Nurse Practitioner Perceptions and Experiences of Interprofessional Collaboration with Physicians in Primary Health Care Settings

By

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ABSTRACT

Primary health care reform is currently underway in Ontario with the goals of improving health care access, quality and continuity of care while increasing patient and provider satisfaction and cost effectiveness. Interprofessional collaboration in the provision of primary health care has been widely espoused in the health care literature as a means of achieving the goals of primary health care reform. Primary health care nurse practitioners in collaboration with physicians and other allied health professionals have a fundamental role in enhancing primary health care in Ontario.

The purpose of this study was to explore and describe nurse practitioners’ experiences and perceptions of interprofessional collaboration with physicians in the provision of primary health care in Ontario. A qualitative descriptive study design was used and six nurse practitioners working in a variety of primary health care settings in Ontario were purposively sampled and interviewed regarding their experiences and perceptions of interprofessional collaboration with partnering physicians. Interviews were analyzed using qualitative content analysis techniques and themes were identified.

Seven themes were identified as key factors influencing collaboration within the nurse practitioner – physician dyad from the nurse practitioner’s perspective. These themes included: quality of communication, complementary vision, physician remuneration methods, establishing and maintaining relationships, investing time and energy, nurse practitioner competency and expertise and mutual trust and respect. A model of nurse practitioner – physician interprofessional collaboration is used to organize the themes identified.
The findings of this study support current recommendations for joint education initiatives for health care professionals and practice initiatives aimed at improving collaboration between partnering nurse practitioners and physicians. Areas for future research include incorporating the client’s experiences and perceptions within collaborative practice as well as developing and evaluating interventions that strengthen collaboration within the health care team.
ACKNOWLEDGEMENTS

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CHAPTER 1

Introduction

Statement of the Problem

Nations around the world are undertaking initiatives to improve health care delivery. Through these efforts, primary health care has once again been brought to the forefront as a means of achieving better health for the most individuals through the most cost efficient means. Primary health care reform is well underway in Canada; however, consensus has not yet been reached on the model that will best reform primary health care in Canada or Ontario. There is widespread agreement in both the research literature and Ontario policy documents that interprofessional collaboration is necessary to achieve the objectives of primary health care reform. More specifically, collaboration between health professionals is believed to improve both the delivery and health outcomes of primary health care services.

The policy synthesis undertaken by the Canadian Health Services Research Foundation [CHSRF]. (2003), entitled Choices for Change: The Path for Restructuring Primary Healthcare Services in Canada, supports this belief. In this policy synthesis, four models for organizing primary health care are outlined: the integrated community model, the non-integrated community model, the professional co-ordination model and the professional contact model. Both the integrated and non-integrated community models are based on the provision of medical, social and community services through teams of health professionals. The professional co-ordination model is more limited in that the care-giving team consists of only nurses and physicians. In contrast, the professional contact model provides primary health care services through physicians
working independently with no interprofessional collaboration. Each model was
evaluated and ranked on effectiveness, quality, accessibility, continuity, productivity and
responsiveness. The community integrated model was assessed as the best delivery
model, followed by the community non-integrated model. The professional co-ordination
model and the professional contact model ranked third and fourth, respectively.

Currently, in Ontario, the professional contact model is the principal mode of
primary health care provision via private practice general and/or family physicians.
However, Ontario has seen primary health care initiatives that are congruent with the
community model. The best example of such an initiative can be found within
Community Health Centres (CHC). Initiated in the 1970’s, and currently servicing
approximately 300,000 Ontario residents through 54 CHCs across the province, CHCs
provide a range of primary health care services based on a philosophy of health
promotion and illness prevention (Association of Ontario Health Centres [AOHC], 2009).
CHC expansion is currently underway in Ontario and 21 new CHCs as well as 28 new
satellite centres are scheduled to open by the end of 2009. CHCs are non-profit,
community-governed organizations that provide services through the use of collaborative
interprofessional teams of health providers. These teams include physicians, nurse
practitioners, nurses, social workers, nutritionists and a variety of other allied health
professionals to provide comprehensive care to the community. Similar to CHCs are
Community Health Access Centres (CHAC), which provide comprehensive primary
health care services to Aboriginal individuals and communities.

Models of primary health care delivery based on the professional co-ordination
model have also been implemented in Ontario. These include the older Health Services
Organizations, Primary Care Networks and the more recent Family Health Teams (FHT). Provision of primary health care within these settings involves primary health care nurse practitioners (NP) and physicians collaborating to deliver care to clients. At present, Ontario has seen the creation of 150 FHTs with 50 more FHTs being implemented across the province over the next four years. In addition, 3 NP-Led clinics have been established in Northern Ontario communities and an additional 22 NP-Led clinics will be developed within Ontario over the next four years (Ministry of Health and Long Term Care [MOHLTC], 2009).

Investigation into interprofessional collaboration within primary health care settings is limited. To date, Canadian research has been largely descriptive and exploratory. This may be due to the dominance of the professional contact model in the provision of primary health care services. Studies of the potential role of NPs in Ontario have been available for decades (Spitzer et al., 1974; Lomas & Stoddart, 1985). NPs have a fundamental role in enhancing primary health care in Ontario and have been shown to increase health care accessibility and availability while containing costs and effecting positive health outcomes (IBM Business Consulting Services [IBM], 2003). There is also evidence from patient surveys that NPs provide comprehensive health services that are acceptable and satisfactory to the client population (IBM, 2003).

In Ontario, NPs were only recognized and endorsed by the provincial government within the last 15 years, thus making the study of interprofessional collaboration between NPs and physicians in the provision of primary health care a relatively new endeavor (Sidani, Irvine, & DiCenso, 2000). Although a large body of research on interprofessional collaboration exists, the majority of this work has been concentrated
within acute care settings. A review of the health care literature reveals that collaboration has proven a difficult concept to define and even more difficult to quantitatively measure. It is a concept that is used frequently within the health care literature without definition and it is a concept that may have different meaning for different health disciplines, further complicating its measurement. Furthermore, since interprofessional collaboration is a central tenet of primary health care, it is reasonable to assume that physicians and NPs working within interprofessional primary health care teams would have significantly differing attitudes and perceptions regarding collaboration than their acute care counterparts.

Introduction and integration of NPs in Ontario has highlighted the importance of interprofessional collaboration within primary health care. An investigation of interprofessional collaboration between NPs and physicians would significantly add to the primary health care literature. Further research of NP – physician collaboration within primary health care is necessary to explore how collaboration occurs within primary health care settings. Moreover, to date, there is little research available describing NPs’ experiences with interprofessional collaboration in the provision of primary health care. Specifically, after more than a decade of NP integration into primary health care practices in Ontario, it is valuable to explore NPs’ perceptions and experiences of collaboration with partnering physicians.

Purpose of the Study

The purpose of this study was to explore and describe interprofessional collaboration between NPs and physicians in Ontario primary health care settings from the perspective of NPs’. Specifically, the following question is proposed as a
problematic for investigation: “How do nurse practitioners in primary health care
describe their experiences and perceptions of interprofessional collaboration with
physicians?” As the NP workforce grows and becomes integrated into primary health
care and as primary health care practitioners are faced with increasingly complex health
care issues there is a need to understand how interprofessional collaboration works, what
facilitates or hinders it and how it may differ depending on the primary health care setting
or context.

Organization of the Thesis

The next chapter of this thesis is a review of the literature on interprofessional
collaboration. Chapter three is a description of the design and methods used to conduct
this study as well as a discussion of the studies trustworthiness. In chapter four the
findings of the study are presented including a description of the participants followed by
a thematic description of each of the seven themes identified. Chapter five includes a
model of NP – physician interprofessional collaboration and a discussion of each of the
seven themes in relation to the literature. The final chapter of this thesis includes the
study’s limitations, implications for education, practice and future research.
CHAPTER 2
Literature Review

The literature review has been organized into three sections. First, a discussion of the evolution of the NP role and employment in Ontario is presented. Second, researchers’ efforts to clarify and define the concept of interprofessional collaboration in health care are outlined. Third, an evaluation of the current state of interprofessional collaboration in Canadian primary health care settings will be presented.

A literature search was undertaken using CINAHL and Medline databases. CINAHL (1984 – July 2009) search terms included, “multidisciplinary care teams”, “nurse-physician relations”, “nurse attitudes”, “collaboration”, “interprofessional relations” and “nurse practitioners” and resulted in 953 articles. The MEDLINE (1996 – July 2009) search included the MESH terms “interprofessional relations”, “nurse practitioners” and “patient care team” and resulted in 705 articles. All abstracts were reviewed and all articles with a declared focus on interprofessional collaboration were retrieved. Published bibliographies and web sites of Canadian professional associations and organizations were also utilized to identify additional relevant work on interprofessional collaboration.

Nurse Practitioners in Ontario

The early 1970’s marked the beginning of initiatives in Ontario to educate nurses into an expanded Primary Health Care Nurse Practitioner (PHC NP) role (DiCenso et al., 2007; IBM, 2003). This came at a time when Ontario was experiencing a physician shortage and policy documents were advocating for the enhancement of primary health care. Between 1970 and 1983 two hundred and fifty PHC NPs graduated from university
programs in Ontario. However, by 1983 all PHC NP education programs in Ontario were closed due to a lack of support, legislation, public awareness of the role, remuneration mechanisms and a family physician surplus. The 250 PHC NPs previously trained continued to work in Ontario, primarily in CHCs and northern nursing stations. Through the Nurse Practitioner Association of Ontario (NPAO) these PHC NPs continued to advocate for re-establishment of the PHC NP programs in Ontario universities. In 1993 the New Democratic Government of Ontario, with a renewed interest in primary health care accessibility, commenced a new PHC NP initiative, which resulted in the Council of Ontario University Programs in Nursing (COUPN) forming a consortium of the 10 Ontario nursing faculties to provide a PHC NP program. The program began in the fall of 1995 and continues to graduate approximately 75 PHC NPs each year across Ontario. As of 2007, 800 PHC NPs are registered and working in Ontario (Health Force Ontario, 2008).

The College of Nurses of Ontario (CNO) regulates PHC NPs as Registered Nurses (RN) who have earned an Extended Class (EC) designation. The title of Nurse Practitioner (NP) is now a protected title in Ontario and can only be used by those RNs registered in the EC. NPs in Ontario work in both acute and primary health care settings. The NP scope of practice is determined by the Expanded Nursing Services for Patients Act, which amended the Regulated Health Professions Act (1991) and the Nursing Act (1991) and includes the controlled acts for the RN in the general class as well as an expanded scope for the RN(EC). Within this expanded scope NPs can communicate a diagnosis, prescribe and administer specified drugs, order specified laboratory tests, order
specified tests such as diagnostic ultrasound, x-ray and electrocardiograms and complete a medical certificate of death (College of Nurses of Ontario [CNO], 2009).

NPs work with individuals, families and communities within the areas of health assessment, health promotion, illness prevention, rehabilitation and community development. Currently, NPs in Ontario work in a variety of practice settings including, Community Health Centres (CHC), Primary Care Networks (PCN), Family Health Teams (FHT), Fee – for – Service Practices and Public Health Units (IBM, 2003). NP services are not eligible for coverage under the Ontario Health Insurance Plan (OHIP) therefore NPs are compensated via salary or contract. NPs in Ontario must be linked to a partnering primary health care physician in order to meet the CNO’s standard of practice regarding physician consultation, however, models of practice between NPs and physicians within primary health care in Ontario are varied. For example, within the FHT model NPs and partnering physicians are physically co-located however; within NP-led clinics partnering physicians are often off site and accessible for collaboration by phone or email.

*Conceptualization and Definition of Interprofessional Collaboration*

Collaboration has been defined as “to work together, especially in a joint intellectual effort” (Marckwardt et al., 1977, p.123). However, in health care, collaboration has been difficult to define, conceptually and operationally. Within the health care literature several definitions for collaboration are found, ranging from simple definitions such as “a partnership” (American Nurses Association [ANA], 1980, p.7) or “a complementary relationship of interdependence” (Fagin, 1992, p.354) to more complex definitions such as “a process by which individuals from different professions
structure a collective action in order to co-ordinate the services they render to individual clients or groups” (Sicotte, D’Amour & Moreault, 2002, p.992). The former definitions focus solely on the interaction between health care providers, whereas the latter includes the target group the collaboration aims to serve. Weiss and Davis (1985) defined collaboration in much the same way, as: “synergistic interactions to influence patient care” (p.300). However, these definitions are problematic in that they can be interchanged with concepts related to collaboration such as coordination, cooperation and sharing. Although these related concepts might play a part in collaboration, they are not in and of themselves collaboration.

Kilmann and Thomas’ (1977) model of conflict handling serves to illustrate the conceptual difference between collaboration and some related concepts. Within this model, collaboration is achieved through the combination of assertiveness and cooperation. Assertiveness represents actions aimed to meet one’s own needs, while cooperation represents actions aimed to meet other’s needs. Therefore, cooperation is identified as necessary to collaboration. Kilmann and Thomas also state that accommodation results from low levels of assertiveness and high levels of cooperation; competition results from a high level of assertiveness and a low level of cooperation; avoidance results from a low level of both dimensions; compromise results from a moderate level of assertiveness and a high level of cooperation.

