Physicians' Perceptions

of

Nurse Practitioners and Collaboration

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A practicum project submitted in partial fulfilment
of the requirements for the degree of Master of Nursing

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THE UNIVERSITY OF MANITOBA

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Master's Thesis/Practicum Final Report

The undersigned certify that they have read a Master's Thesis/Practicum entitled:

"Physicians' Perceptions of Nurse Practitioners and Collaboration"

submitted by **Jane A. T. MacDonald**

in partial fulfillment of the requirements for the degree of

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The Thesis/Practicum Examining Committee certifies that the thesis/practicum (and the oral examination, if required) is:

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BY

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A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of

Master of Nursing

ABSTRACT

Physicians' Perceptions of Nurse Practitioners and Collaboration

The nurse practitioner is a relatively new member of the health care team in Manitoba. A collection of agencies have worked both independently and mutually since the mid 1990s to formally implement the nurse practitioner role. Manitoba Health, Winnipeg Regional Health Authority, Manitoba Association of Registered Nurses, College of Physicians and Surgeons and University of Manitoba Faculty of Nursing have all been involved. While it is envisioned that the nurse practitioner role will mesh with the physician role in a collaborative relationship, a paucity of literature exists that examines physicians' perceptions of nurse practitioners and collaboration with nurse practitioners.

This qualitative project explored physicians' knowledge of nurse practitioners and perceptions of collaboration with nurse practitioners. Focus group discussions with eleven physicians (8 resident physicians and 3 faculty physicians) were conducted to develop an understanding of their knowledge and perceptions. Both resident and faculty physicians had specific, yet largely contrasting concerns about the nurse practitioner role, which subsequently influenced their perceptions of collaboration with nurse practitioners. Resident physicians tended to accept the nurse practitioner

role but were restrictive in terms of responsibilities and capabilities. Faculty physicians tended to view the nurse practitioner role and collaboration without limitations but very much dependent on the individual nurse practitioner and his/her background, personality and ability.

It is hoped that the findings of this project will contribute to the body of knowledge about physician and nurse practitioner collaboration. Additionally, themes emanating from this project may guide future discussions between the disciplines with respect to nurse practitioners and collaboration with nurse practitioners.

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While formally these pages represent only a partial requirement for a Master's degree, theoretically they reflect the culmination of two years of course work, and symbolically a journey that has taken my family and myself to a better place.

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To the resident and faculty physicians at Family Medical Centre who participated in this project, thank you for speaking freely and honestly in my presence. Your openness has reinforced in me the importance of trying to understand others.

To my girls, Caitlin and Elise, thank you for your patience, support and understanding; I only hope I have demonstrated to believe in yourselves - don't let anyone stomp on your dreams. And lastly to my husband, Randy, my best friend and greatest supporter - these past two years you have unselfishly given of yourself as usual, in support of my pursuit for more...thank you.

TABLE OF CONTENTS

Chapter Four - Findings (continued)...

LIST OF FIGURES

CHAPTER ONE - DESCRIPTION OF PROBLEM

Introduction

Collaboration between health care professionals may be defined as a dynamic interprofessional process of interaction that synergistically influences client care (Way, Jones & Busing, 2000). The success of collaboration is built on the mutual trust and respect of the unique and complementary perspectives each discipline brings to the relationship (Buchanan, 1996; Makaram, 1995; Torres & Dominguez, 1998; Venegoni, 2000). Both client and professional may benefit from such a relationship including enhanced care for the client and increased job satisfaction for the professional from working with other professionals (Makaram, 1995; Norsen, Opladen & Quinn, 1995; Stichler, 1995; Venegoni, 2000; Way et al., 2000). The literature suggests that a collaborative relationship between nurse practitioners and physicians in particular may be an efficient approach to providing health care, yet a number of barriers exist which may impede the process including issues surrounding role definition, liability and degree of autonomy of nurse practitioners.

In Manitoba, there has been a movement to formally establish a relatively new role in the health care team - that of the nurse practitioner. It is envisioned that the advanced practice role of the nurse practitioner will mesh with the physician role in a collaborative relationship. Discussions regarding

collaboration involve the consideration of differing points of view depending on one's position within the health care system. Developing a greater understanding of physicians' perceptions of collaboration with nurse practitioners may contribute to defining the collaborative relationship and was the subject of this practicum project.

Manitoba Perspective

In 1997, Manitoba Health's Provincial Nursing Advisor's Office released a decision paper entitled "The Registered Nursing Role in Primary Health Care". The document identified the need for an advanced practice nursing role in primary care, with the acknowledgement of certain challenges to implementing the role including educational preparation, legislative issues, funding and public education. Primary stakeholders were given the task of fulfilling their particular challenge. The result has been overall progress towards the development of a nurse practitioner role in primary care (Manitoba Health, 1997).

The University of Manitoba Faculty of Nursing is entering its fourth year of offering a two-year Master's program in Primary Care Advanced Practice Nursing, aimed at preparing graduates to work as nurse practitioners in the community. Two nurse practitioners graduated in 2000, and four more are expected to graduate in 2001.

The Manitoba Minister of Health, the Honourable David Chomiak, has

publicly endorsed the nurse practitioner role. He has also supported changes by the Manitoba Association of Registered Nurses (MARN) to the current provincial Registered Nurses Act to include language for nurses working in advanced nursing roles. Bill 36 has been passed by the legislature, with proclamation anticipated for August 2001. Once proclaimed, the development of regulations and standards for nurse practitioners can begin (D. Wilson-Mate, Director of Policy Development and Regulation, MARN, personal communication, March 07, 2001).

The Winnipeg Regional Health Authority (WRHA) released a position paper in January 2001 regarding the role of advanced practice nursing within the Authority, which specifically identifies the nurse practitioner role in collaboration with primary care physicians. The WRHA is currently lobbying for funding to establish a number of nurse practitioner positions (M. Robinson, Director of Primary Care and Program Integration, WRHA, personal communication, March 02, 2001).

The main parties involved in these discussions (Manitoba Health, WRHA, MARN & College of Physicians & Surgeons - Manitoba) visualize the nurse practitioner role meshing with the physician role in a collaborative relationship. Each party has its own interpretation of the nurse practitioner role and the meaning of collaboration. While collectively the parties share the goal of providing health care to the people of Manitoba, each of them contribute uniquely to that goal by virtue of their respective mandates.

Background

The nurse practitioner-physician relationship involves the interaction of two professions, each bringing a different approach to client care based on separate education and training. On the one hand, a nurse practitioner typically has a four-year baccalaureate nursing degree, followed by two years of graduate education. On the other hand a physician has a four-year baccalaureate degree, four years of medical school, and at least two years of residency. Nursing education tends to focus on health of individuals and families throughout the life span, whereas physicians are primarily educated in diagnosis and treatment. In a collaborative relationship, nurse practitioners spend more time with clients and manage their basic needs, while physicians manage more complex medical problems, resulting in a more effective health care team (DeAngelis, 1994).

Collaboration involves several benefits to the two practitioners. A collaborative relationship takes time to develop, but the rewards often lead to a greater understanding of each other's roles and responsibilities, improved satisfaction with one's own work, and enhanced valuing of working with others. Other positive outcomes are improved confidence and respect, changes in attitude toward collaboration among health professionals, increased productivity and effectiveness, and enhanced professional development (Arcangelo, Fitzgerald, Carroll & Plumb, 1996; Makaram, 1995; Stichler, 1995).

While ideological support for nurse practitioners and their collaboration with physicians is in abundance, considerable debate still occurs within the medical profession as to the actual role of nurse practitioners in collaborative arrangements with physicians (DeAngelis, 1994; Makaram, 1995; Mundinger, 1994). The introduction of nurse practitioners has been met with trepidation by some physicians, despite the benefits cited in the literature. While the medical community in general accepts the concept of the nurse practitioner and acknowledges the supporting literature on collaboration, physicians' concerns seem to focus more concretely on **how** the nurse practitioner role should mesh with their own role, not **if** it should (DeAngelis, 1994; Makaram, 1995; Mundinger, 1994; Sox, 2000). Physicians' concerns regarding collaboration with nurse practitioners revolve around issues such as scope of practice, degree of autonomy, liability, cost effectiveness and role definition (Arcangelo et al., 1996; DeAngelis, 1994; Sox, 2000).

Physicians are generally supportive of nurses with advanced training working with them, yet some report feeling threatened by nurses expanding their practice into the traditional domains of medical practice (DeAngelis, 1994). Inconsistent terminology and conceptualization as well as variations in training requirements have led to confusion about the nurse practitioner role (DeAngelis, 1994). DeAngelis (1994) stated that collaboration between nurse practitioners and physicians at an organized level was pursued in the 1970s in the United States, but did not succeed due to disagreement on issues of

control related to nurse practitioner scope of practice. This remains a current point of debate in the United States.

The definition of the scope of practice of nurse practitioners is an area of contention. The Canadian Nurses Association (CNA) defines scope of practice for all nurses as "the activities nurses are educated and authorized to perform, as established through legislated definitions of nursing practice complemented by standards, guidelines and policy positions issued by professional nursing bodies" (May 2000, p.17). Until Bill 36, (revised Manitoba Registered Nurses Act) is proclaimed and the attendant regulations developed, individually negotiated contracts are necessary to define the scope of practice for nurse practitioners.

Limited knowledge of disciplinary approach, lack of common goals, poor communication, and lack of recognition for the need to collaborate are other issues of concern to physicians and nurse practitioners (Arcangelo et al., 1996; Blickensderfer, 1996; Makaram, 1995). One physician was quoted as saying that the underlying message he received from nursing was that medicine needed to change its behaviour in order to collaborate, whereas nursing did not acknowledge its own need to change (Alpert, Goldman, Kilroy & Pike, 1992). Fagin (1992) challenged nurses to identify barriers between themselves and physicians, and urged them to propose strategies to change, recognizing that formidable cognitive and perceptual barriers must be overcome to achieve effective collaboration. Huntington and Shores (1983)

stated that taking risks to confront others on difficult issues, tempered with mutual respect and sensitivity, can lead to clarification of issues and discovery of common ground. By developing an understanding of physicians' perceptions of collaboration and potential barriers, nursing has the potential to develop strategies to overcome some of the gaps, and thus improve the collaborative relationship.

Purpose of the Project

At present, the bulk of literature regarding nurse practitioner-physician collaboration is written by nurses. Several articles report successful collaborative relationships, but the context is outside Manitoba and most are in the United States (Hawkins & Thibodeau,1996; Kyle, 1995; Norsen et al., 1995; Payne & King, 1998; Rauckhorst, 1989; Torres & Dominguez, 1998; Walton, Jakabowski & Barnsteiner, 1993). What does exist concerning a physician's perspective is mostly anecdotal, with only a few studies utilizing a formal research method. In-depth knowledge of physicians' perceptions could enhance an understanding of collaboration and its challenges. The purpose of this project, then, is to address the need for in-depth knowledge, and develop an understanding of physicians' perceptions of nurse practitioner-physician collaboration. A better understanding of their perceptions may aid in integrating the nurse practitioner role within the Manitoba primary health care system. Specifically, the following six questions

were addressed in this project:

- What do physicians know about nurse practitioners?
- How do physicians visualize the nurse practitioner role?
- Are physicians ready to collaborate with nurse practitioners?
- What do physicians perceive to be the benefits and disadvantages of a collaborative relationship?
- What elements do physicians identify as contributing to the establishment of a successful collaborative relationship?
- What do physicians need in order to move towards a greater acceptance of the nurse practitioner concept?

Significance of the Project

It is anticipated that the results of the project will provide a basis for understanding physicians' perspectives of collaboration with nurse practitioners. Furthermore, nurse practitioners' acknowledgement of physicians' concerns about their role will facilitate communication between the two professions.

Operational Definitions

The definition of a nurse practitioner comes from the WRHA document "Position Paper on Advanced Practice Nursing in the WRHA" (2001):

nurse practitioner: "a skilled health care provider who utilizes critical

judgment in the performance of comprehensive health assessments, differential diagnosis, and the prescribing of pharmacological and non-pharmacological treatment in the direct management of acute and chronic illness and disease ... integrates health promotion and illness prevention strategies in the application of advanced nursing knowledge" (p.2).

With respect to collaboration, a definition of the Ontario College of Family Physicians will be used:

collaboration: "an inter-professional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided" (Way et al., 2000, p.3).

Conceptual Model

Elements from a collaborative model published in 2000 by the Ontario College of Family Physicians (Way et al.), hereafter referred to as the Ontario Model, was utilized to provide direction for this project. Barriers and benefits to collaboration identified in the literature were also used. The advantage of the Ontario Model is its identification of elements that are dynamic and interpersonal. The model is broadly based and promotes flexibility and transferability in implementation of the collaborative process, whereas other collaborative models have been developed to fit certain organizational or structural characteristics already in place.

Seven elements have been identified in the Ontario Model as essential to successful collaboration. They are:

Responsibility and accountability, implying that both the nurse practitioner and physician are jointly accountable for decision making with respect to client care, and both accept responsibility for the outcomes of those decisions.

Coordination is the "efficient and effective organization of the necessary components of the treatment plan" (Way et al., 2000, p.5). This element requires that partners coordinate client care based on who is most qualified to address the client's problem, thereby reducing duplication and fragmentation of care.

Communication is the succinct, clear and concise exchange of information in an atmosphere of respect and equality. When this element is present, each partner will feel that his/her opinion is being heard by the other, and will reciprocate with respectful listening. There should not be feelings of superiority or inferiority, but rather an atmosphere of mutual support and affirmation.

Cooperation involves the respect and acknowledgement of each partner's approach to care.

Assertiveness is linked to cooperation. Respect and acknowledgement for each other's discipline (as defined under cooperation) should create an atmosphere which allows each discipline to present

opinions resulting in the integration of approaches into a synergistic solution for client care.

Autonomy allows for the independent action and decision making of each partner when carrying out a treatment plan. In Manitoba, a nurse practitioner's autonomy is guided by the Registered Nurses Act, with separate agreements negotiated between the nurse practitioner and employer as to delegation of medical functions not covered in the Act. Physicians are guided by the provincial Medical Act. Each partner is liable for independently made decisions and outcomes. It is important that each partner recognize and understand the other's scope of practice to support shared decision making.

Mutual trust and respect is the element that binds all the others together and forms the foundation for success in collaboration.

Conclusion

Nurse practitioner-physician collaboration has as its ultimate goal to enhance client care. Increased productivity, increased job satisfaction and confidence in knowing that optimum care is being provided are some of the reported consequences of collaboration.

