want and expect to practice according to the knowledge and skills they’ve acquired in their education and past clinical experiences (College of Nurses of Ontario, 2007, pp. 37-38).

In addition to the mismatch between nursing education and allowed nursing practice, nursing organizations noted that many nurse practitioners in Ontario already had clinical experience performing some controlled acts in their everyday working lives via delegation processes and medical directives⁷⁵. For example, the NPAO asserted that:

⁷⁵ Delegation is “... a formal process by which a regulated health professional who has the authority and competence to perform a procedure under one of the [thirteen] controlled acts delegates the performance of

NPAO recommends access for RN(EC)s⁷⁶ to the ... controlled acts...[of] [s]etting or casting a fracture of a bone or a dislocation of a joint [and] [d]ispensing and selling of drugs. In the current environment, these acts are often part of everyday practice for RN(EC)s under delegation. RN(EC)s have demonstrated the skills, knowledge and expertise to perform these acts. Their patients and professional colleagues have come to expect that these activities are an essential part of their practice...In northern and remote communities, RN(EC)s are often the only health professional available to the community and have long worked under delegation to set or cast fractures or dislocations. RN(EC)s have proven to be competent to perform these acts and should have independent authority to perform both (Nurse Practitioners' Association of Ontario, 2005b, p. 2).

The CNO similarly argued that nurse practitioners are competent upon entry to practice to prescribe, and that many already possess considerable clinical knowledge about drugs through everyday practice, enabled through medical directives (College of Nurses of Ontario, 2009c, p. 9).

Though medical directives were instrumental in allowing nurse practitioners to practice these clinical skills, the nurse practitioner profession highlighted fundamental flaws in the medical directives process, particularly the superficial involvement of physicians. For example, the NPAO noted that “[m]ost often, the physician will not have any interaction with the individual patient for which the directive is being used” (Nurse Practitioners' Association of Ontario, 2005b, p. 2). The CNO asserted that “NPs are writing their own directives that are signed off by physicians” (College of Nurses of Ontario, 2009b, p. 6). p.6). The NPAO also noted that “...nurse practitioners in different

that procedure to others under certain conditions” (College of Nurses of Ontario, 2011a, p. 6). A directive is “[a]n order for a procedure or series of procedures that may be implemented for a number of clients when specific conditions are met and specific circumstances exist. A directive is always written by a regulated health care professional who has the legislative authority to order — and the ultimate responsibility for — the procedure (College of Nurses of Ontario, 2009a, p. 12).

⁷⁶ The reader is reminded that RN(EC) stands for Registered Nurse of the Extended Class, and is the formal term for a nurse practitioner in Ontario (Nurse Practitioners' Association of Ontario, 2007b, p. 1).

settings report that there is poor understanding about medical directives among administrators and physicians. Nurse practitioners are frequently called upon to provide clarification” (Nurse Practitioners’ Association of Ontario, 2007b, p. 12).

Medical directives and delegation were further characterized by nursing organizations as expensive, inefficient workaround solutions to the restrictions on nursing practice set by legislation. The NPAO, for example, stated: “The amount of time spent developing, reviewing and updating medical directives as well as taking them through physician and administrative approval processes is very labour intense and time consuming” (ibid, p. 12). These arguments serve to highlight the inefficiencies created by limited scope of practice, as well as to highlight the absurdity of nurse practitioners doing all the work of overseeing themselves. The conditions created by these inefficiencies run counter to the discourse of primary care reform as creating efficiencies and making better use of the extant skills of non-physician practitioners.

The NPAO also argued that relying on medical directives detracted from effective interdisciplinary teamwork. For example, they stated:

Nurse practitioners...have reported that medical directives may cause confusion and distrust within interprofessional teams. Other professionals (e.g., respiratory therapists, physiotherapists and radiology technicians) often question nurse practitioner authority to direct patient care through a medical directive (Nurse Practitioners’ Association of Ontario, 2007b, p. 13).

Similarly, it argued in its subsequent submission to HPRAC in 2008 that medical directives create a culture of mistrust of nurse practitioner competencies, contradicting the “true essence of interprofessional practice,” and failure to acknowledge that scopes of practice and professional roles can change over time (Nurse Practitioners’ Association of Ontario, 2008c, p. 8).

As with physician organizations and political speakers in other chapters, the NPAO is attempting to shape a fundamental definition of interprofessional practice in order to advance its position on scope of practice issues. In this case, the NPAO is suggesting that true interprofessional practice will only occur if restrictions on nurse practitioners' scope of practice are amended to reflect their actual competencies; a fundamental transformation of the old order must occur.

Nursing organizations also argued that restrictions placed on nurse practitioners' ability to prescribe drugs interfere with interdisciplinary care. Prior to 2009, nurse practitioners were limited to independently prescribing drugs from a pre-approved list (called list-based prescribing), and relied on consultation with physicians to prescribe beyond the list. In its submission to HPRAC regarding the scope of practice review for nurse practitioners, the CNO cited anecdotal evidence from its membership of the shortcomings of list-based prescribing, including its effect on team function:

One member wrote that the current drug, laboratory and diagnostic lists are inadequate and outdated. As a result, the arbitrary limits caused by the lists have caused delays in obtaining the most appropriate care for the client as well as placing unnecessary burdens on other members of the health care team (College of Nurses of Ontario, 2007, p. 35).

The CNO also claimed that open prescribing for nurse practitioners was supported by other health professionals: “[r]ecent consultation with interprofessional health [sic] care providers made it clear to CNO that NPs require access to drugs that may be relevant to countless clinical situations - beyond what can be predicted by a list of classes” (College of Nurses of Ontario, 2009c, p. 11). It notes on the next page that its bid for open prescribing was supported by the College of Medical Radiation Technologists of Ontario, the College of Physicians and Surgeons of Ontario, the Ontario College of Pharmacists

and the College of Respiratory Therapists of Ontario (ibid, p. 12). It also notes, however, that the Ontario Medical Association was not supportive (ibid); this again highlights the segmented nature of professions and the differences of opinion within them.

The NPAO also made its case for open prescribing for nurse practitioners in the name of improving the function of interdisciplinary teams. It stated:

NPAO maintains that a change in drug regulations, that is, moving to open prescribing for NPs would have a positive impact on multidisciplinary team health care delivery and ultimately patient care. For example, by removing the limitation on prescriptive authority, NPs would be able to use clinical skills and knowledge to their fullest and prescribe appropriate medications for their patients. This helps to minimize unnecessary utilization of physician consultation time, and duplication in care, and improves timely access to best-evidence-based care for patients (Nurse Practitioners' Association of Ontario, 2008c, p. 17).

The NPAO also stressed that allowing open prescribing would enhance team spirit by highlighting and reinforcing the important role to be played by nurse practitioners to other members of the team, as well as building trust in the nurse practitioner role among team members (ibid).

In addition to making claims about why their scope of practice should be expanded in the name of advancing interprofessional teamwork, the nursing organizations in my study also drew on the ideal of interprofessional collaboration to alleviate concerns about the proposed expansion of their scope of practice. The CNO, for example, appears to be addressing the concern of medical organizations that increasing the scope of practice of non-medical health professionals into the areas of independent prescribing, diagnosis, and/or patient management would hinder “true collaboration”⁷⁷ when it stated:

⁷⁷ This concern was outlined in Chapter Five.

CNO's proposed changes [to nurse practitioners' scope of practice] will enable NPs to better contribute to client care activities – whether they are working independently in isolated practice settings or in a team environment... Supporters of truly collaborative inter-professional practice recognize that collaboration and autonomous practice are not mutually exclusive concepts (College of Nurses of Ontario, 2007, p. 37).

Again, as in other examples highlighted throughout this dissertation, there is an attempt being made to outline what constitutes “true collaboration”. For the CNO, collaboration is not threatened in the least by nurse practitioner autonomy, a clear departure from the discourse presented by medicine. Rather, the CNO is presenting an alternate vision of how autonomy of nurse practitioners will result in better patient care. Indeed, the NPAO built further on CNO's assertion, and also appears to be addressing the same fears:

Changes requested in the CNO submission do not suggest that nurse practitioners are seeking to diminish or limit collaboration. In actual fact, nurse practitioners actively seek out opportunities to develop and reinforce collaborative practice relationships with physicians and other professional groups to ensure that patients have access to high quality care based on their needs and available resources (Nurse Practitioners' Association of Ontario, 2007b, p. 16).

Nursing organizations also highlight that interprofessional collaboration is seen by nurse practitioners as a routine and expected part of their practice. In its submission to HPRAC in 2007 regarding the review of the nurse practitioner scope of practice, the CNO states that:

...all NPs work collaboratively with other health providers. In particular, they consult with physicians for a variety of clinical reasons, including when they have reached the limit of their legal scope of practice or individual competency level. This collaboration and consultation is embedded in the [Canadian Nurses' Association⁷⁸] core competency framework. Likewise,

⁷⁸ The CNO Practice Standard states that nurse practitioners in Ontario must adhere to and demonstrate the competencies as outlined in the Canadian Nurses' Association *Canadian Nurse Practitioner Core Competency Framework* (College of Nurses of Ontario, 2011b, p. 4).

CNO has been informed that many physicians refer clients to NPs, acknowledging the unique and specific expertise of these practitioners as they participate in the inter-professional care of clients (College of Nurses of Ontario, 2007, p. 3).

Similarly, in its discussion of changing the scope of practice to include open prescribing, the NPAO argued that collaboration was an expected component of practice, mandated by the profession's Practice Standards document (Nurse Practitioners' Association of Ontario, 2008c, p. 11). Indeed, interprofessional care and collaboration are included in the CNO's Nurse Practitioner Practice Standard (College of Nurses of Ontario, 2011b, p. 12)⁷⁹. The CNO's description of a practice standard demonstrates its gravity:

A practice standard is an authoritative statement that describes the required behaviour of every nurse and is used to evaluate individual performance. It could be considered professional misconduct if a nurse fails to comply with College practice standards (ibid, p. 3).

The NPAO further linked the professional ideal of self-regulation to interprofessional collaboration to address concerns about the safety of allowing open prescribing by nurse practitioners. It argues that nurse practitioners have a professional duty, identical to that of physicians, to assess their skill level in prescribing in every clinical situation they encounter and to refer to a more qualified colleague when their skill is not sufficient:

Self-regulation is a key concept underpinning the Regulated Health Professions Act (1991). While physicians in all areas of specialty can prescribe most medications and perform many types of procedures, lack of familiarity with specific conditions and/or the use of specific drugs or procedures results in physicians referring patients to other physicians with specific knowledge to address patients needs as appropriate. Why would nurse practitioners not be given the same level of self-regulation? Referral

⁷⁹ They are also listed as such in the 2009 version of the CNO Practice Standard (College of Nurses of Ontario, 2009a, p. 10).

among health care professionals is the true essence of interprofessional collaboration (Nurse Practitioners' Association of Ontario, 2007b, p. 14).

Presumably, the NPAO means that referral by nurse practitioners would be to physicians, and not other nurse practitioners, as they are specifically arguing that this action would enhance *interprofessional* collaboration. The nurse practitioner profession thus relied on anecdotal evidence, the fact that interprofessional collaboration is built into its code of practice, and the professional ideal of self-regulation in referral to assuage fears that expanding their scope of practice would promote independent practice and hinder interprofessional collaboration.

HPRAC endorsed most of the nurse practitioner organizations' requests in its March 2008 report (Health Professions Regulatory Advisory Council, 2008a, pp. 86-96). However, HPRAC reserved judgment on the profession's request for open prescribing pending another investigation into non-physician prescribing for a number of professions, which it completed in January 2009 (Health Professions Regulatory Advisory Council, 2009). In that report, HPRAC reiterated the nurse practitioner profession's request that no limitations be placed on their prescribing authority and that no lists of drugs or categories of drugs would be required for them to prescribe (*ibid*, p. 290). However, after hearing concerns voiced by physician key informant interview participants in its investigation about "...the implications of bypassing the traditional gate-keeping role of MDs and pharmacists if open prescribing by NPs were to become a reality" (*ibid*, p. 291), HPRAC proposed implementing a new drug approvals framework, rather than endorsing the nurse practitioners' request for open prescribing (*ibid*, p. 293).

The CNO responded to HPRAC's decision by highlighting the fact that HPRAC's proposed Drug and Therapeutics Formulary Committee did not adhere to

interprofessional ideals, since the committee would consist of physicians and pharmacists. CNO argued that “...to support interprofessional collaboration and retain elements of self-regulation in the process, CNO recommends that representation on the committee include all health care professionals with the authority to prescribe who will be affected by its decisions, including NPs” (College of Nurses of Ontario, 2009c, p. 8).

The NPAO’s response highlights two additional strategies for addressing HPRAC’s reservations about granting open prescribing to nurse practitioners. It first pointed to the forty year history of nurse practitioner safety and efficacy in prescribing in Ontario, and then cited letters from front line physicians:

Individual physicians, especially those who work directly with nurse practitioners, report that they value the knowledge, skill and judgment of nurse practitioners and recognize that they deliver safe, effective, quality care to patients. Many also express frustration with the limits of nurse practitioner scope of practice and support expanded scope of practice including prescribing (Nurse Practitioners’ Association of Ontario, 2009, pp. 6-7).

It further reiterated that the College of Physicians and Surgeons of Ontario support open prescribing for nurse practitioners (ibid, p.7).

In the end, the government did not follow HPRAC’s suggestion for the new framework. Rather, open prescribing, along with all of the other requested expansions to the scope of practice sought by nurse practitioner organizations listed earlier in this chapter, were granted by the government through Bill 179⁸⁰ (College of Nurses of Ontario, 2010, October 20; “Bill 179”, 2009). While drawing heavily

⁸⁰ It is important to note, however, that the changes are being implemented in phases. The most current progress of changes may be found at: <http://www.cno.org/what-is-cno/regulation-and-legislation/legislation-governing-nursing/faq-bill-179/>, accessed July 29, 2013. Further, nurse practitioners’ open prescribing in Ontario is still subject to limits set by the federal government; nurse practitioners may not prescribe controlled substances as defined by federal law (College of Nurses of Ontario, 2010, October 20).

on ideals of interprofessional collaboration in its arguments for scope expansion likely helped solidify the nurse practitioner profession's success in obtaining those expansions, I think the basis of their success is due more likely to other factors. These include its long history and clinical experience in the province, the support of the College of Physicians and Surgeons of Ontario and front-line physicians, and the government's longstanding interest in making better use of nurse practitioners' skills. As I will demonstrate later in this chapter, heavy reliance on ideals of interprofessional collaboration did not net dietetics the same success in obtaining scope expansion as nurse practitioners.

Inequities between Nurse Practitioners and Physicians in Teams

An important theme in the NPAO data is concern with inequities between the medical and nursing professions working in team structures, both in terms of resources and recognition. The NPAO, for example, produced a position statement addressing the issue of inequitable distribution of financial incentives for performing the preventive aspects of primary care delivery⁸¹ in teams. The NPAO's chief concern is that these incentives are provided to physicians only, despite the interdisciplinary structure of the models (Nurse Practitioners' Association of Ontario, 2008b p. 1). The NPAO states:

One of the key strategies to improving access to care is the development of interprofessional teams. Within primary health care, the focus over the past three years has been to establish 150 Family Health Teams (FHTs) and expand the number of Community Health Centres (CHCs) across Ontario. Primary Health Care Nurse Practitioners (PHCNPs) are recognized as valued members of these interprofessional teams. As well, one component of the

⁸¹ Examples of the kinds of preventive care and screening activities subject to financial incentives include smoking cessation counseling, vaccinations, PAP smears, mammograms, colorectal exams, and home visits (Nurse Practitioners' Association of Ontario, 2008a p. 1).

financial framework for these initiatives was the implementation of financial incentives for physicians to direct preventive care and screening practices in primary health care. While there are potential benefits to the utilization of incentives as a policy to influence practice, this approach is in conflict with the policy that underlies primary care reform, specifically the development of effective patient-centered interprofessional teams. Negotiated as part of Ontario Medical Association (OMA) – Ministry of Health and Long Term Care (MOHLTC) bilateral agreements, these physician compensation models present significant negative implications for the successful long-term implementation of interprofessional models of health care delivery and threaten the integration of nurse practitioners as part of these new and emerging teams. As currently structured, this model is inequitable and inconsistent with the government's commitment to interprofessional teams (Nurse Practitioners' Association of Ontario, 2008b, p. 1).

The NPAO also expressed its indignation over physicians receiving incentive money for preventive work that is done mainly by nurse practitioners. This practice is portrayed as unjust and inequitable for nurse practitioners working in these models, and as contradicting the spirit of interdisciplinary teams:

NPAO takes the position that the incentive payments, as currently structured, contradict rather than support an interprofessional team approach to care. Legally, this payment model can be seen as a form of unjust enrichment wherein one person is unjustly enriched at the expense of another without any legal reason for the enrichment. Some may argue that physicians are entitled to these payments based on the requirement within nurse practitioner practice for a collaborative relationship with a physician. However, the work that is included in these payments can be completed by the nurse practitioner within his/her scope of practice⁸²...Finally, the perception may exist that, given that the salary for the nurse practitioner to provide patient care is funded through the public health care system, that compensating physicians for the work done exclusively by the nurse practitioner is a form of double dipping (Nurse Practitioners' Association of Ontario, 2008b, pp. 2-3).