The difficulty encountered by researchers in adequately defining the concept of collaboration in health care has also caused difficulties in operationally defining collaboration and developing tools that measure its intensity or its effect on health care.
In order to measure collaboration and subsequently correlate collaboration with health outcomes, cost of service provision or work satisfaction, a definition of collaboration must include its measurable attributes. Baggs and Schmitt (1988) undertook a review of the literature to determine how the concept of collaboration was being utilized in the health care literature in order to clarify and define the concept in a measurable way. Although the researchers were specifically interested in collaboration between nurses and physicians in the clinical ICU setting, their work sheds light on the conceptualization of interprofessional collaboration in other health care settings. Through this review, Baggs and Schmitt found that the concept of collaboration was often being utilized in the literature without definition. However, they also found that significant work had already been undertaken to elucidate the critical attributes necessary for collaboration to occur in an interprofessional context. Baggs and Schmitt identified the first eight attributes listed in Table 1.
Table 1

Critical attributes for the concept of collaboration.

<table>
<thead>
<tr>
<th>Critical Attributes of Collaboration</th>
<th>Reference</th>
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<tbody>
<tr>
<td>Sharing in planning</td>
<td>Alt-White, Charns, &amp; Strayer, 1983</td>
</tr>
<tr>
<td>Making decisions</td>
<td>Alt-White, Charns, &amp; Strayer, 1983</td>
</tr>
<tr>
<td>Solving problems</td>
<td>Alt-White, Charns, &amp; Strayer, 1983</td>
</tr>
<tr>
<td>Setting goals</td>
<td>Alt-White, Charns, &amp; Strayer, 1983</td>
</tr>
<tr>
<td>Assuming responsibility</td>
<td>Alt-White, Charns, &amp; Strayer, 1983</td>
</tr>
<tr>
<td>Working together cooperatively</td>
<td>Lamp &amp; Napadano, 1984</td>
</tr>
<tr>
<td>Coordinating</td>
<td>Prescott &amp; Bowen, 1985</td>
</tr>
<tr>
<td>Communicating openly</td>
<td>Prescott &amp; Bowen, 1985</td>
</tr>
<tr>
<td>Willing participation</td>
<td>Henneman, Lee &amp; Cohen, 1995</td>
</tr>
<tr>
<td>Team approach</td>
<td>Henneman, Lee &amp; Cohen, 1995</td>
</tr>
<tr>
<td>Contribution of expertise</td>
<td>Henneman, Lee &amp; Cohen, 1995</td>
</tr>
<tr>
<td>Non-hierarchical relationship</td>
<td>Henneman, Lee &amp; Cohen, 1995</td>
</tr>
<tr>
<td>Power sharing based on knowledge and expertise versus role or title</td>
<td>Henneman, Lee &amp; Cohen, 1995</td>
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</table>

Baggs and Schmitt utilized these attributes to develop a definition of collaboration as, “intensive care nurses and physicians cooperatively working together, sharing responsibility for solving problems and making decisions to formulate and carry out plans for patient care” (p. 145).

The concept analysis of collaboration carried out by Henneman, Lee and Cohen (1995) supports the critical attributes for interprofessional collaboration previously outlined by Baggs & Schmitt; however, it also adds five attributes identified in the bottom half of Table 1. The health care definition of collaboration utilized to guide Henneman and colleagues concept analysis is Coluccio and Maguire’s (1983) which
states, “collaboration is the joint communicating and decision-making process with the expressed goal of satisfying the patient’s wellness and illness needs while respecting the unique qualities and abilities of each professional” (p. 63).

More recently, Canadian researchers within primary health care have attempted to clarify essential elements of collaboration. Anderson (2004) undertook a review of the interprofessional collaboration literature during the development of a Multidisciplinary Collaborative Primary Model for Maternity Care. Through this review, Anderson identified that effective collaboration requires health professionals to commit to several features of collaboration. Table 2 provides a list of the features required for effective collaboration. Anderson includes some of the critical attributes identified in Table 1 and also identifies eight new features that require attention for effective collaboration to occur. These eight new features are shaded in Table 2.

Table 2

Features requiring commitment for effective collaboration

<table>
<thead>
<tr>
<th>Open, honest communication</th>
<th>Shared decision-making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mutual trust</td>
<td>Shared values, goals and visions</td>
</tr>
<tr>
<td>Respect</td>
<td>Willingness to openly discuss differences</td>
</tr>
<tr>
<td>Understanding and valuing each other’s perspective and way of thinking</td>
<td>Willingness to devote time and energy to the relationship</td>
</tr>
<tr>
<td>Familiarity with and valuing each other’s style and scope of practice</td>
<td>Unified front and mutual support</td>
</tr>
<tr>
<td>Equality and shared power</td>
<td>Willingness to share information</td>
</tr>
<tr>
<td>Professional competence</td>
<td>Frank discussion of financial issues</td>
</tr>
<tr>
<td>Shared responsibility and accountability</td>
<td></td>
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</tbody>
</table>
Included in Anderson’s review was the work completed by Way, Jones and Busing (2000) which identified seven essential elements for collaboration as, mutual trust and respect, autonomy, responsibility, communication, coordination, assertiveness and cooperation. Moreover, collaboration is defined as “an interprofessional 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). This definition of collaboration has garnered some acceptance by Canadian researchers investigating primary health care collaboration as well as within a collaborative practice education module (Office of Interprofessional Education and Practice, 2009).

The World Health Organization’s (WHO) definition of Health Manpower in primary health care teams is useful here to illustrate how the above definition of interprofessional collaboration includes those principles, which are deemed important to primary health care teams. Health Manpower in primary health care teams is defined as:

“a group of persons who share a common health goal and common objectives determined by community needs, to which the achievement of each member of the team contributes in a co-ordinated manner, in accordance with his/her competence and skills and respecting the functions of others” (WHO, 1985, p.3).

Although this is not a definition of interprofessional collaboration and it lacks the measurable attributes included in the previous definition, it serves to illustrate how interprofessional collaboration is viewed as necessary to successful primary health care teams.

Researchers have found differing attitudes in studies in which the amount of interprofessional collaboration was measured within health care settings. Specifically,
several studies indicate that physicians consistently rate the amount of interprofessional collaboration achieved as much higher than nurses within the same setting (Grindel, Peterson, Kinneman, & Turner, 1996; Thomas, Sexton & Helmreich, 2003; Copnell et al., 2004). Alternatively, a study of ICU nurses and residents comparing their perceived amount of collaboration in making a decision to transfer their patients demonstrated a significant, though weak, correlation ($r=0.19$, $p=0.04$) (Baggs & Schmitt, 1995). The researchers postulated that this weak correlation might be due to physicians and nurses assigning different meanings to the concept of collaboration. Subsequently, Baggs and Schmitt (1997) undertook a qualitative study utilizing grounded theory methods to explore the perceptions of 10 nurses and physicians surrounding the process of collaboration in the ICU setting. From this study, a model of the collaborative process within the ICU was developed. The model includes the nurses and physicians perceived antecedent conditions, core and outcomes of the collaboration process. This model serves to clarify the concept of collaboration and identify its process within the ICU (see Figure 1).
Figure 1. A model of nurse-physician collaboration (Baggs & Schmitt, 1997). Used with permission.
The antecedent condition identified as being receptive requires that the health care professional be interested in collaboration. Interest in collaboration has been investigated utilizing The Jefferson Scale of Attitudes Towards Nurse-Physician Collaboration. The Jefferson Scale is a 15 Likert-type instrument that measures attitudes towards physician-nurse collaboration (Hojat et al., 1999). The following four factors are used to measure nurse-physician attitudes: shared education and teamwork, caring as opposed to curing, nurses autonomy and physicians dominance. Administration of the Jefferson Scale to 639 hospital physicians and nurses in the United States and Mexico found that nurses have more positive attitudes towards collaboration than physicians (Hojat et al., 2001). A subsequent study of 2522 hospital physicians and nurses in the United States, Israel, Italy and Mexico confirmed these results (Hojat et al., 2003). Additionally, these studies found that there are significant cross-cultural differences of attitudes towards interprofessional collaboration. Specifically, American, Israeli and Italian nurses had the most positive attitudes towards collaboration, whereas Italian and Mexican physicians had the least positive attitudes (Hojat et al., 2003). Hojat et al. utilize social role theory (Hardy & Conway, 1978) and the principle of least interest (Waller & Hill, 1951) to explain their findings.

Social role theory maintains that cultural and societal attitudes and expectations inform nurse-physician collaboration. Cultures and societies that value physician dominance in decision making and place little importance on nurse autonomy foster hierarchical nurse-physician relationships that are adversarial, not collaborative. However, cultures and societies that are considered complementary, value the shared autonomy and mutual authority of nurses and physicians, thus setting the stage for
collaborative practice. The principle of least interest is thought to shed light on the finding that nurses express more positive attitudes towards collaboration in all cultures studied by Hojat et al. (2003). Waller and Hill (1951) describe the principle of least interest as those in a greater power position having the least interest in collaboration. Therefore, within health care settings the principle would predict that physicians, who traditionally have held the most power, would be least positive towards collaboration and the sharing of power. Hojat et al. (2003) conclude that nurse-physician shared education has the potential to change the expectations and attitudes held by these two health disciplines and foster increased collaboration.

Additional research exploring nurses’ attitudes and perceptions surrounding interdisciplinary collaboration has found that interest in collaboration increased with nursing education level (Jordan & Hughes, 1998; Mansourimoaied, Boman & Causley, 2000; Chaboyer & Patterson, 2001). Mansourimoaied and colleagues (2000) also found that positive perceptions of interprofessional collaboration were correlated with years of nursing experience. Qualitative analysis of how increased nursing education affects nursing practice found that nurses who completed an applied physiology course reported an increase in interprofessional discussion and decision-making (Jordan & Hughes, 1998). However, nurses within this study described a pattern of interaction with physicians that is far from collaboration and is akin to the “doctor-nurse” game first described by Stein in 1967.

The “doctor-nurse” game is often referred to within the collaboration literature, as it was an early attempt at describing the professional relationship between nurses and
physicians. Stein (1967) maintained that nurses made suggestions and recommendations regarding patient care in a covert manner, never directly challenging physician’s orders. In response, physicians often accepted and relied on these nurse recommendations; however, physicians maintained their power and status within the relationship by claiming the recommendation as their own. Stein and colleagues undertook a follow-up examination of the “doctor-nurse” game dynamic and concluded that the rules of the game are no longer as they were originally described (Stein, Watts & Howell, 1990). However, Jordan & Hughes’ (1998) qualitative analysis does not support this assertion; rather, it lends support to Stein’s original “doctor-nurse” game dynamic, primarily surrounding decision making.

Decision-making, and specifically who is responsible for making decisions regarding patient care, continues to challenge health professionals attempting to work in collaboration. To date, researchers have found that physicians continue to have ultimate decision-making power. An ethnography examining the nurse’s role in clinical decision making within three ICU settings found that medicine continues to dominate decision making and nursing knowledge is largely unacknowledged and devalued (Coombs & Ersser, 2004). Research investigating second year residents, advanced practice nursing and masters level social work students’ attitudes regarding interprofessional collaboration and the physician’s role within the team found that 73% of residents believe that the primary purpose of the health care team is to assist physicians in achieving treatment goals for patients (Leipzic et al., 2002). Similarly, Baggs and colleagues (1997)
investigated collaboration between nurses and physicians and decision-making in three ICUs. Within this study, the researchers developed a questionnaire entitled the Collaboration and Satisfaction About Care Decisions (CSACD) to measure collaboration between nurses and physicians in making care decisions and their satisfaction with those care decisions. The results of this study indicated that nurses were less satisfied with decision making than physicians, thus lending support to the belief that true collaboration between nurses and physicians has not yet been achieved.

Baggs & Schmitt’s model of nurse-physician collaboration also identifies discussion, respect and trust within the antecedent condition of being receptive. Research undertaken by Hallas, Butz and Gitterman (2004) to explore attitudes of pediatric nurse practitioners and pediatricians to interprofessional collaboration found that both nurses and physicians identified open communication and relationships built on mutual trust and respect as necessary to collaboration. However, nurses rated the value of “respect for you as a professional” significantly higher than physicians surveyed. The researchers suggest that this finding may indicate that nurses, upon entering the nurse-physician collaborative relationship, have to prove their competence and knowledge in order to gain the respect of physicians. Support for this suggestion can be found in a critical ethnography of six nurses working in a critical care unit, which indicates that nurses utilize policies and protocols to legitimize both their knowledge and their actions (Manias & Street, 2000). The researchers conclude that nurses use written documents to support their efforts at
collaboration, physicians, however, tend to base their decisions on their experience and background.

A more recent investigation used a phenomenological approach to evaluate the process of integration of a clinical pharmacist within a health care team of hospital NPs and physicians (Makowsky et al., 2009). Through the analyses of reflective journals and key informant interviews the researchers found that team process variables such as role clarity and mutual trust and respect were necessary to successful integration of pharmacists to the collaborative health care team. Additionally, professional development opportunities that focused on teamwork and collaboration were identified as necessary. Moreover, it was identified that organizational and practice structures often posed a barrier to collaborative care.