Collaboration takes time and effort to evolve with certain key elements necessary for success. A firm understanding of each discipline's roles and responsibilities, common goal sharing and effective communication are some of the elements imperative for collaboration to reap the maximum rewards for

all involved.

Collaboration of physicians and nurse practitioners has been identified in Manitoba as a means to enhance primary care services to the public. There has been support for the nurse practitioner role from a number of key sectors, including the medical profession. While the health care community supports the nurse practitioner concept, debate surrounds role definition and how this role might fit in a collaborative relationship with a physician. Common themes of concern that emerge in the literature are level of independence, degree of autonomy, communication methods and prescriptive authority.

Development of a greater understanding of physicians' perceptions of collaboration with nurse practitioners, and nurse practitioners' acknowledgement of physicians' concerns about the nurse practitioner role, will facilitate communication between the two professions. It was the subject of this practicum project.

CHAPTER TWO - LITERATURE REVIEW

Introduction

This chapter is divided into two sections. The first section provides a historical overview of the nurse practitioner movement in Manitoba and Canada, along with references to the role in the United States. Issues surrounding education, practice and autonomy are discussed. The second section explores the concept of collaboration. Benefits and disadvantages of collaboration are examined in detail, along with in-depth analysis of existing research of physicians' perceptions of nurse practitioners. The Ontario Model elements of collaboration, those qualities necessary for collaboration to succeed between two professionals, are also discussed.

Nurse Practitioners

Introduction

The term, nurse practitioner, is commonly used in the United States, with the role now well established since its inception in the 1960s. The nurse practitioner role is now gaining momentum in other parts of the world. Both the United Kingdom and Australia are experiencing expansion of this role within their respective health care systems (Keyzer, 1997). In Canada, the nurse practitioner movement initially parallelled that of the United States, faltered for a variety of reasons, but is now resurfacing. In this section, an

overview of the nurse practitioner movement in the United States, Canada and Manitoba is provided, along with explanation of education, roles and responsibilities, autonomy and research support for the role.

Brief History of the Nurse Practitioner Movement

United States

The first nurse practitioner program in the United States was initiated in 1965 at the University of Colorado as a means of providing comprehensive pediatric primary care through the use of nurses in expanded roles (Bigbee, 1996). The advantages of the program were soon recognized and other programs followed in other universities. By 1992, there were approximately 50,000 nurse practitioners in the United States, practising in a variety of settings and a number of specialties (Bigbee, 1996). Each state has different legislation regarding scope of practice, reimbursement, liability and prescriptive authority, with the trend being towards a higher level of independence for the nurse practitioner (Harper, 1996). Educational preparation for a nurse practitioner has been possible through either certificate or graduate programs, but the emphasis and current standard is on graduate preparation. Mechanisms for certification and credentialing are available through several means depending on the specialty (Harper, 1996).

Canada

Discussion regarding the nurse practitioner concept began in Canada in the 1960s as a result of several issues: a perceived physician shortage, the

effects of a trend within medicine towards specialization, and changing roles in nursing (CNA, February 1993). In 1971, the Boudreau Committee was established by the federal government to study the role of the nurse practitioner in the overall pattern of Canadian health services. The committee's report, released in 1972, recommended high priority development of the nurse practitioner role to meet primary health care needs in Canada. In 1973, the CNA and the Canadian Medical Association released a joint document with recommendations for the delegation of certain medical tasks to nurses. Subsequent formation of a number of university programs for nurse practitioner preparation across Canada occurred, but by the mid 1980s, momentum for the nurse practitioner role dissipated and the programs were cancelled (CNA, February 1993). This dissolution was attributed to a surplus of physicians, incorporation of nurse practitioner program content into regular degree programs and lack of funding for these relatively expensive programs (CNA, October 1993).

The current climate of health care reform has led to renewed discussion of the nurse practitioner role. Economic recession, decreased federal transfer health payments to the provinces and recommendations of both provincial health care commissions and task forces earlier in the 1990s have all contributed to this renewed interest in the nurse practitioner role (CNA, October 1993). Ontario, Newfoundland and Alberta have legislation in place for the expanded nursing role, while the remaining provinces and

territories are following with their own initiatives and respective political approaches (D. Wilson-Mate, Director of Policy Development and Regulation, MARN, personal communication, March 07, 2001).

Manitoba

The national nurse practitioner movement in the 1970s inspired a 1974 MARN position paper on nurse practitioners. At the same time, a one year program was initiated at the University of Manitoba to provide advanced clinical skills for community nurses. The position paper did not lead to further development and the university program was closed after the first year. Thus ended Manitoba's brief foray into nurse practitioners (MARN, May 1994).

In the early 1990s, discussion of formal nurse practitioner role development resurfaced in Manitoba amidst a climate of health care reform, due mainly to decreased federal transfer health payments and an overall economic recession. The 1997 decision paper "The Registered Nursing Role in Primary Health Care" released by the Manitoba Health Provincial Nursing Advisor's Office, has been pivotal. As a result of the decision paper, primary stakeholders initiated the respective changes necessary for the development of the nurse practitioner role: MARN initiated changes to the RN Act to include language for advanced practice nursing roles, the University of Manitoba Faculty of Nursing has developed a graduate program to prepare nurse practitioners, and the WRHA has taken steps to create nurse practitioner positions.

Nurse Practitioner Education

In the United States, a variety of nurse practitioner education options were available, but this educational diversity resulted in role confusion within and outside of nursing. The current trend is towards graduate preparation of nurse practitioners, with the number of certificate nurse practitioner programs on the decline (Vessey & Morrison, 1997). It was expected that a uniform standard of graduate preparation would decrease role confusion (Vessey & Morrison, 1997).

In Canada, a similar trend is evident. McMaster University offers a post-basic program but is considering changing to graduate preparation. Dalhousie University offers a nine month program, but this is available to federal government health employees only. There are only a few other universities offering graduate preparation for advanced practice nursing roles: University of Alberta, Athabasca University, University of Toronto and University of Manitoba. Only the University of Manitoba program is based on American curriculum guidelines; these guidelines were used to give graduates the broadest options with respect to writing American certification exams. There are no Canadian standards for nurse practitioner education or for certification or credentialing of nurse practitioners (D. Fraser Askin, Assistant Professor, University of Manitoba Faculty of Nursing, July 23, 2001). The CNA has recommended in its 2000 document on advanced nursing practice that graduate preparation be the standard for acquiring

advanced nursing practice competencies. Each provincial regulating body for nursing can choose to adopt this standard. In fact, adoption of a consistent national standard of graduate education might reduce the potential for role confusion.

Roles and Responsibilities

The role of the primary care nurse practitioner is that of a health care provider in a primary care setting. Approximately 80% of time is spent in direct practice, with the remainder in educative, consultative, research and administrative roles (Hanna, 1996). Primary responsibilities include teaching and counselling, and the management of health and illness. Comprehensive health assessments, differential diagnoses, prescription of pharmacological and non-pharmacological treatments, integration of health promotion and illness prevention strategies are responsibilities that require the application of advanced nursing knowledge (Hanna, 1996).

Autonomy

At present in Manitoba, nurse practitioners are covered under the provincial Registered Nurses Act, with functions not covered in the Act negotiated in transfer of function agreements between nurse practitioners and their respective employers. The degree of autonomy is individual, dependent on the skills and experience of the nurse practitioner. The current Registered Nurses Act has been revised to contain legislation for an expanded nursing role, which would negate the need for these individual

agreements. Once proclaimed, Bill 36 will entitle nurses who meet set competencies to diagnose, treat and prescribe for certain conditions without the need for delegation of physician services (D. Wilson-Mate, Director of Policy Development and Regulation, MARN, personal communication, March 07, 2001). This development will alter the nature of the relationship between physicians and nurse practitioners in that the nurse practitioner will be working within a scope of practice under the Registered Nurses Act.

Acceptability, Cost-Effectiveness and Quality of Care

It has been well established that nurse practitioners provide cost effective quality care that results in a high level of client satisfaction (Brown & Grimes, 1995; Mundinger, Kane, Lenz, Tottey, Tsai, Cleary, Friedewald, Siu & Shelanski, 2000; Spitzer, Sackett, Sibley, Roberts, Gent, Kergin, Hackett & Olynich, 1974).

The Burlington Randomized Trial of the Nurse Practitioner (Spitzer et al., 1974) was a Canadian study that assessed the effects of substituting nurse practitioners for physicians in primary care practice. The results demonstrated that a nurse practitioner could provide first contact primary care as safely, satisfactorily and effectively as a physician. The investigators concluded that 67% of client care could be safely provided by a nurse practitioner without quality of care being compromised.

A meta-analysis conducted by Brown and Grimes (1995) analyzed fourteen outcomes in 38 nurse practitioner studies. The results

demonstrated greater client compliance with treatment recommendations, and greater client satisfaction and resolution of pathological conditions with nurse practitioners compared with physicians, in the areas of health promotion and assessment, and treatment of minor acute and stable chronic conditions.

Mundinger et al. (2000) measured client satisfaction, self-reported health status, physiological test results and service utilization between nurse practitioners and physicians. It was concluded that there was no difference between the two types of practitioners with respect to these client outcomes.

Conclusion

While the nurse practitioner role is well established in the United States, it has recently resurfaced as an optional primary health care provider role for a second time in Canada. Education at the graduate level with a focus on collaborative clinical care presents the ideal conditions for a nurse practitioner. Research supports the utility of the nurse practitioner role, with evidence to support client satisfaction, quality of care, service utilization and client compliance.

Collaboration

Introduction

Collaboration is a concept that is applied within various contexts of society and depicts relationships developed for the benefit of working

together (McGrath, 1998). Businesses and organizations utilize collaboration as a means to improve exposure, increase profits, expand a product base and/or enhance their profile in the community (Fishbaugh, 1997), educators to improve student performance (Yamasaki, 1998), and politicians as a means to secure funding and services (McGrath, 1998). The health care system is now utilizing collaboration in ways to improve client outcomes.

Research has indicated that an improved understanding of the key elements involved in nurse-physician collaborative interactions is integral to improving both clinical outcomes for clients as well as improving contemporary worksite conditions for clinicians (Baggs, 1998; Baggs & Schmitt, 1997; Corser, 1998; Fagin, 1992; Siegler & Whitney, 1994; Stichler, 1995). Comprehensive health care today requires a broad spectrum of knowledge across disciplines, and an emphasis on cost containment and efficient teamwork between nurses and physicians (Baggs, 1998; Fagin, 1992). Collaboration improves access to a broader range of services resulting in a more comprehensive, cost-effective practice (Mundinger, 1994; Working Group on Interdisciplinary Primary Care Models, 1997).

As empirical evidence supports the links between collaboration and client outcomes, corresponding steps to further enhance the collaborative process are needed (Baggs, 1998). Physicians have traditionally participated less in research on collaboration compared with nurses, but as improvements in client care are reported, participation will likely increase (Baggs, 1998).

An understanding of the potential benefits and barriers of collaboration, along with analysis of existing models and identification of the elements of collaboration are examined in the next section.

Benefits to Collaboration

The foundation of collaboration is the belief that comprehensive, quality client care is achieved by contributions of multiple care providers (Arcangelo et al., 1996; Blickensderfer, 1996; Corser, 1998; Stapleton, 1998; Stichler, 1995). The benefits to collaboration include enhanced comprehensive client care and interprofessional understanding.

Comprehensive Patient Care

Collaborative provision of health care allows for more comprehensive care to the client (Mundinger, 1994). The unique contribution that each member of the team makes to the plan of care from his/her own field of expertise results in a synergistic client outcome where the benefits exceed what each could accomplish alone (Arcangelo et al., 1996; Blickensderfer, 1996; Keleher, 1998).

Nurse practitioners bring certain skills to a practice by virtue of their education. They are more likely to assess the context of care with clients and adapt medical regimes to a client's preference, family situation or environment, as well as more likely to provide disease prevention counselling, health education and discussion of health promotion (Mundinger, 1994). Arcangelo et al. (1996) supported Mundinger's (1994) findings, but added

management of certain acute and chronic illnesses to the skill set.

A joint practice between a nurse practitioner and a physician allows the nurse practitioner to focus on health promotional, educational and psychosocial aspects of care, while the character of the physician's practice focuses on more medically complex issues. This type of shared care promotes higher levels of client (and provider) satisfaction (Campbell-Heider & Pollock, 1987; DeAngelis, 1994).

Collaboration leads to enhanced client satisfaction, increased access to care and cost effective health care (Arcangelo et al., 1996; Campbell-Heider & Pollock, 1987; Keleher, 1998; Mundinger, 1994).

Interprofessional Enhancement

A greater understanding of mutual and separate roles and responsibilities, improved nurse and physician satisfaction, and enhanced valuing of working with others have all been identified in the literature as positive outcomes for the partners (Stichler, 1995). Nurses and physicians have both identified increased job satisfaction, increased work productivity and decreased stress related to working in a collaborative practice (Corser, 1998). Nurses further cited decreased staff turnover and increased professional awareness as benefits to collaboration, whereas physicians identified enhanced interprofessional communication as an additional benefit (Corser, 1998). Collaborative practice recognizes and rewards the unique contributions of each professional; it creates feelings of competence, value

and self-worth while at the same time enhancing collegiality, and promoting interprofessional cohesiveness and cooperation (Stapleton, 1998).

Barriers to Collaboration

While the need and support for collaboration between nurse practitioners and physicians has been identified along with evidence to support improved client outcomes, collaboration has been difficult to achieve. Many reasons for this difficulty have been cited in the literature. Some of the recurring issues specific to nurse practitioners revolve around prescriptive authority, reimbursement, scope of practice and role confusion. Other less tangible issues relating to nursing and medicine as a whole are ineffective communication and dysfunctional relations rooted in educational, gender and professional socialization differences (Campbell-Heider & Pollock, 1987; Clark, 1997).

