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A qualitative study of collaboration in general practice: understanding the general practice nurse's role

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Abstract

Aims and objectives: To explore the nature of collaboration between registered nurses and general practitioners in Australian general practice.

Background: There is international recognition that collaboration between health professionals can improve care coordination, enhance health outcomes, optimise the work environment and reduce healthcare costs. However, effective collaboration requires a clear understanding of each team member's role.

Design: A qualitative approach guided by Naturalistic Inquiry was used to elicit and interpret participant narratives.

Methods: Eight general practitioners and fourteen registered nurses working in general practice were purposefully recruited. Data were collected via individual, semi-structured face-to-face interviews during February to May 2015. Interviews were audio recorded and transcribed verbatim. Data were analysed using thematic analysis.

Results: Data revealed three overarching themes. This paper presents the data for the overarching theme 'Understanding the general practice registered nurse's role'. Many general practitioner participants lacked clarity around the role and scope of practice of the registered nurse. At the same time, nursing participants often articulated their role as an assistant rather than as an independent health professional. This limited collaboration and the nurses' role within the team. Collaboration was enhanced when general practitioners actively sought an understanding of the registered nurses scope of practice.

Conclusion: Clarifying the nurses' role promotes collaboration and supports nurses to work to the full extent of their practice. This is important in terms of optimising the nurses' role within the team and reinforcing their professional identity.

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than as an independent health professional. This limited collaboration and the nurses' role within the team. Collaboration was enhanced when general practitioners actively sought an understanding of the registered nurses scope of practice.

Conclusion

Clarifying the nurses' role promotes collaboration and supports nurses to work to the full extent of their practice. This is important in terms of optimising the nurses' role within the team and reinforcing their professional identity.

Relevance to clinical practice

Identification of key issues around understanding the nurses' role may help inform strategies that improve collaboration and workplace relations.

Keywords

Australia, family practice, nurse-physician relations, primary care, qualitative, teamwork.

What does this paper contribute to the wider global clinical community?

- This study provides the reader with an insight into the concepts underpinning collaboration between registered nurses and general practitioners from the perception of these two groups.
- The paper highlights how role ambiguity limits the registered nurses practice and impairs collaboration in general practice.
- Analysis has identified the issues that challenge the registered nurse's professional identity in general practice and how these act as barriers to collaboration.

INTRODUCTION

There is growing recognition that no single professional can manage the increased prevalence of chronic and complex illness treated in the community (McKinlay *et al.* 2013, Samuelson *et al.* 2012). This has stimulated global interest in interdisciplinary collaboration to deliver safe, efficient and cost effective care (Gilbert 2010, McInnes 2015, Wagner *et al.* 2001). Wagner *et al.* (2001) describes the importance of interdisciplinary collaboration as a means of having the right health professional providing the right care at the right time for consumers. While collaboration between health professionals has been shown to improve care coordination, enhance client outcomes and reduce healthcare costs, it is predicated on a clear understanding of each team member's role (Barrett *et al.* 2007, Dieleman *et al.* 2004, San Martín-Rodríguez *et al.* 2005).

Poor role clarity is reported in the literature as a costly barrier to effective collaboration (Besner *et al.* 2011, White *et al.* 2008). Where there is role ambiguity, individuals often express frustration and report increased incidences of work place dissatisfaction and conflict (Akeroyd *et al.* 2009, Almost *et al.* 2016). Ambiguity is also linked to *ad hoc* negotiations regarding the nurses' role and a lack of clarity in their scope of practice (Merrick *et al.* 2012). Role clarity however, is reported to facilitate collaboration, role optimisation and professional identity (Besner *et al.* 2011, Phillips *et al.* 2008).

BACKGROUND

General practice provides primary care services within community settings. In Australia, this system has historically comprised of individual general practitioners (GPs) working in a small business environment (OECD 2015, Pearce *et al.* 2011). This financial arrangement exposes GPs to multiple pressures associated with clinical workload, practice ownership, employee contracts, regulatory demands and inter-professional relationships (McInnes *et al.*

In press, Sinsky *et al.* 2013). Despite these stressors and the perceived benefits of collaboration, there is little evidence to suggest that GPs collaborate with nurses to capitalise on available expertise in this dynamic environment (Besner *et al.* 2011, McInnes 2015).