⁸² Thus negating the need for physicians to charge a consulting fee for those particular procedures.

NPAO also argues that “[t]his model of compensation reflects an outdated and hierarchical model of care that is not sustainable within a transformed patient focused health care system” (ibid, p.3).

Yet another concern for the NPAO about the current arrangement of providing financial incentives for preventive and screening work in interdisciplinary primary care teams is that the reporting procedures used by physicians to claim incentive money from the government render the work done by nurse practitioners invisible. The NPAO asserts that the current system has the effect of “[d]evaluating the work of nurse practitioners as part of primary health care teams as their work is attributed to the physician members of their teams through shadow billing⁸³” and “[i]nterfering with the collection of reliable data on the important contributions of nurse practitioners to Ontario’s health care system” (Nurse Practitioners’ Association of Ontario, 2008b, p. 3). The work of nurse practitioners in interdisciplinary primary care teams could still be made visible through physicians’ claim process. The NPAO suggests that “...data collected in order to achieve performance targets... be extracted and compiled in such a manner so as to clearly demonstrate the role and contribution of nurse practitioners to primary health care goals” (ibid, p.4). Finally, the NPAO noted the lack of evidence of the efficacy of financial incentives for patient care (ibid, p. 2).

Interestingly, the NPAO did not subsequently argue to end financial incentives for providing preventive care and screening measures in interdisciplinary primary care teams. This is due in part to their recognition that incentives were firmly entrenched in the

⁸³ Shadow billing is the procedure used by physicians to report health care services provided that are covered by non-fee-for-service payment systems (such as capitation), allowing the government to track these activities (Nurse Practitioners’ Association of Ontario, 2008b; PricewaterhouseCoopers & Ministry of Health and Long-term Care, 2001, p. 14).

system of physician compensation: "... the...OMA-MOHLTC Memorandum of Agreement regrettably requires nurse practitioners and the taxpayers of Ontario to accept participation in this process by virtue of existing employment relationships" (ibid, p. 4).

Rather, the NPAO pointed to incentive systems in other nations, which reward the team as a whole, as better examples to follow. The NPAO also pointed out the importance of challenging the inequity of the existing system of financial incentives, in the name of enhancing interdisciplinary teams:

The current incentive model [targeting physicians only] interferes with team development... While there is no literature suggesting incentives for the entire team produce better outcomes than incentives for physicians, examples in Australia and the U.K indicate new reimbursement models are being developed to reward interprofessional teams not individuals ...Challenging prevailing systems and norms that act as barriers to interprofessional team practices is considered necessary for real health care change... The current mixed message of policies directed to support implementation of primary health care teams in Ontario does not challenge or transform an old and ineffective system (Nurse Practitioners' Association of Ontario, 2008b p. 2).

The NPAO concluded its 2008 statement with the suggestion that the Ministry of Health and Long-term Care consider alternatives to the current system, and to involve nurse practitioners and other professions in the design of future incentive payment systems (ibid). NPAO reiterated the importance of the issue during the 2011 election, encouraging all the parties to support team-based incentives (Nurse Practitioners' Association, 2011, p. 6).

Throughout their discussion of this issue, the NPAO highlights what it views as the incongruence between the government's commitment to teams and its policy of providing financial incentives to only one profession on the team. This highlights NPAO's view that interdisciplinary primary care teams are, or ought to be, about promoting greater equality of reward and recognition among the professions therein, with the intent of

enhancing team function (though their argument is incomplete in that the mechanism linking greater equality to enhanced team function is not outlined). The discussion also highlights the underlying view that the traditional hierarchy of health care marked by physician dominance is in need of change in order to truly transform the system.

Another issue addressed by the NPAO concerning perceptions of material inequity between physicians and nurses working in interdisciplinary primary care teams concerns the referral of patients to medical specialists. NPAO noted in their position statement on this matter that specialists are paid from 24 to 39% less to see patients referred to them by nurse practitioners than by physicians, due to differences between the respective referral systems (Nurse Practitioners' Association of Ontario, 2008a p. 1). Further, the structure of the nurse practitioner referral system does not provide any incentive for the specialist to provide a plan of care in writing to the referring nurse practitioner, unlike the referral system for family physicians (*ibid*).

Subsequently, the NPAO made appeals to collaboration and teamwork to argue that reimbursing medical specialists for nurse practitioner referrals in a manner equal to physician referrals would enhance patient care:

When NPs make referrals to specialists, it is done in collaboration with the team and is based on an assessment with the patient including knowledge of practice interests, preferences, knowledge, skill and experience of all team members. Nurse practitioners collaborate and consult with physician team members according to the CNO Standards of Practice, and for the benefit of the patient. The most effective healthcare teams are built on the foundation of trust and respect for each others' skills knowledge and expertise. These effective high-functioning teams use a variety of referral patterns and make choices that best meet the healthcare needs of the patient. Enabling specialists to bill for a referral from a nurse practitioner would not alter the existing respectful, supportive and collaborative relationship NPs currently enjoy with physicians and other members of the interprofessional team and would

improve access for patients (Nurse Practitioners' Association of Ontario, 2008a, p.3)

The above passage highlights several noteworthy patterns. First, careful boundaries are drawn around how nurse practitioners make referrals, with reminders that referrals are made in collaboration with other team members. Second, reassurances are made that equal reimbursement for specialists for nurse practitioner and physician referral will not disrupt existing harmony in interdisciplinary teams. While making these assurances, the NPAO is also constructing good teams as those that respect all team members and that are flexible in their approach to referrals, making referrals by nurse practitioners seem a natural act in such a context. Overall, these appeals are being made by NPAO in an attempt to gain equality of validity in their referrals to specialists, and to increase the uptake of nurse practitioner referral by specialists. However, this strategy has not yet proven successful, as no changes have been made (Nurse Practitioners' Association of Ontario, 2012, February 22).

Overall, the nurse practitioner profession has drawn heavily on ideals about interdisciplinary primary care teams and teamwork to advocate for changes to team structures and processes, and to nurse practitioner scope of practice. Their discussion of interdisciplinary teams and teamwork highlight the importance to the nurse practitioner profession of “true” transformation of the health care system by challenging the medically dominated hierarchy of health professions, of securing greater recognition of the skills and role to be played by nurse practitioners in the system, and of recognition of nurse practitioner clinical autonomy as a means of promoting “true” team spirit.

Dietetic Profession

Arguably, the dietetic profession is the most weakly situated of the three professions in my study in terms of being able to claim a unique body of knowledge, a traditional hallmark of professions. Dietetics has been a regulated health profession in Ontario since 1991, with the passing of the Regulated Health Professions Act and the creation of the Dietetics Act in the same year (College of Dietitians of Ontario, 2004, Winter, p. 2). Though the title of Registered Dietitian is protected in Ontario dietitians do not hold exclusive jurisdiction over nutrition expertise (anyone, for example, may call themselves a nutritionist) (College of Dietitians of Ontario, 2008, Fall, p. 2; HealthForce Ontario, 2007, p. 13). Until 2009, dietetics could not perform any of the 13 controlled acts in Ontario. Health care reform has been a double-edged sword for the dietetic profession. Registered dietitians working in hospital-based outpatient clinics, for example, lost their positions during the restructuring of the health care system away from hospital care toward community-based care in the 1990s. However, the subsequent investment in community-based health care has opened opportunities for registered dietitians in long term care homes and interdisciplinary primary care teams. In this section, I examine how primary care reform and interdisciplinary teams have been viewed as an opportunity by the dietetic profession, how the profession sought to expand its scope of practice in the name of interdisciplinary teams, and how reform has affected the pay and working conditions of dietitians.

Primary Care Reform and Teams as an Opportunity for the Dietetic Profession

Similar to the nurse practitioner profession, the dietetic profession views primary care reform and the movement toward interdisciplinary primary care teams in Ontario as

an opportunity for the profession to further integrate into the health care system.

Dietitians of Canada states: “[p]rimary health care reform presents new opportunities for Registered Dietitians to contribute to health promotion, disease prevention and treatment in interdisciplinary and collaborative primary health care settings” (Ciliska et al., 2006, p.7). In its vision statement for the profession, entitled *Vision 2020*, DC predicted that “roles [for dietitians] are diverse, rewarding, and novel” (Dietitians of Canada, 2007, p.2). It further predicted:

[By the year 2020] [d]ietitians are performing and contributing to the full potential of their scope of practice, using their most advanced skills and knowledge in new roles and new settings. They are accessed as often in the community as in institutional settings and across many sectors of our economy. Dietitians lead on new frontiers in the application of food and nutrition science and technology from the farm gate to the table, as team members, policy planners, practice-based researchers, educators, facilitators and managers. The health professional entrepreneur, business owner, private practitioner and group practices fully participate on inter-professional teams across the continuum of Canada’s health systems (Dietitians of Canada, 2007, p.2).

Interprofessional primary care teams are thus envisioned as an important, integral part of the future of the profession.

Dietetic organizations also encouraged dietitians to take leadership roles in promoting and enacting interdisciplinary care in primary care team settings. In one edition of its professional communiqué, *résumé*, CDO registrar Mary Lou Gignac stated:

The IPC [interprofessional care] Charter⁸⁴ is presented on the next page. It provides simple but powerful statements that commit caregivers and leaders

⁸⁴ The IPC [Interprofessional Care] Charter, developed in 2010, was the resultant document of a consultation process between unspecified health professionals and patients, sponsored by HealthForce Ontario’s Interprofessional Care Strategic Implementation Committee. Mary Lou Gignac served as a member of the Core Competencies Working Group for the project (College of Dietitians of Ontario, 2010, Summer, p.3).

to transformative behaviours. I invite RDs [registered dietitians] to consider ways to personally adopt the Charter showing continued leadership and commitment to IPC. I would also hope that all health teams would carefully review the IPC Charter and determine how to embed it in everything they do (College of Dietitians of Ontario, 2010, Summer, p.3).

A research document by DC asserts that the profession of dietetics has long been versed in interdisciplinary care from other settings, making dietitians a potential resource for family physicians transitioning to primary care teams: “[w]hile interdisciplinary team practice is relatively new to family medicine, many RDs have substantial experience from other sectors that can be applied in the development of interdisciplinary practice in primary care” (Davidson et al., 2007, p. 8). This assertion naturalizes the dietetic profession’s place as leaders and mentors on interdisciplinary primary care teams.

The dietetic profession in Ontario capitalized on the primary care reform movement to expand its educational base and further promote the uniqueness of its body of knowledge and capacity to work in interdisciplinary primary care teams. In its Fall 2008 communiqué, the CDO highlighted three new master’s programs developed in Ontario universities that year. Ryerson University’s Master of Health Science degree in Nutrition Communication was promoted specifically as enabling its graduates to provide advanced counseling in the province’s emerging family health teams (College of Dietitians of Ontario, 2008, Fall, p. 6).

The dietetic profession also conducted research into the dietitian’s role in primary care reform and interdisciplinary primary care teams as a way of adapting to and thriving in the new conditions of the health care system. In its professional journal, *Canadian Journal of Dietetic Practice and Research*, DC devoted a supplementary issue (Fall 2006) to research examining the role of dietetics in primary health care. On its website,

DC featured a number of research projects in which it played a role (<http://www.dietitians.ca/Dietitians-View/Primary-Health-Care.aspx>, accessed March 24, 2011). One study was a “visioning” project involving Ontario stakeholders and opinion leaders from all sectors of dietetics that was organized and undertaken by DC’s Central and Southern Ontario Primary Health Care Action Group (CSO-PHCAG) (Cantwell et al., 2006, p. S54). The purpose of the study was to:

...discuss the advocacy agenda for PHC [primary health care] nutrition services. Discussing the variety of settings in which RDs [registered dietitians] currently provide PHC, reviewing position roles and responsibilities to find common ground, and articulating a shared vision were some of the key activities (Cantwell et al., 2006, p. S54).

DC was also involved in a multifaceted demonstration project funded by the Ontario Primary Health Care Transition Fund; executive members of DC were researchers or sat on the steering committees of the sub-projects. The sub-projects included key informant interviews with researchers working on Primary Health Care Transition Fund projects in Canada that included dietitians in their programs (Davidson et al., 2005, p. 2); an extensive systematic literature review “to bring together recent reviews of nutrition interventions that were known to be feasible or to be potentially feasible in Canadian primary health care settings” (Ciliska et al., 2006, p.7); integrating three registered dietitians into three Family Health Networks in Ontario and using a Delphi process⁸⁵ to determine “the preferred options for organizing interdisciplinary nutrition services in Ontario Family Health Networks and similar primary health care

⁸⁵ The Delphi process included dietitians and physicians from the three FHNs where dietitians were integrated, as well as academics and representatives from unspecified regulatory colleges (Brauer et al., 2006, p.7).

organizations⁸⁶” (Brauer et al., 2006, p. 6); and a cost analysis of integrating dietitians into Family Health Networks (Davidson et al., 2006). These research studies culminated in a Tips and Tools document designed to help registered dietitians integrate into family medicine-based practices (Davidson et al., 2007, p. 4). Finally, DC released a position paper regarding the role of dietitians in primary health care based in part on these studies in 2009 (Dietitians of Canada, 2009). DC was thus very active early in the process of determining the role dietitians would come to play in the rapidly developing primary health care sector in Ontario. The CDO does not appear to have an equivalent record of research regarding interdisciplinary primary care teams; its research mandate is focused on health human resource issues, which became part of the CDO’s mandate in 2008 (College of Dietitians of Ontario, 2010, Fall, p. 3). However, the CDO was very active, along with DC, in promoting expansion of the scope of practice of dietitians, examined below.

Scope Expansion of Dietetics in the Name of Teams

As in the nurse practitioner data, arguments that scope of practice needs to be expanded to promote interdisciplinary teamwork features prominently in the dietitian data. In June of 2007, Health and Long-Term Care minister George Smitherman approached HPRAC for advice about how to facilitate interprofessional collaboration among the health professional Colleges in the province, including “...the development of standards of practice and professional practice guidelines where regulated health

⁸⁶Family Health Teams are mentioned specifically as a model where the findings could be applied (Brauer et al., 2006, p.24).

professions share the same or similar controlled acts” (George Smitherman, as quoted in Health Professions Regulatory Advisory Council, 2008c, p. 9).

HPRAC took the liberty of broadening the goal of the Minister’s request, stating that any efforts toward this end must also focus on “...finding ways to... [a]ssist health regulatory colleges *and their members* to work collaboratively, rather than competitively” (ibid). Helping the Colleges to collaborate with each other would only be achieved by “... seeking ways for the Colleges to progress by removing or minimizing any unnecessary barriers that exist and to ... enable interprofessional care by their members *at the clinical level* (Health Professions Regulatory Advisory Council, 2008c, p. 10, my emphasis).” To this end, HPRAC initiated an extensive survey of health professions in Ontario (ibid). In March 2008, HPRAC produced an interim report, where it promised to further investigate, based on assessment of the results of its survey, the scopes of practice of professions whose work fundamentally required interprofessional collaboration (Health Professions Regulatory Advisory Council, 2008b, p.9) Dietetics was one of the professions identified. In June of 2008, at HPRAC’s invitation, the College of Dietitians of Ontario (CDO) and Dietitians Canada (DC) made a joint submission to HPRAC outlining the dietetic profession’s recommendations for expanding its scope of practice (Health Professions Regulatory Advisory Council, n.d., “Current Ministerial Referrals: Dietitians Scope of Practice Review”, n.p.). These events and resultant documents inform my subsequent discussion.

The dietetic profession requested four broad changes to facilitate interdisciplinary teamwork. First was a request to change their scope of practice statement (College of Dietitians of Ontario & Dietitians of Canada, 2008, p. 2). Second, they sought access to three of the thirteen controlled acts outlined in the Regulated Health Professions Act

(ibid, p. 2). These were: communicating a diagnosis; performing a procedure below the dermis; and prescribing or dispensing (ibid, pp. 2-3). Third, they sought to add two areas of dietetic expertise (prescribing therapeutic diets⁸⁷ and prescribing enteral and parenteral nutrition⁸⁸) to the list of controlled acts (ibid, pp. 4-5). Finally, they sought changes to three existing acts⁸⁹ to enhance their ability to order diagnostic tests (ibid, pp.5-6). These requests were made in the name of interdisciplinary teamwork and efficiency. In updating its membership about the submission, the CDO stated in its professional communiqué:

Our submission... focuses on how granting legislative authority to RDs [registered dietitians] to perform some controlled acts and to order diagnostic tests and nutrition therapy would enhanced [sic] client care and create efficiencies within collaborative practices. We look forward to a time when chasing authorization for nutrition care orders and time intensive development of medical directives is replaced with efficient and meaningful interprofessional communications about client care (College of Dietitians of Ontario, 2008, Summer, p. 3).