History

Alpert et al. (1992) discussed a history between physicians and nurses that is fraught with conflict. The evolution of nursing has been largely influenced by the power of physicians, resulting in a marked power differential between the two professions and less than optimal patterns of communication. Stein typified these communication patterns in his 1967 satirical analysis of nurse - physician relations which examined the traditional, hierarchical relationship between the two professions. Campbell-Heider and Pollock (1987) further analysed the nurse - physician relationship from an

anthropological approach in which they proposed that despite the stated benefits of collaborative practice, physicians have resisted change in practice style and legislation that would enhance the nurse's role. To substantiate the argument, Campbell-Heider and Pollock (1987) acknowledged physicians' support for the expanded training of nurse practitioners, but noted that the medical system does not promote changes which would allow expanded nursing roles. Taking a feminist perspective, Campbell-Heider and Pollock (1987) argued that the medical establishment maintains the hierarchical relationship that is based on gender differences and the domination of women by men. Campbell-Heider and Pollock (1987) contended that while the medical establishment argued that quality of care, authority and responsibility were at the root of concerns, it was really an issue of gender dominance. Campbell-Heider and Pollock (1987) suggested that men are socialized differently from birth and since medicine until recently has been a male dominated profession, this socialization and gender dominance has played itself out between the disciplines of medicine and nursing in the form of dysfunctional communication patterns (Lenz, 1994; Sheer, 1996). The historical status and power of physicians over nurses has led to a power differential which has now resulted in competition, conflict and distorted communication (Makaram, 1995). This legacy of unilateral relationships and subsequent power struggles has created an atmosphere of territorialism and competitiveness (Alpert et al., 1992) and may partially explain why

collaboration is difficult to achieve.

Fortunately, the power differential between nurses and physicians has changed over the past couple of decades as social change and changes within both professions have altered the power relationship (Alpert et al., 1992; Stein, Watts & Howell, 1990). Nurses are increasingly aware of their important role in health care, and are becoming more comfortable with having greater authority.

Prescriptive Authority

Lack of clarity around prescriptive authority has been identified as a barrier to collaboration. Limited prescriptive authority restricts the nurse practitioner's ability to provide accessible, competent and cost effective primary care (Anderson, Gilliss & Yoder, 1996; Neale, 1999; Sox, 2000; Wilson, 1994). In states where there is increased autonomy related to prescriptive privileges, it has been found that nurse practitioners are more likely to be located in under served areas, thereby increasing availability of health care (Wilson, 1994).

Reimbursement

Reimbursement criteria which require a physician to be in attendance while a nurse practitioner is working can inhibit nurse practitioner practice and is clearly restrictive (Anderson et al., 1996; Neale, 1999; Way & Jones, 1994; Wilson, 1994). Such a restriction defeats the goal of providing cost effective care and increased access to care. Lack of consistency with respect to

government reimbursement has also been identified as a barrier to collaboration (Baggs, 1998; Blouin & Brent, 1996; Campbell-Heider & Pollock, 1987; Fagin, 1992; Martin & Coniglio, 1996; Wilson, 1994).

Scope of Practice

Scope of practice describes the authority to practice as vested by the government. It draws boundaries among the individual professions, creating domains of practice control and providing a means to protect the public. An expanded scope of practice allows for increased access to care for the public. Studies indicate that nurse practitioners working under expanded scope of practice provide as good as or better care compared with physicians and failure to use nurse practitioners within their full scope of practice can result in increased cost to the system (Anderson et al., 1996).

Lack of legislated scope of practice (which delineate roles and functions), perpetuates role confusion within the disciplines of nursing and medicine (Blouin & Brent, 1996; Way & Jones, 1994; Wilson, 1994). In the United States, lack of consistency in state practice laws and regulation have also been identified in the literature as barriers to collaboration (Baggs, 1998; Blouin & Brent, 1996; Campbell-Heider & Pollock, 1987; Fagin, 1992; Martin & Coniglio, 1996; Wilson, 1994). The consequence is misunderstanding of the tasks that nurse practitioners may or may not perform.

Physicians' limited knowledge of the nurse practitioner's scope of practice has been cited as a barrier to collaboration (Alpert et al., 1992).

Physicians' questioning of the adequacy of nurse practitioner knowledge and training, as well as the quality of care and overall competence of nurse practitioners has been reported (Anderson et al., 1996). It is vital to define the differences in scope of practice between nurse practitioner and physician. A well educated and well trained nurse practitioner can provide health education, routine physical exams and immunizations, and diagnosis and treatment of certain acute common illnesses - the legal accountability for which should rest with the nurse practitioner (DeAngelis, 1994).

Role Confusion

As nursing roles have expanded, a resulting increase in the gray zones of practice shared between nursing and medicine has led to role confusion (Blickensderfer, 1996). The lack of understanding that each discipline has of the practice components of the other has been documented (Alpert et al., 1992; Martin & Coniglio, 1996; Neale, 1999). A lack of understanding of the educational background of nurse practitioners on the part of physicians, and the lack of consistency in educational standards for nurse practitioners are barriers to collaboration (Wilson, 1994).

Clear role definition is needed in collaboration. Attention to areas of role overlap as well as unique areas of function is necessary so that each discipline can productively function in a collaborative relationship (DeAngelis, 1994; Fagin, 1992; Lundeen, Friedbacher, Thomas & Jackson, 1997; Sheer, 1996).

Professional and Educational Socialization

The acquisition of knowledge, skills, values, roles and attitudes associated with the practice of a particular discipline is known as professional socialization (Clark, 1997). Nursing and medical students are taught using different cognitive and value maps that consequently lead to different approaches to client care (Clark, 1997). Physicians are encouraged to be decisive, independent problem solvers whereas nurses are encouraged to be collaborative and advice seeking (Blickensderfer, 1996). This educational socialization can result in conflict and ineffective communication between professions (Blickensderfer, 1996; Keleher, 1998; Martin & Coniglio 1996; Sheer, 1996).

Differences in educational preparation also result in barriers to collaboration. Hammond, Bandak and Williams (1999) state that the nature of the education of the two professions has led to little experience of shared responsibility, while the very nature of the shorter educational process for nurses is in itself a barrier for some physicians leaving them to question the adequacy of knowledge and training (Anderson et al., 1996; Neale, 1999; Keleher, 1998). The advanced graduate education for nurse practitioners has increased their skill set and ability to interact with physicians (Stichler, 1995). Nurse practitioners prepared at the graduate level are better able to articulate information and demonstrate competence and confidence. As educational levels and professionalization of nursing has advanced, so

consequently have collaborative relationships (Stichler, 1995).

Physicians' Perceptions of Nurse Practitioner/Physician Collaboration

There are few formal studies regarding physicians' perceptions of collaboration with nurse practitioners, and most reports are anecdotal.

Anecdotal evidence suggests misunderstanding and suspicion between the two professions. For example, MacMillan (1997) stated that the distinction between medicine and nursing later in the 20th century "was vulgarized to the notion that while physicians cured, nurses cared, suggesting that while they might not be as powerful, or as well educated, they could at least be morally superior" (p.152). Goldman, a physician and co-author in the Alpert et al. article (1992), states that the dichotomy that nurses care and are client advocates, while doctors cure, makes 'the hair on the back of his neck bristle' (p.54). He found himself being portrayed as uncaring and not interested in client's welfare. "The patient was the focus of conflict, and, at times, the excuse but usually not the issue" (p.54). As a physician in the 1970s, Goldman heard more and more that the two professions needed to work together toward a goal of improved client care. While this was appealing on the surface, what he felt was really being said was that physicians and not nurses needed to change their behaviour. Goldman's observation may typify a deep concern felt by other physicians (Alpert et al., 1992).

The American Academy of Family Physicians (2001) has recently

released a statement in which it recognizes that regulatory variations and professional turf battles create a gap and make collaboration difficult. The statement further recognizes that collaboration improves health outcomes and supports the notion that the two professions should work together to create collaborative care.

Four studies have been identified in the literature that specifically examine physician perceptions of nurse practitioners. Two of the studies (Cairo, 1996; Ford & Kish, 1998) were published by one specific nursing journal, the third was in an American medical journal (Aquilino, Willard, Momany & Levy, 1999), while the fourth was published in a British medical journal (Offredy & Townsend, 2000). Overall, the literature indicates that physicians are supportive of the nurse practitioner role, but have reservations around issues such as reimbursement and prescriptive authority. Misinformation about nurse practitioners and their role, and lack of exposure to nurse practitioners in general are cited as likely reasons for the reservations.

Cairo (1996) conducted a qualitative study to examine attitudes of five emergency room physicians towards collaborative practice with emergency room nurse practitioners. The results indicated both acceptance and reluctance to accept the nurse practitioner role. Although physicians recognized the benefits of the nurse practitioner role, they wanted to maintain a hierarchical relationship. It was speculated that this was due to a lack of

understanding of the nurse practitioner role - that is, a fear that nurse practitioners wanted to replace the physician role instead of expanding the nursing role. There were also concerns about liability, but Cairo (1996) suggested that this was unfounded because previous evidence had not demonstrated that nurse practitioners present increased liability risk. Cairo (1996) found a correlation between physicians with little exposure to nurse practitioners and a negative attitude towards the role. Over time, trust and knowledge of the nurse practitioner and the role developed, resulting in a positive attitude change (Cairo, 1996).

Ford and Kish (1998) used a semi-structured interview format to examine perceptions of faculty physicians and family medicine residents towards nurse practitioners and physician assistants in a family practice residency site. Of importance to note is that nurse practitioners had never worked in the site, whereas physician assistants had been placed in the site for two years. The study revealed an overall acceptance of nurse practitioners as cost effective providers in the site, but perceptions reflected role misinformation on a number of issues. Lack of knowledge about educational background, credentialing requirements and prescriptive authority contributed to a negative impression of the role. Overall, physicians felt that nurse practitioner education appropriately prepared them to see clients with common acute and chronic illnesses, but they did not recognize unique contributions that nursing could make to client care. There was concern that

third party reimbursement mechanisms and less restrictive prescriptive authority would encourage independent nurse practitioner practice. Prescriptive authority was therefore thought best to be restrictive and reimbursement controlled through a supervising physician. Both Cairo (1996) and Ford and Kish (1998) support a general trend that the more experience a physician had with a nurse practitioner, the more positive the attitude of the physician was towards the nurse practitioner role.

Aquilino et al. (1999) conducted a mail-out survey of primary care physicians in Iowa to evaluate physician attitudes towards nurse practitioners providing primary care, and physician experience with nurse practitioners in the primary care role. Overall, physicians were supportive of nurse practitioners, with a more positive attitude expressed by physicians who had worked with nurse practitioners. It was felt that this positive outcome of work experience had and still has implications for the training of both professions.

Offredy and Townsend (2000) conducted semi-structured interviews with general practitioners, nurse practitioners, receptionists and clients to explore the role and practice of nurse practitioners in primary care. While the results of this British study reveal wide differences in the nature of the practice of nurse practitioners, some data illustrated barriers to practice. One general practitioner was greatly concerned when the nurse practitioner did not consult with him since he was still legally responsible, whereas another general practitioner was aware of the legal implications but stated he knew

and trusted the nurse practitioner with whom he worked.

Models of Collaboration

A review of the literature revealed two themes regarding models of collaboration between nurses and physicians. One theme focussed on the structural and organizational aspects that are needed to help a particular collaborative endeavour succeed. While this is vital for a positive outcome, it is the dynamic, interpersonal elements that are truly crucial to a successful collaborative practice and are the essence of the second theme. There are few models in the literature which illustrate features of the second theme, and even fewer that discuss it at the level of the nurse practitioner and physician. The Ontario Model (discussed in Chapter One) and five others will be discussed in this next section as exemplars of the second theme.

Corser (1998) described a conceptual model of collaborative nurse-physician interactions in which mutual trust and respect, compatible role perceptions, joint goal setting and decision-making, and power symmetry are identified as key to successful collaboration. Schurmans and McCrank (1997) also described a nurse-physician collaborative practice in which mutual trust, respect and cooperation are the key elements to success.

At the level of the advanced practice nurse, Arslanian-Engoren (1995) identified five elements crucial to collaborative practice, but these elements have been presented from the view of advanced practice role development, versus a view to building practice. Mutual trust and respect,

acknowledgement of the difficulty in establishing collaboration, collegial relations, maintenance of a nursing perspective, and living a positive experience were all recognized as essentials for collaboration.

Wells, Johnson and Salyer (1998) recognized communication, cooperation, assertiveness, negotiation and coordination as items basic to collaboration between advanced practice nurses and physicians.

Norsen et al. (1995) described an advanced practice nurse - physician collaborative relationship in an acute care setting in which cooperation, assertiveness, responsibility, communication, autonomy and coordination were six principal elements bound together by mutual trust and respect.

Way et al. (2000) developed a collaborative conceptual framework based largely on the work of Norsen et al. (1995) in which seven interpersonal elements were identified as key to the success of a collaborative relationship: responsibility and accountability, coordination, communication, cooperation, assertiveness, autonomy and mutual trust and respect.

Elements of Collaboration

The key elements from the models just described have been integrated in this section. The seven elements of the Ontario Model have been used to organize the material. The order of the elements reflects the author's ranking according to importance and two extra categories have been added to encompass material that does not fit the seven elements with the

Ontario Model.

Communication

Stapleton (1998) described communication as being the essence of collaboration. Without it, communication is impossible to develop relationships. It is seen as the vehicle to express two other essential components of collaboration: respect and trust. If communication is effective, partners can negotiate constructively by drawing on the contributions of everyone on the team to develop creative solutions to problems. One must listen to the other's perspective, and pay attention to the other person. For communication to be effective, each partner must be aware of the other's perspective, thought process and communication style. There is no right or wrong way to talk, listen or show one cares, but at times one may need to alter his/her communication style to complement the style of the other (Stapleton, 1998). Arcangelo et al. (1996), Blickensderfer (1996), Lorenz, Mauksch and Gawinski (1999) and Wells et al. (1998) all identified the importance of recognizing differences in communication style and finding common ground that will result in fewer misunderstandings.

Norsen et al. (1995) and Way et al. (2000) described communication as critical to the success of the collaborative team. Each partner is responsible for sharing critical information about client care; there is no room for unnecessary or superfluous communication. The constructive and honest exchange of ideas guarantees that communication lines remain open and

unencumbered. Norsen et al. (1995) pointed out that a key component of communication is actually being accessible to each other for the exchange of ideas and discussions. An environment without fear of retaliation or ridicule must exist, and partners must accept and try to understand the others' opinions and feelings. Communication requires superb skill and high level of trust (Stapleton, 1998).