While the practice nurses' role is well established in the United Kingdom and New Zealand, it is only in the last decade that nursing in Australian general practice has experienced significant growth and expansion (Halcomb 2014, Jolly 2007). The rapid growth in the general practice nurse workforce was largely brought about by Federal government policies which provide financial incentives to employ practice nurses (Halcomb *et al.* 2014, Medicare Australia 2016). Since 2007, the number of nurses working in Australian general practice has increased by over 4,000 nurses to now number approximately 12,000 nurses (AMLA 2012, ANMF 2014). Of these, the vast majority (86%) are general practice registered nurses (GPRNs) (AMLA 2012). While this shift in workforce seeks to manage the shortage of health professionals and the growing demand for primary care services, it also brings new challenges for staff as the nature of the workforce evolves.

There is an abundance of literature describing the roles of general practice nurses in Australia and internationally (Akeroyd *et al.* 2009, Halcomb *et al.* 2006, McCarthy *et al.* 2012, Merrick *et al.* 2012). Where nurses were once viewed as GPs assistants, they now play a central role in managing chronic disease, facilitating lifestyle risk factor modification and supporting acute health issues across the lifespan (Akeroyd *et al.* 2009, Condon *et al.* 2000, Halcomb 2005, McCarthy *et al.* 2012). However, there has been limited attention focussed on how this clinical role integrates with the care provided by general practitioners (McInnes *et al.* In press), or the impact of the growth in the general practice nursing workforce on the inter-professional relationships in this setting (Currie *et al.* 2010). While Australian general practice was once predominately characterised by sole GPs working in isolation, the growth of the GPRN workforce has coincided with a move towards large group and corporate

practices. Such changes have created significant shifts in ways of working and the need for health professionals to work both with others from their own profession and with other health professionals (Currie *et al.* 2010). The challenges created by such a shift have not been well explored.

In view of this, a qualitative study exploring the nature of collaboration between GPRNs and GPs was undertaken in Australian general practices. Given the richness of the data and the disparate themes which emerged, the data for the other themes are reported separately. Other themes present the influence of funding models on collaboration (McInnes *et al.* In press), and the collaborative practices between GPs and GPRNs working in Australian general practice.

METHODS

Study Design

This qualitative study used naturalistic inquiry to explore the narratives of both GPs and GPRNs. Naturalistic inquiry is founded on the ontological premise that "realities are wholes that cannot be understood in isolation from their context" (Lincoln & Guba 1985 p. 39), and that the relationship between the researcher and participant is interactive and inseparable (Lincoln & Guba 1985). Given the anthropological relevance of the researcher as an instrument, naturalistic inquiry relies on the responsiveness, adaptability and trustworthiness of the researcher to deliver credible findings (Lincoln & Guba 1985).

Sample and setting

General practitioners and GPRNs were purposefully recruited from two Primary Health Networks in New South Wales, Australia. Individuals were invited to participate if they had worked in a general practice employing a registered nurse for at least twelve months. Practices were located in city, metropolitan and rural settings and included solo practices

through to larger group practices. Due to their different scopes of practice and regulatory considerations, nurse practitioners and enrolled nurses were excluded.

Data collection

A semi-structured interview guide was developed following consultation with experts and an integrative review of the literature (McInnes *et al.* In press). In addition to identified questions, prompts were used to elicit further information and to clarify responses (Polit & Beck 2014). All interviews were audio recorded and to ensure consistency, were conducted by one researcher (SM) between February and May 2015. In all naturalistic studies the potential exists for the subjectivity of the researcher to influence the collection and interpretation of data (Darawsheh 2014, Lincoln & Guba 1985). To ameliorate this, reflexivity was incorporated into all aspects of data collection and analysis. The position of the lead researcher as a doctoral student with experience as a registered nurse and in general practice research was communicated to participants. Following each interview, reflective field notations were made to record the researcher's observations, thoughts and feelings. All audio recordings were uploaded to a professional transcription company and transcribed verbatim.