In its submission to HPRAC, the dietetic profession argued that the extant scope of practice statement for the profession failed to properly convey the true extent of the profession's activities and abilities: “ ‘...the assessment of nutrition and nutritional conditions and the treatment and prevention of nutrition related disorders by nutritional means’ ...does not adequately capture the breadth of the functions and contributions made by RDs [registered dietitians] to nutrition and health” (College of Dietitians of Ontario &

⁸⁷ Therapeutic diets are “...individualized nutrition therapy designed to manage a disease or condition” (College of Dietitians of Ontario & Dietitians of Canada, 2008, p. 26).

⁸⁸ Enteral and parenteral nutrition incorporate “...common technologies to feed people through artificial means when they cannot take in their nutrition requirements orally” (College of Dietitians of Ontario & Dietitians of Canada, 2008, p.26). Enteral nutrition “...provides nutrition through a tube into the gastrointestinal tract” and parenteral nutrition “...provides nutrients intravenously” (ibid, p. 52).

⁸⁹ These were: The Public Hospitals Act, Laboratory Specimens and Collection Centres Act, Health Care Consent Act, and Long Term Care Act (College of Dietitians of Ontario & Dietitians of Canada, 2008, pp.10-11).

Dietitians of Canada, 2008, p. 16). The profession sought to change the statement to be “...more reflective of the extent of dietitians’ involvement in population health, nutrition therapy, food systems management, and health promotion” (College of Dietitians of Ontario & Dietitians of Canada, 2008, p. 2). To this end, it proposed the following statement:

Dietetics is the assessment of nutrition related to health status and conditions for individuals and populations, the management and delivery of nutrition therapy to treat disease, the management of food systems, and building the capacity of individuals and populations to promote or restore health and prevent disease through nutrition and related means (ibid, p. 16).

Recognition of the health promotion component of its proposed statement was portrayed as particularly important given the rise of interdisciplinary primary care teams in the province:

Health promotion and disease prevention...comprise a significant role for RDs working in Community Health Centres and Family Health Teams, which are growing areas of employment, and currently represent almost 10% of RDs in Ontario. These RDs use multiple methods to support the nutrition needs of patients and communities, including nutrition therapy for individual clients, community health promotion programming and disease prevention initiatives as members of the inter-professional team (College of Dietitians of Ontario & Dietitians of Canada, 2008, p. 18).

The dietetics profession also argued in its submission to HPRAC that the extant system of controlled acts in Ontario did not allow dietitians to fully engage in interdisciplinary teamwork; again, emphasis was placed on the lack of recognition of the dietetic profession’s skills that would allow them to safely perform certain controlled acts:

The system of controlled acts in the RHPA [Regulated Health Professions Act] was developed to ensure that only qualified persons perform health care procedures that carry a risk of harm. Registered Dietitians agree that public safety is paramount in professional practice and interprofessional care. The

system of controlled acts can be an enabler of interprofessional collaboration on patient care as it facilitates overlapping professional activities while clearly controlling those activities that are risky if not done by a qualified person... While apparently achieving the intent of public protection, the RHPA has also created barriers to providing interprofessional care that are [sic] in the best interest of the patient. Registered Dietitians' diverse roles and competencies are not recognized under the current system of controlled acts, and this limits the RD's ability to provide safe and effective care (ibid, p. 19).

In a manner similar to that of nurse practitioners, the dietetic profession pointed to inefficiencies in patient care that resulted from being excluded from performing the three controlled acts to which they sought access. These were sometimes followed by predictions of how being allowed to perform the controlled act would improve efficiency and quality of patient care and/or teamwork. For example, the dietetic profession argued in its submission to HPRAC that not being able to communicate a diagnosis to patients sent to them by physicians or nurse practitioners often created inefficiencies:

Initial counselling sessions [for a diet-related illness] with the RD are not productive if the client does not fully understand the reason that the changes are needed. In some instances, the client may have been informed of the diagnosis by the physician or nurse practitioner, but if that is not clearly documented in the patient record, the RD may be reluctant to repeat this information in case they are "communicating a diagnosis" that the client had not yet been informed of. The RD may then feel obliged to refer the client back to their primary provider so that the diagnosis can be communicated, resulting in lost time for the client and both practitioners. Communicating a diagnosis that has already been made and recorded by authorized health professionals provides much more streamlined and efficient care. The RD is able to discuss the nutritional implications of the diagnosis and ensure the client understands the rationale for lifestyle changes and nutrition therapy (College of Dietitians of Ontario & Dietitians of Canada, 2008, p. 22).

A similar argument was made by the dietetic profession for the controlled act of performing a procedure below the dermis; for dietitians, this is limited to the skin prick test for assessing blood glucose levels:

Skin pricking to obtain blood glucose readings is a simple procedure that is performed by patients on a daily basis, yet cannot legally be performed by an RD [registered dietitian] in practice... The patient and other healthcare providers should not be inconvenienced by this barrier to efficient care. RDs need to be able to teach clients with diabetes how to use their glucometer to perform self blood glucose monitoring, which is an important element of disease management. Inability to perform skin pricking greatly limits the RDs ability to properly teach the skill to clients (ibid, p.23).

The dietetic profession's request for access to the controlled act of prescribing or dispensing was presented to HPRAC with very clear limitations. The request was worded as “[p]rescribing or dispensing, specifically for the adjustment of insulin and oral hypoglycemic regimens” (ibid, p. 3). This particular request relied heavily on appeals to the ideal of interdisciplinary teamwork while also emphasizing the unique role and expertise of the dietitian on the team:

Interprofessional team-based care in the area of diabetes management is an effective way to provide comprehensive, continuous care. As RDs assess the food intake and physical activity of the client, minor adjustments to insulin dosages or timing can be addressed to achieve optimal glycemic control. Clinical guidelines for the management of diabetes developed by the Canadian Diabetes Association indicate that dietitians are integral in the decision of which agent/regimen may be best suited for the eating habits and lifestyle of people with diabetes... Enabling RDs to make insulin adjustments for individuals with diabetes on existing insulin regimens supports effective interprofessional team-based care and contributes to patient self-management and safety by preventing hypoglycemia and reducing the risk of long term vascular complications (College of Dietitians of Ontario & Dietitians of Canada, 2008, pp.23-24).

Appeals to increasing the efficacy of patient care and to improving cost efficiency of patient care in the context of interdisciplinary teams were also made in the case of the

profession's request to amend legislation to allow dietitians to order a greater variety of diagnostic tests. For example, in its request to change the Laboratory Specimens and Collection Centre Licensing Act, the dietetic profession stated:

It is proposed that RD be added to the list of professionals authorized to order specified tests as prescribed in the regulation, within their scope of practice and limited to those of particular relevance to managing nutrition therapy... Timely access to lab values expedites and improves patient care by enabling the RD to tailor nutrition therapy to the individual. Authorizing the RD to order specific laboratory tests in a judicious manner and in coordination with the entire healthcare team will optimize care while ensuring that patients are not subject to excessive blood draws and that costs are contained (ibid, p.6, italics in original).

As with the request to gain access to the controlled act of prescribing or dispensing, the above request for dietitians to order diagnostic tests was limited to specific types of tests (i.e., only those relating to nutrition therapy) and with the caveat that only tests within the scope of practice of dietitians would be sought. The profession also assured that granting dietitians the ability to order diagnostic tests would not foster independent practice of dietitians, pointing to the fact that interdisciplinary practice was already codified in the dietetic profession's standards and ethics document:

It is important to note that the ability to independently order diagnostic and treatment procedures does not reduce RDs' responsibility to communicate and consult with the interdisciplinary team. As noted in the profession's Code of Ethics, Standards of Practice and Competencies...the RD is prohibited from working outside of their personal area of competence, and has a responsibility to take steps to achieve competence as needed. The requirement to consult with appropriate others, including other members of the healthcare team, is clearly stated in the standards and competencies (College of Dietitians of Ontario & Dietitians of Canada, 2008, p. 27)

While it is unclear to whom exactly these reassurances are directed, it is quite possible they are aimed at physician organizations. As I demonstrated in Chapter Five, physician

organizations spoke out against the more independent practice of non-physician health professions. At any rate, the dietetic profession has been careful to state clearly that their requests for scope expansion are limited to their domain of expertise, and are done in the name of teamwork.

A unique strategy employed by the dietetic profession to enhance its position in the health care system in the name of interdisciplinary teams was to advocate for the addition of two new controlled acts to the Regulated Health Professions Act and for dietitians to be granted access to these controlled acts. This could be considered a bold request, given that at the time there were only thirteen controlled acts⁹⁰ governing twenty-six regulated health professions in Ontario⁹¹. The dietetic profession acknowledged that “While we appreciate that creation of new controlled acts is not undertaken lightly, we are confident that the evidence is strongly in favour of this approach” (College of Dietitians of Ontario & Dietitians of Canada, 2008, p. 26). These were the prescription of enteral and parenteral nutrition, and the prescription of therapeutic diets. The claim to enhancing interprofessional care through the creation of a controlled act was explicitly made only in the case of therapeutic diets, though I will argue below that the dietetic profession’s attempt to add enteral and parenteral nutrition also incites interdisciplinary collaboration.

The explicit claim of the need for a controlled act for the prescription of a therapeutic diet to promote interprofessional collaboration is made a minimum of four times in the dietetic profession’s submission to HPRAC. However, these statements,

⁹⁰ There are now 14 controlled acts; psychotherapy was added in 2007 via the Health System Improvements Act (http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=519, accessed July 29, 2013).

⁹¹ This number comes from the Federation of Health Regulatory Colleges of Ontario, <http://www.regulatedhealthprofessions.on.ca/WHOWEARE/default.asp>, accessed July 29, 2013).

which vary little from each other, do not provide a clear explanation of how interprofessional collaboration is supported by creating a controlled act. Two examples follow:

Our goal is to ensure public safety and support interprofessional collaboration by delineating the situations of highest risk. Patient safety will be enhanced when prescription of therapeutic diets is a controlled act (College of Dietitians of Ontario & Dietitians of Canada, 2008, p. 42).

A new controlled act for prescribing and managing therapeutic diets would restrict who would be able to formulate diets related to a diagnosed disease and nutrition-related related disorder. As discussed in response to question 15 i. ('Patient Safety') and question 20 ('Risk of Harm'), these changes are intended to support interprofessional care by delineating the areas of highest risk related to therapeutic diets (ibid, p.46)⁹².

No further explanation of how adding the controlled act promotes interprofessional collaboration is provided.

However, in reviewing the remainder of the document, I was able to deduce possible links between the proposed new controlled acts and the promotion of interprofessional collaboration. The dietetic profession claims that the proposed controlled acts are high-risk activities requiring highly specialized knowledge and skills to execute safely, and that dietitians possess the requisite knowledge and skills to safely execute these activities. For example:

New controlled acts for the prescription and management of enteral and parenteral nutrition, and prescription and management of therapeutic diets, are proposed. These activities carry a significant risk of harm, require specialized knowledge and experience to appropriately prescribe, monitor, and adjust to patient response. Registered Dietitians have the knowledge, skills, and judgment to safely manage EN/PN and therapeutic diets. In fact, it is central to the profession of dietetics (College of Dietitians of Ontario & Dietitians of Canada, 2008, p. 63).

⁹² The other two instances may be found on pages 5 and page 26 of that document.

In the case of prescribing therapeutic diets, the dietetic profession claims that “Registered Dietitians are the profession trained specifically to assess the need for, and plan implementation of, therapeutic diets” (College of Dietitians of Ontario & Dietitians of Canada, 2008, p. 59). The dietetic profession also notes that:

Patients and clients are ...confused by therapeutic diet advice given by other practitioners that is inaccurate and must be subsequently contradicted by the RD. The creation of a controlled act for prescription and management of therapeutic diets will help reduce these inaccuracies and related risks to a person’s health by relying on the expertise of RDs and other competent health care professionals as appropriate (ibid, 2008, p. 45).

The dietitian is posited as the expert possessing the most accurate knowledge. The latter sentence of the quote also places the dietitian first in the claim of expertise, with other health professionals posited as peripheral (“as appropriate”). These assertions serve to position the dietitian as the most knowledgeable health professional in this area.

Similarly, in the case of prescribing enteral and parenteral nutrition, the profession also claims that dietitians have the best claim to the unique skills and knowledge for these activities, more than even the majority of the medical profession:

The evidence of risk for prescribing and managing enteral and parenteral nutrition requires that it be limited to only highly trained individuals. In the present system, only dietitians and *some* physicians have the necessary knowledge and competencies (ibid, p. 63, my emphasis).

In its submission, the profession also cited numerous findings from an extensive literature review written jointly by CDO and DC about dietetics’ expertise in prescription and management of these specific forms of nutrition. These included findings that dietitians’ involvement in interdisciplinary teams in prescribing and managing enteral or parenteral nutrition improved patient outcomes, prevented complications, and saved money (ibid, p.

56). Additionally, the findings from “a survey of enteral nutrition prescription practices revealed that physicians, compared to dietitians, did not have a strong understanding of the various enteral formulae and their specific indications” (College of Dietitians of Ontario & Dietitians of Canada, 2008, p. 55). These findings further bolstered the profession’s argument that dietitians are the most knowledgeable professionals about these forms of nutrition.

Despite making these claims, the dietetic profession is careful to state that other professions will likely attempt to gain access to these controlled acts (should they come to be defined that way), and note that in the case of prescribing enteral and parenteral nutrition, that the medical profession would likely be “...considered for authority to perform this [potential] controlled act” (ibid, p. 64). However, while they are not excluding the possibility of other professions applying, their claims to possessing unique knowledge and skills, and their references to scientific studies highlighting dietetics’ solid claim to unique knowledge in these forms of nutrition suggest that the majority of other professions would not be successful in their application to these new controlled acts.

Exactly how interprofessional collaboration might improve by making the prescription of therapeutic and enteral/parenteral diets controlled acts was not explicitly outlined in the data. However, in creating controlled acts to which dietitians might very well be the only profession to have a solid claim, other health professionals would be forced to cede control over this area of patient care to the dietitian. Thus, the dietitian would become an obligatory member of the patient’s health care team for this aspect of the patient’s care—the professional with whom others must consult—rather than just a potential team member, or bypassed as a member of the team altogether.

The dietetic profession suggested that the requested changes to scope of practice and controlled acts would help to alleviate concerns of some front line dietetic practitioners about their professional credibility among patients:

The public perceives dietitians as a credible and reliable source of nutrition information. [However] Registered Dietitians have reported that sometimes their advanced clinical expertise is not recognized by patients. Expansion and clarification of the scope of practice of dietetics will assure patients that their nutritional care is being managed by the expert in food and nutrition. Registered Dietitians report that their credibility is decreased when having to refer patients back to the physician for communication of their diagnosis, and by an inability to order laboratory tests (College of Dietitians of Ontario & Dietitians of Canada, 2008, p. 45).

The dietetic profession also argued that changes to their scope of practice would improve dietitians' credibility among team members from other professions:

The extent of RD's expertise is not universally recognized according to discussions with RDs. Some health professionals' perception of RDs is limited to general nutrition counselling and meal planning, without the recognition of advanced clinical expertise. This has presented a barrier to interprofessional care in some cases. As noted by one RD "some of the team thinks the dietitian just hands out Canada's Food Guide and recipes". Mutual respect for team members' knowledge and expertise is critical to interprofessional collaboration. The proposed changes to scope of practice may serve to educate other health professionals about the extent of RDs' competencies (ibid, p. 45).

Recognition of, and respect for, every profession's competencies is thus seen by the dietetic profession as a vital component of interdisciplinary teamwork.

Similar to the nurse practitioner profession, the dietetic profession portrayed scope expansion as a formalization of aspects of dietetic practice already occurring under a variety of authority-granting mechanisms, such as medical directives, rather than an unjustified attempt to expand their professional domain (ibid, p.10). And, like the nursing

profession, the dietetic profession argued that authority mechanisms, such as medical directives, impeded rather than enhanced teamwork and the quality of patient care:

Although the increasing use of medical directives demonstrates the interprofessional team's reliance on the RD to assess, treat and manage nutrition therapy, the complicated and cumbersome process of creating these does not represent the best use of limited resources in the health care system and compromises optimal patient care. Authorizing the RD to order diagnostic and treatment procedures in consultation with the interdisciplinary team supports optimal patient care (College of Dietitians of Ontario & Dietitians of Canada, 2008, pp.5-6).

In addition to these arguments for scope expansion, the dietetics profession, like the nursing profession, reminded HPRAC that the dietitians' commitment to professional standards and ethics would act as a safeguard to ensure competent practice:

The following proposed changes in the RHPA and Dietetics Act are supported by the RDs' current professional activities and are founded in existing dietetic knowledge, competencies and standards. While not all RDs currently perform all the proposed changes in legislated scope of practice, many currently do depending on the setting and on medical directives and delegation. The dietetic profession's code of ethics, professional misconduct regulation, competency statements and standards of practice prohibit RDs from undertaking activities for which they are not personally competent (*ibid*, p. 19).

