



Perceptions of the Role of the Registered Nurse in an Urban Interprofessional Academic Family Practice Setting

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Abstract

Registered nurses (RNs) in Ontario have been asked to work collaboratively with family physicians (FPs) and other healthcare professionals in the family practice setting to improve the efficiency and effectiveness of healthcare delivery (OFPN 2005). Yet, little is known about the optimal utilization of the RN's role in family practice. This study builds on recent conversations regarding utilization of the nursing workforce (Oelke et al. 2008) and the nursing role (White et al. 2008) in the acute care setting by presenting perceptions of the role of the RN in an urban academic family practice setting. Interviews were conducted with 23 healthcare professionals of varying disciplines across three interprofessional academic family practice units in a Canadian city. Interviewees were asked about their perception of the RN's role as it relates to interprofessional collaboration (IPC). Our findings suggest that ambiguity surrounds the RN's role in family practice in general and in IPC in particular. Also, an FP's level of trust in an RN was found to be a central theme and an important variable in determining FP–RN collaboration, with higher levels of RN trustworthiness associated with higher levels of FP–RN collaboration. Optimal utilization of the family practice RN requires leadership in clarifying the RN's role in IPC, and why and how trust among IPC members is cultivated and nurtured.

Introduction

In October 2007, the Canadian Nurses Association (CNA) and the College of Family Physicians of Canada (CFPC) announced a joint vision statement on interprofessional collaboration (IPC) as a way of improving consumers' access to, and reducing wait times for, primary healthcare:

All people in Canada will have access to a family practice/primary care setting that offers each person the opportunity to have his/her care provided by each of the following: A personal family doctor and a registered nurse and/or a nurse practitioner. (CNA–CFPC 2007: 1)

IPC is defined as two or more health professionals of different disciplines working collaboratively to deliver comprehensive, high-quality care to patients (HealthForceOntario 2007). It is considered an effective way to improve patient outcomes, utilize limited health human resources and enhance health professional satisfaction (CHSRF 2006).

A key determinant of IPC is a clear understanding of roles (San Martin-Rodriguez et al. 2005). Role can be defined as a shared set of expectations, values, attitudes, norms and beliefs governing one's behaviour in a particular position in society

(Linton 1945) that may be shaped by educational preparation and legislation (Oelke et al. 2008). In this study, we build on recent conversations in the nursing literature regarding clarification and optimization of the registered nurse's role (Oelke et al. 2008; White et al. 2008). We add to this conversation the link between realizing the full potential of the RN's role and trusting FP–RN relationships.

A broad search of the literature revealed limited knowledge of the RN's role in family practice, particularly of RNs working in Canadian family practice settings. Countries leading this field of knowledge include New Zealand, the United Kingdom and Australia, which has a professional infrastructure for the RN's role in family practice that includes competency standards, career pathways, professional organizational support and role descriptions (Watts et al. 2004). While such infrastructure is underway, Watts and colleagues (2004) emphasize that the success of the family practice RN's role in Australia depends upon greater emphasis on family practice nursing as a viable career pathway, with appropriate educational opportunities to support the role.

Interest in the RN's role in Canadian family practice settings is growing. Todd and colleagues (2007) surveyed RNs working in family practices in Halifax, Nova Scotia, Canada to understand their functional work tasks in an attempt to delineate the role of the family practice RN. While these researchers uncovered common nursing tasks across family practice settings, they learned that the RN's role is mainly defined by tasks. As well, many nurses in their study did not know that some procedures, for example, the Papanicolaou smear, are within the RN's scope of practice. An Alberta-based study of nurses (RNs, licensed practical nurses and nurse practitioners) and other stakeholders (managers, physicians and other health professionals) in family practice found a similar gap in knowledge: "... there was a sense of ambiguity in defining a unified primary care nursing role across the data, but also excitement and enthusiasm for optimizing the role of nursing within the [family practice setting]" (Besner et al. 2007).