It has been recognized that a non-hierarchical relationship between partners is a crucial element of effective communication. It is assumed that the 'contribution of each participant is based on knowledge or expertise brought to the practice rather than the traditional employer/employee relationship' (Arcangelo et al., 1996, p.106). Stapleton (1998) described this quality in great detail stating all partners work together with equal power and responsibility, not in isolation with the physician bearing full responsibility for all of the care. Each partner must have autonomy within his/her scope of practice which allows for a non-hierarchical relationship to exist (Clark-Coller, 1998; Mundinger, 1994; Stapleton, 1998). A characteristic of equal power is shared decision-making where all viewpoints are important, none is dispensable, and quality of the clinical decision is enhanced greatly when all are involved equally, with different aspects of one's care being directed by different partners, depending on their knowledge and expertise. Mundinger (1994) stated that differences of opinion are resolved in a horizontal relationship by the partner that has the greatest degree of professional

competence for that particular issue.

Mutual Trust and Respect

Respect is often paired with trust as two elements that cannot be separated. Norsen et al. (1995) and Way et al. (2000) stated that trust is the bond that unites cooperation, coordination, autonomy, responsibility, assertiveness and communication. Without it, cooperation does not exist, assertiveness is seen as a threat, responsibility is avoided, communication is hampered, autonomy is suppressed and coordination is haphazard. This element is essential in understanding the unique and complementary perspectives each profession makes to client care (Alpert et al., 1992; Arcangelo et al., 1996; Keleher, 1998).

Lack of trust creates an insurmountable barrier; and one must be able to depend on the support, honesty and integrity of the other (Stapleton, 1998). Trust develops over time as a result of multiple positive experiences and requires that people get to know and understand each other. "Truth, honor, professionalism, honesty, dependability: all come together in trust. You cannot screen or recruit for trust, but without it you will get nowhere" (Devereux cited in Stapleton, 1998, p.14).

Alpert et al. (1992) and Stichler (1995) described mutual respect as the acknowledgement for the contribution of each partner and each partner's right to participate. The presence of mutual respect implies a recognition of a body of knowledge, talents and skills, and of the uniqueness and value of

each discipline by the other. Knowledge and experience allow for the collaborative relationship to be established more readily (Alpert et al., 1992). The awareness of the other's level of knowledge and experience enhances the development of trust and removes the need for supervision (Stapleton, 1998; Arcangelo et al., 1996). An investment in time and effort to share a discipline's unique contribution and value with other professionals is required (Stapleton, 1998). Lorenz et al. (1999) simply stated that mutual respect is exemplified by the willingness of one to step down and share authority.

Autonomy

Autonomy allows for the independent action and decision making of each partner when carrying out a treatment plan. It is important that each partner recognize and understand the other's scope of practice to support shared decision making (Way et al., 2000). A clear understanding of each discipline's scope of practice will prevent any one professional from being placed in a situation that is beyond his/her scope of practice (Norsen et al., 1995; Stapleton, 1998). A well delineated scope of practice strengthens collaborative relationships by defining roles and responsibilities, otherwise there will be confusion as to how each partner may best work (Norsen et al., 1995).

Norsen et al. (1995) expanded on the concept of equality through their description of autonomy: that which authorizes individual partners to carry out the plan of care as exists within the boundaries of an individual's skill and

competence, but bestows the trust of the team on the individual and empowers that person to practice independently within a defined scope of practice. Without the opportunity to practice autonomously, the work of the team becomes unmanageable and inefficient. This view has been reiterated in the literature by Arslanian-Engoren (1995), Stichler (1995) and Way et al. (2000).

Cooperation

Cooperation stresses the interdependence of the team by recognizing the individual talents of each partner and acknowledging his/her contribution to the overall plan of care (Norsen et al., 1995). The emphasis is on collegial relations where hierarchy is replaced by equality and shared decision making; decisions are made by compromise but also according to the expertise of qualified individuals to whom other partners may defer (Norsen et al., 1995; Way et al., 2000; Wells et al., 1998).

Stapleton (1998) stated that understanding and valuing each other's perspective and way of thinking, and practice style are crucial components of cooperation. Familiarity with the characteristics of the partner's discipline will allow the other to better communicate that discipline's strengths, values, limitations and contributions to colleagues from other disciplines, as well as to present a unified front to the client. If this element is fulfilled, it will be clear to the client that the two professions trust and respect each other and are working in the client's best interest (Schurmans & McCrank, 1997). A more

comprehensive view of the client will also be achieved, which leads to more creative solutions. It requires a high level of professional maturity and confidence in professional knowledge to recognize a discipline's limits; and the tendency to discount any perspective that does not fit one's own (Alpert et al., 1992; Stapleton, 1998; Stichler, 1995).

Responsibility and Accountability

Norsen et al. (1995) and Way et al. (2000) made the distinction within this element between individual and shared responsibility. They described individual responsibility as accepting accountability for a personal viewpoint or action; whereas shared responsibility is the active participation in decision making, the supporting of a decision determined by consensus and the participating in plan implementation. Shared responsibility requires professional sophistication to advocate a decision that may not reflect personal opinion or preference. Stapleton (1998) echoed Norsen et al.'s (1995) description, but elaborated on the fact that each partner is cognizant that one's decisions affect not only the client, but one's colleagues as well.

Lorenz et al. (1999) and Wells et al. (1998) acknowledged responsibility and accountability simply by describing it as the willingness to give and take with an awareness that limitations foster the development of this element.

Coordination

The proper coordination of care promotes the use of all team

members' skills, prevents duplication, enhances the productivity of the practice (Alpert et al., 1992; Arcangelo et al., 1996) and guarantees that the most qualified person addresses the problem (Norsen et al., 1995; Way et al., 2000). Coordination of care, which often falls to one person to direct, is necessary to carry out an agreed upon plan of action (Norsen et al., 1995; Wells et al., 1998).

Assertiveness

This element is not cited as frequently as others in the literature, but has been identified by Norsen et al. (1995) and Way et al. (2000) as a key element for collaboration. Characteristics of this element exist when partners support their viewpoints with confidence. It is self-advocacy with the caveat that the issue being advocated is focussed, rational and factually accurate. But there is a difference between being assertive and being aggressive, which can be demeaning and destructive to a relationship. Each partner that is able to exhibit assertiveness assures that his/her viewpoint is fully aired and that consensus can be achieved.

Miscellaneous

Two additional categories that do not fit into the elements of the Ontario Model are included here. These elements are optimism and energy, and shared goals and values.

Optimism and Energy. Partners in a collaborative relationship must feel a strong commitment to making it work by including times for clinical

discussions, discussions of philosophy and values, and analyses of interactions (Stapleton, 1998). It involves emotional and intellectual energy to be sensitive to others and the understanding that developing relationships take time and effort (Alpert et al., 1992; Stapleton, 1998). Arcangelo et al. (1996) stated that optimism is the most effective method of delivery of quality care, a belief that promotes success.

Shared Goals and Values. It is important to recognize the goals of the collaborative arrangement. While Lorenz et al. (1999) recognized that goals can be different as long as they are not mutually exclusive and there is a common purpose, Stapleton (1998) and Norsen et al. (1995) valued shared goals. Open discussion about values and goals is critical to avoid misunderstanding later on and must be completed prior to the establishment of a relationship (Lorenz et al., 1999).

Conclusion

Collaboration within health care is an approach to delivery that is increasingly recognized as a viable and productive means of improving client outcomes. In particular, collaboration between nurse practitioners and physicians has utility in terms of providing comprehensive client care, but also with respect to enhancing interprofessional relations. Despite the benefits to collaboration, there remain a number of barriers which impede the expansion of this approach. Historically, lack of clarity over issues such as liability, autonomy and education continue to block professional development to nurse

practitioners. By examining the benefits and barriers to collaboration between nurse practitioners and physicians, as well as identifying successful models of collaboration and their individual elements, one can glean a greater understanding of what is needed to enhance the development of a collaborative relationship between the two professions.

Conclusion

This chapter has presented a historical overview of the development of nurse practitioner education and practice. Issues related to inconsistency of education and training, role definition and responsibilities have been highlighted. The concept of collaboration has been explored in terms of benefits and barriers. The empirical research on collaboration has been presented with a discussion of four studies that explore physicians' perceptions of nurse practitioners. The elements of collaboration have been outlined in detail. The next chapter describes the methods undertaken in this practicum project to develop a greater understanding of physicians' perceptions of collaboration with nurse practitioners.

CHAPTER THREE - METHODOLOGY

Introduction

The purpose of this project was to develop a greater understanding of resident and faculty physicians' perceptions of collaboration with nurse practitioners through a qualitative approach. Specifically, six questions were addressed:

- What do physicians know about nurse practitioners?
- How do physicians visualize the nurse practitioner role?
- Are physicians ready to collaborate with nurse practitioners?
- What do physicians perceive to be the benefits and disadvantages of a collaborative relationship?
- What elements do physicians identify as contributing to the establishment of a successful collaborative relationship?
- What do physicians need in order to move towards a greater acceptance of the nurse practitioner concept?

Qualitative research has been described as a holistic approach to examining the complexities of humans and their environments (Polit & Hungler, 1995). An understanding of behaviour is incomplete if there has not been an attempt to capture the subjective reality of a situation (Sim, 1998). The patterns and themes that emerge from qualitative data may be used for the further generation of hypotheses and theory development (McDougall,

1999; Polit & Hungler, 1995). Certain qualitative data collection methods are sensitive to eliciting perceptions and beliefs of individuals. The focus group technique is one such method which has recently gained popularity in the health care field (Sim, 1998).

This chapter will outline the methodology used for the project. Details regarding project participants, setting, instrumentation and data collection are included, along with description of data analysis and validation.

Site Access

This project was carried out at Family Medical Centre, a family medicine clinic in the City of Winnipeg, Manitoba. The clinic is a family medicine residency training site affiliated with the University of Manitoba and St. Boniface General Hospital. Resident physicians are physicians who have graduated from medical school and are in the process of completing two years of post-graduate education in their specialty of family medicine. Faculty physicians are family medicine physicians who are responsible for directing the learning of the resident physicians. Each faculty physician has his/her own practice population within the clinic. Approximately 12 residents per year are trained for general family medicine practice and about six faculty physicians are employed at the site. The investigator completed 400 hours of clinical practicum at the clinic during the months of April through July 2001 in partial fulfilment of her Master's degree, as well as having completed clinical

hours at the clinic part-time from September 2000 through April 2001.

A formal proposal outlining the rationale, objectives and methodology of the project was submitted to the Clinic Director for approval approximately six weeks prior to the first focus group (see Appendix A). A subsequent letter of approval was received by the investigator from the Clinic Director (see Appendix B).

Study Participants

Three focus groups involving a total of 11 participants were involved in the research project. Two focus groups were composed of resident physicians completing a portion of their family medicine residency at the clinic. One of these two groups was present full-time in the clinic for four weeks in May (n=5), while the second of the two groups was present for four weeks in June (n=3). The third group of participants were faculty physicians who were present on a continuous basis at the clinic (n=3).

Recruitment

Potential participants were approached individually two weeks prior to the respective focus group discussion. Each individual was provided with a brief explanation of the project and invited to participate. A 'letter of invitation' (see Appendix C) outlining the purpose of the project and the current nurse practitioner situation in Manitoba was given to the potential participant. Potential participants were encouraged to seek out the investigator prior to

the focus group if they had questions. All resident physicians who were approached agreed to participate (n=8). Of the eight faculty physicians approached, four declined to participate due to scheduling conflicts while the remaining four consented to participate, with three ultimately participating in the focus group.

Consent

Written consent for participation in the focus group was obtained between the initial recruitment and the beginning of the focus group (see Appendix D). Participants could choose to not answer some of the questions while in the focus group discussion, and could withdraw from the group at any time. Participants were assured that information gathered would remain confidential with no identifying information attached to the data. Participants were given the option to obtain a summary of the project results from the investigator by completing the bottom portion of the consent form.

Setting

The focus group discussions were conducted in the conference room at Family Medical Centre over the course of 60 minutes during a lunch hour. This location and time was convenient for both the participants and the investigator.

Instrument

Each of the six broad questions used to guide the project had from one to four specific questions developed to elicit data within the focus groups (see Figure 1, page 50). In total, 12 questions were utilized during the focus group discussions, and served as a guide for the investigator.

Data Collection

Focus Groups

The focus group technique has been described as "a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, nonthreatening environment" (Krueger cited in Torn & McNichol, 1998, p.18). Members tend to be homogeneous and involved in a loosely formatted discussion with the intent to gain an in-depth understanding about a specific topic (Torn & McNichol, 1998). Five to fifteen people are usually involved, with a facilitator to guide discussion. The facilitator may utilize a set of predeveloped questions to direct discussion and to ensure adequate coverage of the topic (Sim, 1998).

The role of the facilitator "is pivotal to the nature and quality of the data collected" (Sim, 1998, p.347). The personality, social identity and interpersonal skills of the facilitator will influence the quality of the interaction that takes place (Sim, 1998). The facilitator must generate interest and discussion around the topic, but also must find a balance between degree of

RESEARCH QUESTIONS:	FOCUS GROUP QUESTIONS:
What do physicians know about nurse practitioners?	What is your understanding of what nurse practitioners do? What qualities are brought by the nurse practitioner due to her educational background?
How do physicians visualize the nurse practitioner role?	What do you feel the role of nurse practitioners should be? Should nurse practitioners be reimbursed as fee for service or salary?
Are physicians ready to collaborate with nurse practitioners?	What do you understand collaboration to mean? Are physicians in general ready to collaborate with nurse practitioners? Issues? Are you personally ready to collaborate with a nurse practitioner? Issues? Is the shorter educational process for nurse practitioners an issue?
What do physicians perceive to be the benefits and disadvantages of a collaborative relationship?	If you were to enter a collaborative relationship with a nurse practitioner, what might be some of the benefits to patient, nurse practitioner, yourself? What might be some of the disadvantages to patient, nurse practitioner, yourself?
What elements do physicians identify as contributing to the establishment of a successful collaborative relationship?	What qualities need to be in place for collaboration to succeed?
What do physicians need in order to move towards a greater acceptance of the nurse practitioner concept?	What would you like to see from nursing to more fully embrace the nurse practitioner concept?

Figure 1: Research Questions Linking Focus Group Questions.

participation and observation. An attitude of wanting to learn must be conveyed. It is crucial to ensure dialogue between the participants versus between the participants and the facilitator (Sim, 1998).