As noted earlier, interdisciplinary teamwork is a formal component of the dietetic profession's ethics and standards.

The dietetic profession's application to HPRAC for these changes resulted in limited success. In its review of the profession's application, HPRAC praised the dietetic profession's place within health teams:

The strength of this profession is its unique place in multi-disciplinary patient care, bringing its knowledge and skills to a team whose members together make decisions and deliver care to patients. HPRAC recommends that dietitians receive additional tools so they can better contribute to team-based

care, and to the education and monitoring of patients who rely on their skills (Health Professions Regulatory Advisory Council, 2008b, p. 122).

HPRAC also acknowledged that the requested changes “...seek to raise the profile of dietitians as key members of interprofessional care teams, and to recognize those areas where dietitians are qualified to take lead roles” in such teams (Health Professions Regulatory Advisory Council, 2008b, p. 134). Despite these acknowledgements by HPRAC, it endorsed only two of the dietetic profession’s requests in its report to the Minister of Health and Long-term Care: access to the controlled act of a procedure below the dermis (specifically, the skin prick test) (Health Professions Regulatory Advisory Council, 2008b, p.144), and the ability to independently order certain laboratory tests (ibid, pp.151-152). HPRAC explained its overall position of limited endorsement by stating that it would endorse some legislative changes, but that “[i]n the end, HPRAC finds that greater efforts to develop interprofessional collaborative arrangements and processes will maximize the benefits derived from dietitians’ participation in patient care” (ibid, p. 141). HPRAC thus viewed the profession’s concerns and frustrations as being better resolved through improving interdisciplinary teamwork processes than through legislation amendment.

Several of the dietetic profession’s requests for legislation amendment to expand their scope of practice were rejected specifically due to this reasoning. For example, the profession’s request to add the prescription of enteral/parenteral nutrition and the prescription of therapeutic diets to the list of controlled acts was not endorsed by HPRAC on the grounds that their own review process revealed that these processes are already functioning smoothly because of interdisciplinary teamwork:

HPRAC is impressed with the shared responsibility and team-based care that marks patient nutritional support. There is no single professional who can be

uniquely identified as the essential participant in this process. Rather, the skills, experience and combination of numerous professional experts and specialists strengthens HPRAC's confidence in interprofessional collaboration. During its consultations, HPRAC noted the emphasis placed on coordination and cooperation in nutrition services to ensure that patients received the best possible care. HPRAC has concluded that authorizing new controlled acts could fundamentally alter what is generally a working collaborative model of providing clinical care – a model where the expertise of each profession on the team is recognized... HPRAC is not convinced of the need for new controlled acts for these therapeutic modalities (ibid, p. 149).

In response to the dietetic profession's concerns regarding these processes outlined earlier, HPRAC re-stated its central position that such concerns are better addressed through increased collaboration between the professions, rather than through legislation amendments:

...when one part of a team expresses such deep concerns, there are matters that need to be addressed. They cannot be addressed, nor should there be an expectation that they can be addressed, by changes to legislation or regulation. The Ontario Hospital Association, along with representatives of professions who are involved in prescribing or providing nutritional therapy, should jointly engage in discussing these process matters (Health Professions Regulatory Advisory Council, 2008b, p. 149).

In the case of the request to access the controlled act of communicating a diagnosis, HPRAC stated its position that the act of communicating a diagnosis to a patient must be done firsthand by the diagnosing professional, and concluded that "...dietitians do not have the competencies to validate a diagnosis made by another professional when a patient has been referred for the purpose of receiving care" (ibid, pp.142-143).

Rather than endorsing legislative changes to grant access to the controlled act of communicating a diagnosis, HPRAC recommended dietitians not let the lack of a communicated diagnosis stop them from proceeding; dietitians could still perform an

“...assessment of the patient’s physical signs and symptoms, communicat[e] the results of the assessment to the patient, and subsequently commenc[e] a course of treatment with the patient’s consent” within their existing scope of practice (ibid, p. 143). However, HPRAC appreciated the profession’s concerns about patients not having the diagnosis prior to starting treatment, stating that “[t]reatment of the matters within the competence of the dietitian should not be delayed as a result of the dilatory performance of another professional” (ibid). It again pointed to a collaborative process as a solution, recommending:

That an early dialogue take place between the College of Dietitians of Ontario and the College of Physicians and Surgeons of Ontario to establish, for both professions, guidelines on referral and reporting practices to and from the professions, and that those be communicated to members of both professions (ibid, p. 143).

The dietetic profession’s request to access the controlled act of prescribing or dispensing (limited to the adjustment of insulin and oral hypoglycemic regimens) was also not endorsed by HPRAC. HPRAC determined that “...altering a drug dose or the timing of a dose from the original prescription is in fact prescribing, and therefore requires the knowledge and competencies of a professional authorized to prescribe” (Health Professions Regulatory Advisory Council, 2008b, p. 144). Since dietitians do not have access to the controlled act of prescribing or dispensing to begin with, the request was rendered moot by HPRAC. Further, HPRAC asserted that “[c]hanges to such prescriptions should not be made by dietitians in the absence of the expertise of other health professionals such as physicians, nurse practitioners, or pharmacists” (ibid, p. 145), implying that collaboration between the dietitian and the prescriber is needed.

HPRAC concluded that “... this prescription adjustment activity is properly suited to delegation [to a competent dietitian] from an authorized provider or prescriber” (ibid).

The dietetic profession’s remaining request was not endorsed by HPRAC for another reason. The request to change the scope of practice statement was not endorsed because such amendments should only be made if “...additional controlled acts are being authorized to the profession, and if those acts alter or expand the role of the profession” and subsequently concluded “...that references to ‘food systems management’, ‘health promotion’ or ‘population health’ are not directly related to a controlled act as set out in the *RHPA*” (ibid, pp. 149-150, italics in original).

This latter instance aside, HPRAC often drew on the ideals of interdisciplinary teamwork to refuse the requests that were made by the dietetic profession in the name of interdisciplinary teamwork. It appears, based on their prose, that HPRAC’s assumption is that effective communication is part of interdisciplinary teamwork; its view is that many of the problems outlined by the dietetic profession can be resolved by initiating or improving communication between the affected parties. In this case, HPRAC’s version of what constitutes the essence of interdisciplinary teamwork took precedence over the dietetic profession’s vision of what constitutes interdisciplinary teamwork. Dietetics used ideals of interdisciplinary teamwork to make their case, only to be disciplined by a slightly different version of the discourse of teams by HPRAC.

The dietetic profession responded to HPRAC’s review by submitting an appeal directly to the Ministry of Health and Long Term Care early in 2009. In their appeal, the profession reaffirmed their commitment to interdisciplinary teams and encouraged the government to pursue the changes endorsed by HPRAC (College of Dietitians of Ontario & Dietitians of Canada, 2009, pp. 2 and 4). Further, it reiterated the importance of two

requests not endorsed by HPRAC: to allow dietitians to order tests and diets for patients in hospital, and to change their scope of practice statement (ibid, p. 9 and p. 5). These latter requests were also emphasized by both DC and CDO when each made a presentation to the Standing Committee on Social Policy regarding Bill 179, the Regulated Health Professions Statute Law Amendment Act⁹³.

The dietetic profession's efforts to expand their scope of practice as outlined above initially met with the same level of limited success with the Ministry of Health and Long Term Care as with HPRAC. It appears that the government followed HPRAC's advice. Of all the requests discussed above, only two were granted by the Ministry. First, the profession gained access to the controlled act of performing a procedure below the dermis (the skin prick test), which was granted with the passing of Bill 179, The Regulated Health Professions Statute Law Amendment Act, in December 2009 ("Bill 179", 2009). Bill 179 also allowed for future changes to be made to the regulations of The Public Hospitals Act and the Laboratory and Specimen Collection Centre Licensing Act to allow dietitians to order laboratory tests in hospital or community settings, contingent on the development of a list by the CDO (College of Dietitians of Ontario, 2010, Winter, p.8). A list was developed in a consultation process with the CDO's membership and submitted to the Ministry of Health and Long Term Care in 2011 (College of Dietitians of Ontario, 2013, Spring, p. 12). However, the Ministry informed the CDO in 2013 that changes to the regulations would not be pursued in the immediate future, with the Ministry's decision being "...based on finances and other priorities, not

⁹³ DC made its presentation on September 29, 2009 (http://www.ontla.on.ca/committee-proceedings/transcripts/files_pdf/29-SEP-2009_SP034.pdf) and CDO made its presentation October 5, 2009 (http://www.ontla.on.ca/committee-proceedings/transcripts/files_pdf/05-OCT-2009_SP035.pdf), each accessed July 29, 2013.

the competence of RDs to order lab tests” (ibid). In the meantime, the CDO was informed that “RDs may continue to order laboratory tests through medical directives” (ibid).

Despite its considerable efforts, and its arguments that scope expansion would enhance interdisciplinary teamwork, the dietetic profession saw little change in their scope of practice, even in an environment rife with talk of teams.

Inequities in Teams for Dietitians

As with the nursing data, the dietetic profession data indicated concerns about the financial effects of interdisciplinary primary care teams on the profession, though these were only expressed in the interview data. The nature of these concerns differed from those of nurse practitioners; whereas the nurse practitioner data shows concerns about the distribution of financial incentives for performance among team members, key informants from the dietetic professional social world highlighted the negative effects of the shift from working mainly in teams in hospital settings into primary care settings. For the dietetic profession, the shift meant a decline in pay and a decline in full time positions. According to one key informant:

[008]: ...I would say that at that time [the 1970s and early 1980s] almost every hospital in Ontario had an outpatient clinic

[SH]: Mm-hmm

[008]: uh with a dietitian as part of the, um, you know, delivery - it was interdisciplinary at that time, and often those dietitians were full-time in those settings

[SH]: Okay

[008]: so, you know, I – I would say dietitians have been involved in that delivery for quite a long time

[SH]: Okay, and uh, did...uh, now - do they still operate in a manner – are there still outpatient clinics or did they disappear during the 90s?

[008]: Most of those clinics and teaching hospitals have transitioned to family health teams

[SH]: Okay

[008]: Okay? And, um, some of them in the smaller hospitals have closed, and uh, because they have, uh, family health teams in the communities

[SH]: Okay

[008]: so that has been a little bit, um, difficult for some of the dietitians in those communities, um, because the hospitals often, um, were using salary scales that were hospital-based

[SH]: Right

[008]: and competitive

[SH]: Right

[008]: and the family health teams were using, uh, a salary scale that was constructed by the government, and, um, so the salaries were often probably significantly less

[SH]: Mm-hmm

[008]: and so it created that little bit of discord in the profession

[SH]: Okay, um, yeah - it seems to be the case that if you're in a smaller area, uh, you don't even get one full-time equivalent, you kind of have to cobble together...

[008]: Mm-hmm

[SH]: a career I guess. It must be difficult for dietitians, I mean is there – I mean with pharmacy, you may be able to work, uh, say running a pharmacy or working in a pharmacy but um, where do dietitians work otherwise?

[008]: Okay, so working in private practice you could

[SH]: Okay

[008]: you know, it's not – it's not very common, and it's not – doesn't pay well.

[SH]: Okay

[008]: I think it's because most – most dietetic services are covered by the government

[SH]: Mm-hmm

[008]: and so people are not looking to pay additional for a dietitian

[SH]: Right

[008]: and, uh, so, private practice is a small piece, um, people will cobble together these full-time positions with long-term care, frequently

[SH]: Okay

[008]: because long-term care is also, you know, you have a small home and they're not given enough funds for a full-time dietitian, so they may just have two days a week or something like that

[SH]: Okay. Hmm.

[008]: and again, that's not necessarily very well-paid, neither, and I was going to say - well-paid by comparison to the hospitals

[SH]: Right

[008]: so we have this kind of disparity in the profession where if you work in the hospital you're on a different kind of salary scale

[SH]: Okay, and it's still better than what you would get working in primary care

[008]: generally, yes

Another key informant for the profession (006) noted that, while the move toward interdisciplinary primary care teams has opened up more positions overall for dietitians, the part time nature and poorer rate of pay relative to other settings makes it difficult to recruit and retain dietitians in primary care settings in Ontario.

A third key informant from the dietetic professional social world who had work experience in the primary care sector, and who was involved in promoting dietetics in primary care, also noted a difference in the way dietitians and other health care professions in Family Health Teams are paid, with this condition being set by the Ministry of Health and Long Term Care:

[011]: Some of the other challenges, for example, compensation for dietitians in family health teams in Ontario is an issue

[SH]: Okay

[011]: and so seeing how, um, a united front can help advocacy for example for compensation, you know, put money on the table and people get excited

[we laugh]

[SH]: Right

[011]: that's been one of the ways that we've, uh, been convinced to have a united front [between primary care, public health and private practice segments of the profession]

[SH]: Okay. Uh, and that actually ties into, uh, the next question, which is, are there specific issues for FHT's regarding the provision of interdisciplinary care that have come to light and if so, what are these? So, compensation has been one...

[011]: Compensation is definitely one.

[SH]: Okay, can you tell me...some of the specifics about the problem?

[011]: Yeah. So, the ministry categorized dietitians as health promoters, not as health professionals

[SH]: Oh! Okay.

[011]: So we get paid on a much lower scale

[SH]: Okay

[011]: than every other health professional.

[SH]: Really? Okay.

[011]: Mm-hmm

[SH]: Health promoters. Okay. And yet—but the College has uh – sorry, the profession has a college, it's a regulated profession and so on

[011]: Yeah, yeah.

[SH]: Okay, uh, do you know when the ministry did that?

[011]: As soon as – right when they started FHT's, we are still in discussions with our health minister

[SH]: Really?

[011]: Yeah.

[SH]: Okay, has this happened to other health professions as well?

[011]: No.

[SH]: Just dietitians?

[011]: Yeah.

[SH]: Okay, I'm just going to say this one more time – the ministry saw you [dietetics] as health promoters rather than as providers, right?

[011]: Right.

[SH]: and this is only been an issue for dietetics?

[011]: Yeah

Interestingly, while the key informants indicated pay disparities as outlined above were a significant issue for the profession, my textual data indicate that neither the profession's college nor its professional association have made any official statement about the negative effects of primary care reform on dietitians' remuneration or working conditions. This silence at the level of organizations is in contrast to the nursing profession, which actively critiqued imbalances in financial rewards in teams, and to the chiropractic profession, which approached government representatives about funding to reduce the need for pro-bono work done by chiropractors in Family Health Teams for vulnerable populations. It would seem that, for the time being, the dietetic organizations in Ontario are focused on gaining formal recognition of the profession's unique skills and body of knowledge in the context of interdisciplinary primary care teams.

Overall, the dietetic data reflects the profession's desire for official recognition of its professional expertise through scope expansion, and greater respect for the potential role in interdisciplinary primary care teams. Despite appealing to ideals of

interdisciplinary teamwork to advance their views in an environment conducive to advancing interdisciplinary teamwork, their efforts were not totally successful. The possible reasons for this are outlined in the discussion section of this chapter.

Chiropractic Profession

Since the 1920s, the overarching concern and main professionalizing strategy of chiropractic in Ontario has been to gain legitimacy, particularly in the eyes of the state and the public (Coburn & Biggs, 1986, pp. 1038, 1040). My data suggest that the chiropractic profession in Ontario has used the broad shifts toward primary care reform, interdisciplinary collaboration, and interdisciplinary primary care teams as opportunities to continue its longstanding professionalization project. These processes are examined below, after first examining the early interest of the state in chiropractic services.

Early Discussions of Chiropractic and Teams

No materials regarding interdisciplinary primary care teams produced by the chiropractic organizations were found prior to 2002. However, in 1993, the provincial government of Ontario funded a University of Ottawa study about the efficacy of chiropractic and its role in health care reform, to learn more about potential cost savings in using chiropractic to resolve low back pain issues. In their report to the government (posted on the Ontario Chiropractic Association website), the authors of that study (health economists and health administrators) recommended that “[c]hiropractic services should be fully integrated into the health care system...community health centres, comprehensive health organizations, and health service organizations... should employ chiropractors on a full-time and/or part-time basis” (Manga et al., 1993, p. 82). A follow-

up study conducted in 1998 by the same principal author, written this time for the OCA, made the same recommendation (Manga & Angus, 1998, p. 4). To date, the recommendation has still not been fully implemented. The initial interest in chiropractic services in health care reform thus outwardly appears to be from the government first, followed by the chiropractic organizations in the province.

Incorporating Teamwork into the Chiropractic Profession's Ethos

The earliest discussion of teams in my textual data from the chiropractic organizations dates back to 2002; it focuses on incorporating teamwork into the profession's ethos and official documents. The Ontario Chiropractic Association Code of Ethics (2002) document declares that “[t]he chiropractor will collaborate with other recognized health care practitioners toward the ideal of teamwork, in which the rights and best interest of the patient are paramount” (p. 1).