Both these studies indicate a limited understanding of the actual and potential role of the family practice RN. This role must be clarified if it is to achieve the CNA–CFPC vision of improved patient access to primary care and reduced wait times through IPC. Uncovering people's perceptions of a role is one step toward role clarification (Scott 1970). Perceptions can be gathered from role occupiers, those who interact with role occupiers and those who govern the role. The specific question addressed in this study was: "What are registered nurses, family practitioners and allied health professionals' perceptions of the role of the RN in an urban interprofessional academic family practice setting?"

Methods

A descriptive, qualitative design was chosen because of the dearth of knowledge about this topic. Interest in the topic arose while we were exploring another topic: communication among health professionals in academic family practice units. In that study, we identified a sense of confusion surrounding the role of the family practice nurse. This confusion influenced how, when, where and why communication took place between health providers and the family practice nurse.

Two social science researchers collected data from three Canadian, urban inter-professional family practice clinical teaching units. The researchers held one-on-one, semi-structured interviews with interdisciplinary healthcare team members ($N=23$) including clinical managers ($n=2$), a dietician ($n=1$), family physicians ($n=11$), occupational therapists ($n=2$), a pharmacist ($n=1$) and registered nurses ($n=6$). All participants were asked the same question: "What is your perception of the RN's role in the practice and in IPC?" Data were recorded by hand as "scratch notes" that were later elaborated and transformed into descriptive field notes (Sanjek 1990).

In addition, the researchers made observations of interactions between RNs and those who work alongside them. Staff were observed as they participated in their daily activities. In gathering these data, we focused on the types of interactions that promoted or limited interprofessional collaboration. Each researcher was positioned at communal areas on the unit, such as the main team desk. The researchers focused on interactions, including team meetings. The researchers did not have direct access to patient charts but observed the use of charts and other patient records by healthcare staff. Each researcher recorded observational field notes by hand. A coding system was employed to number participants by profession (e.g., MD1). Reflective field notes were also written following observations to synthesize the reflections.

Our thematic analysis employed Braun and Clarke's (2006) five-phase approach. The interview transcripts were read and re-read by the team to develop a rich understanding of the depth and breadth of the content. Participants' quotations were systematically coded, then organized into themes. Themes were reviewed by the team for internal homogeneity (data relating meaningfully within a theme) and external heterogeneity (distinctive, non-overlapping differences among themes) (Patton 1990). The research team chose a brief, informative name for each theme. As the data analysis proceeded, relevant literatures were consulted in order to refine and elaborate our interpretive understanding of emergent themes, and to integrate our findings with ongoing conversations in the nursing and IPC literatures.

Lincoln and Guba's (1985) four criteria – credibility, dependability, confirmability and transferability – of scientific rigour for qualitative research guided our research method and analysis. For example, credibility was enhanced by the choice of three practice settings instead of one or two. As well, our results centre on participants' quotations to “stay true” to their experiences. To address the issues of dependability and confirmability of our findings, the research team – made up of clinicians, qualitative researchers and educators – met regularly to create a replicable “decision trail” of thematic analysis. While transferability of our results to non-urban and non-academic settings may be limited, replication of our study in such settings is feasible.

Institutional research ethics approval was obtained from all relevant institutions. All members of the family practice teaching units were invited to participate voluntarily in this research study. Potential participants were identified through staff lists obtained from the leadership of each profession. Information notices about the study were posted in the common areas of each of the family practice teaching units. All participants signed a consent form.

Results

Two main themes emerged from our participants' descriptions of the role of the RN in three urban interprofessional academic family practice units:

- *Role ambiguity*: The RN's role in the interprofessional family practice setting is poorly contextualized. Participants struggled to find a common description of the RN's role, often admitting that it is poorly defined, largely defined by tasks and blurred with other health professionals' roles.
- *Trustworthiness*: The RN's level of trustworthiness, as perceived by FPs, is a critical factor in the level of collaboration between RNs and FPs, with higher levels of trustworthiness associated with greater collaboration.