Several researchers have identified barriers to collaborative practice between NPs and physicians. Clarin (2007) undertook a literature review of research studies (n = 6) and overview articles (n = 6) on NP and physician collaboration to determine the common barriers to their interprofessional collaboration. Six common barriers were identified and included; lack of knowledge of NP scope of practice, lack of knowledge of NP role, poor physician attitude, lack of respect, poor communication and patient and family reluctance to accept NP care. Strategies to overcome these barriers were identified by the investigator as providing education to physicians on NP scope of practice, developing collaboration models with mutually defined goals and ensuring opportunities for regular communication.
Interprofessional Collaboration in Primary Health Care

A descriptive study surveyed all primary care nurse practitioners (NP) in Ontario to determine their professional characteristics, employment setting, scope of practice, practice pattern and work satisfaction (Sidani, Irvine, & DiCenso, 2000). Of the 123 survey respondents who were employed as NPs, the majority worked in CHCs and provided a range of care services including wellness care, management of chronic illnesses, care of major and minor acute illnesses and palliative care. The second leading location of NP employment was reported to be within private practice offices. Although this study did not aim to evaluate or describe interprofessional collaboration, the researchers found that the NPs were satisfied with their work and felt that they were equal partners within the health care team. More specifically, they reported the 5 most positive aspects of their work as, autonomy, independence, NP-client relationship, collaboration and being part of a multi-disciplinary team.

However, an investigation of two rural Ontario primary health care practices did not find evidence of strong collaborative practice between NPs and physicians (Way, Jones, Baskerville & Busing, 2001). In order to determine the division of service provision and the degree of shared care established between NPs and physicians working together in a primary health care setting, 2 NPs and 4 physicians completed a patient encounter form for every patient they provided service to within a two month time period. Within this study, the percentage of in-house referrals was used to determine the amount of collaborative practice occurring. Analysis of 400 patient encounters found that of the referrals made, 16% were from NPs to physicians and only 2% were from...
The researchers interpret this lack of shared care as indicative of limited collaboration between NPs and physicians, likely due to limited interprofessional education, lack of knowledge of NP scope of practice and legal concerns regarding medical accountability.

A Cochrane review was undertaken to assess interventions aimed at improving interprofessional collaboration between health professionals (Zwarenstein, Goldman & Reeves, 2009). Only five randomized trials were included. Interventions aimed at improving interprofessional collaboration included team ward rounds, interprofessional meetings and externally facilitated interprofessional audit. It was found that due to the small number of studies, small sample sizes and the variety of interventions employed generalizable conclusions on the key elements of interprofessional interventions could not be made. This review identified that the process of collaboration has not yet been clearly defined, therefore making it difficult to develop interventions to strengthen collaboration in health care teams. The reviewers called for further qualitative research to identify barriers to collaboration and to assist in the development and testing of alternative interventions.

The 2002 Romanow Report entitled *The Future of Health in Canada* asserts that barriers to health professional collaboration are entrenched within the current health care system and professional health culture. Romanow states that professional specialization continues to increase and health care professionals tend to guard their professional scope of practice, which is contradictory to collaboration and the sharing of client care. Furthermore, the health care delivery structure in Canada has not fostered interprofessional collaboration; rather health care services have traditionally been
organized into “fragmented ‘silos’ based on who delivers the service and where it is delivered” (Romanow, 2002, p. 119). Health care professionals traditionally place great value on professional autonomy and work in parallel with other health disciplines with little coordination and sharing of professional responsibilities (Abbott, 1988). Additionally, interprofessional collaboration relies on professionals, trained within different philosophies and with different health care expertise, to work as a team to provide comprehensive care despite very little or no training in interprofessional teamwork (Leipzig et al., 2002). Increased qualitative research on interprofessional collaboration between health professionals may be useful in further clarifying the barriers to collaborative practice experienced by primary health care professionals.

Collaborative practice is a means by which interprofessional health care teams work together to provide integrated health care services that meet the needs of a practice population and effectively apply the knowledge and skills of providers (Way, Jones, Baskerville & Busing, 2001). An investigation of Quebec Community Health Care Centres (CHCC) provides some evidence of this type of collaborative practice in the provision of primary health care. Based on the criteria outlined in the 2003 CHSRF policy synthesis, Quebec CHCCs are an excellent example of a community based interprofessional primary health care practice. From its inception, the Quebec CHCC model has held interprofessional collaboration as an objective. With the aim of determining the amount of interprofessional collaboration achieved within Quebec CHCCs, Sicotte, D’Amour and Moreault (2002) surveyed all 157 CHCCs. CHCCs were studied by programme and surveys were sent to 554 programme co-ordinators of which 343 were returned and included in analysis. Combined scales were used to measure
intensity of interprofessional collaboration and the results indicated that professionals within Quebec CHCCs are collaborating in moderate amounts. Mean scores for interprofessional collaboration were approximately 3.5 on a 5-point scale for all programs.

Sicotte & colleagues utilized the following analytical framework of interprofessional collaboration:
Figure 2. Analytical framework of team effectiveness (Sicotte, D’Amour & Moreault, 2002). Used with permission.
This analytical framework is based on organizational theory and, like the model outlined in Figure 1 by Baggs & Schmitt (1997), has an input-process-output structure. Within this model, the output factor is the intensity of interprofessional collaboration achieved rather than improved health outcomes, work satisfaction or cost effectiveness, which were the outcomes of Baggs & Schmitt’s model of nurse – physician collaboration within the ICU.

An additional objective of Sicotte et al.’s (2002) study within Quebec CHCCs was to identify the influence on collaboration of characteristics of management, structural characteristics of the program, intragroup processes and the nature of the task. A stepwise regression analysis revealed that administrative formalization, including organizational policies and procedures, was significantly associated with collaborative intensity. The researchers postulate that administrative formalization towards a work model of interprofessional collaboration may counter balance the effects of the traditional model. Consequently, the formalization of interprofessional collaboration as an organizational model is an area requiring further research.

Also associated with intensity of collaboration are the nature of the task and intragroup processes. Nature of the task was defined by type of clientele and the results indicated that health professionals in the Elderly Home Care Programme, which serviced clientele with complex chronic conditions, were more inclined to employ collaborative practice. However, within the Ambulatory Walk-in Clinic Programme the acute needs of the clientele limited the collaborative efforts.

Intragroup processes were found to both foster and limit interprofessional efforts. For example, “agreement with interdisciplinary logic” and “agreement with disciplinary
logic” were both statistically significant variables associated with collaboration intensity; however, the former fosters collaboration whereas the latter limits collaboration. Similarly, “social integration with work group” and “level of conflicts associated with interdisciplinary collaboration” were significant variables, with the first increasing and the second decreasing collaborative efforts. It is these conflicting intragroup variables that had the largest effect on interprofessional collaboration. Therefore, efforts to increase interprofessional collaboration must attend to intragroup variables. Once again, the researchers put forth the possibility that interprofessional education models need to be developed in order to promote interprofessional values and advance interprofessional practice.

Sicotte and colleagues (2002) utilized a combination of scales to measure interprofessional collaboration. Jones, Way and Associates (DiCenso et al., 2007) developed the Collaborative Practice Questionnaire (CPQ), which is a two-scale tool that aims to measure amount of collaboration as well as satisfaction with collaboration between NPs and physicians. However, DiCenso and colleagues (2007) have only recently reported reliability and validity testing of the CPQ. Moreover, increased collaboration and satisfaction with collaboration does not indicate improved health outcomes for client populations. Despite the lack of outcome research linking interprofessional collaboration with improved health outcomes within primary health care settings, collaboration between disciplines remains an objective for health care organizations. This may be largely based on the theoretical assumption that the contribution of multiple professionals utilizes all relevant information available to inform decision-making resulting in improved outcomes for health (Baggs et al., 1999).
However, before collaboration can be empirically linked to improvements in health status qualitative research describing the process of collaboration between health professionals working in primary health care is necessary. Researchers have recently undertaken qualitative investigations to explore health professionals’ collaboration experiences in the provision of primary health care. A descriptive study by Fletcher, Baker, Copeland, Reeves and Lowery (2007) found that NPs and physicians providing primary health care to veterans in the Midwestern United States described their relationship as collegial. NPs in this study perceived themselves as well accepted by physicians and physicians identified NPs’ teaching and interpersonal skills as important to patient satisfaction. However, physicians also identified that NPs were not well equipped to provide primary care to clients with numerous co morbid conditions.

Researchers in Canada and specifically in Ontario have also undertaken qualitative investigations of collaborative practice in primary health care. Bailey, Jones and Way (2006) used narrative analysis to determine experiences with collaborative practice of 13 physicians and 5 NPs working in 4 rural primary care practices. Several themes relating to collaborative practice experiences were identified including; issues of scope of practice, emphasizing the importance of role clarity and trust, the ideological difference regarding disease prevention and health promotion, differences in the perceptions about the operation of collaborative practice, and the understanding that collaborative relationships evolve. The investigators conclude that orientation to the NP role and collaborative practice prior to implementing NPs in a primary care practice is imperative to achieving successful collaboration.
The importance of ensuring the NP role is clearly defined and physicians have an understanding of the NP scope of practice was also found in an Ontario study investigating the integration of NPs into a Family Health Network (FHN) (Humbert et al., 2007). Humbert and colleagues (2007) used surveys, focus groups, in-depth interviews, case studies and daily logs collected over an 18 month period to evaluate the process of integrating NPs and a pharmacist into a FHN to care for patients with complex multiple chronic illnesses. Along with role clarity and understanding scope of practice additional findings included the need for excellent communication, coordination of care, individual respect and trust, and a willingness to change the way primary health care is provided.

Similarly, a qualitative case study undertaken with 10 Ontario FHTs evaluated the contextual factors influencing the quality of collaborative mental health delivery (Mulvale, Danner & Pasic, 2008). The researchers identified remuneration mechanisms, practice scope clarity and accountability as global-level factors affecting quality of collaboration. Additionally, within-team factors affecting quality of collaboration included; communication, professional culture/practice style, non-hierarchy, team vision, space and co-location.

It is evident that significant work to clarify the concept and process of collaboration has been undertaken. Specifically, there is a growing body of literature investigating collaboration between nurses and physicians. In Ontario, the NP role has been integrated into primary health care practices for over a decade; therefore, research on the experiences of NPs working in collaborative primary health care practice is appropriate. In order to explore primary health care nurse practitioners’ experiences and
perceptions of interprofessional collaboration with physicians in a variety of primary health care settings, a qualitative descriptive study was undertaken.
CHAPTER 3
Methodology

Qualitative Design

Qualitative research has a significant history in enabling investigators to explore, in rich detail, specific phenomena. Investigators undertaking qualitative research aim to understand fully the phenomenon of study. More specifically, the researcher undertaking a qualitative description aims to explore a particular phenomenon in its natural setting through inductive processes. In this way, qualitative descriptive studies are similar to naturalistic inquiry (Lincoln & Guba, 1985). The result of a qualitative descriptive study is a description of the phenomenon within the context of its natural occurring setting.

Several methodological principles drive the qualitative descriptive design. These include conducting the study in a natural setting, utilizing the investigator as the primary data collection instrument, purposive sampling of participants, an emergent research design, inductive data analysis, context dependant interpretations, and a descriptive summary of the phenomenon of study.

Study Design

A qualitative descriptive study design, as outlined by Sandelowski (2000), was used in this thesis. Due to the limited research available on NPs’ experiences and perceptions of interprofessional collaboration with partnering physicians in the provision of primary health care a qualitative study was chosen. This study design allowed the researcher to explore and describe, in detail, interprofessional collaboration with physicians from the NP perspective. The following sections describe each of the methodological principles used in greater detail.
First, the ethical considerations of the study are provided. Second, the research question guiding this inquiry is provided. Third, the methods of participant recruitment and data collection are discussed. Fourth, the method of data analysis and member checking is described while the final section outlines the measures utilized to ensure trustworthiness of the investigation. It is important to note here that for the purpose of this study, the use of the title NP will refer to those NPs working within primary health care settings.

Ethics

Approval from the Queen’s University Health Sciences Human Research Ethics Board was obtained prior to the commencement of data collection (Appendix A). Signed consent was acquired from NPs participating in individual interviews. Permission to tape record interviews was sought out in order to promote accuracy of transcripts and findings; however, participants were informed that taping could be stopped at their request at any time during the interview. The researcher has undertaken several measures to protect the individuals interviewed. Firstly, the names of participants are not identified in the text, nor do they appear in any written material resulting from this study. For example, pseudonyms and disguising information have been used, as required, to mask identity. Secondly, taped interviews and transcripts are available only to the investigator and thesis supervisor and have been stored in a locked cabinet. Moreover, the data management software, which holds all available data, is accessible only by password. Lastly, tapes with recorded interviews and raw data will be kept in secure storage at the Queen’s School of Nursing for five years post thesis completion and will then be destroyed.
Research Question

The overarching research question was: How do Nurse Practitioners (NPs) in primary health care describe their experiences and perceptions of interprofessional collaboration with physicians?

Recruitment

In order to explicate NPs’ experiences with collaboration, the investigator utilized purposive sampling to recruit and select participants. Purposive sampling involves selecting participants for study based on their expertise and first hand knowledge of the study phenomenon (Lincoln & Guba, 1985). Therefore, criteria for NP participation included current employment in a primary health care setting as a NP with a self reported collaborative relationship with a physician in Ontario; a minimum of two years experience as a NP; and a willingness to participate in two interviews regarding their experiences and perceptions of collaboration with physicians and a third interview to review the study’s findings and provide feedback.