Strengths of Focus Groups

As a means of data collection, focus groups offer several strengths. A focus group is a quick, economical way to obtain data (Krueger cited in Sim, 1998; McDougall, 1999), usually easy to conduct, with the data collected generally being of the subject of interest (McDougall, 1999). It offers the opportunity for the researcher who acts as facilitator to be directly involved, leading to accurate observation and recording of results (McDougall, 1999). Focus groups encourage a greater degree of spontaneity compared with the interview technique (Butler cited in Sim, 1998). It is a safe forum where one does not need to answer every question (Vaughn cited in Sim, 1998) and participants may feel supported and empowered by group membership (Goldman, Peters cited in Sim, 1998). Typically focus groups have good face validity, with a main criticism being that focus groups "may do little more than confirm and support assumptions and prejudices" (Reed & Payton, 1997, p.770).

Weaknesses of Focus Groups

Focus group data collection has several weaknesses. Focus group analysis can be time consuming and tedious (McDougall, 1999). The focus group is not based in a natural setting, and participants may not truly state

what they actually think or feel (McDougall, 1999). A 'mismatch' between the facilitator and group members may result in a reluctance to express opinions. An ineffective facilitator may allow dominant members to dominate with less assertive members participating less fully (McDougall, 1999). The researcher has less control over the data generated (McDougall, 1999).

Data Collection Technique

Each focus group discussion (three in total) lasted no more than 60 minutes with discussion guided by a list of questions. The questions were not asked in any particular order other than the first two questions and the final question. The first two focus group questions were "What is your understanding of what nurse practitioners do?" and "What do you feel the role of the nurse practitioner should be?". The final focus group question asked what the participants would like to see from the nursing discipline in order for them to more fully embrace the nurse practitioner concept. The order and pace of questions allowed the discussion to follow a natural flow. Discussions were audiotape recorded for later transcription and data analysis.

Confidentiality

Participants were not identifiable and names were not used in either the transcription of the audiotapes or in the data analysis. Tapes and transcripts will be kept in a locked cabinet at the investigator's home for a

period of one year following graduation. After the one year period has expired, the tapes and transcripts will be destroyed.

Ethical Considerations

This project received approval from the Education/Nursing Research Ethics Board (see Appendix E). At all times during the project process, rights of the participants were respected. Participants were given the opportunity to read their individual comments and were free to delete any comments.

Data Analysis

Each focus group had the respective audiotape transcribed to written word (verbatim). Transcripts of each focus group were then analyzed using a technique outlined in Polit and Hungler (1995):

- **reductionist phase:** transcripts were first read with colour coded highlighting of data pertinent to each of the twelve questions. Following this was the manual conversion of data to smaller, more manageable segments by the writing of words and phrases in the margins.
- **constructionistic phase:** the words and phrases in the margins, as well as the colour coded highlighted data were then collated under each of the individual questions with subsequent theme exploration.

Data Validity

Concurrent analysis was conducted by the investigator's practicum Chairperson, thereby addressing inter-rater reliability of the analysis (Torn & McNichol, 1998). Content validity was achieved through the comparison of categories with themes from the literature (Holsti cited in Torn & McNichol, 1998). There was a comparison of the themes to elements of the Ontario model of collaborative practice (Way et al., 2000).

Conclusion

This chapter has described the qualitative methods used to examine resident and faculty physicians' perceptions towards nurse practitioners and collaboration. The strategy of conducting focus group discussions with subsequent qualitative content analysis suited an exploratory inquiry of this nature.

CHAPTER FOUR - FINDINGS

Introduction

This chapter reports data analysis from the 12 focus group questions that were developed to address the six research questions. Results are presented under each of the six research questions, with further delineation of resident physician responses from faculty physician responses where appropriate. A brief summary is provided at the conclusion of each of the six sections.

Present Knowledge of the Nurse Practitioner Role

The first research question was intended to develop an understanding of physicians' knowledge of nurse practitioners. Two questions were asked: "What is your understanding of what nurse practitioners do?" and "What qualities are brought by the nurse practitioner due to his/her educational background?"

Resident Physicians

The majority of resident physicians speculated at length as to the particular settings and skills associated with nurse practitioners, but qualified their responses by stating they did not really know what nurse practitioners did. The primary role of the nurse practitioner was seen by the majority of resident physicians as filling in gaps in primary care settings where there

were not enough physicians. In particular, settings such as northern reserves and rural remote areas were identified. Comments below illustrate this theme.

> ***...[nurse practitioners] provide a primary care role, filling in some of the gaps that are left by primary care physicians...***
>
> ***Well, I've heard that too and think they are very beneficial... they are going to be filling in health gaps where you cannot get family physicians to go...or if there are not enough physicians in the area...***
>
> ***...they are more beneficial...when the family physicians are less in number like northern communities...***
>
> ***...they are supposed to fill in a gap, and the gap as I see it is essentially numbers...***

The role of the nurse practitioner in the northern and rural remote settings was described as that of an independent, autonomous practitioner. Skills associated with physicians, such as assessment, diagnosis, treatment and dispensing of medications were associated with the nurse practitioner role.

Urban or acute care settings were identified less often as nurse practitioner work settings. The exceptions were city clinics and a neonatology intensive care unit.

> ***There are nurse practitioners that work there [neonatology intensive care unit] and they work like the pediatricians...***

Management of stable chronic and common acute conditions or conditions that were seen as "routine" for the physician, were cited as appropriate responsibilities for the nurse practitioner.

> ***...working in a dialysis clinic or something like that where the patient has already been diagnosed and it is just a matter of maintaining their dialysis, or...a drug rehab centre...and you just need somebody to watch them...***

It was acknowledged by some resident physicians that nurse practitioners bring specific nursing skills to the role, such as communication and ability to assess changes in conditions. Overall, though, resident physicians did not articulate what distinct qualities nurse practitioners had to offer by virtue of their educational background.

Faculty Physicians

Faculty physicians' knowledge of nurse practitioners indicated that while nurse practitioners work in a primary care settings, this was not the only setting.

> ***...their primary role is in a primary care setting...or in specialty clinics...***
>
> ***I think that there may be different roles in different settings...***

The north was identified by all faculty physicians as a setting for nurse practitioners, with one faculty physician describing the nurse practitioner role as extremely comprehensive.

> ***...a group of people who are incredibly independent and knowledgeable and capable in terms of diagnosis and treatment both in highly stressful and often difficult complicated medical situations...they deliver babies, they run codes, they suture things up, they are pretty comprehensive...***

It was suggested that a nurse practitioner's scope of activities, while complementary and similar to a physician, was broad and might include such activities as preventative health, education and counselling.

> ***...they function in a supplementary role in a primary care setting with the family physicians...mostly I see their role in preventative health and in screening and to a certain degree managing common non-threatening conditions...***

The role was also described as unlimited and based on the ability of the individual nurse practitioner and the need of the setting within which he/she may be working. While management of common non-threatening conditions was identified, it was qualified that the role may go beyond that.

> ***I think they have the skills to function in whatever capacity...you cannot limit the role and it could be expanded as much as you [want]...***

Nurse practitioners were described as offering care that was more holistic and less reductionistic than physicians.

Summary

Overall, the role of nurse practitioners was not clearly understood by the physicians. While faculty physicians displayed a greater understanding of the nurse practitioner role than the resident physicians, neither group articulated a clear understanding of the role. Resident physicians identified the nurse practitioner role primarily as one of filling gaps in areas where physicians were lacking, utilizing an expanded skill set (normally associated with a physician) to manage routine, stable conditions. Faculty physicians articulated the nurse practitioner role as complementary to a physician in the

primary care setting, but not necessarily restricted to that setting. Faculty physicians viewed nurse practitioners as providing a holistic approach to client care.

Visualization of the Nurse Practitioner Role

"What do you feel the role of the nurse practitioner should be?" was intended to elicit perceptions for the second research question of how physicians visualized the nurse practitioner role. Also, a specific question surrounding reimbursement was asked and is included in this section since it reflects aspects of role visualization.

Resident Physicians

The resident physicians' responses clustered into four main categories with contrasting views within some: settings, responsibilities, education and funding. While it was acknowledged by a few resident physicians that the nurse practitioner role should become more mainstream with plausible opportunities in urban settings, it was felt by others that the nurse practitioner role should remain in northern and remote rural locations.

> ***...there is sort of a movement to have [the role] not just in outlying places...becoming more a part of the community clinics...I imagine the role that you guys are going to be doing in the future is sort of the northern nurses where they basically run almost the same as a physician's office...***
>
> ***I think a need exists in the rural and remote areas. ...but I would be careful about expanding.***

With respect to responsibilities, the prevailing theme was that of an attendant role to physicians; such descriptors as "assist", "under supervision", "assistant", and "helper" were used.

> ***...maybe something like what the physician's assistants are like in the States...they can provide under supervision a lot of primary care things that the family physicians can do...***
>
> ***A physician's helper.***
>
> ***Maybe they could assist in some way...instead of us being swamped say like getting thirty of them [patients] all at once...if the nurse practitioner took...say 50% of them so that you wouldn't be so swamped...***

Territorial issues also emerged. Some resident physicians were concerned that nurse practitioners might make the family physician role obsolete and take over routine tasks in a physician's office.

While the question was intended to elicit thoughts on the working responsibilities of a nurse practitioner, comments revolving around the educational preparation became apparent. Apprenticeship training was recommended by some.

> ***...you could have that apprentice training and I see that fulfilling just about everything in the office practice...***

Development of formal standards and testing was recommended by others. Concern was conveyed that the nurse practitioner role as it presently exists should not change without direct physician supervision or specific training.

> ***I do have some concerns over the role changing or expanding or even being what it is without direct physician supervision or information about specific training, qualification, that type of thing...some formal standard put in place to assess competency and skills ...I think the role right now is probably appropriate in those areas [rural remote] but I would be careful about expanding a lot without looking into whether they are qualified to do this...***

Cost effectiveness was also seen as an essential feature in the validation of the role. Specifically, if the role was not cost effective, then perhaps it should not be an option within the health care system. Further to that, funding for the role did not necessarily need to be restricted to a salaried position. Fee for service funding was seen as a possible option by some resident physicians for the nurse practitioner, as long as the nurse practitioner was independently liable for his/her actions.

> ***I think if they are insured and liable for their own decisions then they should be able to bill the government like a physician.***

Faculty Physicians

The faculty physicians' responses regarding the nurse practitioner role were more comprehensive and flexible in nature than the resident physicians. Faculty physicians suggested that the most logical location for a nurse practitioner would be in primary care, but the role should not restricted to just that setting. Location should be guided by the needs of the setting and the capabilities of the nurse practitioner.

> ***...it should be based on the training of the individual nurse practitioner and the need at the place and time... I wouldn't like to limit it based on something that I define as this is the job and this isn't the job because I think philosophically that is the reason. I think it should be based on need and ability.***

The consensus was that the broader the role a nurse practitioner played, the more beneficial that would be to not only the nurse practitioner but to the health care system in general.

> ***...you don't want to narrow down to one area...you want to keep it as broad as you can...diversity is the best thing...***
>
> ***...so I think the point is really good...don't get narrow. Definitely don't get narrow.***

It was suggested that nurse practitioners in a fee for service arrangement would be inappropriate for both the nurse practitioner and the patient. Decreased quality of care was likely to result as less time would be spent with each patient. Salaried positions in globally funded clinics were preferred.

> ***...not fee for service...because you immediately create a hierarchy...potential misuse of the nurse practitioner ability...***
>
> ***...you get better quality with salary whether it is a family physician or nurse practitioner...salary's the best choice...***

Summary

While resident physicians indicated that the nurse practitioner role should become more mainstream, they continued to visualize the role as more of a physician's helper. Faculty physicians' visualization of the nurse practitioner role was more flexible and comprehensive in nature. Any setting

would be plausible for a nurse practitioner, with encouragement to keep the scope of practice broad.

Are Physicians Ready to Collaborate?

Four questions were posed to the focus groups as a means of developing an understanding of perceptions of collaboration with nurse practitioners. An understanding of the word "collaboration" was first elicited, followed by thoughts on personal readiness to collaborate with a nurse practitioner. Physicians were also requested to speculate on whether physicians in general were ready to collaborate with nurse practitioners, and if not, what might be the issues. The fourth question asked whether the shorter educational process for nurse practitioners was an issue for physicians.

Definition

Overall, both resident and faculty physicians responded similarly in their understanding of collaboration and their responses are grouped together.

Resident and Faculty Physicians

The overwhelming response was that collaboration simply meant to ***"work together"***. This was expanded by two resident physicians to ***"consultation between two sets of professionals"*** and meeting ***"a common need or goal"***.

Faculty physicians elaborated on their definition with the following:

> ***A level of equal status in working together...respect for the role of that individual...isn't a hierarchical structure.***
>
> ***...long term get together.***

Personal State of Readiness

Responses on personal state of readiness by resident physicians were diverse while faculty physicians were more similar.

Resident Physicians

Resident physicians' responses were quite diverse in their responses to their own personal state of readiness in collaborating with nurse practitioners. Some of the resident physicians exhibited uncertainty, citing not enough understanding of the nurse practitioner role, or enough knowledge regarding qualifying standards to answer affirmatively.

> ***I don't think I know enough about the parameters of the role to be able to answer that.***

A few of the resident physicians indicated that they were unconditionally ready to collaborate with a nurse practitioner.

> ***I think that a lot of the things that I do in family medicine so far are relatively routine and I think that I would be happy, I don't think it would take away from my gratification of the whole practice to give some of those away...***

On the other hand, a few resident physicians indicated that they could not collaborate with a nurse who possessed less education, revealing that equality was an element in collaboration.

> ***...if the nurse practitioner is considered to be equivalent to myself in terms of what they are expected to do and I don't feel they have the same qualifications...I don't know if I can consider them to be an equivalent colleague...***

Another position was resignation. That is, because evolution of the nurse practitioner role within the health care system was inevitable, rather than put up barriers, it was best to just accept it.

> ***I think we have to be honest and face facts...it shouldn't be a threat, it's just one of those things...how to respond to [nurse practitioner evolution] is the issue, not to deny it.***

Faculty Physicians

The faculty physicians, on the other hand, stated unconditionally that they were prepared to collaborate with nurse practitioners and no specific issues were identified.

General State of Readiness

When asked to speculate if physicians in general were ready to collaborate with nurse practitioners, territorial issues predominated.