Role ambiguity

In this study, most FPs identified daily RN tasks as the RN's role. Others blurred the RN's role with the role of others working in the family practice unit, and some perceived the RN's scope of practice appreciably differently than others.

Family physicians who conflated the RN's role with daily nursing tasks spoke about RNs performing vaccinations, wound care, well-baby appointments, history taking and counselling of patients on lifestyle issues: They “work up patients for physicals and things like that” (FP). “Basically they [nurses] can do anything to do with vital signs” (FP). Another FP cited an advantage of the role of the nurse practitioner (NP) over that of the RN as the NP's ability to “do Paps.”

While the predominant tendency was for participants to describe task-as-role, a few participants responded with more conceptual notions of the RN's role (such notions are italicized). A clinical manager described the RN as "the *contact point* for all medical issues ... she helps with follow-up and the continuity piece." An RN characterized her role as "the triage ... [I am] the *link* between the patients and doctors. ... My goal is *continuity of care*." Another RN talked about supervising nursing and medical students as well as residents: "As far as supervising the students, the nurses supervise procedures such as ear flushing and injections. The first time [I'll] do it and the resident will watch; the second time the resident will do it and [I'll] supervise."

Some participants reported confusion of the RN's role with other professional roles in the family practice unit. One RN described FPs as blurring the nurse's role with that of the clerical staff: "Sometimes the physicians think that all females can do is clerical work, and they don't realize that nurses are not clerical staff." Another RN commented: "Right now, the lines are blurred between nurses and clerks." Similarly, the clinical manager of one site stated: "They [nurses] do stuff that a clinical aide could do. The nurses are trying to work on strong, well-defined role descriptions."

There was disagreement among participants about the RN's actual and potential scope of practice. Some argued that the RN's scope of practice was too narrow, while others thought it was too broad. One FP commented: "The doctors have given feedback to the nurses and have encouraged them to take on bigger roles in patient care, but there is resistance." To this, an RN responded: "It is not in [our] scope of practice to do more." Another FP suggested that RNs do not have appropriate training and continuing education to support broader roles: "They [nurses] need more education to support their role as nursing clinicians" (FP). Others disagreed and argued that the RNs' skills and knowledge were not optimized: "Their skills are underutilized" (clinical manager). Likewise, a pharmacist comparing the RNs at two sites stated: "Nurses at one of the other sites don't do nearly as much as the nurses at X or Y." Even still, some conflated scope of practice with knowledge and skill. For example, an RN's "inability" to "do Paps" is being confused with scope of practice issues versus lack of knowledge and skill. In Ontario it is within the RN's scope of practice to perform Papanicolaou smears (CNO 2005) as long as the nurse has the knowledge, skill and judgment to do so.

Participants in our study acknowledged the existence of ambiguity regarding the RN's role: "The nurses are trying to work on strong, well-defined role descriptions" (RN). "[I am] working on the role of the nurse right now" (clinical manager). While many factors may account for ambiguity regarding the RN's role,

within the academic family practice teaching centres we encountered allusions to the need for medical residents to “do everything for [one]self,” suggesting that collaboration is not part of everyone’s medical training. As one medical resident stated: “[The supervising physicians] want you to do everything for yourself. It is very isolating. They won’t even let the nurse dip the urine for you. They don’t want you to talk to the nurses.”

Trustworthiness

Trustworthiness emerged as the other key element in participants’ descriptions of the RN’s role in IPC. FPs described trusting, and thus collaborating with, RNs who were perceived as competent and responsible in patient care.

Both RNs and FPs described RNs’ competence as good judgment in decision-making and thoroughness in patient care. One FP enthusiastically shared her thoughts about an RN she collaborates with in patient care: “She’s amazing, thorough and competent.” An RN in our study commented that she gained the trust of FPs when she demonstrated good judgment in decision-making: “An FP [in our practice] has a policy in which he wants to see ‘sick’ patients within 48 hours. ... Today, a patient had an abnormal ultrasound of her foetus. [I] felt the FP should be notified. [I] called him at home. ... the doctors trust [my] decisions.” Another FP compared her trust of casual versus full-time nursing staff, and highlighted the importance of competence over time spent on the job: “even though A is casual, I trust her judgment and will give her more responsibility.”