The earliest discussion of interdisciplinary teamwork by the CCO appears in its inaugural Core Competencies document (2004), where collaboration is declared as one of eight identified competencies to be held by practicing chiropractors: “[c]ompetent, professional doctors of chiropractic facilitate collaborative inter- and intra- professional relationships” (College of Chiropractors of Ontario, 2004, p. 14). Interprofessional collaboration officially became part of the CCO's Strategic Plan in 2008, having been identified as one of “...a number of areas that require some in-depth discussion and decision making” by the profession's leaders (College of Chiropractors of Ontario, 2008a, p. 11). In the same document, the CCO expressed its desire to move into “...a position of influence with the government and other key stakeholders, including the

public, the media, other chiropractic organizations, and other regulated health professionals” (ibid, p. 2). To that end:

...CCO has been taking steps to remove any barriers – real and perceived – to interprofessional collaboration. We have met informally with CPSO [College of Physicians and Surgeons of Ontario], ... OCP [Ontario College of Pharmacists] and CMRTO [The College of Medical Radiation Technologists of Ontario] to discuss the possibility of working collaboratively on future projects (College of Chiropractors of Ontario, 2008a, p. 6).

Finally, CCO President Denis Mizel requested of the CCO membership “...that you play your part and communicate often with our health care partners. Opportunities present themselves endlessly – take advantage of them. Patients benefit when we collaborate with the whole health care team” (ibid). These actions and statements reflect the profession’s positive orientation toward interprofessional collaboration and its desire to participate and increase its influence in Ontario’s mainstream health care system.

Unfunded but Undeterred: Working as Unfunded Team Members

In May 2004, the McGuinty Liberal government delisted chiropractic services from the Ontario Health Insurance Plan (OHIP), ending more than three decades of partial government funding (Ontario Chiropractic Association, 2004, p. 1). In its response paper, the OCA argued that this move ran counter to the government’s primary care reform goals of decreasing costs, improving access to health services, improving integration of health services, and more generally, of transforming the existing system (ibid p. 12). Delisting chiropractic, it argued, would result in “[r]educed access and longer wait times resulting from off-loading of patients from chiropractors to already scarce and over-burdened physicians” (Ontario Chiropractic Association, 2004, p.11). Costs would increase due to patients using more costly physician and hospital services

(ibid). Delisting chiropractic services from OHIP would also result in "...a directional shift away from the governments [sic] transformation and integration agenda, as chiropractors are further marginalized from the healthcare delivery system" (Ontario Chiropractic Association, 2004, p.12). Finally, in that same document, the OCA appealed to the ideal of primary care teams to argue the potential benefits of including chiropractic services and its congruence with the government's goal of system transformation:

[c]hiropractic services are not integrated into the multi-disciplinary care setting necessary to transform the delivery of healthcare services... Collaboration and integrating chiropractic services into multi-disciplinary teams and Primary Care Renewal will bring the benefits of chiropractic care—improved access, appropriate clinical care and cost-effective care, into the transformation of the healthcare system (ibid, p. 13).

Thus, for the OCA, the shift toward primary care reform and teams presented an opportunity to promote the role of chiropractic and further integrate into the health care system, despite being delisted. Unfortunately, no data were available for the College of Chiropractors of Ontario regarding its view of delisting.

The OCA's hopes for government-supported integration of chiropractors into multidisciplinary teams were not fulfilled until October 2013 (Ontario. Ministry of Health and Long-term Care, 2013a). Prior to this, the OCA made considerable efforts to convince the government of the need to integrate chiropractors into teams. In his presentation to the Standing Committee on Finance and Economic Affairs regarding the provincial budget in 2010, the Executive Director of the OCA, Dr. Bob Haig, reminded the committee of the McGuinty government's early commitment to including chiropractors (as well as other rehabilitative professions) in the FHT model:

The government is on the right track with its approach. It is widely acknowledged that Family Health Teams are by far the most promising primary care model that Ontario has ever seen...The initial concept and announcement by the government included roles in FHTs for rehabilitation professions. By this I mean chiropractors, physiotherapists and occupational therapists, primarily. When the government originally announced family health teams, there were 17 professions that were included in the list of family health team professionals. Despite this, there are no rehab professionals included in any of the family health teams announced to date (Haig, 2010, February 2, p. F-1417).

The two Liberal MPPs who heard the OCA's presentation (Phil McNeely and Wayne Arthurs) were sympathetic to the need to integrate chiropractic and other rehabilitation professions into FHTs, but said nothing indicating a commitment to remedying the situation (ibid).

However, the lack of government support did not stop the integration of chiropractors into interdisciplinary primary care teams. Both my textual and interview data indicate that chiropractors cooperated with individual FHTs and CHCs to integrate the services of chiropractors, an arrangement that occurred without government funding. In their presentation to the Standing Committee on Finance and Economic Affairs regarding the provincial budget in 2010, two representatives from the OCA explained this arrangement to the government committee:

Despite the original intentions and despite the progress to date, family health teams are not living up to their full promise yet...The inclusion of chiropractors in family health teams would provide improved acute and chronic back pain management for patients and improved alignment of the care provider to patient needs, all as part of a coordinated, interdisciplinary team... We believe that the government can make a lot of progress in enhancing interdisciplinary team care within the context of family health teams on an unfunded basis—without actually funding the services. This is happening now in a number of family health teams and it's working well. In those circumstances, the chiropractors are renting space from the family health team, so the family health team has an economic benefit there. Essentially, they've made their own infrastructure arrangements. But

importantly, those arrangements provide many of the key facilitators for team-based care: co-location and access to the common medical record. So even though the services are unfunded, the coordination of care, which is the key to an effective primary care system, is still beginning to happen there. We believe the government should take steps to ensure that its policies facilitate rather than discourage this kind of collaboration and the inclusion of unfunded services (Haig, 2010, February 2, p. F-1417).

The OCA further focused on how coverage for marginalized populations in unfunded collaboration models in interdisciplinary primary care teams would enhance the success of unfunded collaboration by providing better access to care and improving coordination of health services:

The facilitation and provision of unfunded services is obviously not a complete answer to things. Funding for those services comes either from the patient or from third party health insurance, and that means the most vulnerable patients—those on social assistance, the working poor, the elderly—who don't have access to chiropractic services now still won't be able to access them. It's not a perfect solution for the health care system, but it is a start at providing the coordination of care that is fundamental to making the system work well. We also believe that as the government's finances improve and as Ontario's finances improve, family health team and community health centre funding should be considered for those most vulnerable patients (Haig, 2010, February 2, p. F-1417).

The provision of chiropractic services in FHTs or CHCs to individuals from marginalized populations without private insurance has often been done on a pro-bono basis by the chiropractor (005).

My key informant from the chiropractic social world (005) also discussed unfunded models of care, explaining to me that there is both a clinical case and a business case for this arrangement. They made the clinical case for unfunded collaboration as follows:

[005]: Well, I mean, uh, the elephant in the room, obviously, is that chiropractors are not funded, so in 2004 they were delisted

[SH]: Mm-hmm...

[005]: and, um, we all know that we are at a crisis and tipping point,

[SH]: Mm-hmm

[005]: so we need to work with what's out there

[SH]: Mm-hmm

[005]: so part of that is the reorganization of primary health care team

[SH]: Mm-hmm

[005]: so how can DCs [chiropractors] be part of that?

[SH]: Right

[005]: Well, specifically, it is unfunded collaboration, and *that's* what we've been pushing

[SH]: unfunded? Sorry?

[005]: unfunded collaboration.

[SH]: Okay, can you expl—

[005]: sure

[SH]: can you explain that for me?

[005]: So, I mean, there is a – a strong clinical case for that, obviously we know that PCPs [primary care physicians], a huge problem for them is MSK [musculoskeletal] and low back pain, specifically

[SH]: Mm-hmm

[005]: Um, simply – they – they don't know what to do with them

[SH]: Right

[005]: uh, and so, a lot of times what's happening, is they're being sent for unnecessary MRIs

[SH]: Mm-hmm

[005]: and they're being sent for unnecessary specialist referrals. We know that the literature says that 90% of referrals to spine surgeons in particular

[SH]: Mm-hmm

[005]: 90% are not needed

[SH]: Okay

[005]: so it means that they'd be better off with conservative care therapy, or better management within the community system alone. Um, so what happens is, is they're waiting, you know, six or seven months or longer depending on the area of the province to see a spine surgeon, so during that time they're provided with no care, you can imagine six or seven months then seeing the spine surgeon and the spine surgeon saying unfortunately you're not a candidate for spine surgery, I'm sending you back to the PCP

[SH]: Uh-huh [laughs]

[005]: so incredibly frustrating for that particular patient, so from a patient perspective I mean, so much better.

This informant then explained the business case for unfunded models of collaboration for chiropractors, describing it as a “win-win” situation for everyone:

[SH]: Okay, so, that begs the question – I guess that just begs the question of -- so how do they-- are they [chiropractors] donating their time? Is...?

[005]: Certainly, there is a high percentage of pro bono care, yes, um but the business case behind it certainly is they're having a higher referral to the DC's [chiropractors], so where patients that have extended benefits, so in Ontario most do

[SH]: Mm-hmm

[005]: and um, and then for seniors, students, things like that, and for those on low-income modules like ODSP [Ontario Disability Support Program] or Ontario Works

[SH]: Mm-hmm

[005]: Um, the chiropractor often provides pro bono services, so it's a win-win for – for the family health team as well as for the chiro...and the chiropractor's also contributing towards, you know, the – whether it's um, rent towards the facility, towards the overhead costs, and them really being invested in the interprofessional model, so contributing in team meetings, case rounds, things like that.

In addition to benefitting from increased integration into mainstream health care, garnering patient referrals from physicians, and actively contributing to the functioning of FHTs, working in an unfunded arrangement allowed chiropractors to circumvent the government's rules for determining the available method of payment for non-physician

health professionals (typically salary or sessional payment), and the criteria for determining the full time equivalencies (FTEs) that non-physician health professions are allowed to work in the FHTs. FTEs for non-physician health professionals are based on the number of patients enrolled to the FHT (Interviews 001, 002, 013). Often, as a result of this policy, the FHT is only allowed to hire non-physician health professionals on a very low FTE basis—sometimes as low as 0.1 or 0.2 FTE (Interviews 001, 002, 011). It is thus not surprising that in the instance I described earlier, the OCA did not petition the government committee for chiropractors to be funded in the same manner as other non-physician health professionals working in FHTs, but focused rather on the benefits of unfunded models of collaboration and on asking for a funding mechanism that would cover marginalized populations (those least likely to have private insurance) in FHTs. These conditions allowed chiropractors the most professional freedom, in allowing traditional fee-for-service payment, in negotiating the terms of co-location directly with the FHT, and in determining how many hours are spent working in the FHT. However, with the introduction of guidelines for paying chiropractors working in FHTs (Ontario. Ministry of Health and Long-term Care, 2013a, p.6), this freedom has likely been curtailed, as FHTs would have to apply to the government to include a chiropractor. However, chiropractors are the only profession in the Ministry of Health and Long-term Care's *Guide to Interdisciplinary Provider Compensation* without a stated salary range; instead, the guide indicates that FHTs wanting to pay a chiropractor should consult with their ministry contact (ibid), meaning there is a possibility that chiropractors still charge on a fee-for-service basis.

Interdisciplinary Research as a Way to Gain Scientific Credibility

The chiropractic profession in Ontario also sought to increase its legitimacy and integration into the health care system by bolstering its presence in the scientific social world. Moreover, the profession specifically sought to characterize that presence as interdisciplinary and collaborative in nature. In 2008, the OCA, the Canadian Chiropractic Research Foundation, and the University of Guelph worked together to create a university research chair in spine mechanics and neurophysiology, with the explicit goal of strengthening the scientific base of the profession (Srbely, 2009, p. 1). The research chair, John Srbely, outlined how the weak scientific base threatened the acceptance of chiropractic into mainstream health care, and presented collaborative scientific work as a solution to chiropractic's credibility issue:

For chiropractic to be universally accepted into mainstream healthcare, it must first be accepted into mainstream science. For this to happen, chiropractic must characterize and validate its physiologic effects using the language of basic science. There is currently an inadequate body of basic science substantiating the physiologic mechanisms of spinal manipulative therapy (SMT). The credibility and value assigned to chiropractic by the scientific and medical communities, government, insurance and other stakeholders is and will be directly linked to the quality of basic science (RCT studies), published in high ranking peer-reviewed journals, validating its physiologic mechanisms. Health policy and health funding will be evidence-based; accordingly, greater emphasis must be placed on systematically building a larger chiropractic research infrastructure that will facilitate world-class research. In particular, chiropractic must seek to enhance its research presence in the basic sciences by creating collaborations with leading international academic and research institutions and creating positive interdisciplinary relationships. This paradigm will enhance our value as spinal experts and facilitate full acceptance and integration of chiropractic services into mainstream healthcare (Srbely, 2009, p. 1).

In his 2010 annual Progress Report to his sponsoring institutions (including the OCA), Dr. Srbely explains how the ideals of interdisciplinarity and collaboration at the level of

university research can potentially facilitate chiropractic's acceptance into the mainstream health care system:

Exposing chiropractic to the daily university setting and culture allows and facilitates open communication and interdisciplinary/interprofessional cooperation. I have had the opportunity to engage in many informal discussions with my academic colleagues and peers about chiropractic. These discussions have served to increase awareness and understanding of the benefits of chiropractic as well as the challenges we face as a growing profession. Ongoing interactions such as these nurture positive interprofessional rapport between chiropractors and other healthcare and research professionals (Srbely, 2010, p. 15).

Dr. Sberly is thus hoping for a top-down influence from the university level to the clinical level. The push for university affiliation by chiropractic, which has been limited until the formation of the university chair program in 2008, highlights the continued importance of mainstream educational and research institutions in legitimizing the professions (Abbott, 1988, p. 196; Freidson, 1986, p. 82).

Overall, chiropractic's strategies with regard to teams are the most inward-looking and enterprising. Similar to nurse practitioners and dietitians, chiropractors built interdisciplinary teamwork into their professional codes, and highlighted the ways that allowing their participation in interdisciplinary primary care teams would improve efficiency and cost savings. However, the chiropractic profession has also used the impetus of teams to revamp its approach to its professional knowledge base. Realizing its weak claim to a unique scientific knowledge base threatens its credibility and potential for acceptance in the health care system, chiropractic has sought to place itself strategically in university settings and has focused on speaking the language of interdisciplinarity and collaboration in research. The fact that it has managed to participate in interdisciplinary primary care teams despite a longstanding lack of

government support shows its strong desire to participate in the new milieu of health care in Ontario. The independent pursuit of participating on these teams also allowed it more freedom from government rules concerning remuneration, though as noted above the new *Guide to Interdisciplinary Provider Compensation* may have limited this freedom.

Discussion

Each of the professions in this chapter view teams positively, drawing on the common discourse of how teams will improve the health care system. As well, each profession has used interdisciplinary teams as an opportunity to improve their professional lot. The differences in each profession's discursive strategies in relation to teams may be explained by their previous positions in relation to the medical profession and the state. These are examined in more detail, below.

The discussion of teams by the nurse practitioner profession adds an interesting dimension to the data examined so far in this dissertation. This profession utilizes a unique discursive strategy among the professions I studied in attempting to define "true" teams as those with greater egalitarianism among team members. This pattern is also long-standing; an American study from three decades ago also noted assertions by the nursing profession that teamwork ought to be egalitarian (Temkin-Greener, 1983, p. 642). Appeals to greater egalitarianism in teams reflect nursing's historical relationship to medicine. Historically, the nursing profession in Canada experienced extensive control over its education and practice by the medical profession (Coburn, 1994, p. 142; Adams & Bourgeault, 2003, p. 78). This historical relationship has been called the subordination of nursing by medicine (Coburn, 1994, p. 155). According to Coburn (1994), much of nursing's professionalization efforts in Canada have focused on escaping this

subordination (p. 154). One significant strategy employed by the profession in recent decades has been to establish a theory base to distinguish itself as a health care discipline that is separate but equal to medicine (Coburn, 1994, p. 154; Angus & Bourgeault, 1998, p. 67). The talk of egalitarianism may be in part due to the desire to be recognized for these advancements, and to ensure there is no return to the old pattern of subordination in micro-level settings such as teams, especially in models that are physician-centered.

Second, this particular discursive strategy may only be used by nurse practitioners because they have the greatest overlap with physicians in terms of skills compared to dietetics and chiropractic. Nurse practitioners claim skill (and now a scope of practice) in diagnosis and prescribing in primary care, areas once only the purview of physicians. In contrast, dietitians in Ontario do not diagnose or prescribe at all, and chiropractors only diagnose in areas related to disorders of the spine, nervous system, and joints as outlined in their legal scope of practice in the Chiropractic Act (1991)⁹⁴. It is thus not surprising that dietetics and chiropractic would not attempt to portray true teamwork as egalitarian, given that their respective claims to skill in diagnosis and prescribing in primary care are weaker or non-existent.