Resident Physicians

Resident physicians described some of the concerns and fears of other physicians:

> ***I think a lot of people [physicians] are threatened by this... feeling very threatened...that they are going to be out of a job if you can train an APN [advanced practice nurse] to basically do what we do and you know pay them a third as much so I think there is that sort of fear if we let them in what are we opening to door to and that's why most people are sort of reluctant to go there.***

> ***I've had pediatricians and other people in internal medicine tell me that the nurse practitioners are going to make family physicians obsolete...I don't know if this is a real fear...people are getting paranoid over this.***

An inverse relationship between years of experience and acceptance of the nurse practitioner role was suggested by one resident physician:

> ***I think most [family physicians] are leery of it...I think it depends on when they graduated...somebody who has been in practice a little longer, the less I think they would be open to collaboration.***

Faculty Physicians

Faculty physicians responded similarly:

> ***...incredible insecurity and fear of nurse practitioners... family docs out there are threatened by this...'it's a government plot that you're going to take our work away and nurse practitioners will be cheaper than us' and we felt really threatened by this...***

Loss of skills was also a perceived concern noted solely by faculty physicians. If nurse practitioners took over routine presentations, then physicians would be left with complex clients only. This was not necessarily a desired outcome for some physicians.

> ***...left with rashes that do not get diagnosed and other complicated patients...***

> ***...skim off the easy patients like the walk in clinics do and leave us with the challenges...***

Another issue identified by faculty physicians was that if physicians felt they were losing parts of their practice, some might react by questioning the

educational preparation of the nurse practitioner.

> ***...the next step is you think, well, they can't do the job as well as [physicians] anyway...it becomes a competence issue.***

Shorter Educational Process

Resident and faculty physicians were asked whether there were issues surrounding the shorter educational process for a nurse practitioner compared with a physician. Both groups identified concerns, but these were of a contrasting nature.

Resident Physicians

Some of the resident physicians seemed to view the shorter educational process negatively, especially given that the trend in medicine is towards more education before qualifying to do primary care.

> ***The trend in medical education has been to more education...I wonder if that's a step backwards to say that maybe we could do this with shorter periods of education.***

> ***If you are starting at a lower level of academics and then shorter education period, I don't know if that's where we want to be going or not.***

But a contrasting view was also expressed in that

> ***...the years of training don't necessarily matter, I think it depends on the person and what they have taken out of the training that they did get...it more important to have someone that I would trust...than how many years of school you have had.***

For some resident physicians, the shorter educational process was seen as a

sign of inferior training, leaving them to question the quality of care a nurse practitioner could provide.

> ***...so you wonder, do they really know what they are basing their decision on...it just makes me wary that I am going to be liable for the person...and I'm not going to have all the answers either, but I mean that they are not going to have the appropriate background to be making decisions.***
>
> ***I would be very concerned about quality of care, not knowing exactly how well prepared these people [nurse practitioners] are...and how exactly they are trained and what exams they have passed to get into that situation... the quality of care to the patient...I think has to suffer from it...***

Faculty Physicians

For the faculty physicians, the issue was one of concern as to the format of the educational process rather than its length.

> ***...nurse practitioners...often lack the reasoning behind what they say [although] most of the times they are right.***
>
> ***...it's the inability to put the puzzle together...is that a deficit in the education...do you really have to go through the medical school process to get that didactic training to be able to put that puzzle together?***

Faculty physicians indicated comfort with the educational preparation in relation to their experience working with nurse practitioner students.

> ***I think yes we have confidence in what we are seeing as a process but I think it is a genuine concern...certainly not so long ago there was some significant concern in the literature about the quality of care the patients get from nurse practitioners and the fact that everyone that comes in with a runny nose gets Amoxil or a cephalosporin, for instance...***

I don't feel as such [concerned about the educational process], but then I am biassed because of my setting and the nurse practitioners that I have come across. So I think that those who haven't come across [nurse practitioners] in training or otherwise...it is probably going to be an easy excuse [the shorter educational process]...

Summary

To ***"work together"*** was identified by all participants as their understanding of collaboration. Resident physicians were not in agreement on whether they personally were ready whereas faculty physicians as a group indicated readiness. Both resident and faculty physicians speculated that territorial and educational issues would hinder the acceptance of nurse practitioners by the medical community.

Benefits and Disadvantages to Collaboration

The fourth research question was to determine perceived benefits and disadvantages to collaboration for the client, nurse practitioner and physician. This section is presented in two components: benefits and disadvantages.

Benefits

Participants were asked to identify what the benefits of collaboration with a nurse practitioner might be to the client, nurse practitioner and physician for research question four. Neither the resident physicians nor the faculty physicians recognized benefits to the nurse practitioner, but an extensive list of benefits to both client and physician were identified.

Resident Physicians

Client. Increased time with clients was the prevailing benefit identified by resident physicians. Collaboration with a nurse practitioner would result in the client receiving more time during the visit, the consequences of this being an overall more positive experience for the client.

> ***...they [nurse practitioners] may...have more time to be able to see patients more frequently, they might be able to monitor routine conditions effectively and give patients closer and more thorough follow up than in a busy physician practice.***
>
> ***...a more holistic approach...something that physicians don't routinely provide just because of time constraints...***

Numerous other positive benefits were cited by resident physicians.

> ***...overall the patient may be set up for better care. Some primary prevention things would have more focus to them, some counselling issues would take more attention, we actually experience that in our own clinic with the dietician and the other registered nurse.***
>
> ***...like a psychosocial situation that we should be focussing on then maybe the nurse could do that.***

Client advocacy, gaining trust, more holistic and organized care were some of the other benefits that emerged.

Physician. In terms of benefits to physicians, resident physicians identified that by working with a nurse practitioner, the complexity and variety of their individual practice would increase - a desired outcome for some resident physicians and one that could enhance their practice.

> ***I think that for me it could significantly enhance my practice...I don't think it would take away from my gratification of the whole practice...rather than me... trying to see three colds in 15 minutes...I would much rather spend a full half hour with someone who is more complicated.***

It was also identified that they themselves would be able to spend more time with each client, as well as decrease their workload.

> ***...if the [nurse practitioner were] easing the load...it might give me more time to spend with each patient.***

Sharing of ideas and exposure to different approaches to client care were also seen as benefits.

> ***...it is nice to have someone there with some training you can bounce ideas off of and say come and have a look at this, I don't know what this is, what do you think. Just working with somebody else that has that ability to sort of share, brainstorm and consult with.***

Faculty Physicians

Client. Compared with resident physicians, faculty physicians identified similar benefits to the client. Collaboration would allow a nurse practitioner to spend more time with each client, thereby increasing the quality of that visit.

> ***Time. The vast majority of nurse practitioners that I've worked with spend a lot longer with patients than I do... so the patient is more relaxed, a more relaxed interaction.***

> ***Health promotion is a bigger thing...education... counselling...where we do not have...time.***

A nurse practitioner may take a different approach to client care, as well as

provide increased access to services.

> ***Accessibility to a collaboration of people rather than one individual...I see it as one of the strongest advantages with a slightly different approach philosophically and a different set of eyes and ears that will see and hear different things in a different way...would add another dimension to the care relationship.***

Physician. The faculty physicians felt that by working with a nurse practitioner, they then would be free to spend more time with clients.

> ***That in turn will actually save time for myself and then I am able to spend a little more time with the patient as well.***

Another identified benefit was the opportunity to enhance physician knowledge base by being challenged and exposed to a different approach, rather than working in isolation.

> ***I think one of the biggest problems of family care physicians is functioning in isolation and losing perspective of issues by virtue of that. You tend to reinforce your own approach and behaviours based on the fact that there isn't a good feedback loop other than the patients that continue to come and see you...by collaborating with other people you are continually having some reality checks...***

Disadvantages

The physicians were asked to identify possible disadvantages to collaboration related to client, nurse practitioner and physician. Slightly different themes emerged from the responses of resident physicians compared with faculty physicians.

Resident Physicians

Client. The prevailing theme amongst the resident physicians revolved around decreased quality of care, with a variety of issues cited as contributing factors to a perceived compromise in care. The different assessment style of a nurse practitioner by virtue of educational background was voiced by a few resident physicians as possibly compromising quality of care:

> ***...there is often a different focus in terms of the questions...so I have been concerned about the care that people get sometimes because it comes from a different perspective...***
>
> ***I would be very concerned about quality of care, not knowing exactly how well prepared these people [nurse practitioners] are...and how exactly they are trained and what exams they have passed to get into that situation... the quality of care to the patient is I think has to suffer from it...***
>
> ***I don't think that in my experience I've seen nurses do a better job at health promotion in terms of prevention than say a family doctor.***

A nurse practitioner was identified as "the next best thing" if a physician was difficult to access. Conversely, the option to see a nurse practitioner might fragment care, resulting in a less than optimal health care experience for the public.

> ***...in Canada we want a homogeneous health care experience for everyone.***

Physician. Most resident physicians were concerned about liability with respect to disadvantages to the physician.

> ***...who is ultimately responsible for that patient...where the liability lies and what is there for liability insurance.***
>
> ***...how many physicians are going to be made legally liable for [nurse practitioners'] decisions.***
>
> ***I have these concerns around liability that if someone else is going to be giving advice and I don't know what it is, I don't want to be responsible for it.***

Resident physicians were also concerned about interrupted continuity of care with respect to their professional connection to the client.

> ***...losing contact with patients if [nurse practitioners] are doing some of your work.***
>
> ***Like when you are doing well baby care...if I don't know what's happening with the baby...that's not continuity of care.***

Nurse Practitioner. One resident physician was concerned that if a nurse practitioner were collaborating with a physician in a fee for service arrangement, the nurse practitioner may be inclined to spend less time with clients.

> ***...if the nurse practitioner were a salaried individual as compared to fee for service, then they would probably have less incentive to move through patients quicker and maybe give some more time to the patients that want more time to talk, and more education to them, rather than rapidity of the care that is associated with fee for service physicians.***

Faculty Physicians

Client. Faculty physicians reflected concerns over fragmentation of care versus quality of care if they were to collaborate with a nurse practitioner. Having to learn to trust another provider, perceiving the nurse practitioner as another barrier to seeing the physician, and being subjected to a different style, possibly even a differing opinion than that of the physician, were identified as possible disadvantageous consequences of collaboration with a nurse practitioner.

> ***...patients will have to start trusting professionals in general.***
>
> ***...another wall between the patient and the physician.***
>
> ***...if the doctor has a different opinion from what the nurse practitioner has, the whole thing is undermined.***

While shared care was identified as an element of collaboration, the validity of this approach was questioned in terms of continuity for the client.

> ***So I suspect shared care is really part of collaboration, and if it is then it is a threat to the patient provider relationship...to the continuity of that relationship.***

Physician. Another area of concern was the possibility of working with an incompetent nurse practitioner.

> ***... a nurse practitioner [who] is not as competent as a staff physician...it makes me worry about the type of practice [the nurse practitioner is] doing and how you are handling the patients.***

Summary

Resident physicians cited the main benefit to the client being increased time per visit, while the main benefit for physicians would be a more varied, complex practice. The main disadvantage would be decreased quality of care to the client. Faculty physicians believed that the main benefit to the client would be increased quality of care per visit with interprofessional enhancement as the main benefit to physicians. Possible fragmentation of care was the main disadvantage.

Elements of Collaboration

For the fifth research question, participants were asked to identify what mechanisms need to be in place for collaboration to succeed - what qualities would one envision for collaboration to be successful. The responses to this question are grouped according to the seven elements identified in the Ontario Model:

- communication
- mutual trust and respect
- autonomy
- cooperation
- responsibility and accountability
- coordination
- assertiveness.

Communication

Communication is the succinct, clear and concise exchange of information in an atmosphere of respect and equality. If this element is present, each partner will feel that his/her opinion is being heard by the other, and will reciprocate with respectful listening. There should not be feelings of superiority or inferiority, but rather an atmosphere of mutual support and affirmation.

Resident and Faculty Physicians

Resident physicians identified both communication and openness as elements to collaboration, while faculty physicians identified equality and humility as two elements that would enhance communication.

Mutual Trust and Respect

This is the element that binds all the others together and forms the foundation for success in collaboration.

Resident and Faculty Physicians

Resident physicians identified both respect and trust as necessary qualities, whereas faculty physicians identified only respect.

Autonomy

Autonomy allows for the independent action and decision making of each partner when carrying out a treatment plan. Each partner is liable for independently made decisions and outcomes. It is important that each partner recognize and understand the other's scope of practice to support

shared decision making.

Resident Physicians

Resident physicians felt that assurance of regulatory body involvement was crucial to trusting the autonomy of the nurse practitioner.

> ***...that would make a collaboration acceptable to me knowing that these people...have malpractice insurance ...and that I won't be liable for sending them to that person and having something happen to that person under their care.***
>
> ***...I also want to know the profession and know that there is some regulatory body saying that these people are certified to do this so that I feel comfortable referring to anybody in that body as opposed to taking a chance...***

Resident physicians suggested that the quality of being an understanding person, and more specifically, role understanding were elements of collaboration. Independence and awareness of limitations also were also identified as important qualities.

> ***An understanding of one another's roles.***
> ***Yeah, I think so too.***
> ***That would be the most important thing to me.***
> ***So there is no stepping on toes...***

Faculty Physicians

Faculty physicians felt that independent functioning, role understanding and role definition/expectations and awareness of limitations were crucial qualities that fit under this element.

...if we are going to collaborate [I need to know how] you define your role and what you expect of your role and I have to understand that and respect that. If I don't accept what you're saying your role is then I don't see us being able to work together.

...what I've ended up appreciating is independence, confidence, a knowledge of limitations, much the same as I look for in physician colleagues or that I expect from myself...

Cooperation

This involves the respect and acknowledgement of each partner's approach to care.

Resident and Faculty Physicians

While neither resident nor faculty physicians' responses tie in closely to this element, both groups did identify that in order to collaborate effectively, a sharing of the same practice philosophy to care was necessary.

...similar practice styles, philosophies about medicine...I don't think it would be right if patients are exposed to both people and one...has one way of doing things and the other says no, no, no, that's no good. So I think very similar practice styles and philosophies are important.

...there has to be that sense that we are both giving the patient the same message or it's a little bit like kids... if they don't get what they want from Mom I think I will go to Dad...

Responsibility and Accountability

This implies that both the nurse practitioner and physician are jointly accountable for decision making with respect to client care, and both accept

responsibility for the outcomes of those decisions.

Resident and Faculty Physicians

It was identified by both the resident and faculty physicians that being responsible for one's own decisions was an element in collaboration.