FPs’ perception of an RN’s trustworthiness was also based on the RN’s sense of shared responsibility in patient care. FPs described responsibility in practice as the ability to leave a task with an RN, knowing that it will get done: “Once you tell her something you never have to think about it again” (FP). Characteristics such as proactiveness, receptivity and willingness to be challenged were key features of responsibility in FPs’ descriptions. One FP explained, “[I] feel I can go to X [the RN] and Y [another RN] because they welcome responsibility and take on challenges.” Another FP stated that she “love[s] working with [a particular] RN because it seems like she enjoys what she does and wants to take on more responsibility. This makes for a better relationship and more respect.” As well, an FP told us that she feels supported by the RN with whom she works because “she [the nurse] is a team player.”

Observation data demonstrate what shared responsibility looks like in practice:

The RN returns to the secretary desk where she and the FP meet. They have a quick muffled exchange of words. As the FP proceeds back to one of the exam rooms he turns and motions to the same RN to do a visual

test on the next patient, which she says she's already done. The physician happily replies: "You're way ahead of me," and closes the exam room door.

Distrust between FPs and RNs was also evident, and participants reported that distrust was negatively associated with collaboration. The clinic manager at one study site told us, "Physicians often take on nurses' duties because they don't trust their nurses." FPs spoke about distrust in the context of RNs requiring more knowledge and skill to perform competently, and needing more initiative in assuming challenges in daily practice. When explaining her lack of trust in a particular nurse, one FP stated: "[She] is not very thorough when she sees patients." Two FPs commented that the RNs require more knowledge to perform in their role competently: "I am unsure if the nurses participate in continuing education such as tutorials on triage"; "They need more education to support their roles as nursing clinicians." Another FP rationalized that some nurses with long tenure at the hospital just "don't seem to want to learn and do more." As trust was predicated in part on receptivity and proactiveness, lack of trust emerged when team members perceived the absence of these characteristics in RNs. As one FP commented: "The doctors have given feedback to the nurses and have encouraged them to take on bigger roles in patient care, but there is resistance." Some of the nurses say they are "too busy and it is not in [their] scope of practice to do more" (RN). This perception of a lack of initiative could produce frustration and poor relations among the team: one FP described the RNs' lack of proactiveness this way: "They are here to punch in and out."

In contrast to the FP who felt more confident with some of the casual RNs rather than the full-time RNs because of the casual staff's higher level of competence in daily practice, a medical resident told us that she had more confidence in the competence of full-time RNs because of their time spent on the job: "I only use the two full-time nurses who have been here a long time. I feel that I can trust their judgment over the casual nurses because of their longevity and permanency at this hospital."

Discussion

This study elicited perceptions of the RN's role within three urban interprofessional academic family practice units from interviews and observations with RNs, FPs and other allied healthcare professionals. We chose a descriptive method for this study because of limited knowledge on this subject. Our intent was to offer the next step in this path of inquiry. While role ambiguity and trustworthiness were found to be important factors in perceptions of the RN's role within an IPC setting, our choice of method limits our ability to

draw conclusions about why and how ambiguity and trustworthiness exist. In addition, our results may not represent non-urban and or non-academic family practice settings.

Our analysis of participants' sense of the RN's role in these urban academic interprofessional family practice units reveals a tension between the RN's role as a set of concrete tasks or duties (e.g., "wound care and well-baby appointments") and the nurse's role as a more conceptual function or goal (e.g., "the link between doctors and patients"). The predominant tendency to conflate task with role may foster role ambiguity, both among RNs and across members of the family practice team, because tasks and roles are not synonymous. Roles differ from tasks in that the former are "reflected in the knowledge base of the profession" (White et al. 2008: 49) while the latter constitute "the application of knowledge within parameters defined by legislation, experience, competence and contextual factors in the environment" (White et al. 2008: 49). When the two are conflated, ambiguity may arise.