NPs in Ontario work in a variety of primary health care settings. Therefore, purposive sampling also included the selection of NPs from a range of primary health care settings. The settings included a Family Health Team (FHT), a Primary Care Network (PCN), a community sponsored clinic, a corporate sponsored community clinic and a Community Health Centre (CHC). For a description of each of these settings refer to Appendix B.

Recruitment of NP participants commenced in July 2005 and was completed in March 2006. The investigator contacted the first NP participant via email with an introductory letter and study proposal summary (Appendix C) to invite her participation
in the investigation. This participant met the eligibility criteria and had considerable experience with interprofessional collaboration with physicians in the provision of primary health care. Snowball sampling was utilized to further identify NPs appropriate for study inclusion as well as NPs working in a range of primary health care settings. Therefore, the initial participant identified additional NP participants with knowledge and experience of collaboration with physicians in primary health care practice in varied primary health care settings. The investigator also approached these participants via email inviting participation in the study. Subsequent participants directed the investigator to additional eligible participants.

The investigators intent was to interview NP participants until the data collected was recurring and no new key themes or data were forthcoming. A minimum of four NPs were to be included in this study and follow up interviews were to be scheduled for clarification of the initial interview if required. Six NPs were interviewed; however, only one NP was asked to complete a second interview to clarify her previous interview. The five other NPs completed only one interview each. Upon completion of the seven interviews the data were repetitive in nature and no new themes were identified.

Data Collection

In order to obtain rich data of NPs’ experiences with the collaborative process open-ended interview technique was used. Open-ended questions allow participants to fully share their experiences and point of view of the phenomenon of interest, interprofessional collaboration with physicians. Moreover, open-ended questions utilize the investigator as an instrument and provide an opportunity for NPs to present a first hand account of interprofessional collaboration. Semi-structured interview questions
(Appendix D) were developed and included demographic questions and open-ended questions and prompts. The demographic questions were direct questions that were used to begin the interview and obtain demographic and contextual information. The open-ended questions and prompts were used to elicit discussion of participants’ experiences and perceptions of interprofessional collaboration. Interviews concluded when participants felt they had shared their perspective fully.

A practice interview was undertaken to assist the researcher in gaining experience with interviewing. A NP participant with seven years of experience as a NP was identified by the thesis supervisor and approached by the researcher to participate in a practice interview. The interview took place at the School of Nursing at Queen’s University and provided an opportunity for the researcher to refine the interview guide and interview technique. The interview was transcribed verbatim and reviewed by the researcher and thesis supervisor. The practice interview was entered into qualitative data management software, NVIVO 2.0, and coded by the researcher. The thesis supervisor hand coded the interview and the resulting codes were compared to those of the researcher. A high level of agreement between the thesis supervisor and the researcher was reached on the coding of the practice interview. As a result of this activity the final interview guide that was used for the interviews was refined (Appendix D). The practice interview was not included in the overall analysis, as the NP participant did not meet the eligibility criterion of being employed as a NP in Ontario.

All interviews were face-to-face in a setting chosen by the participants. One participant completed two interviews of approximately an hour in length per interview. The first interview took place in a restaurant while the second took place in the
participant’s office. All other participants completed one interview of approximately an hour in length. Of these interviews, two took place in the participant’s home and the remaining three took place in their practice setting.

Data Analysis

Seven interviews were transcribed verbatim and entered into NVIVO 2.0 for coding. This software was used to assist in the management of the data set. NVIVO 2.0 facilitated coding, indexing and searching of the data during analysis. Although data analysis is presented independently from data collection, data collection and analysis occurred simultaneously. Data analysis commenced after the first interview was transcribed and continued throughout the data collection process. Qualitative content analysis was used to analyze the data. Qualitative content analysis is described by Sandelowski (2000) as the principal mode of processing data within qualitative descriptive studies. Using this method of analysis the researcher categorizes and organizes the data into a rich description of the phenomenon.

Analysis began with the reading and re-reading of the data collected. As the data became familiar to the investigator, units of data were identified and assigned a category. Categories were initially assigned based on the intuition of the investigator. As units of data were assigned to categories they were compared to other data units previously assigned. Data unit assignment continued until all data units were assigned to a category.

As analysis continued, categories were refined; this included a refinement of the conceptualization of categories and identification of relations between categories. This also included the integration and/or reduction of categories, as well as identifying saturation of categories. Saturation refers to data units within categories becoming
repetitive in nature as well as no new categories emerging from the data. In this stage, some categories were merged together and major themes of NP–physician collaboration were identified. The final stage of analysis involved describing each category while including rich description in the form of quotes from the interviews to illustrate the category.

*Member Check*

Upon completion of the data analysis, a draft summary of the seven identified themes was compiled (Appendix E) and sent to each NP participant. Participants were asked to review findings and provide feedback. Specifically, NP participants were requested to comment and provide thoughts on identified themes as well as identify any important items or themes that may be missing. The investigator requested that feedback be scheduled via a telephone interview. One participant provided feedback via email while no other feedback was received. The feedback of this participant was considered prior to completion of the final draft of the findings.

*Trustworthiness*

In discussing trustworthiness Lincoln & Guba (1985) state: “How can an inquirer persuade his or her audiences that the findings of an inquiry are worth paying attention to, worth taking account of?” (p. 290). Lincoln & Guba go on to describe the four components of trustworthiness; credibility, transferability, dependability and confirmability. The investigator attended to each of these components as follows.

*Credibility*

Credibility refers to increasing the probability that credible or believable findings have been produced by the investigation (Lincoln & Guba, 1985). To increase credibility
the researcher spent a considerable amount of time becoming familiar with NP education, history and practice in Ontario. To this end, the investigator interviewed one of the directors of the NP education program in Ontario. This interview was transcribed verbatim and studied to further the investigator’s knowledge and understanding of NP education and practice in Ontario. Additionally, several policy documents related to NP history in Ontario and NP education were reviewed.

Second, field notes were written after each interview to capture elements of the setting, NP participants’ body language and the investigator’s thoughts and perceptions related to the interview and interview process. Moreover, the investigator and thesis supervisor met regularly during the analysis of interviews to review each transcript, and discuss codes and themes.

Third, the investigator reflected on her perceptions, knowledge and experiences in relation to interprofessional collaboration, NPs and physicians. As previously discussed, qualitative description aims to inductively derive findings from the data collected within the natural setting. It is therefore imperative that the investigator be aware of any bias, and previous theoretical interpretations of the phenomenon under study. Lincoln and Guba (1985) describe this measure of trustworthiness as neutrality. To this end, prior to the commencement of data collection and analysis the investigator reflected on knowledge, assumptions, beliefs and biases related to the phenomenon of study, specifically, collaboration between NPs and physicians. These reflections were written down in a journal and set aside throughout the investigation. Refer to Appendix F for a discussion of the researcher’s previous experiences and perceptions related to interprofessional collaboration in primary health care.
Transferability

In order for this study’s findings to be transferred to others in similar situations the researcher has provided rich description in the discussion of findings. Through this rich description the reader of the investigation can determine if the context is similar enough to allow for transfer of findings to their own setting. Inclusion criteria and demographic data of NP participants are also provided to assist the reader in determining the transferability of the findings.

Dependability & Confirmability

Dependability in naturalistic inquiry is described by Lincoln & Guba (1985) as similar to that of reliability in conventional research. In other words, would another investigator analyzing the same interview data come up with similar findings? Confirmability, on the other hand, is akin to conventional researchers’ criteria for objectivity and aims to ensure that an audit process can confirm the investigators findings. Both dependability and confirmability are satisfied by providing the readers with enough methodological details that replication of the study could be undertaken. To this end, the investigator has kept all field notes, coding notes, written transcripts and audio taped interviews. These materials can be utilized to audit the study in future.
CHAPTER 4

Findings

Seven themes were identified in this investigation. The themes were: Quality of communication, complementary vision, physician remuneration methods, establishing and maintaining relationships, investing time and energy, NP competency and expertise, and mutual trust and respect. Outlined below is a description of the participants and their setting followed by a description of each theme along with interview data that illustrates it.

Profile of Participants and Their Work Settings

Six NPs participated in this study. All participants received their diploma in nursing and have been practicing nursing from 15 to 34 years. Five of the NPs completed the Ontario Primary Health Care Nurse Practitioner Program while one NP completed a portfolio of prior learning and a 13-week transition program for nurses already functioning in the NP role. Participants have been registered in the Extended Class (EC) for a minimum of 5 years to a maximum of 9 years. At the time of interview all participants were practicing NPs and the time spent in their current position ranged from 1 year to 9 years. Practice settings varied amongst the participants. Three of the NP participants worked in community clinics, two of them working together in the same clinic, with their partnering physician off site. One NP participant worked with two physicians in a FHT and another NP participant worked with three physicians within a PCN. The last NP participant worked in a CHC with four physicians and four other NPs. Practice sizes also varied, ranging from approximately 350 to 5000 patients (see Table 3, p.41)
Table 3

Selected Demographic Characteristics of the Participants and Their Practice Setting

<table>
<thead>
<tr>
<th>NP</th>
<th>Years Nursing</th>
<th>Years as NP</th>
<th>Years in Current Position</th>
<th>Current Setting</th>
<th>Number of Physicians on Team</th>
<th>Number of NPs on Team</th>
<th>Practice Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>26</td>
<td>5</td>
<td>5</td>
<td>Family Health Team</td>
<td>2</td>
<td>1</td>
<td>2600</td>
</tr>
<tr>
<td>2</td>
<td>32</td>
<td>6</td>
<td>6</td>
<td>Primary Care Network</td>
<td>3*</td>
<td>1**</td>
<td>3000 – 3500</td>
</tr>
<tr>
<td>3</td>
<td>26</td>
<td>5</td>
<td>3</td>
<td>Community Sponsored Clinic</td>
<td>1</td>
<td>2</td>
<td>2200 – 2500</td>
</tr>
<tr>
<td>4</td>
<td>34</td>
<td>5</td>
<td>5</td>
<td>Community Sponsored Clinic</td>
<td>1</td>
<td>2</td>
<td>2200 – 2500</td>
</tr>
<tr>
<td>5</td>
<td>15</td>
<td>8</td>
<td>1</td>
<td>Corporate Sponsored Community Clinic</td>
<td>1</td>
<td>1</td>
<td>350</td>
</tr>
<tr>
<td>6</td>
<td>21</td>
<td>9</td>
<td>9</td>
<td>Community Health Centre</td>
<td>4</td>
<td>5</td>
<td>4500 - 5000</td>
</tr>
</tbody>
</table>

*One physician was on leave at the time of the interview.

**An additional NP has been assisting 2 days per week while physician was on leave.

Quality of Communication

Communication methods between NP participants and partnering physicians varied considerably. Primary methods of communication described by NP participants included face-to-face, telephone and electronic. The following paragraph describes the varying methods of communication utilized by the NP participants in their specific primary health care settings.
Three NP participants worked in community clinics. Two of these NPs worked together in the same clinic while their collaborating physician was off site in a neighbouring town. In this practice setting, both NPs had their own patients and communication with their collaborating physician primarily occurred over the phone. The third NP working in a community clinic also had her own patients, however, her collaborating physician attended the clinic one afternoon per week to collaborate and see those patients requiring physician consultation. In this case, the NP reported communication primarily occurred as face–to–face during the physician’s weekly visit. The remaining three NPs worked in settings where their collaborating physicians worked on site. One NP worked in a Family Health Team with two physicians. She reported face–to–face as her primary method of communication. Alternatively, the remaining two NPs worked in a Primary Care Network and a Community Health Centre with three and four physicians, respectively. Both of these NPs reported their primary method of communicating with physicians as electronic. It was found that the organizational model of the NP’s primary health care setting influenced the primary method of communication and thus the design of the collaboration.

Despite the variety of methods utilized by NP participants to communicate with their collaborating physicians all participants identified communication as necessary to successful collaboration. One NP participant listed communication when outlining her cues that identify successful collaboration with a physician: “Cues to success; trust, respect, competencies, communication, having the same mandate to serve the patients in the community.” Other NP participants also outlined the importance of quality communication to the success of the collaborative relationship with physicians: “And
that’s easy collaboration too, for the same reason. He’s… a good communicator.” More specifically, communication was identified as important to collaboration because it provides the NP – physician dyad the opportunity to keep up to date and informed on patient care:

Working together, hopefully, for the best interest of the client. So both are, and the thing is there has to be a real communication that happens between the two practitioners when that occurs…. So that’s really some method to kind of keep both practitioners informed of the changes with clients is really important.

Establishing methods of communication that both the NP and the physician utilize to impart information regarding patient care is perceived as important to the collaborative relationship and to patient safety. One NP participant discussed the establishing of communication methods as a barrier that has been overcome within her NP – physician dyad. She stated: “…the establishment of communication methods that sort of thing has been overcome.” Another NP participant described a work environment in which communication methods were not well-established and utilized thus resulting in poor collaborative relationships and compromised patient safety.

I think there were issues of communication and safety. Patient safety in documentation records…. There was a computer system but some people used paper charts, some used the computer and there was different doctors coming and going so it made it very difficult to ensure that my records were going to be where they needed to be and be seen when they needed to be. Plus that I would be able to access appropriate information. I would sometimes find that I ordered something and that I would come back and my lab reports have been filed, signed by somebody else and filed away. So I wouldn’t necessarily see the labs on the patients that I had ordered.