Similar to the nurse practitioner profession, the dietetic profession attempted to link scope expansion to teams. However, where the nurse practitioner profession emphasized greater independence in the name of teams, the dietetic profession emphasized the need for greater interdependence among team members. The dietetic profession was very careful to state its belief that diagnosis was clearly the purview of physicians and nurse practitioners, and stated how dietetic expertise could be used after

⁹⁴ http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91c21_e.htm, accessed January 9, 2014.

diagnosis. Dietitians, like nurse practitioners, emphasized the importance of having their professional skills and unique body of knowledge recognized in order to facilitate interprofessional teamwork. Also like nurse practitioners, they made appeals to expanding scope of practice to increase efficiency of teamwork. While the dietetic profession's requests for scope expansion were ambitious (for example, in wanting to add two controlled acts in which it could claim expertise), its claims to having specialized knowledge in nutrition and specialized feeding regimes do not seem unwarranted. Further, dietitians did not specifically call for greater egalitarianism within teams, nor did they call for fundamental reform of the health system, as did nurse practitioners. It is thus surprising that, even with its highly circumscribed and cautious approach, the dietetic profession's efforts to expand its scope of practice were largely unsuccessful, despite a policy environment intent on promoting and facilitating interdisciplinary teamwork.

Even more surprising is the fact that it was not the medical profession that stymied the dietetic profession's efforts. Rather, it was HPRAC's refusal to endorse the changes, and the provincial government's apparent heeding of HPRAC's recommendations. O'Reilly (2000) made similar observations about the lack of gains in dietetic scope of practice in her examination of the original Regulated Health Professions Act of 1991; the rejection of dietitians' requests for scope of practice changes at that time was by legislators, rather than by the medical profession. She notes that the medical profession in Ontario has historically had little interest or concern with the scope of practice of dietitians (O'Reilly, 2000, p. 120). Rather, the rejection of dietetics' requests for expanded scope of practice was due to two factors. First, legislators disagreed with dietetics' assertion that activities within their scope of practice posed enough risk to

warrant any new controlled acts (*ibid*). In fact, dietitians *and* physicians both failed to convince legislators to give either profession control over the prescription of therapeutic diets at that time (*ibid*).

Second, in not viewing dietetics' activities as risky to patient health, legislators were reluctant to limit diet-related practice to the profession because it would have increased the cost of nutrition services in small hospitals and home care services (*ibid*). Further, diet plans "...are now big business, and officials are not very comfortable with granting professional monopolies in such markets" (*ibid*). Indeed, both unregulated professions and commercial enterprises successfully lobbied the government to prevent professional monopolies in the area of nutrition (*ibid*). This highlights the importance of looking not just at professions' effects on each other, but at other contextual factors as well, including private industry (Coburn & Biggs, 1986, p. 1037; Coburn & Willis, 2003, p. 384).

O'Reilly's findings may help to explain why neither HPRAC nor the government saw the need during the legislative review of 2008 to regulate the prescription of therapeutic diets. However, they do not explain why the prescription of enteral or parenteral nutrition, shown by the literature review in the profession's submissions to HPRAC be subject to physician error (College of Dietitians of Ontario & Dietitians of Canada, 2008, p. 55), was still not seen as dangerous enough by HPRAC to warrant creation of a controlled act. HPRAC's assertion that the existing level of interprofessional collaboration has worked well thus far for this activity has not placated the dietetic profession. In its response to HPRAC, the profession declared that a system is needed to track errors made by physicians in prescribing EN/PN and the mitigating effect of dietitian intervention on these errors (College of Dietitians of Ontario & Dietitians of

Canada, 2009, p. 8). Thus, in failing to convince legislators to expand their scope of practice in the name of teamwork, the dietetic profession has promised to turn its attention to producing clinical evidence to support its case.

The discussion of teams by the chiropractic profession in my data builds on trends identified in literature as early as the 1980s. Literature indicates chiropractic in Canada has sought further integration into the mainstream health care system (Mills & Larsen, 1981, p. 248). To facilitate this, the profession has moved away from its original broad claims about cause of disease and cure of disease through spinal manipulation in favor of a narrower set of claims of being experts in the treatment of spinal and musculoskeletal issues (Mills & Larsen, 1981, p. 242; Coburn & Biggs, 1986, p. 1043; Coburn, 1994, p. 157). Further, the profession has embarked on producing a scientific base to explain its efficacy and elevate its standing (Mills & Larsen, 1981, p. 247; O'Reilly, 2000, p. 148), a strategy promoted in particular by the profession's elite (Coburn & Biggs, 1987, p. 376). This process has been called "medicalization", since chiropractic is replicating medicine's strategy of aligning itself with science, which has been asserted as medicine's source of strength (Coburn & Biggs, 1987, p. 376, 381). My data indicate that chiropractic has continued these trajectories in the era of teams. The profession has made efforts to integrate into new primary care settings such as FHTs, promoting itself as specializing in identifying and treating spinal and musculoskeletal afflictions in those settings. It has also continued to expand its research base and affiliation with universities in the province.

However, the chiropractic data also shows interesting departures from older studies and historical patterns. For the first time in decades, chiropractic's endorsement by the state has declined, in being completely de-listed from the provincial health

insurance plan in 2004, and in its de facto exclusion from FHTs by the provincial government. This is in stark contrast to past studies that credit state endorsement and funding of chiropractic as an important reason for its survival in Canada, especially in the face of hostility from the medical profession (Mills & Larsen, 1981, p. 243; Coburn & Biggs, 1986, p. 1040; Coburn & Biggs, 1987, p. 373; Coburn, 1994, p. 156). In another reversal of historical patterns, chiropractic is building a working relationship with medicine in the context of interdisciplinary primary care teams. Such a relationship was not even possible thirty years ago, when the Canadian Medical Association still officially forbade interprofessional relations between physicians and chiropractors (Coburn & Biggs, 1986, p. 1038).

Chiropractic's historical position in the Ontario system as an excluded—rather than a subordinated—profession in relation to the medical profession (as per Coburn & Biggs, 1986, p.1037) has given it an interesting position and opportunity in the milieu of teams. Aside from the medical profession speaking out against chiropractic (Mills & Larsen, 1981, p. 237; Coburn & Biggs, 1987, p. 369), and banning its own members from collaborating with chiropractors (Mills & Larsen, 1981, p. 237; Coburn & Biggs, 1987, p. 370), chiropractic did not experience interference into its education or practice by the medical profession. Chiropractic's longstanding independence may explain why the profession sought unfunded working relationships with physicians in FHTs. These actions continue a pattern observed by Coburn (1994, p. 158) that chiropractic has generally escaped bureaucratic control by the state. The chiropractic profession likely sought unfunded models of collaboration within FHTs precisely because it allows the profession to garner referrals and participate in the team milieu while continuing to elude government control over its labour process.

Another finding that warrants further discussion is the acceptance of all of the team models by the three professions. That these three professions do not argue for one particular model of interdisciplinary primary care team to the exclusion of another model makes practical sense; the expansion of any of these models provides new work opportunities for all three professions. Since the expansion of the CHC model and the introduction of the FHT model, the demand for dietitians has increased significantly; prior to this expansion, positions for dietitians was limited to hospitals, long-term care facilities, and private practice (College of Dietitians of Ontario, 2006, Winter, p. 7; Interview 006; Interview 008). The demand for nurse practitioners has also increased, due at least in part to the proliferation of interdisciplinary primary care teams (College of Nurses of Ontario, 2007, p. 22; Nurse Practitioners' Association of Ontario, 2005a, p. 1). In demonstrating their efficacy in treating patients with musculoskeletal issues for patients in the FHT model (Riva et al., 2010, p. 151) and CHC model (Garner et al, 2008, p.20), chiropractors have garnered referrals from physicians that might not otherwise have occurred.

Interdisciplinary teams also present new opportunities for intrinsic professional rewards. Mills and Larsen (1981) note the importance of patient contact to professional satisfaction at the individual level (p. 246), and the importance to professionals of being held in regard by patients and the public (p. 247). They also note the satisfaction for professionals that may derive from collegiality with other professions (ibid, p. 246). Team settings present new opportunities for patient contact, and the opportunity to demonstrate professional skills to patients and colleagues alike, potentially enhancing professional satisfaction.

However, as noted in this chapter, these benefits come with financial costs for nurse practitioners (in doing much of the work that garners physicians financial bonuses), and for dietitians, who must contend with part-time work and lowered pay. More research into the motivation for working in teams is needed, especially for those professions that suffer financially, to shed light on this seemingly counter-intuitive pattern. The intrinsic professional rewards of working in a team setting may be one factor.

The non-preference of team model by these professions has other possible implications, particularly if this pattern were also exhibited in other non-medical professions. The endorsement of any and all team forms as acceptable could mean that physician-centered models such as the FHT go unchallenged by non-medical health professions. This, in combination with my data from Chapter Four suggesting that the broader Ontario public does not appear to be aware of the nuances in team forms, and the strong preference by the ruling Liberal government and the medical profession for FHTs, could mean that FHTs (a physician-centered model) will become the uncontested or dominant form of team in Ontario, rather than the more egalitarian models such as the CHC or NPLC models. As I noted in the discussion section of Chapter Five, the physician-dominated FHT model may do little to change the culture and delivery of health care, replicating the existing limitations of the physician-dominated model of care. FHTs may be potentially less effective in the areas of preventive health care, chronic disease management, and in serving marginalized populations compared to the CHC model (e.g., Russell et al., 2009, p. 312; Muldoon et al., 2010, p. 679). More empirical study of other health professions in Ontario would need to be done to determine whether other non-medical professions would have the same broad acceptance of all models of interdisciplinary primary care team.

Chapter Seven

Conclusion

My main goal in this study was to scrutinize interdisciplinary primary care teams in new ways. To this end, I employed strategies that allowed me to focus on the lesser studied aspects of teams. I used macro-level contextual and historical approaches, and utilized a critical approach that focused explicitly on how the state and health professions talk about, and attempt to shape, interdisciplinary primary care teams. Further, I employed a method not yet used in this subject area. These resulted in new insights in the study of interdisciplinary primary care teams. In this chapter, I outline the substantive, theoretical, and methodological contributions of my work to the literature, and suggest areas in need of further empirical study.

Substantive Contributions

The Professions and Interdisciplinary Teams: Mutual Influence

As noted in Chapter Two, literature has highlighted the lack of studies of macro level factors pertaining to interdisciplinary primary care teams. Authors have noted the need for attention to how the professions, as part of the broader system surrounding teams, may affect teams and teamwork. San Martin Rodriguez et al. point to the need for more study of the effects of inequality of status between the professions, as well as the potential influence of the professions' longstanding concern with autonomy, on teams (2005, p. 135). Salhani and Coulter assert that professional projects (in other words, a given profession's efforts at the macro level to maintain or expand its prerogatives and/or jurisdiction) must be understood since these were found in their study to be an integral component in the dynamics of interprofessional teams (2009, p. 1227). My study

contributes new knowledge to these areas by providing a detailed empirical examination of the professional projects of four health professions as they relate specifically to interdisciplinary teams. My study found that concerns with professional autonomy, scope of practice expansion, and differences in status were indeed an integral part of these professions' arguments, strategies, and actions concerning teams at the macro level.

Some of the assertions around professional issues and teamwork made by the professions in my study may be tested empirically in future studies of team function. For example, now that nurse practitioners have been granted full diagnostic and open prescribing rights in Ontario, studies could be done testing the assertion made by the nurse practitioner profession that these expansions will improve interdisciplinary team function. Conversely, the assertion made by the medical profession that this expansion of scope for nurse practitioners will only foster independence, thus inhibiting collaboration, may also be tested in team settings in this province.

In addition to addressing concerns expressed in the literature about the possible influence of the professions on teams, my study has also examined the reverse—that is, the effects of the movement toward interdisciplinary teams on the professions. As demonstrated in my findings, all the professions in my study were active participants in the accelerated movement toward interdisciplinary primary care teams. The leadership organizations of each profession took action to prepare for this change, or to make their profession a significant part of the change, in order to maximize their position in the new milieu. They conducted research, they consulted with and lobbied the government, and they created policies and protocols with regard to interdisciplinary teamwork. Indeed, interprofessional collaboration has been written into the practice standards documents for each profession (College of Physicians and Surgeons of Ontario, 2008, p. 10; College of

Nurses of Ontario, 2009a, p.10; College of Dietitians of Ontario, 2012, p. 17; College of Chiropractors of Ontario, 2004, p. 14). These efforts are a testament to the power of the idea of teams; interdisciplinary teams have not only started to change the landscape of health care in Ontario, but the structure of professions and their work as well. A search of the literature shows that this area of study is neglected; my study may well be among the first to examine the effect of the interdisciplinary team movement on the professions at the level of leadership and regulatory bodies.

Finally, my study provides a foundation toward filling a gap in empirical study noted by San Martin Rodriguez et al. (2005), namely, that studies of collaboration focus mainly on nurse-physician relations. In outlining the professional concerns relating to interdisciplinary teams of two other professions, dietetic and chiropractic, my findings may inform future studies of relations between other combinations of professionals on teams. The new working relationship between chiropractors and family physicians in FHTs and CHCs seems an especially interesting area of future study, as it defies the historical pattern of poor relations between the two professions in Ontario (Mills & Larsen, 1981, p. 237; Coburn & Biggs, 1986, p. 1037; Coburn, 1994, p. 156).

Interdisciplinary Teams and Politics

My study adds new dimensions to a growing body of literature investigating the variety of models of interdisciplinary primary care teams in Ontario by highlighting how teams are affected by politics. My study shows an interesting duality surrounding interdisciplinary teams in the political social world. Interdisciplinary teams are a source of political unity, in that all political parties in Ontario see teams as an important strategy in changing health care delivery. At the same time, there are disagreements among parties about how interdisciplinary teams ought to be structured and governed. Further, there is

a struggle among the political parties to highlight and secure their respective legacies regarding interdisciplinary teams. While the Liberals implemented three types of interdisciplinary primary care teams, they clearly promoted the FHT model as their “signature” on primary care reform, devoting the lion’s share of resources to this model.

The Liberals’ decision to promote the FHT model as its signature piece creates opportunities for further study. For example, in Chapter Four, I noted how Health Minister George Smitherman stated in the legislature in October 2004 that 100 communities that had requested a CHC would be the first communities considered for FHTs instead. A follow-up study could investigate those communities to see if an interdisciplinary primary care team was granted, and, if a substitution was made, whether the FHT model was felt to have met the needs of the community. Further, it would be interesting to find out whether some of the key differences between the two models, such as levels of community representation on the governing boards, or the level of egalitarianism among the team members, would be of concern to the people that made the original requests on behalf of their communities.

My study also provides insights for policymakers in other provinces considering widespread implementation of interdisciplinary teams. Policymakers in other provinces might expect similar actions from the professions regarding scope expansion in the name of teamwork, or disagreements about scope expansion as those found herein. They might also expect differences in opinion between professions about what models of teams are considered desirable (or even legitimate) as those outlined in my study. Policymakers in other provinces seeking to implement teams on a wide scale may also need to consider whether their legislative infrastructure will allow the flexibility of task completion implied in teamwork. Ontario took a bold and unprecedented legislative step in the early

1990s in implementing the Regulated Health Professions Act, which fundamentally changed the tone of professional regulation that went from state recognition of exclusivity of professional work to state encouragement of overlap and sharing of tasks among the professions. Similar legislation has since been enacted in British Columbia (1996)⁹⁵ Alberta (1999)⁹⁶, Quebec (2003)⁹⁷, the Yukon⁹⁸ (2003), Manitoba⁹⁹ (2009), Newfoundland and Labrador¹⁰⁰ (2010), and Nova Scotia¹⁰¹ (2012). Such legislation has yet to be implemented in the remaining 5 provinces and territories, though Prince Edward Island¹⁰² and the Northwest Territories¹⁰³ are actively considering such legislation. Those provinces without this type of legislation may encounter more difficulty in gaining the flexibility in task completion believed to be important to teamwork.

My study may also provide insights for the citizens of other provinces. My study showed that the design and implementation of interdisciplinary teams are influenced by

⁹⁵ http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96183_01, accessed February 9, 2014.

⁹⁶ <http://www.health.alberta.ca/documents/Health-Professions-Act.pdf>, accessed February 9, 2014.

⁹⁷ Thirteen health professions in Quebec have had their governing legislation changed to allow overlap of some activities between some health professions; (<http://www.professions-quebec.org/index.php/en/element/visualiser/id/7>, accessed February 9, 2014). Otherwise, the regulation of professions in Quebec remains an exclusive scope of practice model, with medicine being one of these.

⁹⁸ <http://www.gov.yk.ca/legislation/acts/hepr.pdf>, accessed February 9, 2014

⁹⁹ <http://web2.gov.mb.ca/bills/39-3/b018e.php>, accessed February 9, 2014;
<http://news.gov.mb.ca/news/index.html?archive=2009-04-01&item=5681>, accessed February 9, 2014.

¹⁰⁰ <http://www.assembly.nl.ca/business/bills/Bill1017.htm>, accessed February 9, 2014.

¹⁰¹ http://nslegislature.ca/legc/bills/61st_4th/3rd_read/b147.htm, accessed February 9, 2014.

¹⁰² Consultation has been underway since 2012 (<http://policymonitor.ca/pei-health-professions-legislation>, accessed February 9, 2014).