Data analysis

Analysis commenced following completion of the first interview. Transcripts were de-identified and assigned a unique code. Accuracy in transcriptions was confirmed through reading and listening to audio recordings at the same time. Transcripts were imported into NVivo 10™ and underwent an inductive process of thematic analysis as described by Braun and Clarke (2006). Data were coded by SM and categorised through a recursive process of moving back and forward through raw data (Braun & Clarke 2006). Codes were cross checked for accuracy by EH & KP registered nurse academics with extensive expertise in

qualitative and general practice research. A fourth research team member AB is an academic general practitioner who ameliorated the risk of introducing discipline bias. Differences were discussed and consensus on all themes was reached.

Ethical considerations

The ethical conduct of this study was approved by the University of Wollongong and the Illawarra Shoalhaven Local Health District Human Research Ethics Committee (approval number HE14/459). All participants were provided with an information sheet explaining the voluntary nature of the study and any risks and benefits of their participation. Participants signed an informed consent and gave additional verbal consent prior to commencing the audio recording of interviews.

Rigor

Quality in this study was established through addressing components of trustworthiness described by Lincoln and Guba (1994, 1985). A prolonged and rigorous process of analysis, reflective journaling, peer debriefing and achieving data saturation helped establish rich and credible findings. Diversity in the sample has facilitated external judgement and transferability. Dependability was established through clearly describing the purpose of the study, its setting and participants. Confirmability was addressed through the independent cross checking of codes and reaching consensus around themes.

RESULTS

Eight GPs and fourteen GPRNs participated in individual interviews (Table 1). The gender of the GP voice is represented equally in the findings. Data from the overarching qualitative study revealed three themes, namely; *the influence of funding models on collaboration, Understanding the general practice registered nurse's role* and *Understanding collaboration in general practice.* Each of these overarching themes has several sub-themes. Given the

depth and richness of the data with each theme they have been presented separately in individual publications.

This paper reports on the overarching theme: *Understanding the general practice registered nurse's role;* and its three sub-themes. The first sub-theme: *The importance of role clarity*, explores the link between role clarity and collaboration. The challenges GPRNs experienced in establishing their professional identity is described in the second sub-theme: *The GPRNs' perception of their own identity*. The value of the GPRNs role in collaborative care is presented in the final sub-theme, *Appreciating the GPRNs' expertise*.

Table 1: Participant characteristics

Participant Characteristic	**GPRN (n)**	**GP (n)**
Total	14	8
Gender: Female	14	4
Age: Mean years (range)	30-59	42-62
(average)	49.6	54.5
Highest Qualification (GPRN):		
Hospital certificate	8	-
Bachelor Degree	5	-
Masters	1	-
Average number of years worked:		
As a RN	24.8	n/a
In general practice	8.6	20.25
GPs and GPRNs working @ this practice:	1-6	1-16
Employment status:		
(Full time)	4	3
(Part time)	10	5

The importance of role clarity

Many GP participants admitted *"not having a good understanding of what they can do for you, what a practice nurse can do for you"* (GP3). As evidence that GPs may not have a full appreciation of the GPRNs scope of practice, GP4 described that; *"sometimes on rare occasions we might get the nurses to actually talk to patients about quitting smoking or just*

general dietary advice" (GP4). So whilst patient education and lifestyle risk factor modification are well within the nurses' scope of practice this comment identifies that these skills are rarely enacted by this participant.

A further misconception expressed by some GP participants was that they were responsible for the supervision of RNs. *"We are supposed to be supervising. I've got a nurse just right opposite my door so I'm in and out a lot. So I am supervising"* (GP7). While as an employer, GPs hold a level of responsibility for patient safety, in Australia the RN is a licensed health practitioner who is responsible for their own clinical practice.