This NP participant also described how the lack of communication regarding patient care negatively affected her job satisfaction.

So, I just didn’t feel comfortable with those kinds of things and I wasn’t really happy practicing where I felt there was substandard level of care and communication and trust.
Several NP participants discussed the qualities and skills both practitioners need to be good communicators. NP participants identified being assertive, direct, clear and concise as desirable communication skills. They described the importance of being clear when communicating with their collaborating physician. One participant stated: “We have to be very clear in our communication about…what we need help with.” Other participants stated:

Example 1:

Open honest communication, and that’s a tricky one, you know to be assertive. Positively assertive and not that kind of undermining communication. You know where it is that; I’m trying to think of the word of that you know sort of (pause) passive aggressive is what I’m thinking of.

Example 2:

We try to be really clear in what we’re asking when we consult. So that if it’s a matter of I just want your opinion or it’s a matter of I want you to come in the room and assess or I want to transfer the care of this client to you. We try to be really clear on what the actual issue is.

Example 3:

… Very clear concise communication skills. Those are the keys. And remembering it's not a social relationship. I'm not calling to say "Hi, how are you today," even though you always do that. Okay, the bottom line is what you’re calling about, so you quickly move to what you're calling about.

Example 4:

My perspective, if you take too long to tell the story the person loses parts of it or else they're having to scribble. Okay, they should be able to just listen quickly and get a handle on what's going on.

One participant identified the communication skills of her collaborating physicians as assertive and direct. This participant perceived these communication skills as a facilitator
to collaboration and felt that she could learn from her collaborating physician how to communicate more effectively.

And I think that might be something that these folks are all pretty good at but they don’t mince words or they don’t try and get around something and put it in another way, they just say it. I’m the one that needs more assertiveness in that regard (laughs). You know, to be able to just not worry about being direct.

Another NP participant identified communication as an ongoing collaborative challenge and a skill that both she and her collaborating physicians could improve within their practice.

I would really like to work on improving that so I stay in touch with what’s happening and maybe they need to be. Maybe I should be a bit more, you know copying them a little bit more to keep them informed. Because there are times when I’ve gone in and said: “You know so and such patient?” And they’ve said; “I haven’t seen them in five years.” And I’ve said; “No, I’ve been seeing them for five years.” You know that kind of thing, so that could probably work both ways…. So, that’s the biggest challenge, as far as collaborative challenges, communication would be the only one we could, if we had more time to, be better at.

Along with communication skills, NP participants perceived physician attitudes and willingness to communicate as necessary to the collaborative relationship. One NP participant included “poor communicator” as an attribute of a physician with whom she does not have a good collaborative relationship. Moreover, this participant felt that this physician lacks the willingness to improve the communication and therefore the collaboration. She stated: “He’s a poor communicator and… there’s no willingness to devote time or energy to it. So it’s more of consultative model.” Another NP participant identifies a past work environment in which she felt there was poor communication with collaborating physicians due to their attitude. She stated: “And communication tended to be a problem as far as direct communication. I always felt that I was kind of patronized and that I was listened to but then nothing would happen.”
In summary, NP participants utilized various methods of communication when collaborating with their partnering physicians and these methods are largely influenced by the organizational model of the primary health care setting in which they work. However, regardless of the method utilized, NP participants perceived communication as essential to the collaborative process. Communication was perceived to be vital to patient care and safety. Specifically, establishing communication methods that both the NP and the physician utilize to stay informed about their patients was important to collaboration and patient safety. NP participants identified clear, concise, assertive and direct communication skills as an asset to collaboration. While some participants felt their NP – physician dyad had good communication that facilitated collaboration, another NP identified communication as a skill that could improve and would thus ultimately improve the collaborative process. Physicians’ attitude and willingness to communicate were also identified as necessary to quality communication and collaboration and NP participants provided examples in which collaboration was negatively effected by substandard communication.

Complementary Vision

NP participants identified that collaboration with physicians works best when both the NP and physician have similar views of health care provision. One participant described this as a health practitioner’s “practice style and philosophy.” This participant made a distinction between those practitioners that choose to work in salaried positions compared to those that work for fee for service:
We have a similar practice style and a similar practice philosophy. I mean there’s some variance within the group itself obviously and that keeps it nice and interesting and dynamic…. But we have… yeah it’s practice style and philosophy. I mean obviously you’re attracting a certain type of physician or nurse practitioner if they want to practice… in a salaried position versus a fee for service practice. So most of them want to practice in a way that is more comprehensive… and have more time for a relationship with their clients.

Other NP participants stated that a physician’s philosophy on their role and practice perspective is important to the collaborative relationship. Participants provided examples on how opposing philosophies can cause difficulties within the relationship:

*Example 1:*

… like I said if the personalities of the partners are flexible enough that they’re willing to share patients and… it’s their philosophy on their role and you know if their role is the… gate keeper and the controller then it’s much more difficult.

*Example 2:*

…this is our practice perspective because we don’t see eye to eye on this and it causes conflict within a dyad. A NP – family physician dyad. I, we have rostered patients and I say, “we have a commitment to serve our rostered patients” and he says, “no, we have a commitment to the whole community, we have to see anybody and everybody that walks in.” And I said, “so basically we’re running an ER, because what about those people who’ve booked and we keep letting the walk-ins walk in.” That would be fine if we had a policy on it and prioritized and triaged and had adequate resources but we don’t. So although it’s a nice thing to say, “you’re going to serve the whole community” it’s unrealistic to think you can do it without the, you know there’s a trade off and our rostered patients suffer.

One participant described her collaborative relationship as “ideal” and when asked to identify some of the things that make this collaborative relationship ideal she responded: “Complementary vision.” This participant described her collaborating physician’s vision of health care as not only complementary to her own but closely related to that of the nursing profession in general:
And I guess he found out that I was starting the… project and his, his vision for the health care system is quite… complementary to what mine might be or a number of nurse practitioners might be or nursing….my partner, as I said, had some interest, had a complementary vision of what the health care system should be moving towards and that, in his case, includes a team. He has very specific terminology about it. I just love to hear him talk about it… because it’s… so complementary to what a nursing holistic view.

Complementary vision or similar practice styles and philosophy of health care were seen as important to the collaborative NP – physician relationship. NP participants described their experiences in collaborating with physicians that have similar visions of health care provision as themselves as, “positive”, “ideal” and “exemplary”. Conversely, NP participants identified that differing visions of health care provision and practice philosophies can cause difficulty within the collaborating relationship.

**Physician Remuneration Method**

All NP participants mentioned physician compensation as a factor, which can affect the NP – physician relationship. Several participants discussed how the method of physician remuneration can be a barrier to the collaborative relationship. However, the participants working in community clinics described how “the financial barrier has been overcome somewhat.” These NP participants explained how their collaborating physicians are compensated and how this compensation has alleviated feelings of “burdening” or “disrupting” their partnering physician:

**Example 1:**

…the financial aspect… I think the physicians can bill right now for the patients they see but again it was always, a barrier would be how much, I was conscious of how much time I kept him beyond to talk about patients verbally.

He was not compensated for that half hour after the patients were gone where I had to go over a few things with them just for advice or when I’d make those phone calls I felt like a burden. I was conscious of taking his time away from a patient in one of his clinics to have them on the phone to talk about two or three
people that I was concerned about. So the benefits… there just recently was a
new fund that provided $800 a month for collaborating physicians. That’s part of
the OMA [Ontario Medical Association] contract and if you’re linked with a
project that has ties with a nurse practitioner then the physicians can obtain that
$800 a month. So now I don’t feel that I’m… interrupting his day and having
financially a negative impact on him because one, he can bill for the patients he
sees but he’s getting the extra stipend of 800 a month so those few minutes that I
take of his time or that he stays a little bit later is covered, so that’s ideal.

Example 2:

…the physician we work with gets $10 000 annually for each nurse practitioner.
And that was a new thing in the OMA contract. And that was the monies that was
suggested and that’s what’s being paid. And once again that acts as an incentive,
it’s worth her while. Okay, because she’s being paid to do that. It’s not out of the
kindness of her heart. And it makes it, once again, easier for everybody you
know, otherwise if you’re very busy in your own practice you might get a bit
annoyed.

The NP participant employed in a CHC believed that in her work setting
remuneration of NPs and physicians by means of salary eliminates the possibility of
physician compensation as a barrier to the collaborative relationship:

I mean I work in the ideal type of setting where everyone’s on salary so it doesn’t
have a negative impact on them. We’re not worried about billing or you know, so
in that sense and it’s also people that you know, are again open to that concept of
working in this type of team environment.

One participant provided a detailed example of how Ministry funding may affect
the practice environment. This participant described how the physicians in her current
setting are less concerned with financial compensation and more interested in patient
care. She also attributed their willingness to focus on patient care despite the financial
repercussions as a demonstration of the value they place in her role:

And the doctors respect my role and they value what I have as input regardless of
the implications financially. For instance, they do have these same bonus codes
and they’re happy to not worry about them…. we had a new project whereby [the]
Ministry will fund the doctors per month just for consulting with me. So they get
150 dollars a month for this clinic for consulting with me. To do that I would’ve
had to keep track in detail of every consultation and what it was and I’m already
doing this tracking (pointing to spreadsheet). Plus I was going to have to do another tracking and they said, “for fifty bucks each a month, forget it, I’d rather we see patients.” …there’s another code that they can now bill. We just had this discussion on a conference call, that they would have for seniors over 75, they could, out of the basket, cause you know how rostering works they’re paid per patient per year, right? So if they’re an elderly patient they may get 200 dollars a year. If they’re a young healthy… 25 year old male they may get 100 dollars a…year. So um, so for the 75 year old patient for billing they would see them for a general assessment or if they came in with you know a blood pressure concern that would generally be a certain code because they were 75 they could add on a little extra money for that code. So on our conference [call] I said, “well what about all the patients I see?” [They said,] “forget it, it’s not an issue.”

A participant also described a previous practice setting in which the physician’s priority contrasted with those described above. In this example the NP participant believed that the physician’s concern with “billing” negatively impacted the collaborative relationship as well as patient care:

So the plan was that I would see those first prenatals, like I described, but when a new billing code came in that allowed them access to bill for that patient then all of a sudden I wasn’t… seeing them anymore. And I thought, there was no discussion about, “okay how can we work this out together that I can still get the billing fees that are available but make the best patient care.” It was, “it’s a business and you know it all adds up.” So, it wasn’t… about what was best for [the] patient, which I was sad about.

Another NP participant discussed how physician compensation continues to be a barrier when collaborating with specialists:

Technically we can refer to any specialist but there’s a financial disincentive to taking a referral from a nurse practitioner. … a family doc to a specialist physician is billed at a certain level …a nurse practitioner to a specialist is probably half the price. So most specialists would prefer to have a physician even if it’s just the signature on the letter.

This same participant also described her additional concerns with physician compensation. She believed that physician remuneration methods continue to be a barrier in certain practice settings. She stated that models of practice that compensate
physicians through the rostering of patients negatively impact the collaborative NP – physician relationship:

Even the new Family Health Team model is fantastic in basic description but because the financial remuneration is tied to rostering of the physician alone the rest of the team, as much as we’d like to say we’re real partners, are only in my opinion, unless you’re in with a group of physicians that are, have for some reason a really holistic, a uniquely… team collaborative role. So you’re actually able to share in decision-making and having put greater, significant input over the patient care. For the most part my impression is because the funding is tied to a rostering system it prevents real team collaboration. So again, there needs to be more creative ways of funding.

I would think on a larger, macro level, the trend in the Ministry to fund… projects that are either inadequately funded to overcome the salary issue for physicians and then also the inability or challenges that the Ministry has had to get away from fee for service model…

Similarly, one NP participant felt that although several NPs and physicians are collaborating very well, some physicians continue to have concerns about the financial implications of working with NPs. She perceived that there continues to be concern among physicians as a collective surrounding remuneration for time spent collaborating with NPs:

But one on one, physicians know what collaboration is. They’re doing it and they’re doing it well. We are all doing it, not all but lots of really good examples…. When NP’s are with physicians one on one I think you see pretty good efforts at this and when you get a group of them together in a room it can become quite different and quite nasty and it’s all about money and, “Well yeah they take a lot of our time. How much are we going to get paid to consult with them? …So when you get them together and you get this OMA spin on it, it’s a whole different conversation.

All NP participants discussed physician remuneration. Those NPs working in community clinics and a CHC believed that physician remuneration methods had been adequately addressed within their practice settings and did not negatively affect the NP – physician relationship. In contrast, some participants described how other models of
practice including FHTs, PCNs and fee-for-service due to their funding structures could negatively affect the NP – physician relationship and patient care.

*Establishing and Maintaining Relationships*

All NP participants described how having an established relationship with their collaborating physician facilitates their collaboration. Establishing a relationship with their collaborating physician was perceived as developing over time. Additionally, all NP participants believed that they had achieved a well-established and positive relationship with their primary collaborating physician and that their collaboration was “positive” and “exemplary”:

*Example 1:*

Well yeah, when I started in… the one physician that’s still there is the one that I still probably primarily consult with my clients because we’ve had that established relationship.

*Example 2:*

And once she got to know us it was, it’s a lot easier. We’ve been with her; she came to [town] at the same time that we opened our clinic. She might have been a month or two earlier but so it’s been a good growing relationship.