¹⁰³ <http://news.exec.gov.nt.ca/health-and-social-services-professions-legislation/>, accessed February 9, 2014.

politics. While all political parties in Ontario agreed on the importance of teams, there were differences in preference for model type. The Liberals, for example, touted the physician-centered FHT model more than other models, while the NDP made its preference for the community-governed CHC model known. Any given province's efforts to establish interdisciplinary teams may well vary by who is elected into office and that party's preferences for how teams are to be structured and governed. However, I would caution against automatically assuming party preferences in Ontario would automatically be the same in other provinces. Rather, I would encourage citizens of any province where widespread implementation of interdisciplinary teams is being considered to learn more about the models proposed, particularly if they are concerned about the level of community representation on team governance boards, about being required to roster to a physician or entity in order to receive services, or about the level of egalitarianism among team members. As shown throughout this dissertation, these characteristics vary by model type.

Theoretical Contributions

My work contributes to two major theoretical concepts in the sociology of professions. In Chapter Five, I outlined how my findings build on understandings of medical dominance. Findings from my study also highlight the need for re-examination of another fundamental concept in the sociology of professions, that of jurisdiction. In *The System of Professions* (1988), Andrew Abbott defines jurisdiction as the "...social tie...that binds profession to task—a recognized right, a link between the two" (p. 33). The tasks performed by a profession, and the claim for the right to do so, constitute jurisdiction (ibid., p. 33). For Abbott, jurisdiction is exclusive: "[m]any or most

jurisdictions are uniquely held; the tenancy of one profession generally excludes that of another” (ibid, p. 89). Further, Abbott implies that jurisdiction is typically zero-sum, in that “...one profession’s jurisdiction preempts another’s” (ibid, p. 87), and that a profession “...cannot occupy a jurisdiction without either finding it empty or fighting for it” (ibid, p. 86).

My study, however, highlights challenges to the concept of jurisdiction as exclusive and zero-sum. First, the very idea of interdisciplinary teams challenges the longstanding model of professional work as exclusive; it is now widely believed that health care work has become too complex to be done exclusively. My work in Chapter Five showed this belief was the case even in the medical profession, where the solo practitioner was the preferred model of practice for many years. Teams are argued to enhance efficiency of health care, whether by relieving the burden of work on physicians in allowing other professions to take on some of the physician’s tasks (FHT), or in allowing other health professions to be the first point of contact for patients, doing what they can for them, and referring to physicians as necessary (CHC, NPLC). In either case, the belief among many groups promoting teams is that there must be greater flexibility in task completion between professions.

Second, structural changes to the system of health professions in Ontario in the name of teamwork have reduced the exclusivity of tasks. Ontario’s system of regulating health professions through a system of controlled acts creates greater potential for specific tasks to be done by more than one profession. This regulatory structure has also created outcomes that challenge the presumed nature of jurisdiction as zero-sum. The legal gains made by nurse practitioners in 2009 allowing them to independently diagnose illness and prescribe treatment in primary care patients did *not* subsequently result in

family physicians losing the legal authority to do these tasks, the outcome implied in Abbott's theory (Abbott, 1988, p. 86).

However, despite nurse practitioners' new abilities to diagnose and prescribe at the level of primary care in Ontario, placing them on much more equal footing with family physicians, it is too soon to tell if these new conditions constitute a fully shared jurisdiction¹⁰⁴. First, as noted in Chapter Six, nurse practitioners' ability to prescribe is limited in comparison to family physicians by federal law. Second, also noted in Chapter Six, nurse practitioners have greater difficulty obtaining specialist services compared to family physicians. More empirical study is needed to determine how the legal changes in scope of practice for nurse practitioners will play out in work settings. Abbott identified five patterns of possible outcome when jurisdictional claims are incomplete (1988, p. 69). Of these, three may occur in this situation. An interdependent division of labour may form between family physicians and nurse practitioners; an independent division of labour may form between them (i.e., they share jurisdiction); or the two professions may divide their shared jurisdiction based on the nature of clients—in this case, this particular division may occur based on client location, given that nurse practitioners are often the only providers in isolated areas. Abbott's other proposed patterns do not seem to apply here: subordination of nurse practitioners by physicians is no longer likely the case, as nurse practitioners now have legal backing for their claims to diagnosis and prescription. Advisory control of the jurisdiction by medicine is also not likely to be the case, given that the Ontario Medical Association suggests physicians not characterize their relationship with nurse practitioners as a supervisory relationship [OMA Task Force on

¹⁰⁴ According to Abbott, this is a very rare outcome—the exception rather than the rule (1988, p.89).

the Working Relationship between Physicians and Registered Nurses (Extended Class), 2002, p. 2]. In any case, that nurse practitioners and family physicians now legally share the same essential tasks of primary care (diagnosis and prescription), means more investigation is needed into how Abbott's widely used theory of professional systems may need updating.

Methodological Contributions

Situational analysis is a demanding method, prone to creating large research projects. Even with the limits I placed on my study, my project became large. However, there were distinct advantages in using this approach to study this topic. Clarke's suggestion to "historicize the situation" was particularly useful in providing a basis from which to understand not only how interdisciplinary teams came to be seen as vital, but also provided a solid basis from which I could judge what had changed or not changed since the Liberals implemented their particular plan for interdisciplinary primary care teams. Without historicizing the situation, I would not have fully appreciated just how long the ideal of health care teams had occupied the political scene in Ontario, nor would I have understood the influences that this long history would have on the models I studied. The Liberal government's FHT model combined the physician-centered elements of the Progressive Conservatives' FHN/FHG models of the early 2000s with an explicitly interdisciplinary complement that went beyond physician-nurse combinations. This represents a somewhat subtle political move. However, funding the NPLC model was a bold move on the part of the Liberal government, given the longstanding tension between the medical and nurse practitioner professions in the province, and the fact that it had never been done before. Finally, in historicizing the situation I was able to

distinguish discourses about community in relation to health team models. Whereas talk around the CHC model has long emphasized community governance, the talk around the FHT model emphasized that it would be community-based, de-emphasizing the issue of governance in favour of touting a move away from hospital-based care to community-based care.

In terms of the professions, some trajectories continued, such as the nurse practitioners' pursuit of expanded scope of practice and the medical profession's resistance to this expansion. Another example is dietetics' efforts to be recognized as nutrition experts and the state's seemingly continued indifference to those arguments. In other cases, there were marked divergences from historical patterns, such as the new working relationship between chiropractors and physicians in interdisciplinary teams. Such a marked divergence warrants further study: while we know that chiropractic has long sought greater legitimacy and integration into the system, we do not know why the medical profession has allowed greater contact with chiropractic. More research is needed to determine whether a desire for teamwork by physicians is the answer, or whether other factors account for this change. The advantage of using situational analysis is that we know there *is* something remarkable happening here; a positivist approach to teams, which tends to be a-historical and to assume that teams are a logical progression, would miss this important observation and fail to see it as something worth studying further.

Clarke's suggestion to watch for implicated/silent actors in a situation (2005, p. 46) also yielded valuable insights. In the simple act of noting what groups are being discussed in the talk of teams, but never heard from directly, I saw a glaring omission. While there was talk in the political and professional social worlds that teams were

desired by Ontarians, the evidence for this claim seemed thin. As shown in Chapter Four, Liberal politicians claimed that the expressed desire of individuals from 213 communities in Ontario for a Family Health Team indicated that Ontarians were overwhelmingly in favor of Family Health Teams. However, I was unable to obtain any further evidence to suggest that a significant number of Ontarians were in favor of teams (or any evidence that the population's views on the matter were actively solicited by the government¹⁰⁵). On the contrary, key informants in Chapter Four suggested that most Ontarians are unaware of interdisciplinary primary care teams. Indeed, scholarly literature regarding the general population's views of teams is non-existent, and literature regarding patient views or experiences of care by teams is only starting to emerge (e.g., Shaw, 2008; Martin & Finn, 2011; Jesmin et al., 2012; Kvarnström et al., 2012). It is especially surprising that patient views of teams are virtually absent from discussions about interdisciplinary teams, given that teams are asserted to contribute to patient-centered care (Ateah et al, 2011, p. 207; Cote et al., 2008, p. 457). The movement toward interdisciplinary primary care teams has proceeded in Ontario with considerable sums of money spent, without broad consultation with citizens or patients. More empirical study of these groups is needed to explore their views of interdisciplinary teams and test these against the claims made by politicians and professions.

Finally, Clarke's suggestion to note economic conditions important in the situation (2005, p. 90) brought my attention to issues not addressed in the extant literature about interdisciplinary teams. While I noted in Chapter Two that literature acknowledges tensions between interdisciplinary team members due to differences in professional

¹⁰⁵ My searches of the Government of Ontario website (conducted October, 2012) for evidence of public consultation showed results for several health-related topics (such as northern health, health technology, and Chinese medicine, to name just a few), but not for anything to do with interdisciplinary primary care teams.

status, the effects of inequalities in compensation for performing teamwork are not yet explored. In my study, textual data as well as comments from several key informants noted that these were issues of importance and consequence to non-medical professions. My findings suggest that family physicians benefit financially from working in team arrangements, while some professions, such as dietetics and pharmacy, have much more limited opportunities to benefit financially (or even sustain themselves) working in team models, due mainly to government rules that limit the amount of time they can work in one team. Members of these professions wishing to work in teams would have to piece together a series of jobs in different teams to constitute full time work, or work in another setting as well. Certainly, in terms of financial benefit or opportunity, there is a hierarchy among professions that is developing in the Ontario interdisciplinary team context. The effect of the movement toward teamwork on the working lives of non-medical professions is worthy of further study.

Final Thoughts

I purposely took a different approach to studying interdisciplinary teams. The literature is overwhelmingly focused on making teams work. By excusing myself from this task, and focusing instead on how teams are at once perceived and shaped by language and action by macro-level entities, I have exposed a number of areas affected by the movement toward interdisciplinary teams in need of more study. It is my hope that in doing this study, that I can raise awareness of how teams are made and the effects of these on citizens and practitioners alike.

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Appendix A: Ontario Health Ministers and Critics (2003-2011)

There have been three Ministers of Health and Long-term Care since 2003: George Smitherman (2003-2008), David Caplan (2008-2009), and Deborah Matthews (2009 onward) (Ontario. Legislative Assembly of Ontario, n.d., “George Smitherman”; *ibid*, “David Caplan”; *ibid*, “Deborah Matthews”). The Progressive Conservative Party had three health critics during this period: Elizabeth Witmer (former Minister of Health and Long-term Care) (2003-2004; 2005-2009; 2011-2012), John Baird (2004-2005), and Christine Elliot (2009-2011; 2012 onward) (Ontario. Legislative Assembly of Ontario, n.d., “Elizabeth Witmer”; *ibid*, “John Baird”; *ibid*, “Christine Elliot”). The NDP had two health critics during this period: Shelley Martel (2003-2007), and France Gélinas (2007 onward) (*ibid*, “Shelley Martel”; *ibid*, “France Gélinas”).

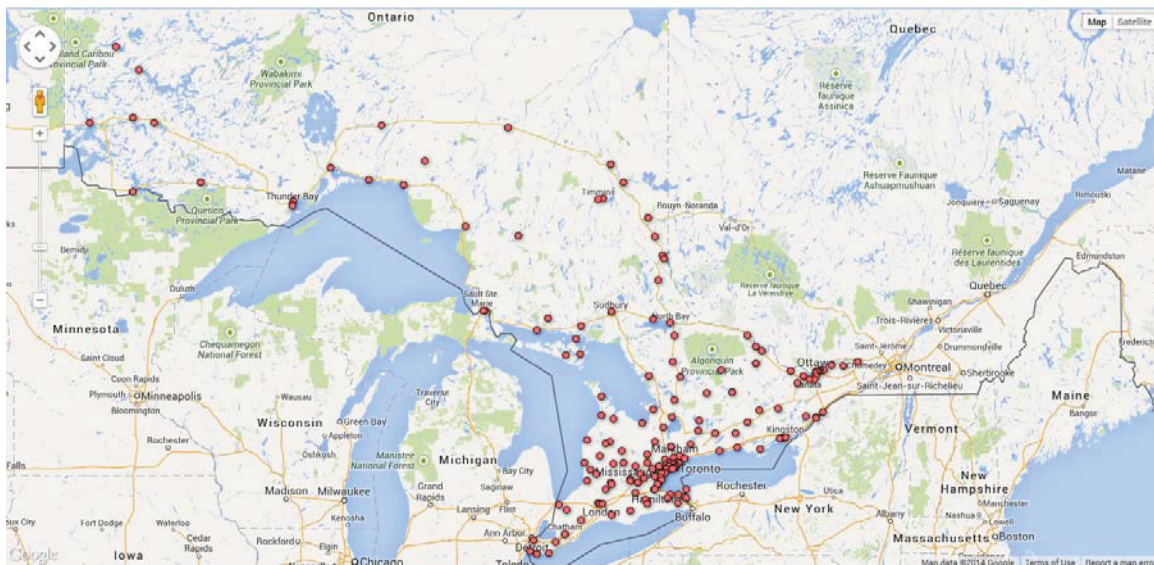
Appendix B: Differences between the FHN, FHG, and FHT Models

	Initiating Government	Structure	Physician Payment Structure	Interdisciplinary Provider Payment Structure
Family Health Network	Progressive Conservative (2001)	Physician Group Practice	Blended capitation	N/A
Family Health Group	Progressive Conservative (2003)	Physician Group Practice	Fee-for-service	N/A
Family Health Team	Liberal (2004)	Physician Group Practice with interdisciplinary team members	Blended capitation (for physician-led entities) Blended salary (for community- or mixed-governance entities)	Salary, sessional funding, or contractual agreement

Information adapted from Health Force Ontario (2007)

Appendix C: Maps of Family Health Teams, Community Health Centres, and Nurse Practitioner-led Clinics in Ontario

Map One: Family Health Teams in Ontario

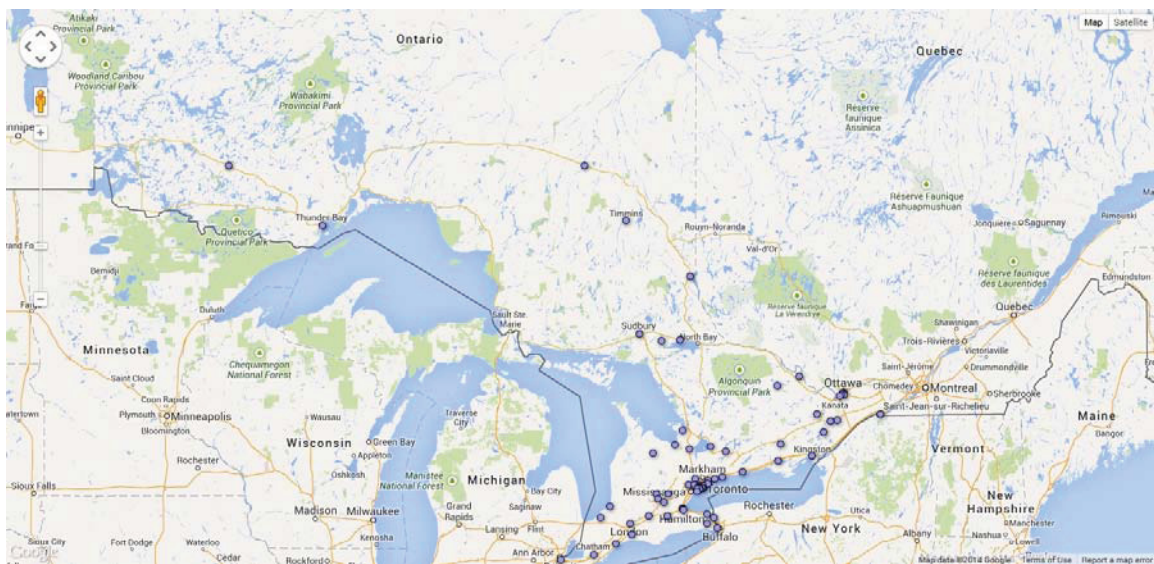


Created by author using Google Fusion Tables

Map available at:

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Map Two: Community Health Centres in Ontario

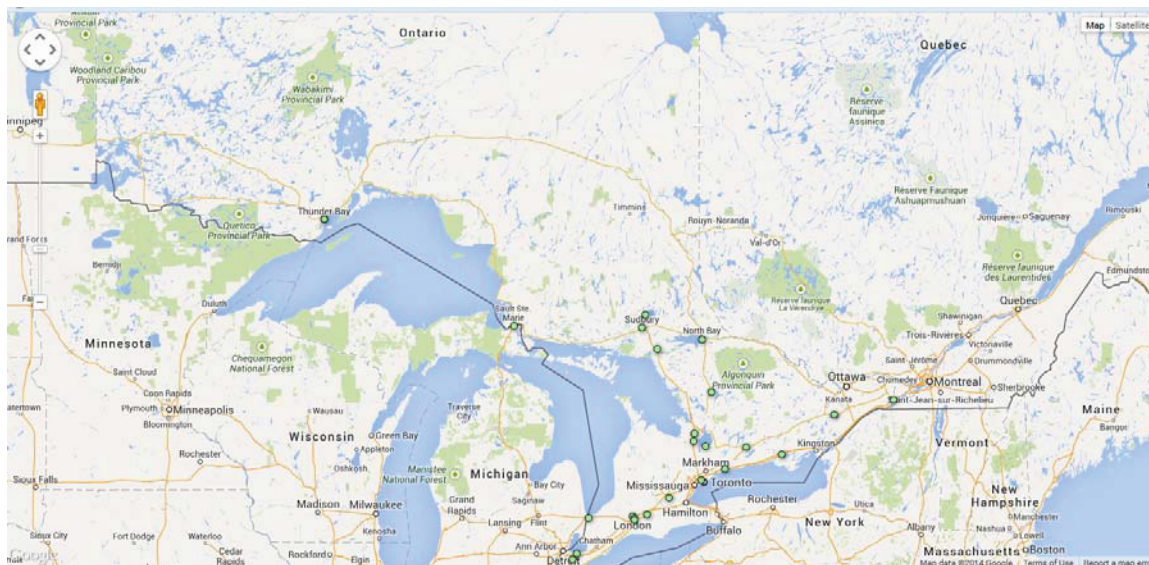


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Map available at:

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Map Three: Nurse Practitioner-led Clinics in Ontario



Map created by author using Google Fusion Tables

Available at:

https://www.google.com/fusiontables/embedviz?q=select+col0+from+1Dnic3XtynaCj5SWAQfv9V8qU0Xpi4i0P4_gFid0z+where+col6+%3D+%27NPLC%27&viz=MAP&h=false&lat=47.404912337162294&lng=-78.81229666562501&t=1&z=5&l=col0&y=2&tmplt=2&hml=ONE_COL_LAT_LNG

Appendix D: Recruitment Scripts

Scripts for initial contact (Recruitment)

The type of initial contact may depend on available contact information.