The age of GP participants was perceived by GPRNs to influence their willingness to adopt collaborative practices. Older GPs appeared to "*struggle with the team approach and the collaborative care that the nurses bring*" (RN7), "*the Y Generation doctors are a lot different. I think they actually have a little bit more respect perhaps for the nursing contribution*" (RN7). A willingness by younger GPs to seek and openly discuss the skill set of individual GPRNs facilitated an understanding of the GPRNs' scope of practice and their role within the team. This was viewed by GPRN participants as a positive move towards collaboration.

> *"The newer GPs honestly come in and just say look I don't know what you do. Can I sit with you and can you show me or can you tell me - weekly they are surprised at either the level of care that we can give or the in-depthness of a health assessment for example"* (GPRN10).

Reflecting on previous experiences, GPRN5 commented;

> *"I think it's a constant battle to educate them [GPs] on what we can actually do. …we're nowhere near respected enough for what*

knowledge we have and what experience we bring to the role" (GPRN5).

Recognising the importance of role clarity, some GPRNs actively sought to explain their scope of practice with GPs. "*Whenever I start working with a doctor I tell them what my skill set is and sometimes I remind them what my skill set is"* (GPRN3).

The confusion around the nurses' role translated to some GPRN participants articulating being allocated specific tasks rather than engaging in collaborative practice. "[I'm] *Running in and out of their offices all day, asking questions, they're telling me what they'd like me to do*" (GPRN4).

GPRN participants felt that enhanced role clarity could support them to work to the full scope of their practice and expressed a desire to work collaboratively in organisational decision making;

"Nurses have been saying, give us more, we don't want to be sitting here. Not that we're really sitting here twiddling our thumbs. But we need to be more involved in chronic disease management. We need to be more involved in the nuts and bolts" (GPRN11).

However, in the absence of well-defined job descriptions, the GPRNs role lacked clarity as all nurses were considered as a homogeneous group regardless of individual education, skills or clinical experience.

"neither [my partner] nor I have really discussed it [job descriptions]. They're [GPRNs] just responding to doing a usual nursing role involving doing care planning, health assessments, helping with excisions and aspirations and dressings, the usual things that nurses would do in a hospital system" (GP4).

A lack of a clearly defined nursing roles often meant that GPRNs were asked by their employing GP to perform administrative tasks;

> *"there was a description of sorts, but over the years my work has slowly evolved into doing reception so the receptionist can have lunch….. Sometimes I just want to be the nurse but I respect the Dr and I do what [GP] asks me to do. It's as simple as that" (*GPRN1).

The underutilisation of GPRNs prompted several others to articulate that they felt they had more to contribute within the framework of a collaborative team. *"I think if they [GPs] can see something where I'm going to save them time, I would do that. Do they see the potential of what nurses can do? No"* (GPRN6). Some GP participants similarly identified that the GPRNs potential had not yet been achieved.

> *"I mean we could probably do more with nurses than we're doing. Over the years we're using them more and more. There's more potential than we're using" (GP7).*

Many participants however, acknowledged that the busyness of the practice created a level of inertia that prevented a forward movement in understanding and working together. As GPRN4 explained; *"I think sometimes you're just too busy. Yeah, that's a hassle".*

The GPRNs perception of their own identity

Several GPRN participants described their role as being ancillary and supportive to the GP; *"Part of my job is to look at the doctors' schedule each day and see what I can do to help them"* (GPRN6), and; "*I always thought the nurse's job was to make the doctor's life easier" (*GPRN3*).* Despite extensive clinical nursing experience, many GPRN participants did not position themselves as independent health professionals who could add value to the delivery of care beyond reducing GP workload. This perception was reinforced by GPs who described

the GPRNs role as; *"mainly as a support person for me"* (GP3). GP2 described "*I mean, if we're lacking something from the equipment and so on, she's also the one which (is) organising that. I don't think we've [GPs] got the time for that*."