*Example 3:*

I had the same medical director [and she] was in charge of both facilities. So she was my main partner and once that was established, from a clinical standpoint it was really rewarding and beneficial that way.

One participant described the establishing of NP – physician relationships as a three to six month process, which she labeled as the “introduction and orientation.” This participant perceived that the introduction and orientation is primarily taken on by the NP:

So for the most part, I would say that most relationships would take three to six months to get through the introduction, orientation during which, it’s been my
experience that, it’s the nurse practitioner that will not have the same expectations for a full scope of practice or the full collaborative role for a time period. And it would be the nurse practitioner in my experience, this is my pattern, that would do a bit, put more energy into establishing that relationship, clarifying the role, introducing their own unique personality and background and experience to it. I think it’s more the nurse, it’s been my experience that the nurse practitioner does that bit of homework or extra effort in that first 3 to 6 months during which time the other partner or the physician sort of assesses things, takes things in, sees demonstration of the role on a smaller less frequent pattern. During which the benefits, the uniqueness, the positive aspects of the role is typically…recognized pretty quickly.

And I think that’s demonstrated by some of the research too, is that there needs to be a certain period for introduction and orientation but more for, I think, I believe for the team building. So projects have to be designed to include that.

This NP participant went on to describe her current relationship with her collaborating physician as “almost ideal” and attributed this to the physician pursuing a partnership with her and thus lessening the time and energy required to establish the relationship:

Certainly, this current situation is, almost ideal. One, he pursued a partnership with me. So the initial introduction, orientation to the role, a lot of the barriers that often are the challenges to establishing real collaboration were overcome. Or initially overcame or much less than what they could have been if it was a new person just testing the waters or you know initiating it.

So in this situation, if I compared it to my current situation, my current experience would’ve been that initial introduction, orientation took two weeks.

Some NP participants illustrated how they have come to develop relationships with their physician partners. A NP participant described how attendance at conferences along with partnering physicians assisted in the establishment of relationships. In her experience attending conferences with her collaborating physician has facilitated the process of establishing a relationship:

And I think she knows how we are. We’ve been on a couple of conferences with her as well in Toronto, so that’s made a difference. You get to know somebody a
little easier during that and, so I think it’s been good, I think that it maybe got us to know each other faster. By spending a weekend.

In addition, this NP participant described how attendance at conferences with physicians outside of their practice fosters the establishment of relationships with community physicians, including specialists and those from local hospitals:

Because we had never, had never done a conference over [town] way. [Because] one way of doing collaboration is by just getting yourself out there and seeing people regularly. Because then the fear, I think the fear factor goes a little easier. But [town] was setting up a congestive heart failure clinic out of hospital care and recognized the fact that a lot of these patients have nurse practitioners. So they send out invitations to all the local physicians and nurse practitioners and we took part in that and it was, and we’ve had a couple of, maybe three sessions with [town] hospital and physicians in various settings. And that’s worked really well. …So I think conferences is a big thing.

Yeah, cause you do that over…a glass of wine and a meal….And it’s kind of a non-threatening environment and…we don’t really have horns, so they see that, you know. So, I think that’s better.

Another NP participant described how informal lunches and gatherings assist the team in establishing and maintaining relationships:

Plus there, you know we do things like we all have lunch together. You know, so everybody brings their lunch and we sit around. We have a summer BBQ, we have a Christmas dinner and so we’re not best friends but we do share in those kinds of things so that there’s that feeling that we’re all friends and colleagues. Everyone, you know, we talk about things at the table with the secretary and admin staff and the nurse when there’s an issue that comes up or you know if there’s a patient issue that, a new diagnosis of cancer or something. Or a family thing that’s going on with the family and we can all sit and you know discuss it and everybody knows what’s happening.

Other NP participants also described how pre-existing relationships with specialists facilitates their collaboration. NP participants outlined how consultations to specialists require a physician’s name and that responses are often sent to the physician
instead of the NP. However, specialists that know the NP or have a previously established relationship will respond directly to the NP:

*Example 1:*

So that referral goes in from me. I write the consultation note with the doctor’s name. So I write; “with Dr. G or with Dr. J.” Of course the docs send it back to the physician, right? Because they have to bill or they have to have that consult fee…They don’t technically have to but traditionally that’s what’s happening. So on my records I put, or on my consult note I put you know; “for best patient care cc me with your response.” But the only guys that do it are the guys in gyne that know me because I used to work there, you know or OB.

*Example 2:*

Yeah, but that is probably because I know them really well. These are the guys I worked with for 20 years. That was my background. So there’s again that element of trust, they know who they’re dealing with too, right?

NP participants tended to use the term “interpersonal relationship” to describe the sense of knowing each other as individuals and “clicking” or achieving a certain level of chemistry as people. This chemistry between NP – physician dyads was thought to improve the quality of the relationship and also the collaboration. Several NP participants referred to this interpersonal dimension that is involved in establishing a relationship:

*Example 1:*

And I think there’s so many dynamics that go with it, you know. Part of that’s experience and training and part of that is you know, the interpersonal aspect that goes along with that.

I think, you know, obviously there’s different personalities and different people will all work different ways.

*Example 2:*

So it’s a matter of, you do have to get to know the practitioner and their style and to understand the best way in which to work with them especially the consultation process.
So, we, you have to develop to find out what, how comfortable they are with the consultation process too and once you get to know their style and their level of expertise there’s ways in which you know, it’s been easy I mean it’s just a matter of them understanding you and you understanding them.

Example 3:

Personalities and experience you know, I would bring something as a nurse practitioner different than a brand new graduate that maybe had been nursing for five years just because of you know my life experience.

NP participants also described how difficulties arise if the collaborating partners have not established a relationship. The first NP participant perceived that not having a well established relationship would pose challenges in communicating concerns or questioning practice decisions. The second NP participant described her experience with a partnering physician with whom she believes there is little collaboration due to the lack of the physician’s interpersonal skills:

Example 1:

I think it’s more of a challenge when you haven’t developed that interpersonal relationship because I think, I find now I would, if I had a concern with a question I wouldn’t have any problem going up to any of the nurse practitioners or physicians and saying, “can you tell me your evidence?” Or what, why the management plan has gone there or whatever. And it’s always important to kind of understand because they may be looking at it from a different perspective or have different knowledge. So I think that’s always a challenge is addressing interprofessional issues.

Example 2:

Because I work with another physician so to be fair I have to tell you I work with two and I collaborate very very differently with them.

But he doesn’t have the same interpersonal skills to collaborate. He just cooperates and acts as my consultant when I need him. And that’s fine, I respect him for his knowledge but that’s not truly collaboration.

Establishing and maintaining relationships was seen as an important and contributing factor to effective collaboration between NPs and physicians. NPs perceived
their current relationships with their primary partnering physician to be well established and collaboration to be positive. Establishing and maintaining relationships takes time and effort from both NPs and physicians; however, NPs perceived that the NP primarily takes on the initial establishment of the relationship. Conference attendance, informal lunches and team gatherings were described as methods of establishing and maintaining relationships with team members. In addition, it was perceived that having a pre-existing relationship with physicians and specialists in the community facilitated the collaborative process. NPs also expressed that achieving a certain level of chemistry with collaborating physicians on an individual level was important in the establishment of relationships and collaboration. Additionally, NPs outlined how difficulties in developing relationships with physicians can lead to challenges in collaborating.

*Investing Time and Energy*

NP participants discussed the need for both NPs and physicians to devote time and energy to collaboration. Investing time and energy was deemed essential to various aspects of collaboration including, developing trust and respect, determining clinical competences, developing best practices, communicating and establishing and maintaining relationships:

*Example 1:*

That again, that takes time because every time there’s a new practitioner coming into the mix everyone has to kind of assess you know, different strengths and weaknesses and over that time you develop that. Who’s the best person for the job type of thing or who has that area of interest, who has that area of expertise.

But that takes time; it takes time to develop that kind of respect and trust.

It does take time and trust and a lot of it is, I think having clinical competence is a really key component to um developing a really sound collaborative relationship too.
Example 2:

But other challenges, time (laughs) to sit and discuss best practice that would be something ultimately I’d like to be able to do and generally we just run by the seat of our pants. You know, everybody’s busy every day and you know we’re all getting out of here [at] six or seven [pm], then there really isn’t the opportunity. So we tend to do a little bit over at lunch but we basically eat together for you know 15-20 minutes and then we all rush back to work on getting our charting completed so we can get out of here earlier. So unless we set a time and we, when [Dr.’s name] was here she’s a little bit more like me that she likes to sit down so we did try and have a few staff meetings but I think we had one (laughs).

So, that’s the biggest challenge, as far as collaborative challenges, communication would be the only one we could if we had more time be better at.

Example 3:

And inadequate time is a huge barrier. Space and time, just the logistics of how you collaborate.

Time and energy were also described as necessary in developing and maintaining relationships that are collaborative. One NP participant reviewed a presentation with the researcher on collaboration between NPs and physicians that she had developed with her partnering physician. This NP participant described how practitioners in collaborative relationships must be willing to give time and energy to the process:

Willingness to devote time and energy and see it’s at the bottom of the list and I think it’s huge. And I think this quote says it all (participant references a quote from a literature review on interprofessional collaboration which emphasizes hard work and time are required to develop and maintain collaboration) Otherwise it’s like the parallel play thing.

This participant also described a positive collaborative relationship with a partnering psychiatrist and contrasted this with a description of a relationship with another partnering physician that has lacked time and energy and has thus limited their collaboration:

That’s easy collaboration too, for the same reason. He’s a good communicator, he’s flexible, he puts time and energy into collaborating with everybody. He’s
really into shared care with the team; you know he thinks psychiatrists can’t do it alone. So that has been a really positive experience too.

Well I would say I felt one, with one physician it’s exemplary and with the other it’s like okay. But you know it’s not negative but there’s a minimal effort on both of our parts. I mean I tried harder at the beginning and then I just thought, “oh this man does not have the a… he’s not willing to put any time or energy into it.” He, I think he trusts me as far as competence goes and respects NPs as a group but he’s a poor communicator and he doesn’t, there’s no willingness to devote time or energy to it. So it’s more of a consultative model. So I’ve experienced both I think.

Developing trust and respect, identifying clinical competence, developing and maintaining relationships, developing best practices and maintaining quality communication are all areas of interprofessional collaboration that NPs perceived as necessitating time and energy. NP participants perceived that willingness to invest time and energy was required by both NPs and physicians in order for successful collaboration to occur.

**NP Competency and Expertise**

NP participants perceived that their own clinical competence affects the NP – physician collaborative relationship. For one participant, “competencies” was included as a term in a list of those elements she perceived as essential to the NP – physician dyad in successful collaboration: “Cues to success: trust, respect, competencies, communication, having the same mandate to serve the patients in the community.” Similarly, another participant outlined her clinical competencies as positively affecting collaboration with her partnering physician: “So my confidence level, my competencies are optimal as well, so I think that impacts too.” NP participants described how demonstrating their clinical competence or area of expertise to their collaborating physician is essential to facilitating collaboration. It is perceived that through the NPs
demonstration of clinical competence and expertise the physician gains “trust” and “confidence in [NP] ability”:

*Example 1:*

And I still remember when I started [with] this practice. I mean I had gone from a practice, very independent…and then I came to this practice. So every time I wanted to consult because at that time I didn’t have any type of prescribing authority. So if I had diagnosed an acute otitis media I’d have the doctor come in there and she would of course want to recheck my history and recheck my physical and recheck. And that again is part of it because they have to kind of understand what your expertise is. And within a short time that no longer became necessary. I could explain the client situation, I could explain my findings, I could explain my diagnosis and then she’d have the support as far as getting the prescriptive [sic]. It does take time to trust and a lot of it is, I think having clinical competence is a really key component to developing a really sound collaborative relationship too.

*Example 2:*

One of the things that's really important over time is that the physician get a sense of just where your strengths sit.

So, it's an opportunity for you to demonstrate your knowledge and skill, it's also an opportunity for them to be reassured that you're not sort of saying, "Gee I wonder what we do."

I think one of the things is that she has a sense that I have an adequate baseline of information. That I can do preliminary problem solving on my own. That I am likely going to be prepared when I call her, so that we try to use our time efficiently….I think another thing that's really important is she has confidence in my ability.

I think one of the biggest things is for the person that you're working with, your collaborating physician, to get a handle on just where you are in your knowledge and skill and if you work on a regular basis with people you get to know that or you can pick up quite quickly if you know clearly what should be assessed then you know what's missing and you can fill that in.

One NP participant outlined an experience in which her collaborating physicians did not recognize her competency or expertise. This participant believed that moving into RN(EC) from a general RN positioned her as a “rookie” to these physicians:
The physicians there felt, I think because I had been a student there, our roles were not as egalitarian because I was seen as a student perhaps and starting from a raw rookie again that maybe my level of expertise was always sort of felt to be at that level.

Similarly, another participant discussed the novice to expert continuum that she experienced when transitioning from a RN to a RN(EC) or to a new area of specialty within her NP practice:

Novice to expertise, first when you start your career as a NP you’re an expert as a nurse prior to the nurse practitioner program but when you start out in your practice you’re a novice again.