Telephone scripts:

Direct contact (if possible and feasible):

Hello, [name]. My name is Susan Haydt. I am a PhD student from the Department of Sociology and Social Anthropology at Dalhousie University in Halifax, Nova Scotia. Would you have a moment for me to explain my call? (If No, ask for a more convenient time to call). (If yes, proceed as follows): I am conducting a research study for my Ph.D. about interdisciplinary team-based health care delivery systems in Ontario, focusing on Family Health Teams, Community Health Centres, and Nurse Practitioner-led Clinics. The purpose of the study is to learn more about the history of these types of systems, and to learn more about how various health professional groups, governments, and community providers talk about actions taken regarding these systems. I would like to ask you to participate in an interview with me in your capacity as [position]. The interview would be conducted by telephone (a recorded interview) at your convenience. If you are interested, I can send you some information about the study so you can decide whether you might be willing to participate. Are you interested in receiving information? (if No, thank them for their time; If Yes, proceed to arrange sending information, and ask if I may contact them in the near future for future correspondence).

Via gatekeeper:

Hello. My name is Susan Haydt. I am a PhD student from the Department of Sociology and Social Anthropology at Dalhousie University in Halifax, Nova Scotia. Would you have a moment for me to explain my call? (If No, ask if I may call back later that day). (If yes, proceed as follows): I would like to reach [person of interest] to tell them about my Ph.D. research project about interdisciplinary team based primary health care delivery systems in Ontario, and to ask if they would like to participate in an interview with me by telephone at a time that is convenient for them. What would be the best way to reach them to provide them with a bit of information about the project?

Email Scripts

Direct contact:

Dear [name].

My name is Susan Haydt. I am a PhD student from the Department of Sociology and Social Anthropology at Dalhousie University in Halifax, Nova Scotia. I am conducting a research study for my Ph.D. about interdisciplinary team-based health care delivery

systems in Ontario, focusing on Family Health Teams, Community Health Centres, and Nurse Practitioner-led Clinics. The purpose of the study is to learn more about the history of these types of systems, and to learn more about how various health professional groups, governments, and community providers talk about actions taken regarding these systems. I would like to ask you to participate in an interview with me in your capacity as [position]. The interview would be conducted by telephone (a recorded interview) at your convenience. Would you consider participating? If so, please respond to this email and I will send you some information about the study.

I thank you for considering this request. If you have any questions please contact me at 902-494-6284, or reply to susan.haydt@dal.ca

Sincerely,

Susan Haydt
 Ph.D. Candidate
 Department of Sociology and Social Anthropology
 Dalhousie University
 Room 1128, 6135 University Avenue
 Halifax, NS B3H 4P9
 902-494-6284
susan.haydt@dal.ca

Via gatekeeper:

Dear [name of gatekeeper, if known, or simply, Hello if not known]

My name is Susan Haydt. I am a PhD student from the Department of Sociology and Social Anthropology at Dalhousie University in Halifax, Nova Scotia. I would like to reach [person of interest] to tell them about my Ph.D. research project about interdisciplinary team based primary health care delivery systems in Ontario, and to ask if they might consider participating in an interview with me by telephone at a time that is convenient for them. What would be the best way to reach them to provide them with a bit of information about the project?

Thank you very much for any assistance you might provide.

Sincerely,

Susan Haydt
 Ph.D. Candidate
 Department of Sociology and Social Anthropology
 Dalhousie University
 Room 1128, 6135 University Avenue
 Halifax, NS B3H 4P9
 902-494-6284
susan.haydt@dal.ca

Appendix E: Consent Form



*Faculty of Arts and
Social Sciences*

Study Information and Informed Consent Form

Study Title: Go Teams? A situational analysis of interdisciplinary team-based care delivery systems in Ontario

Introduction: You are invited to take part in a research study being conducted by Susan Haydt, a PhD candidate at Dalhousie University, for her dissertation. Your participation in this study is voluntary, and you may withdraw from the study at any time with no repercussions. The study is described below. This description tells you about the risks, inconvenience, or discomfort that you might experience. Participating in the study will not benefit you directly, but new knowledge might be obtained that will benefit others. You should discuss any questions you have about this study with Susan Haydt.

Investigator contact information:

Susan Haydt, M.A., Ph.D. Candidate (primary contact)

Department of Sociology and Social Anthropology
Dalhousie University
6135 University Avenue
Halifax, NS B3H 4P9
Ph: 902-494-6284
susan.haydt@dal.ca

Dr. Emma Whelan (Investigator's supervisor)

Department of Sociology and Social Anthropology
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Purpose of the study

The purpose of the study is two-fold. The first goal is to outline the history of interdisciplinary primary health care teams in Ontario. The other goal is to examine how various groups, including government, health professional groups, and health service providers talk about and/or contribute to actions taken regarding such teams, examining both points of agreement and contention among these groups, and focusing on Community Health Centres, Family Health Teams, and Nurse Practitioner-led Clinics.

Study design

This study will be based on analysis of documents about interdisciplinary team-based primary health care in Ontario, and analysis of interviews with approximately 35 people, including leaders of provincial health professional associations, provincial government representatives, leaders of associations representing the different types of teams, and leaders of select Community Health Centres and Family Health Teams. The people to be interviewed are chosen by the investigator,

based on her assessment of documents and knowledge of the history of interdisciplinary team-based primary health care in Ontario.

Who can participate in the study?

Representatives from the groups mentioned above will be interviewed in this study.

Who will be conducting the research?

All of the research will be conducted by Susan Haydt, the investigator.

What you will be asked to do

You are being asked to take part in an interview that lasts about an hour. In the interview you will be asked questions about the emergence of interdisciplinary primary health care teams in Ontario and the various forms these take (i.e., Community Health Centres, Family Health Teams, and Nurse Practitioner-led Clinics), and about the views and actions of your association or centre regarding interdisciplinary primary health care teams. This interview will be recorded and transcribed to ensure accuracy. The interview will take place by telephone at a time and place that are convenient for you, and at the investigator's expense. Below, you will be asked if anonymous quotes from this interview can be used in publications from the research study.

Confidentiality and anonymity

Anonymity: Your name will not be used in anything that is written or presented about this research. An identification number will be assigned to you, and the handwritten file that links your ID number and your name is kept in a locked drawer in the investigator's office at the university, to which only the investigator has access. While every effort will be made to ensure your anonymity, you may, by virtue of your position or the things you say in quoted excerpts used in the write-up of the study, be identifiable to others who know you, especially if you have taken clear stances on interdisciplinary care in public.

Confidentiality: The digital recording of your interview will be stored on the investigator's computer, and password protected with a password known only to her. The transcribed version of your interview will also be stored on the computer, and password protected. Your name will not be in it, and anything that identifies you that you may say during the interview will be changed or taken out when your interview is transcribed. All data collected during this study will be securely stored for five years after the last publication regarding the study is complete.

Your rights: You can choose not to answer any question that is asked. You can stop the interview at any time. If you choose to stop the interview, you can request that the recording of your interview be erased, or determine if the investigator may still use what you have said so far. You may withdraw completely by simply contacting Susan Haydt, up to 3 weeks after your interview. Upon your request she will destroy your interview recording and any typed version of your interview. After 3 weeks, it will no longer be possible to withdraw the information you provided from the ongoing analysis. Upon request, you can receive a copy of your transcript, and/or a summary of results.

Possible risks and discomforts

The investigator will be asking questions about many aspects of interdisciplinary primary health care teams, including questions addressing issues of contention between groups. There is a chance that such questions may make you uncomfortable. Keep in mind that you do not have to talk about anything you do not want to. Remain aware that those who are very familiar with the field of interdisciplinary care in Ontario may be able to figure out who you are.

Possible Benefits

The study will not help you directly, but it could provide a better understanding of how various groups, including government and professional groups understand and contribute to the creation interdisciplinary team-based primary care systems. This may contribute to an enriched understanding of the social origins of the resultant forms of such systems.

If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Patricia Lindley, Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance at (902) 494-1462.

Procedures to obtain your consent to participate

At the beginning of the telephone interview, the investigator will ask if you have any questions about the study or your participation.

The investigator will read the following statements to you to gain your consent to participate. Please verbally indicate yes or no to each:

1. I have read and understand the above information about the research study. I understand that my participation is voluntary, that I may withdraw from the study at any time, until three weeks post-interview, and that I may refuse to answer any question I do not wish to answer (Yes or No)
2. I consent to a recorded interview (Yes or No)
3. I consent to having quotes used in the dissertation or other publications. (Yes or No)
4. I would like a copy of my transcript sent to me, knowing my choices are by email or regular mail. (Yes or No)
5. I would like a summary of study results sent to me, knowing my choices are by email or regular mail (Yes or No)

Appendix F: Interview Guides

Interview Guides (no particular order):

1. Government Representatives
2. Professional Association/Regulatory College Leader

1. Semi-structured Interview Guide: Government representatives

[Greetings and thank you for talking to me today]

[Complete consent procedures]

[Provide very brief overview of the study as reminder of scope of study]

So very briefly, I'll remind you that this a sociological study about the development of interdisciplinary primary health care teams in Ontario since 2004 (focusing specifically on Family Health Teams, Community Health Centres, and Nurse Practitioner-led clinics) and the actions and perspectives of government, professional groups, and communities in shaping these delivery systems in Ontario. I am speaking to you today to gain your insights as [position] and your involvement in/knowledge of [PICK ONE PROCESS: the development of FHTs/the renewal of CHCs/the development of NPLCs].

[Proceed with the interview]

Questions:

- A. [Situate them: Their involvement (how they came to be involved) in **[PICK ONE PROCESS OF THE FOLLOWING THREE: the development of FHTs/the renewal of CHCs/the development of NPLCs]**
 - a. Can you tell me a bit about how you came to be involved [PICK ONE] as [position]?
 - b. What was your role/responsibility in [PICK ONE] as [position]?

- B. From your perspective as [position], why do you think the provincial government of the time (i.e., the McGuinty government) pursued [PICK ONE]?

- C. Could you outline (even roughly) how [PICK ONE] unfolded as a process? What were some of the things that had to happen to move the process along?
- D. Can you tell me about some of the major issues, if any, that you saw raised by various groups involved during [PICK ONE] (the issue raised, from what group, etc.) [ask for elaboration if needed among points raised]
- E. What were the points of contention you witnessed among various groups involved in the process? [ask for elaboration if needed among points raised].
- F. What were the points of agreement or consensus reached among the various groups involved? [ask for elaboration if needed among points raised]
- G. [if no mention of the others already] How does [PICK ONE] fit in with [THE OTHER PROCESSES]? (e.g., is one more likely to be pursued by gov't than others, for what reasons, etc.)?
- H. From your perspective as [position], what does the future hold for [PICK ONE]? What does it hold for [THE OTHER PROCESSES]?
- I. Do you have any other points you'd like to add?

[Conclude the interview. Thank them for their time]

2. Semi-structured Interview Guide: Professional Association/Regulatory College Leader

[Greetings and thank you for talking to me today]

[Complete consent procedures]

[Provide very brief overview of the study as reminder of scope of study]

So very briefly, I'll remind you that this a sociological study about the development of interdisciplinary primary health care teams in Ontario (focusing specifically on Family Health Teams, Community Health Centres, and Nurse Practitioner-led clinics) and the actions and perspectives of government, professional groups, and communities in shaping this system in Ontario. I am speaking to you today to gain your insights as a member of the [X] profession and your position as [position] in [Association/Regulatory College X].

[Proceed with the interview]

Questions:

- A. [Situating as member of Profession X]: First, I'd like to get a broad sense of your experience in [profession X]
 - a. How long (how many years) have you been a [profession]?
 - b. Are you a general practitioner or a specialist within your profession?
- B. [Situating as official of Professional Association/Regulatory College X]
 - a. How long have you been [position] of [Professional Association/Regulatory College X]?
 - b. In what ways, if any, has your involvement in [Professional Association/Regulatory College X] as [position] required your attention to or action regarding interdisciplinary primary health care teams? (i.e., during your tenure as [position], what sorts of issues or activities surrounding interdisciplinary primary care teams have arisen?
- C. [Respondent understanding of emergence of interdisciplinary care and/or team-based interdisciplinary primary health care and its relation to Profession X in Ontario].

- a. When did you first notice interdisciplinary team based care as a topic being discussed, or as something that was starting to be addressed by [profession X] in Ontario?
 - b. What were the issues of importance to [profession X] regarding this type of care at the time as you understood them? What was the talk among your colleagues in the profession?
 - c. [if not already addressed] Were there contentious issues for [profession X]? [if yes, probe for elaboration; determine if these are still current issues].
 - d. (Conversely), were there perceived opportunities or benefits from the perspective of [profession X] [if yes, probe for elaboration]
 - e. [if not already addressed] Overall, to what degree has the movement toward interdisciplinary primary care health teams affected [profession X]?
- D. [Profession X and interdisciplinary team-based primary health care in Ontario (the profession's more current stance(s), involvement(s) at a broader level].
- a. [If relevant] Can you tell me about the development of [Association/Regulatory College X's] policies regarding interdisciplinary team-based care? [i.e., the stimulus for developing the policy and a bit about the process]
 - b. [If relevant] Can you tell me more about [Association/Regulatory College X's] involvement in [address all committees or task forces as revealed in textual analysis portion of the study. If none revealed from the textual analysis, then ask as: Has [Association/Regulatory College X] had any involvement in any special committees or task forces with other groups dealing with interdisciplinary team-based primary care in Ontario? Can you elaborate on these?]
- E. The three models of team-based interdisciplinary primary health care in Ontario
- a. Association **involvement in** and/or **stances regarding** the development of Family Health Teams
 - i. Can you tell me about [Association /Regulatory College X's] involvement in the development of Family Health Teams.

- ii. [if no involvement, or to supplement textual analysis] What is [Association/Regulatory College X's] stance regarding Family Health Teams? [probe for any points of contention and for any points of consensus with the idea of these entities]
 - b. Association **involvement in** and/or **stances regarding** the renewal of Community Health Centres
 - i. Can you tell me about [Association/Regulatory College X's] involvement in the renewal of Community Health Centres in Ontario?
 - ii. [if no involvement, or to supplement textual analysis] What is Association/Regulatory College X's] stance regarding Community Health Centres? [probe for any points of contention and for any points of consensus with the idea of these entities]
 - c. Association **involvement in** and/or **stances regarding** the development of Nurse Practitioner-led clinics
 - i. Can you tell me about [Association/Regulatory College X's] involvement in the development of Nurse Practitioner-led Clinics in Ontario?
 - ii. [if no involvement, or to supplement textual analysis] What is Association/Regulatory College X's] stance regarding Nurse Practitioner-led Clinics? [probe for any points of contention and for any points of consensus with the idea of these entities]
 - F. As [position] of [Association X/Regulatory College], can you briefly speculate on the future of [profession X] with regard to interdisciplinary team-based care?
 - G. As [position] of [Association X/Regulatory College], can you speculate on the future of [Association X/Regulatory College] with regard to interdisciplinary team-based care?
 - H. Do you have any other points you'd like to add?
- [Conclude the interview. Thank them for their time]