Proactively asserting their scope of practice did not come naturally to many GPRN participants, particularly those who had completed their initial qualifications within the hospital system. Tertiary educated GPRNs, however, were noticeably more assertive in communicating their expertise with GPs and establishing their professional identity. *"Being really confident of what our abilities are and saying how - reaffirming to the doctors that we are our own practitioners"* (GPRN10).

The delegation of tasks by GPs did little to develop the GPRNs professional identity or their position within the team environment; *"They just send me a message saying, do an ECG on this woman, do spirometry on this woman, do audiology on this person" (*GPRN4). Indeed, it was evident that the delegation of tasks could limit collaboration when responsibilities, decision making and patient goals were not shared; *"I don't know what's wrong with these patients, unless [GP] tells me for some reason"* (GPRN1).

Appreciating the GPRNs' expertise

In some clinical areas, such as immunisation, diabetes and wound management, GP participants recognised GPRNs as experts and sought their clinical advice. *"I just assume that most of our nurses are better at wounds than I am [laughs]"* (GP5). *"I just say, look, really I think that needs a dressing, let's get the nurse in, see what she recommends"* (GP7);

When their experience was recognised by GPs in this way GPRNs expressed a sense of satisfaction. *"He [GP] knows that I'm doing this reproductive and sexual health course at the moment. He wanted to just check that he was testing for everything that he should be. That's really nice"* (GPRN5).

Conversely, a level of dissatisfaction was demonstrated when responsibilities and decision making were not shared collaboratively or were removed from GPRNs.

> "*To me, if the problem's there, it should be me, within my scope of practice, to be able to identify the problem and then to be able to discuss that with the doctor,….but [for a GP] to actually come in to just say, yes, that's fine, see you later, it's quite insulting for the patient, the nurse or where people are sitting"* (GPRN9).

It was highlighted however, that the GPRNs role was still developing and required a period of adjustment to resolve issues around role boundaries and the distribution of clinical tasks.

> *"It's an expanding role. I can't imagine how we coped without them now. It has taken some getting used to on the parts of the doctors and the nurses to delineate the roles to start with and then to become comfortable with them doing more of the stuff we do"* (GP8).

DISCUSSION

Other data generated from this study has identified ways that funding impacts collaboration between GPRNs and GPs and report the collaborative practices between GPs and GPRNs working in Australian general practice. The data presented in this paper provides new insight into issues around role clarity and the influence of this on collaboration between GPs and GPRNs. It was evident that many participants did not have a clear understanding of the GPRNs role and scope of practice. Indeed, many participants failed to distinguish roles from tasks (Akeroyd *et al.* 2009, Besner *et al.* 2011). Similar to the international literature, the lack of clarity around the GPRNs role appeared to decrease collaboration and the GPRNs potential within the general practice team (Akeroyd *et al.* 2009, McCarthy 2012, McInnes 2015). While it has been suggested that clearly defined roles are an important feature of effective

healthcare teams (Suter *et al.* 2009), a lack of understanding around different team members' roles was a potential source of team conflict (Almost, Wolff et al. 2016). Given the private nature of general practices in Australia and the potential for role conflict to impact team dynamics, job satisfaction and retention, it is vital that each team members role is clarified (Brookes *et al.* 2007, Chen *et al.* 2007).

The delegation of tasks by GPs resonates with the literature (seeMacBride-Stewart 2013, McInnes 2015, Pearce *et al.* 2011), and did little to promote collaboration. It was evident that the practice of delegation limited the nurse's role and was largely viewed by GP participants as a strategic measure to enhance their own efficiencies (McInnes *et al.* In press). Many GPRN participants were frustrated by the delegation of tasks and perceived that this limited the development of their role. This is consistent with other studies undertaken in Australian general practice where GP delegation seemingly restricted the GPRNs practice and utilisation (Halcomb *et al.* 2008a, Halcomb *et al.* 2008b).