So just having the opportunity to brainstorm to validate this is what I’m thinking to discuss a case is really advantageous, any time but particularly when you’re starting out in a new career or a new specialty. Every time you move to, when I moved into gerontology, you became a novice again.

And based on your ability to study and get that experience you became an expert over time. But moving back into primary health care I felt a little bit like a novice when I started doing well women’s care again.

In addition to proving their own clinical competencies and areas of expertise to their collaborating physicians, some NP participants identified that determining the strengths and areas of interest of their partnering physicians was important to both collaboration and team functioning. Both these NP participants described how utilizing the strengths and areas of interest of each team member optimized the work environment as well as the care provided to their clients:

*Example 1:*

And that again, that takes time because every time there’s a new practitioner coming into the mix everyone has to kind of assess different strengths and weaknesses. And over that time you develop that you know who’s the best person for the job or who has that area of interest, who has that area of expertise. So you can try, even as we hire new people in, is to kind of say, “okay, what was the team missing as far as our strengths” and then trying to make sure that we look for that in future practitioners. So, I think we have a nice mix of expertise and interest too which helps I think keep things very dynamic in the practice. As
well as knowing you have somebody who has an expertise in a certain area that you can turn to if necessary.

Example 2:

You know, it’s not just to make me feel better that I know there’s someone I can ask things. It’s if a doc happens to have more experience in addictions issues and what not, which he does, then I know he can manage that better. I’m great with the moms and babies and with the teaching aspect of a role. You know and everybody has their own sort of areas of expertise so that we can work together for the best possible outcome.

NP participants thought that proving their clinical competencies and areas of expertise to their collaborating physicians was necessary for effective collaboration. The participants also perceived that NPs must prove that they have an adequate baseline of knowledge and are able to demonstrate that knowledge to their partnering physicians. Moreover, NP participants perceived that they had areas of strength and expertise beyond baseline competencies that they demonstrated to their partnering physicians. In addition, determining the interests and strengths of partnering physicians was important to team functioning and patient care.

Mutual Trust and Respect

Mutual trust and respect were identified together as necessary elements of effective collaboration between NPs and physicians. NP participants discussed the need for collaborating physicians to demonstrate respect and trust in the NPs themselves and the NP role. Several NP participants listed trust and respect as contributors to the collaborative relationship:

Example 1:

You know, the mutual trust and respect is the absolute top.

The doctors respect my role and um they value what I have as input regardless of the implications financially.
You know if people are open to collaboration or have worked in collaborative roles before and have that respect.

*Example 2:*

You probably, I mean there’s, there’s some of the stuff you know that’s in sort of everything you read, which is sort of true like mutual trust, respect, and the communication and flexibility.

When I went to the practice as a student, I was precepted by a physician who was quite progressive in thinking in terms of collaboration and just demonstrated great respect for NPs.

*Example 3:*

The complementary vision, mutual respect, an atmosphere in which the nurse practitioner is able to control and develop the entire project.

*Example 4:*

So you know the mutual trust and respect, the open communication, the flexibility to be able to adapt to new things.

Some NP participants identified mutual trust and respect within the NP–physician dyad as collaborative elements that develop over time. One participant stated: “But that takes time; it takes time to develop that kind of respect and trust.” Similarly, another NP participant stated: “It does take time to trust…” Moreover, some NP participants perceived public acknowledgment of their role and competencies as a demonstration of physician trust and respect. Acknowledgment of the NP’s competencies and contributions could be to other physicians or to patients:

*Example 1:*

He demonstrates trust and respect in the role and always has something positive to say about NPs. I’ve heard him speaking to residents and stuff.

Anyway, he brought him [a visiting physician] around the clinic to introduce him to everybody and he introduced him to me and I couldn’t believe what he said. He said, “oh yeah [NP name] does just tons of stuff here.” And he said, “she sees
all the women.” You know, he was talking up the role of the nurse practitioner. He said, “but she’s also a consultant for us, we consult her on lots of patient issues around women’s health because that’s her expertise.” And I thought, “wow we’ve really made progress in a few years that he would admit that to another physician… that they actually consult the NP.” Because we know in reality that goes on all the time but you don’t read about that in the literature.

Example 2:

You know even in just having patients see me. You know or saying something to a patient, you know, “you can see the nurse practitioner about that.”

I think indirectly they have demonstrated it when they’ve been out at other venues. You know, been able to, they present, have presented with me. A doc presented with me at… a conference about how we sort of made that change to the roles. We’ve done a little bit of that. We’ve participated in other studies where they’ve talked about me and the role. And I know they’ve talked, I mean [physician name] works at a hospital doing a little emerg-shift there and he talks to them because they’re getting a nurse practitioner or have got just recently. So he would talk about our role and what I can do, you know, he is an advocate, where I don’t think when I started he knew that much, and he was just happy to have an extra pair of hands.

Another NP participant emphasized that collaborating physicians demonstrate trust and respect when they accept her assessment and clinical suggestions:

We’re a team, they respect my opinion you know equally. I never feel like I’m just blown off…

And feeling comfortable that I’m managing this. There’s nobody saying, “well, I haven’t seen that person in a while, how come I haven’t seen them.” You know as long as the results are okay.

You know, they don’t question my decisions if I say, “how about this medication change?” And really they don’t second guess. They don’t have to see the patient. They don’t have to examine that patient themselves to be able to, you know, respect my suggestion.

In contrast, NP participants discussed some of the challenges they’ve experienced in relation to trust and respect. One NP participant identified that physicians may have difficulty respecting the NP’s full scope of practice and thus perceive clients as their own:
And there’s also…a challenge sometimes because I think certain physicians like to be more, even though they respect the nurse practitioners scope of practice sometimes there’s challenges in them truly respecting the full scope of practice because they’re, I don’t know they want to be involved. Like it’s their client. There’s the concept in certain physicians that it’s their clients, okay?

Another NP participant described her discomfort in practicing with a group of physicians that she perceived not to trust her and her role: “So, I just didn’t feel comfortable with those kinds of things and I wasn’t really happy practicing where I felt there was substandard level of care and, communication and, trust.”

The importance of physicians trusting and respecting the NP and the role was perceived as necessary to the NP – physician collaborative relationship. Some NP participants identified mutual trust and respect as elements of collaboration that take time to develop. Additionally, NP participants perceived that physicians demonstrate trust and respect either through public acknowledgment of the NP and the role or by accepting their assessment and clinical suggestions. In the absence of physician trust and respect NP participants identified challenges to practice.
CHAPTER 5
Discussion

The aim of this investigation was to explore NPs’ experiences and perceptions of interprofessional collaboration with partnering physicians in Ontario primary health care settings. Seven themes were identified and described in detail with supporting interview data in the previous chapter. This chapter begins with a description of a model that serves to organize the seven themes within the context of the NP – physician dyad. This description is followed by a discussion of each individual theme.

Model of NP – Physician Interprofessional Collaboration

In Figure 3, the seven themes identified in this study are depicted in the NP – physician dyad. This model visually presents the NP and physician as overlapping circles. Both members have their own domain that does not overlap with the others. Moreover, both members of the dyad overlap in the middle. The centre overlap represents the NP and physician working together to meet healthcare goals.

This model of NP – physician interprofessional collaboration aims to organize the themes identified in this investigation according to the domain in which they fall. For example, the theme of NP competency and expertise falls solely within the domain of the NP and does not overlap with the physician because NPs in this study identified that it was wholly their responsibility to demonstrate their competence and/or expertise to their partnering physician. In other words, demonstrating competency and/or expertise was not perceived as a reciprocal process. Similarly, physician remuneration was an identified theme that falls solely in the physician domain. In this case, physician compensation was perceived as a potential barrier to the NP – physician collaborative
relationship, however, NPs have little or no impact at the practice level on physician compensation methods. It may also be argued that physician compensation is outside of the scope of influence of the practicing primary health care physician. Nevertheless, this theme can be thought of as a system variable with an impact on NP – physician collaboration that is within the domain of the physician. The five remaining themes, quality of communication, complementary vision, establishing and maintaining relationships, investing time and energy and mutual trust and respect fall within the NP – physician domain or where the NP domain and the physician domain overlap. These five themes were perceived by the NP participants as reciprocal and requiring effort or input from both NPs and physicians in order to influence collaboration. The following section provides a more detailed discussion of each theme individually.
Figure 3. Key factors influencing the collaborative relationship in the NP – physician dyad.
Prior to a discussion of each theme it is important to note that the six NP participants included in this study have considerable experience as nurses. These participants report between 15 and 34 years of nursing experience and at the time of interview they had been employed as NPs for 5 to 9 years. Considering NP integration in Ontario began just over a decade ago this group of participants represent the first wave of Ontario NPs. It is possible that NPs with less nursing experience and whom graduated more recently as NPs would have differing experiences and perceptions of NP – physician collaboration than their more experienced counterparts.

*Quality of Communication*

NP participants identified quality of communication between the NP and physician as necessary to successful collaboration. This finding is congruent with the health care literature on collaboration. In fact, communication has so consistently been identified in the literature as an interactional determinant of collaboration that it has been called the central element of collaboration (O’Brien-Pallas, Hiroz, Cook & Mildon, 2005). Certainly, without communication between NPs and physicians no collaboration would occur. It is well accepted that communication is essential to the collaborative process between health care professionals and several studies have affirmed that collaborating health professionals require good communication skills within the collaborative relationship (Baggs & Schmitt, 1997; Hallas, Butz & Gitterman, 2004; Miller, 1997).

NP participants in this study believed communication skills that were “assertive and direct” benefit the collaboration. Assertiveness is often discussed in the collaboration literature with reference to Kilmann and Thomas’ (1977) model of conflict
handling that states a high level of assertiveness coupled with a high level of co-operation results in collaboration. The work of Way and colleagues (2000) also includes assertiveness as one of the seven essential elements of collaborative practice. This study reaffirms that assertive communication skills are required for successful collaboration.

Within this study, the methods utilized for NP–physician communication were varied and included face–to–face, telephone, written and electronic. It was also found that the method used did not appear to impact the quality of the collaboration. In other words, the NP participants utilized a variety of methods and successful collaboration was not dependant on the method used. This is an important finding as new and innovative ways of providing primary health care to Ontarians are developed. For example, electronic health records have been identified as a communication mechanism that allows access to client information for the entire health care team and thus facilitates collaboration (Clements, Dault & Priest, 2006). In their study of factors influencing quality of collaborative mental health delivery in FHTs, Mulvale and colleagues (2008) found that electronic health records were widely used and extremely valued by FHT practitioners.

Overall, the NP participants perceived communication as open and positive with their current partnering physician. However, the NP participants identified previous relationships with physicians in which communication was an ongoing collaborative challenge. Barriers to communication identified in this study included insufficient time for communication and physicians as poor communicators. Moreover, poor communication between the NP and physician was perceived to negatively affect patient care and also led to low job satisfaction. Ineffective communication as a critical barrier
to both collaboration and health care provision in general has been acknowledged in the literature (Clements, Dault & Priest, 2006; O’Brien-Pallas, Hiroz, Cook & Mildon, 2005).

Complementary Vision

A factor that NP participants perceived as facilitating NP – physician collaboration was complementary vision or similar views of health care provision. Site visits undertaken for the Primary Health Care NP integration Study (IBM, 2003) also found that shared vision for the practice, common values and goals that were aligned with the NP role were important to successful NP integration to the health care team. Jones and Way (2004) identified that sharing is a concept integral to collaboration between NPs and physicians and shared values and perspectives of health care philosophy are important to the collaborative process. Mulvale and colleagues (2008) also found that FHTs that had a clearly defined team vision for their practice also seemed to collaborate more successfully. Shared values, goals, vision, as well as common goals for patient outcomes has been documented in the literature as an attribute necessary for collaborative practice (Anderson, 2004; D’Amour, Ferrada-Videla, Rodriguez & Beaulieu, 2005; Stapleton, 1998).

NP participants in this study identified that opposing philosophies on health care can result in difficulties within the NP – physician relationship. Bailey and colleagues (2006) also identified differences between NPs and physicians in ideology regarding primary health care provision. In their qualitative study investigating the experiences of NPs and physicians working in collaborative practice in FHTs, NPs valued health
promotion and community programmes while physicians focused on primary care and viewed health promotion as less important.

Sicotte et al. (2002) report similar results when discussing intragroup processes and agreement with disciplinary logic. In their study of 157 CHCCs, they found that collaboration between health professionals is limited by how strongly those professionals adhere to their own discipline’s philosophy and logic. Professional socialization has been identified by many as a barrier to collaboration within health care because, as stated by Jones & Way (2004): “during the entire professional socialization phase, health professionals are immersed in philosophies, values and basic theoretical perspectives inherent to each profession” (p.17). D’Amour and colleagues (2004) also identified that the professional system has a strong impact on collaborative practice and that it often holds a perspective that is opposite to collaboration.

**Physician Remuneration Method**

NP participants described various methods of physician remuneration. Those in community clinics described how their partnering physicians are remunerated with an $800 monthly stipend to collaborate with them. The NP working in a CHC outlined that her partnering physicians are salaried and the remaining two NPs described their physician’s compensation as linked to rostering of clients to the practice. Although the compensation methods varied, NP participants perceived that physician remuneration has an effect on NP – physician collaboration.