> ***To me that is two independent practitioners, maybe working in the same office, maybe sharing the practice population and working together, but they're each responsible for their own decisions.***
>
> ***...I expect myself to know that I am responsible for the decisions that I am making, if I screw up it's not someone else's fault, it's my fault...take responsibility for those decisions...***

Coordination

Coordination is the "efficient and effective organization of the necessary components of the treatment plan" (Way et al., 2000, p.5). This element requires that partners coordinate client care based on who is most qualified to address the client's problem, thereby reducing duplication and fragmentation of care.

Resident Physicians

Resident physicians identified shared care as an essential component to collaboration, ***"...maybe sharing practice population..."***, but the value of shared care was questioned in that it would result in fragmented care, as well as lead to overlap in roles.

...passing back and forth...would lead to more fragmentation of care...then I guess I wonder what's the point? Either have one or the other do it and function independently. What is to be gained [from collaboration with a nurse practitioner]...?

...there should be very little overlap, which usually creates a problem...if there is going to be overlap... practice will not be very successful...

Faculty Physicians

Faculty physicians also identified and questioned shared care as an essential component to collaboration.

I guess the one thing that I see as being an issue is in having shared care. Now I think collaboration works best when there is...but then there is a threat to the patient provider relationship...but if there isn't some sort of shared care, I wonder what kind of collaboration it is, do we share rent?

The faculty physicians further identified with this element by citing planning and the sharing of expertise for the benefit of the client as crucial elements to collaboration.

...working together we...see what we can do for this patient. Or she calls up ___ and says this seems to be a problem coming in my practice more frequently, I wonder if we should do something about this and we think of some research activity...

...a group of people, each brings his/her focus to a situation and kind of come up with a strategy or a plan of how you're going to deal with any given situation, whether it is patient care or...come up with some ideas together that you implement either individually or collectively.

Assertiveness

According to the Ontario Model, assertiveness is linked to cooperation. Respect and acknowledgement for each other's discipline (as defined under cooperation) should create an atmosphere which allows each discipline to present opinions resulting in the integration of approaches into a synergistic solution for client care.

Resident and Faculty Physicians

Resident physician responses did not reflect this element, while the faculty physicians identified confidence as a crucial element to collaboration.

Miscellaneous

There were a number of qualities identified by participants that did not fit into the elements as defined in the Ontario Model.

Resident Physicians

For resident physicians, a clear delineation of the limits of the nurse practitioner role and a clear understanding / clarification of liability concerns were felt to be necessary components of a collaborative relationship. Honesty and consistency in performance were also key. Some resident physicians wanted to see proof of competency as a prerequisite for collaboration.

> ***...I would have to be shown exactly what these professionals are capable of doing, what they are comfortable of handling and certified to do...and be comfortable that the patient is safe in that environment, then I could collaborate.***

Time and delineation of function were also frequently mentioned as necessary for collaborative development:

> ***...over time you would have to develop a relationship... and you would have to determine at what level you're comfortable in accepting responsibility for a lot of things that they would be doing and seeing...talk about the kind of people that we see so commonly...lumbar back pain, or vertigo, or common cold...looking out for the ominous...***

Faculty Physicians

The faculty physicians felt that taking time to plan the type of practice and to set out guidelines as to how the collaborative process would function were critical. A sense of humour and patience were also stated to be key elements.

> ***...collaboration [involves] some sort of planning process, it makes a lot of sense...if you are going to get into that type of relationship, that the nurse's qualities required would be the understanding of those roles...***
>
> ***...all the mechanisms have to be in place ahead of time... the rules of collaboration, if you want to call them rules or guidelines of collaboration...***

Summary

Qualities associated with assertiveness, mutual trust and respect, communication and responsibility and accountability were not strongly identified from the data. Autonomy, cooperation and coordination were themes of collaboration that were identified in this section.

Recommendations to Enhance Change

The final question posed to each of the focus groups was what would they like to see from nursing in order for them to more fully embrace the nurse practitioner concept. Overlap in themes between the two groups emerged in this section, with the resident physicians having some additional suggestions beyond those that were common to the two groups.

Resident and Faculty Physicians

Resident physicians again requested clarification of the liability issue - as long as they would not be liable, they could be more accepting. Also, reassurance that nurse practitioners could and would recognize their limitations.

One physician suggested that nurse practitioners should be trained by their own profession. While it was acknowledged that exposure to physicians was healthy, it should not be the primary source of training.

> ***...they should be trained by nurse practitioners. I mean they spend some time in physician offices and see how we function but they should not really be trained by us because we process things differently...***

Both groups expressed an interest in why the nurse practitioner role had come about, especially in light of the systemic shortages of nursing in health care. Resident and faculty physicians questioned if nurse practitioners were dissatisfied with the traditional nursing role.

> ***...I'm wondering what's the drive...is it dissatisfaction with their current job and if that's the case what are they bringing to this new job from their old one...***

> ***...presumably you don't want to be physicians because you would have gone to medical school so there is something different that goes on, there is a different role, a different profession, it's a different philosophy. People that go into advanced placement nursing are looking for something different than medicine and I am going to throw the question back at you...what do you want? Where do you see yourselves? How do you see yourselves? You don't want to be doctors but you don't want to be that traditional nurse.***
>
> ***I think that there are genuine concerns that people might have. For instance, there is an incredible shortage of nurses in traditional nurse's roles so why are you training people to do our job when there aren't enough nurses to do nursing jobs. So it doesn't make a lot of sense maybe...***

Both groups wanted answers to the following questions: What is the role of the nurse practitioner in the health care system? Where do nurse practitioners see their niche? Clear articulation based on the answers to these questions would be the basis for understanding and appreciating the nurse practitioner role. Resident physicians' concerns were expressed as:

> ***I need a better understanding of what...they want their role to be...***
>
> ***...what is this nurse practitioner, and what does it entail, what qualifications and educational background do they have? What do they perceive their abilities to contribute to what my practice would be?...how is that going to impact on the care of the patients, how realistic it is to incorporate them into my practice...***
>
> ***...more information on what it really means...what is a nurse practitioner...what does it take for somebody to be able to call themselves that. What courses were involved and what does somebody need to do to be certified to do that.***

> ***...defining the role and providing objective proof of qualifications...***

Faculty physicians' concerns were similar.

> ***I guess I don't understand what nurse practitioners want to do. Why does that niche exist?***
>
> ***What we need from you is to articulate your role in the system so that we can understand it. As for our colleagues who may, we think, be less accepting than we are, the strongest way of dealing with it is to be able to articulate to everybody very clearly what it is that you are offering the system and why, so they can understand and appreciate it.***

Summary

Both resident and faculty physicians indicated that in order for physicians in general to embrace the nurse practitioner concept, the nursing discipline must clearly articulate the nurse practitioner role in the health care system. Until then, it would not be clear what the nurse practitioner provides, and what the benefits to supporting and enhancing the role are. Both groups also wanted nursing to communicate why nurse practitioner education is being pursued, especially in light of the nursing shortage in traditional nursing roles.

Conclusion

Resident physicians identified the nurse practitioner role primarily as one of filling gaps in areas where physicians were lacking, utilizing an expanded skill set (normally associated with a physician) to manage routine,

stable conditions. Faculty physicians articulated the nurse practitioner role as being mainly complementary to a physician in the primary care setting, but not necessarily restricted to that. Faculty physicians viewed nurse practitioners as providing a more holistic approach to patient care.

Resident physicians indicated that the nurse practitioner role should become more mainstream, but continued to visualize the role as more of a physician's helper. Faculty physicians' visualization of the nurse practitioner role was more open and unrestricted in nature. Any setting would be plausible for a nurse practitioner, with encouragement to keep the scope of practice broad.

To ***"work together"*** was identified by all participants as their understanding of collaboration. Resident physicians were not in agreement on whether they personally were ready whereas faculty physicians indicated their readiness. Both resident and faculty physicians speculated that territorial issues would hinder the acceptance of nurse practitioners by the general medical community.

Resident physicians cited the main benefit to the client being increased time per visit, while the main benefit for physicians would be a more varied, complex practice. The main disadvantage would be decreased quality of care to the client. Faculty physicians believed that the main benefit to the client would be increased quality of care per visit with interprofessional enhancement as the main benefit to physicians. They felt that possible

fragmentation of care would be the main disadvantage.

Qualities associated with assertiveness, mutual trust and respect, cooperation and coordination were not strongly identified as elements of collaboration from the focus groups. Responsibility and accountability for personal actions, knowing one's limitations and the importance of communication were themes of collaboration that emerged from the focus groups.

Both resident and faculty physicians felt strongly that in order for physicians to embrace the nurse practitioner concept, the nursing discipline must clearly articulate the nurse practitioner role in the health care system. The nurse practitioner role was not clearly understood and therefore the benefits to supporting and enhancing the role were not clear. Both groups also wanted nursing to clarify why nurse practitioners were being emphasized in light of the nursing shortage in traditional nursing roles.

In summarizing the findings, three major themes seem to stand out most clearly. First, the role of nurse practitioners remains unclear and the lack of clarity pervaded almost all of the other questions. For example, it is difficult to identify benefits and advantages without a clear definitions of what nurse practitioners do. Second, the separate analysis by resident and faculty physicians demonstrated differences that might well be attributed to some of the different elements of these two groups. For example, faculty physicians have had longer practice and greater exposure to nurse practitioners. On the

other, resident physicians seemed more tentative about the role of nurse practitioners compared with faculty physicians. Third, the Ontario Model and the elements identified did not seem to fit as well as anticipated. These three points will be addressed in the following chapter.

CHAPTER FIVE - DISCUSSION

Introduction

This chapter will present a discussion of the three themes that emerged from the analysis. Limitations of the project, and implications for practice, research and education are also addressed.

Discussion

Three major themes emanated from the data: 1) the level of knowledge and understanding reflected in the responses to the first question about nurse practitioner role related to responses to subsequent questions, 2) resident and faculty physicians had contrasting views to some questions, and 3) while a theoretical model of collaboration was used to guide a portion of this project, discussion around elements of collaboration was limited.

Level of Knowledge

Collaborative practice was described in the Ontario Model as an "inter-professional process of communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the patient/client care provided" (Way et al., 2000, p.3). Prior to establishing a successful collaborative practice, each partner must have a clear understanding of the role and responsibilities of the other. Without a full comprehension of the scope of practice of a nurse practitioner, the

collaborative practice will likely not realize its fullest potential. The results of this project indicated that a limited knowledge of the nurse practitioner will in turn affect one's ability to visualize collaboration with a nurse practitioner in terms of state of readiness, benefits and disadvantages. The literature suggested that physicians neither have a complete understanding of the practice of nursing, nor an understanding of the scope of practice of the nurse practitioner (Alpert et al., 1992; Cairo, 1996; Ford & Kish, 1998) and lack of knowledge subsequently influenced views on collaboration (Cairo, 1996). The results of this project parallel findings in the literature.

Resident Physicians

The first question posed to all focus groups revolved around determining knowledge and understanding of nurse practitioners. Resident physician responses reflected a limited understanding of the nurse practitioner. The resident physicians conceded that they did not know or understand what nurse practitioners do. "Filling in the gaps" and "assistant" are two phrases which capture the essence of the resident physicians' understanding of nurse practitioners. Responses to the second and subsequent questions all reflected, to a certain degree, the limited knowledge and understanding of the nurse practitioner role.

Continued identification of the nurse practitioner role with remote rural and northern settings also indicated a limited perspective. Resident physicians indicated the role as "filling in gaps" where there were not enough

physicians.

Because they were not clear about the nurse practitioner role, their subsequent responses to questions on benefits, disadvantages, state of readiness and elements of collaboration were hindered. Most resident physicians stated that they would collaborate with a nurse practitioner, but qualified their answer by stating they would be willing to give up some of the routine tasks. This implies a view of the nurse practitioner as someone who can assist with workload issues. Workload was the predominant theme arising from benefits to physician. A nurse practitioner could decrease physician workload, thereby freeing the physician to increase the variety and complexity of his/her practice. When asked to identify benefits of collaboration to the client, though, resident physicians communicated descriptors often associated with nurses: holistic, counselling, psychosocial focus, trust, advocacy.

Disadvantages to collaboration with a nurse practitioner reflected concerns about the educational process of the nurse practitioner, liability issues, and uneasiness about competency. It can be speculated that these concerns are as a result of a limited knowledge of the nurse practitioner role and its responsibilities. This has been presented in the literature where it was reported that role misinformation subsequently affected thoughts on liability, credentialing and competency (Cairo, 1996; Ford & Kish, 1998).

The final question asked physicians to articulate what they would need

from the nursing discipline in order to more fully embrace the nurse practitioner concept. The expressed lack of clarity about the nurse practitioner role again emerged. Resident physicians wanted to understand the role evolution - what had initiated the move? They also wanted to know how nursing visualized the role in the health care system.

Faculty Physicians

The faculty physicians' knowledge about the nurse practitioner role was greater than that of the resident physicians. They viewed the nurse practitioner as complementary to the physician. Responsibilities of a nurse practitioner were largely dependent on his/her experience and personality. The faculty physicians' view of nurse practitioners was clearer and more broadly based and responses to subsequent questions reflected this view.

Perhaps because of the more comprehensive view of the nurse practitioner, faculty physicians were able to visualize the role more broadly. Health promotion, educative and counselling skills were cited, reflecting skills usually associated with nursing. Benefits and disadvantages were identified including increased intellectual challenge and being more open to another approach or view. Disadvantages reflected responses at the level of the system rather than bringing in to question the competency of the nurse practitioner.

Even though the faculty physicians had a broader knowledge base of nurse practitioners compared to the resident physicians, their needs in terms

of what they wanted to see from nursing, were the same - articulation of the nurse practitioner role in the system.

Residents versus Faculty

When reviewing the data in the context of comparing and contrasting the resident physicians' responses to those of the faculty physicians, some interesting differences became apparent. The reasons for these differences can only be speculated, but the literature indicated that physicians who have more experience with nurse practitioners tend to have a more positive attitude (Aquilino et al., 1999; Ford & Kish, 1998).

Demographic data were not gathered, but it can be surmised that the resident physicians have fewer years of experience compared with the faculty physicians. Resident physicians are in the process of consolidating their own learning and knowledge base, whereas faculty physicians have had a number of years to build and strengthen their knowledge. Resident physicians' concerns regarding educational preparation, competency, and issues around standards of testing for nurse practitioners may be rooted in their beginning role in the health care system. Faculty physicians perhaps were more comfortable with their role in the health care system, and hence were able to better visualize the role of a new member within that system. Faculty physicians were able to articulate at a broader level the potential for the nurse practitioner role, reflecting exposure to nursing in general and perhaps to nurse practitioners, through their years of practice. One might speculate that

with experience comes comfort and openness to change in role and responsibilities.