Our finding of RNs' role ambiguity is echoed in the literature (Patterson et al. 2000; Todd et al. 2007; White et al. 2008) and is a barrier to the success of the CNA–CFPC vision statement, given that numerous researchers have reported that role ambiguity impedes maximizing a profession's contribution to IPC (Arksey et al. 2007; Arslanian-Engorn 1995; Baggs and Schmitt 1997; Howarth et al. 2006; Silen-Lipponen et al. 2002).

RNs' trustworthiness, as perceived by FPs, was the other critical theme found in our study that appeared to affect FP–RN collaboration. This finding is consistent with the IPC literature. In a systematic review, San Martin-Rodriguez and colleagues (2005) established trust as a critical determinant of IPC. Yet, trust is not a necessary condition for collaboration to occur unless trustees perceive that there is risk involved in collaboration (Mayer et al. 1995). The clinic manager at one of our study sites told us: "Physicians often take on nurses' duties because they don't trust their nurses." This remark suggests that FPs in our study perceive a risk involved with collaboration, and that trust in our study may be associated with collaboration – but this point requires further investigation.

An important distinction has been made in the trust literature among trust, trust propensity and trustworthiness (Mayer et al. 1995). Whereas trust and trust propensity encompass attributes of the trustor, trustworthiness describes perceived characteristics of the trustee and can be defined as the

trustor's perceptions of the trustee's worth of being trusted; it can be measured by a trustor's perception of a trustee's level of ability, benevolence and integrity (Mayer et al. 1995). Ability includes qualifications, skills, knowledge, competencies and perceived expertise; benevolence encompasses openness, loyalty, concern, perceived support, receptivity and availability; and integrity is described as fairness, justice, consistency and reliability, and as shared values and principles between the trustee and trustor (Mayer and Davis 1999; Mayer et al. 1995). Collectively, all three of these components – ability, benevolence and integrity – of trustworthiness are necessary to establish a degree of trustworthiness (Mayer et al. 1995). This operational definition has been studied and corroborated (Colquitt et al. 2007). To date, the distinction between trust and trustworthiness has not been made in the IPC literature.

Our data fit well within the framework of trustworthiness described by Mayer and colleagues (1995). In our study, FPs described trusting RNs who display a high level of on-the-job ability (“She’s amazing, thorough and competent”) and not trusting RNs perceived as less capable (“[She] is not very thorough when she sees patients”). Similarly, RNs who could anticipate patient care needs, as in our example of the patient needing a visual acuity test, were perceived as more trustworthy than RNs less capable or willing to be proactive in patient care: “The nurses aren’t being as proactive or involved as the physicians would like.” Finally, FPs perceived RNs as having more integrity, thus being more trustworthy, when FPs could “tell [the nurse] something [and] never have to think about it again.”

Conclusion

Canadian interest in understanding and developing the role of the family practice RN is growing. In this time of healthcare reform, we require policies and strategies to optimize the RN's role in family practice in order to meet the vision of the CNA and CFPC regarding interprofessional collaboration, reducing patient wait times and improving patient access to care. Although this study was limited to three urban, academic family practice units, our findings add to the current conversation about the RN's role and optimal utilization within collaborative relationships by suggesting that both are affected by role ambiguity and trustworthiness. Optimal utilization of the family practice RN requires leadership in clarifying the nurse's role in IPC. Collaborative leadership is required among educators, regulators, interest groups, nursing students, practising nurses, physicians and other allied health professionals. The RN's role in family practice must be recognized as

a career option, and opportunities for continuing education in specific practice settings should be offered. Finally, we need to explore why and how trust among IPC members is cultivated and nurtured.

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