The frequency with which GPRNs articulated a lack of clear job descriptions is comparable with findings by Allard *et al.* (2010), and has previously been identified as a barrier to role development (Halcomb *et al.* 2014). The presence of generic or vague job descriptions in this study were seen to exacerbate role ambiguity, did little to alleviate role blurring, limited the utilisation of GPRNs and ultimately reduced collaboration between GPs and GPRNs (Almost *et al.* 2016). Clear and concise job descriptions that reflected the GPRNs' education and expertise helped clarify the GPRNs' scope of practice and optimised their role within the clinical team.

Data from this study revealed a tendency by many GPRN participants to articulate their role as an assistant to the GP rather than as an independent health professional. This perception of their role was perhaps exacerbated by GPs who viewed the GPRNs role as supportive to their

own (Juruseviciene *et al.* 2013), and influenced by the small business model whereby the GP is also often the employer (McInnes *et al.* In press). While older literature has described a handmaiden type role (Willis *et al.* 2000), more recent literature presents the general practice nurse in an expanded and professional role (Halcomb *et al.* 2016, Mills & Fitzgerald 2010, Pascoe *et al.* 2005). Despite this, Parker *et al.* (2011) report how some "nurses are happy to remain in the 'hand-maiden' role" (p. 229). Regardless of the antecedents, professional identity is a vital component in ensuring high functioning nurses and an important feature in developing the level of professional confidence required to effectively participate in collaborative care (Besner *et al.* 2011, Guzys 2013, Johnson *et al.* 2012).

Previous research has demonstrated the feasibility and acceptability of nurse delivered care in general practice and the importance of this in terms of meeting the demands of chronic and complex illness (Halcomb *et al.* 2015, Hegney *et al.* 2013). Findings from this study demonstrate that significant gains can be made to the utilisation of GPRNs by implementing strategies that clarify the nurse's role and supports them to work to the full extent of their practice (Lane *et al.* 2016). Such strategies have the potential to improve collaboration, job satisfaction, retention and the professional identity of these nurses.

Limitations and strengths

As a naturalistic inquiry, this research adopted a purposeful sampling technique. It is possible that only participants with a particular viewpoint volunteered to participate. Whilst data saturation was achieved, the sample of general practitioners was not large. However, all participants were employed within a private enterprise and recruitment in this healthcare sector is known to be challenging (Halcomb *et al.* 2014, Jones *et al.* 2012). Additionally, presenting findings in a series of papers, each of which explore a single theme has its limitations. However, the richness of data and the complexity of the issues which emerged

made it impractical to report all themes in a single publication. To facilitate linkage other papers have been cited within this paper to allow the reader to further explore other aspects of the data. A significant strength of this paper is that it explored issues around collaboration from the perspective of both GPs and GPRNs. Comparing and contrasting these perspectives provided a deeper insight than would have been possible from a single perspective.

CONCLUSION

The dual role of GPs as employers and clinical colleague appeared to increase the complexities of collaboration between GPs and GPRNs. While inter-professional awareness was viewed as a facilitator to collaboration and supported GPRNs to work to the full scope of their practice, it is evident that issues around role clarity need to be resolved. Despite the workload and busyness of general practice, time to develop a mutual understanding of the GPRNs role has been shown to facilitate collaboration between GPs and GPRNs. Additionally, the implementation of strategies to strengthen the professional identify of GPRNs may assist them to feel more confident in engaging in dialogue around their role within the general practice team.

RELEVANCE TO PRACTICE

Findings suggest that there is a spectrum of understanding around the registered nurse's role in general practice. There are several implications of this to practice. Firstly, a mutual understanding of the nurse's role clearly maximised collaboration between GPRNs and GPs and provided the scope to improve the timely delivery of quality care. Secondly, this study highlights ways that role ambiguity limited collaboration and the nurse's role within the clinical team. Finally, clarity in the nurse's role positively influenced the nurses' professional identity and their willingness to engage in collaborative practices. Insight into these issues

has the potential to increase the role of GPRNs and to inform strategies that enhance the coordination of care in general practice.

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CONTRIBUTIONS

Study design: SM, EH; data collection: SM; analysis: SM, KP, EH. All members of the research team were involved in confirming themes and the editing this paper.

CONFLICT OF INTEREST

None declared

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