Elements of Collaboration

The last theme revolved around the lack of discussion with respect to elements of collaboration. Elements of the Ontario Model served as a guide. Physician responses identified strongest with the elements of autonomy, cooperation and coordination. There was limited identification with the elements of communication, mutual trust and respect, responsibility and accountability and assertiveness. Time, planning and reassurance were miscellaneous elements that emerged from the data.

The core of the discussion reflected a theme of boundaries and tasks. Perhaps this can be attributed to the flow of conversation up until that point in the discussion, where conversation revolved around more concrete content versus abstract. Or perhaps it is again a reflection of where the residents' concerns lie - with a lack of knowledge reflected in their restrictive visualization of the nurse practitioner role. The faculty physicians, being more comfortable with their role, were able to conceptualize the partnership. It must also be addressed that perhaps the wording of the question was poor, thereby affecting responses.

Limitations

The generalizability of findings is limited due to convenience sampling.

The small sample size (n=11) and the difference in quantity between the resident physicians (n=8) and faculty physicians (n=3) also must be taken into consideration. The investigator as facilitator of the focus groups may have biassed results. An element of familiarity between the physicians and the investigator existed in that the investigator had completed clinical experience at the clinic setting during the previous eight months. The extent and direction of bias is difficult to assess.

While the recommended number per focus group is 5 to15 (Sims, 1998), the facilitator found that the focus group of five was too many given the 60 minute time frame, while the two groups with three per session seemed too few. In the focus group with five participants, two questions were not addressed due to lack of time. Given the nature of the questions and the time limit, four would have been optimal.

Implications for Practice, Research and Education

For Practice

While the results of this project are not generalizable, at the very least it would be wise for nurse practitioners to appreciate that physicians most likely have questions and concerns about the nurse practitioner role. Operating from this premise puts a nurse practitioner in a position of accepting responsibility for promoting the role and correcting misinformation or gaps in knowledge in an objective and nonjudgmental way. Taking steps

to educate those within the practice setting, albeit at the team or systemic level is crucial for the development of the role. Possibly the same concerns will emanate from other disciplines as well as from clients. A clear message for nurse practitioners is to acknowledge that definition is needed and to provide clarity.

It is also necessary for nurse practitioners to be involved in the development of standards and competencies for the profession. Set standards and competencies will provide objective measures to help articulate the role and hopefully decrease role confusion.

For Research

A number of avenues for further research emerge from this project. This project uncovered a broad based lack of clarity about the nurse practitioner role. Future research might extend to include examination of self perceptions of nurse practitioners, and/or perceptions of clients of nurse practitioners. An intervention study, such as a pretest and posttest design, examining changes in perceptions after information sessions is another possibility.

Longitudinal studies examining the evolution of a collaborative relationship would be useful to examine elements of collaboration as the Ontario Model utilized in the project was not as helpful as anticipated. An examination to determine what unique qualities nurse practitioners bring to a collaborative practice by virtue of their educational background would aid

nurse practitioners and other health care team members by providing objective evidence to support the nurse practitioner role.

For Education

There are implications for education at two different levels. Examination of the role within the Advanced Practice Nursing program will aid students in articulating the role to other health care team members. General information sessions to other health care team members and the public will aid in dispelling role misinformation and will increase level of knowledge.

Advanced Practice Nursing Program

Within the Advanced Practice Nursing program, there should be consideration for increased emphasis on integrating discussion around unique contributions of the nurse practitioner within the health care system. Encouraging students to examine their personal thoughts on the role and responsibilities of the nurse practitioner may assist them in developing a process for articulating their thoughts to other health care team members. If nurse practitioners want the role to evolve, they need to be proactive and be comfortable with the role. By virtue of the small numbers of nurse practitioners in Manitoba, it is vital that all are able to articulate and present the role in a clear manner.

Informational Sessions

Informational sessions within nursing itself, as well as within medicine and other health care professions will aid in increasing knowledge. Similar

sessions for the public and politicians would also be beneficial. There obviously is a need for educational intervention, therefore information sessions to promote a better understanding of the nurse practitioner role will be a positive step leading to understanding and acceptance.

Conclusion

The purpose of this project was to develop an understanding of physicians' perceptions of nurse practitioners and collaboration. Focus group discussions were conducted with subsequent qualitative content analysis. Three major themes emanated from the analysis, and formed the basis for discussion and implications for practice, research and education.

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PERSONAL COMMUNICATION

Fraser Askin, D. (July 23, 2001). Assistant Professor, University of Manitoba Faculty of Nursing; Winnipeg, Manitoba.

Robinson, M. (March 02, 2001). Director of Primary Care and Program Integration, Winnipeg Regional Health Authority; Winnipeg, Manitoba.

Wilson-Mate, D. (March 07, 2001). Director of Policy Development and Regulation, Manitoba Association of Registered Nurses; Winnipeg, Manitoba.

APPENDIX A - SITE ACCESS REQUEST

Jane MacDonald
147 Woodfield Bay
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1-204-287-8752
ummacd31@cc.umanitoba.ca

April 19, 2001

Dr. Susan Hauch
Clinic Director, Family Medical Centre
5th floor - 400 Tache Avenue
Winnipeg, MB R2H 3E1

Dear Dr. Hauch;

I am writing to request access to Family Medical Centre for the purpose of conducting my practicum project.

The purpose of the project is to develop an understanding of residents' and faculty physicians' perceptions of nurse practitioner-physician collaboration, and will be undertaken in partial fulfilment of the requirements for the degree of Master of Nursing at the University of Manitoba.

The proposed project will involve at least 3 focus group discussions, each involving different participants. Two of the focus groups will coincide with the end of residents' block time in May and June, with the third group involving faculty physicians to take place sometime in June. The project will be conducted in the manner outlined in the attached proposal, and is pending approval from the Education/Nursing Research Ethics Board. Dr. Alan Katz has agreed to sit on my practicum committee and is fully aware of the details of my project.

Thank you for your consideration of this request. If you have any questions, please feel free to contact me.

Sincerely,

Jane MacDonald, RN BN
Advanced Practice Nursing Student

cc. Dr. Alan Katz
Dr. Lorna Guse

PROJECT PROPOSAL

Project Summary

During the 3 months commencing April 2001, I will be consolidating my learning of the past 2 years as a nurse practitioner Master's student. While in the practicum setting at Family Medical Centre, it is expected that I conduct a practicum project in partial fulfilment of the Master of Nursing degree. I propose to conduct a qualitative investigation of residents' and faculty physicians' perceptions of nurse practitioner-physician collaboration utilizing a focus group discussion format.

Principal Investigator

This proposal is being submitted for consideration by Jane MacDonald, RN, BN, Advanced Practice Nursing Student.

Project Setting

This project will be carried out at Family Medical Centre (FMC) on Tache Avenue. FMC is a family resident training site affiliated with the University of Manitoba and St. Boniface Hospital. FMC trains approximately 12 residents per year for general family medicine practice, and employs approximately 6 faculty physicians as faculty members.

Project Objectives

The purpose of the project is to develop an understanding of:

- residents' perceptions of nurse practitioner/physician collaboration, and
- faculty physicians' perceptions of nurse practitioner/physician collaboration.

Rationale for the Project

A careful review of the literature has revealed 3 themes:

- there is an abundance of literature regarding support for the nurse practitioner role,
- there is ongoing debate in the medical community as to what the role of the nurse practitioner should look like, and
- there is a lack of literature regarding physicians' perceptions of collaboration with nurse practitioners.

The current nurse practitioner movement in Manitoba has been supported by University of Manitoba, Manitoba Ministry of Health, Winnipeg Regional Health Authority and Manitoba Association of Registered Nurses. There has also been physician support, but it has been suggested that this support may be enhanced if there were a better understanding of physicians' perceptions regarding collaboration with nurse practitioners.

Critical Path

- **Phase 1 (3rd week of May):** Distribution of a recruitment letter requesting residents rotating through block time at the Centre to participate in a focus group discussion regarding nurse practitioner - physician collaboration.
- **Phase 2 (4th week of May):** One hour taped focus group discussion.
- **Phase 3 (beginning of June):** Validation of results by participants.

This process will be repeated twice more; at the end of June involving a second group of residents, and a third time with a group of faculty physicians sometime when convenient in June. The focus groups will be arranged at the convenience of those involved and will not infringe on clinic activities.

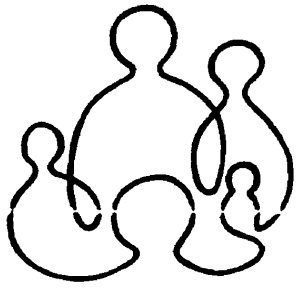
Data Analysis

Data analysis will be carried out during the month of July.

Supervisors

Dr. Lorna Guse: Faculty of Nursing
Debbie Askin Fraser: Faculty of Nursing
Dr. Alan Katz: Faculty of Medicine - Family Medical Centre

APPENDIX B - ACCESS APPROVAL



family medical centre

5th floor, 400 tache avenue winnipeg, manitoba, canada r2h 3e1

Tel: (204) 237-2863
Fax: (204) 231-2648

April 25, 2001

Jane MacDonald
147 Woodfield Bay
Winnipeg, Manitoba
R3R 2Z1

Dear Jane:

Thank you for your letter of April 19th. I have considered your request and have reviewed your project proposal and I am certainly agreeable to your use of the Family Medical Centre to conduct your practicum project.

If I can be of any further assistance, please do not hesitate to contact me.

Yours sincerely,

Susan G. Hauch, MD, CCFP
Clinical Director

SGH/gge
cc. Dr. Alan Katz
Dr. Lorna Guse

APPENDIX C - LETTER OF INVITATION

As you may know, I am a nurse practitioner student completing my Master's of Nursing degree through the University of Manitoba. In partial fulfilment of that degree, I must complete a 400 hour practicum to consolidate learning (which I am completing here at Family Medical Centre) and I must also conduct a project while in the practicum setting.

My project title is "Physicians' Perceptions of Nurse Practitioner/Physician Collaboration". Through the use of small focus group discussions, I hope to develop an understanding of physicians' perceptions of collaboration. I would like to invite you to participate in one of these discussions next week. The focus group will last approximately one hour, and I will be taping it for later transcription and data analysis. If necessary, I may seek you out after the tapes have been transcribed in order to clarify comments discussed during the session. No names will be used at any point in the recording of the data, or in the writing of the project paper, thereby assuring your confidentiality. Confidentiality will be maintained between participants in the focus group. You are free to terminate your participation at any point, and can refuse to answer any specific question. The format for the discussion will be semi-structured - it is meant to be an open dialogue amongst the four of us, with me acting as facilitator. My intent is for you to give me an indication of your true perceptions of nurse practitioners and their role with physicians here in Manitoba, in the anticipation that the results of the project may aid in the enhancement of future collaboration.

In order to stimulate your thoughts for next week, I will give you a brief outline of the general situation here in Manitoba regarding the nurse practitioner movement. There has been a recent initiative within Manitoba to develop the nurse practitioner role in primary care, involving a number of key agencies:

- The University of Manitoba Faculty of Nursing began offering a 2-year Masters' degree for nurse practitioners in 1998, advancing registered nurses' education in the areas of history taking, physical assessment, health promotion and disease prevention. This program graduated two nurse practitioners in 2000, and will graduate six more this year.
- The Winnipeg Regional Health Authority has developed a conceptual framework for nurse practitioners with the intention of introducing nurse practitioners into the local primary health care system in collaborative practice with physicians.
- The current Registered Nurses Act has been revised to contain legislation for an expanded nursing role, which once proclaimed, will entitle nurse practitioners to independently diagnose, treat and prescribe for certain conditions.

If you have any questions, please feel free to speak with me. Thank you for your time.

Jane MacDonald, RN, BN
Advanced Practice Nursing Student

APPENDIX D - FOCUS GROUP CONSENT FORM

'Residents'/Physicians' Perceptions of Nurse Practitioner/Physician Collaboration'

In signing this consent form, I am giving my consent to participate in a focus group discussion facilitated by Jane MacDonald, a registered nurse who is conducting a practicum project as part of the requirements for a Master of Nursing degree from the University of Manitoba. I understand that I will be part of a qualitative study focusing on the perceptions of residents and physicians towards nurse practitioner/physician collaboration.

I understand that I will be part of a focus group. I will be asked to participate in a 60 minute audio taped focus group discussion led by Jane MacDonald, involving myself and up to 3 other persons.

I agree to participate in this focus group freely. I have been informed that my participation is entirely voluntary. I can refuse to answer any specific question I so choose, and I have the right to withdraw from the project at any time. I have been told that no reports of this study will ever identify me in any way because no names will be used. I understand that comments spoken in the focus group will be kept confidential between participants. After the focus group, a transcribed copy of the tapes may be given to me for review of accuracy. I can have any of my comments removed if requested. Transcription will be done by someone other than the investigator; confidentiality will be maintained by the transcriptionist. The investigator's Project Chair, Dr. Lorna Guse, will have access to the transcripts.

The purpose of the study is to develop a better understanding of physicians' perceptions of nurse practitioner/physician collaboration. I will receive no direct benefit or harm as a result of participation.

All data from the study will be kept in a locked cabinet at the investigator's home for a period of one year following the investigator's graduation. This study has been approved by the Education/Nursing Research Ethics Board of the University of Manitoba. The advisor for this study is Dr. Lorna Guse (474-6220).

I understand that a summary of the study results will be given to me if I ask for them and that Jane MacDonald (287-8752 or ummacd31@cc.umanitoba.ca) is the person to contact if I have any questions about the study or about my rights as a study participant. Any complaint regarding a procedure may be reported to the Human Ethics Secretariat (474-7122).

_____ _____

Date Respondent's signature

_____

Researcher's signature

I would like a summary of the results of this study:

Name: _____

Address: _____

_____

APPENDIX E - ETHICS APPROVAL

UNIVERSITY OF MANITOBA | Office of the President

Office of Research Services
244 Engineering Building
Winnipeg, MB R3T 5V6
Canada
Telephone: (204) 474-8418
Fax: (204) 261-0325

APPROVAL CERTIFICATE

03 May 2001

TO: **Jane MacDonald**
Principal Investigator

FROM: **Lorna Guse, Chair**
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2001:026**
"Residents' and Physicians' Perceptions of Nurse Practitioner-Physician Collaboration"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.