More specifically, NP participants were aware and concerned that the time physicians spent in collaboration and consultation with NPs could have a negative financial effect on the physician. Therefore participants perceived that the method of
physician remuneration could be a barrier to the collaborative relationship. NP participants working in community clinics and a CHC felt that the barrier of physician remuneration had been overcome and those physicians were adequately compensated for their time in collaborating with NPs. Those participants working in practices in which physician remuneration was based on patient rostering perceived that NP - physician collaboration could be negatively affected by this method of remuneration. The participants discussed how physicians compensated through rostering, that were concerned with “billing” negatively affected the collaborative relationship and patient care. Conversely, NP participants perceived physicians that were not overly concerned with maximizing income through the use of “bonus codes” as demonstrating value in the NP’s contribution and her role within the practice. NPs perceive that physicians, in general, continue to have concerns about the financial implications of working with NPs.

Physician remuneration methods have been identified in the Canadian primary health care literature as a barrier to collaboration. The Primary Health Care NP Integration Study (IBM, 2003) found that physicians working in fee-for-service practices expressed concern regarding compensation for time spent in collaboration with NPs. However, physicians that were compensated for NP consultation and collaboration time reported that compensation was less of a barrier to collaboration. Mulvale and colleagues (2008) also found that physician remuneration method is a global-level factor that continues to influence collaborative practice. Physicians in this study that were remunerated by capitation perceived that this method of remuneration enabled collaboration while physicians being paid through fee-for-service focused on direct patient care and did not participate fully in collaborative practice.
Physician compensation has also been recognized in numerous policy documents as a barrier to collaboration and teamwork within Ontario’s current primary health care system. A review of three summary reports of projects undertaken under the Canadian Health Transition Fund found that professional compensation, specifically for physicians in fee-for-service practice, was a macro-structural barrier that hindered collaboration (Martin-Rodriguez, Beaulieu, D’Amour & Ferrada-Videla, 2007). The findings of this investigation confirm that NPs continue to have concerns related to the impact they may have on physician’s compensation and this concern influences the collaborative relationship.

*Establishing and Maintaining Relationships*

Within this study all NPs identified that establishing and maintaining a relationship with partnering physicians facilitates collaboration. Moreover, all the NPs had well-established relationships with their collaborating physicians and attributed their good collaboration, in part, to these well-established relationships. It has been recognized in the health care literature that collaboration is a human process that requires interaction between people (Jones & Way, 2004). The interpersonal relationship between health care team members has been labeled an interactional factor within the Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) framework (Oandasan et al., 2004). Sicotte and colleagues (2002) labeled the establishment of relationships between health care providers as “social integration with work group” and assert that as one of the intragroup variables social integration increases collaborative efforts.
Way, Jones and Baskerville (2001) identify four categories of practice – setting variables, which influence collaboration between health care providers. These include: provider variables, client variables, work setting variables, and jurisdictional variables. Provider variables consist of the characteristics, knowledge and skills of the individual health care providers. Similarly, the NP participants in this study identified that personality styles of the physician and NP play a role in the establishment of the relationship and thus the collaborative process. Miller’s (1997) qualitative study of midwives and physicians in collaborative practice also found that the individual attributes of the health care providers was a core category when exploring their attitudes and perceptions of collaboration.

One NP in this study labeled the establishing of a relationship as the “introduction and orientation” and described this as a three to six month process. Within this process, this participant felt that the NP was responsible for making the physician aware of the NP role and scope of practice. Clarin’s (2007) literature review of barriers to collaborative practice between NPs and physicians identified lack of knowledge of NP role and lack of knowledge of scope of practice. Strategies identified to overcome these barriers include educating physicians on NP role and scope by providing a formal orientation to NP practice prior to NP integration. An investigation of the integration of NPs into an Ontario Family Health Network also recommended investing time early in the integration process to clarify roles and facilitate collaborative practice (Humbert et al., 2007).

Site visits undertaken for the Primary Health Care NP Integration Study (IBM, 2003) found that physicians with previous experience working with NPs were very supportive of their particular NP. Specifically, they identified the skills and personality
of the NP they worked with as desirable to their practice. This lends support to the importance of establishing relationships to the collaborative process as physicians identified with their NP and not just the NP role.

Co-attendance at conferences with their collaborating physician, as well as informal gatherings such as lunches and dinners were identified as events that facilitated the establishing of relationships between NPs and physicians. The NP participants in this study identified that difficulties arise in collaborating with physicians when an interpersonal relationship is not established. Examples of difficulties included challenges in communicating concerns and questioning practice decisions. Similarly, Way and colleagues (2001) maintain that the provider variables such as their characteristics, knowledge and skills can either support or constrain collaboration.

*Investing Time and Energy*

Investing time and energy was recognized by the NPs in this study as a requirement for collaboration. It was identified that both NPs and physicians needed to devote time and energy to the collaborative relationship. Additionally, developing mutual trust and respect, determining clinical competence, developing and maintaining the NP – physician relationship, implementing best practices and engaging in communication are all areas that NP participants perceived as necessitating time and energy in order to establish a positive collaborative relationship. The literature has given some attention to time and energy as it relates to collaboration between health care providers. It is has been acknowledged that collaboration takes time and energy to develop and maintain (Baggs & Schmitt, 1997; Anderson, 2004). More specifically,
Stapelton (1998) identifies the willingness to devote time and energy to the collaborative relationship as one of the twelve critical attributes of collaborative practice.

Sufficient time to communicate was identified by some of the NP participants as a challenge within their practice. Jones & Way (2004) identified that time for the NP–physician dyad to interact and share information is an organizational determinant of collaboration that requires an investment of team resources. The findings of this study lend support to this assertion since NP participants provided examples of how a limited investment of time and energy by the NP, physician or due to organizational issues impaired the collaborative relationship.

NP Competency and Expertise

NP participants perceived that in order for collaboration to exist with their partnering physician they needed to demonstrate their clinical competence and areas of expertise. Specifically, they felt they needed to prove an adequate baseline of knowledge to their partnering physician before they could function as a collaborating dyad. Hallas and colleagues (2004) report similar findings while studying collaborating pediatric NPs and pediatricians. They also found that NPs entering into collaborative relationships have to prove competence and knowledge to partnering physicians.

A NP participant in this study referred to Benner’s continuum of novice to expert when discussing her competency. She described how upon becoming an NP she felt that she was beginning again as a novice. Similar perceptions on competency were identified in the NP integration study where NPs indicated that it took six months to one year to become fully comfortable in their new role (IBM, 2003). Competency, or having appropriate knowledge and skill, has been identified in the literature as an attribute

Way, Jones, Baskerville and Busing (2001) make a distinction between confidence in oneself and confidence in other healthcare partners when discussing competency and collaboration. The NPs in this study appeared to be confident with their competencies and were able to demonstrate their knowledge and skill to their partnering physician in order to gain their partners confidence and ultimately collaborate effectively. One NP, however, discussed a scenario in which she felt that her partnering physician had little confidence in her knowledge and skills. In this case, her competency was not recognized and collaboration was negatively effected.

Beyond baseline competencies, NP participants felt that they had areas of expertise that when recognized and utilized appropriately strengthened patient care. Moreover, the NP participants in this study acknowledged that determining the strengths and areas of interest of their partnering physicians was important to the collaborative process because it utilized the best skill set from each of the team members. Similarly, Satin (1994) discusses levels of competency and asserts that competency, expertise and relationship with the patient should determine the assignment of responsibilities.

*Mutual Trust and Respect*

The need for mutual trust and respect between health care providers is an attribute of collaboration that has been well established in the literature (Alpert, Goldman, Kilroy & Pike, 1992; Anderson, 2004; Baggs et al., 1997; Corser, 1998; Henneman, Lee & Cohen, 1995; Miller, 1997; Stapelton, 1998; Stichler, 1995; Way et al., 2001). NP participants in this study reaffirmed that mutual trust and respect is necessary within
collaborative relationships with physicians. They identified mutual trust and respect as elements of collaboration that develop over time. Moreover they acknowledged the need for collaborating physicians to demonstrate trust and respect in them as NPs as well as in the role of the NP. This finding supports the work of Henneman and colleagues (1995) that asserts that building trust takes time, energy, patience and previous positive experiences with the collaborating health professional.

According to the NPs in this study, physicians demonstrate trust and respect by publicly acknowledging their role and competencies to other physicians or patients. They can also demonstrate trust and respect by accepting the NPs’ patient assessment and clinical suggestions. In other words, trust and respect are closely linked to clinical competence and their partnering physician’s recognition of those competencies. Researchers agree that trust and respect is dependent on a health professional’s skill and knowledge as well as their experience (Baggs & Schmitt, 1997; Henneman, Lee & Cohen, 1995; Martin-Rodriguez et al., 2007).

Mutual trust and respect is an interactional determinant of collaboration between health professionals that is identified by Jones & Way (2004) as that which binds all other elements of the collaborative relationship together. The NPs in this study felt that their current collaborating relationships had mutual trust and respect; however, they identified a decrease in job satisfaction when trust or respect was lacking in their relationships with partnering physicians.
CHAPTER 6

Limitations of Study

Seven interviews undertaken with six NP participants were included in the analysis. Although it would seem that an increased number of participants would have strengthened the study findings the researcher utilized purposive sampling of NPs practicing in Ontario for two years or longer. In doing so NP participants were familiar with and reflective of the phenomenon of inquiry and thus had a specific ability to speak to that phenomenon. Additionally, the researcher found that as the analysis progressed the data became repetitive in nature. However, completing second interviews with all NP participants may have strengthened this inquiry as it is possible that participants may be reluctant to disclose all experiences and perceptions during a single interview or interaction with the researcher. Indeed, Lincoln and Guba (1985) outline that a goal of prolonged engagement with study participants is to build the trust of the participant to improve the quality of the data they provide.

Moreover, member checking is described by Lincoln and Guba (1985) as a method of strengthening an investigation’s credibility. Member checking involves returning to participants within a study and having them verify that the data, analysis and conclusions of the researcher are true to them. Although the investigator invited all NP participants to provide feedback on a draft summary of the seven themes identified, only one participant responded. In addition, the NP participant that engaged in two interviews provided some checking of her previous interview transcript and the preliminary analysis of that interview by the researcher. The credibility of this inquiry would have been strengthened if feedback had been received from the remaining five participants.
In addition, triangulation of data collection methods would have also served to strengthen the findings of this inquiry. For example, observation within the NP participants’ practice settings may have provided further data for analysis.

Implications for Education

Education of health care professionals has been recognized as a barrier to interprofessional collaboration. The recommendation for joint education initiatives for health care professionals has been made in a number of Canadian research and policy documents. Significant work has been undertaken to address education as a barrier to interprofessional care and three themes identified in this study reinforce the need for interprofessional education initiatives involving nurse and physician learners. These themes include: quality of communication, complementary vision, and mutual trust and respect.

The findings of this study lend support to the 2004 Health Canada initiative on Interdisciplinary Education for Collaborative Patient-Centred Practice (IECPCP) (Oandasan et al., 2004). The aim of this initiative is to change the way health professionals are educated in order to ensure they have the knowledge and skills to work successfully in interprofessional teams. Specific goals include first, socializing health care professionals to work together. Second, fostering mutual understanding of each other’s roles and disciplines and third, instilling the necessary skills to carry out collaborative practice. NP participants in this study identified the importance of mutual trust and respect and complementary vision to collaboration with physicians. These two themes reinforce the need for education initiatives aimed at the first and second goal outlined above. This study reaffirms the need for health professionals to share education,
when appropriate, in order to change experiences and attitudes between health disciplines. This shared education has the potential to build complementary vision for health care provision as well as mutual trust and respect for differing health disciplines, which in turn, holds the potential to foster collaboration.

The third goal of education initiatives to improve interprofessional collaboration aims to instill the necessary skills required to collaborate. The findings of this study identify that NPs perceive that assertive and direct communication skills are particularly valuable to the collaborative process. NPs require training and practice in order to develop these communication skills that are supportive of interprofessional collaboration with physicians and other allied health professionals.

Implications for Primary Health Care Organization and Public Policy

The findings of this investigation provide support for several practice initiatives identified within Canadian research and policy documents. Specifically, the themes of quality of communication and complementary vision confirm that primary health care practices must develop well articulated practice standards, policies and procedures and documentation methods as well as mission or vision statements (IBM, 2003; Jones & Way, 2004). Moreover, well outlined roles and responsibilities of each contributing team member can assist in determining competencies and expertise and areas of required growth within the team. The Guide to Collaborative Team Practice developed for Family Health Teams (FHT) by the Ministry of Health and Long Term Care (MOHLTC) (2005) also identifies the need for clear practice goals and purpose, and clear delineation of health care provider roles and responsibilities.
Investing time and energy to communicate was identified in this study as essential to collaboration between NPs and physicians. However, enough time to communicate was identified as an ongoing collaborative challenge. Allotting time for formal communication within practice settings is a valuable recommendation to improve team collaborative functioning. Formal, regular team meetings that include all health care providers involved in the practice has the potential to increase communication and strengthen team collaboration (MOHLTC, 2005).

Additionally, it is important that team members have mechanisms for less formal communication in order to allow consistent communication as well as foster ongoing relationship building. The MOHLTC (2005) also recommends the organization of educational events for FHTs on a periodic basis. The finding in this investigation that conference attendance aids in the establishment of relationships further supports this recommendation.

Physician remuneration method was also identified as a potential barrier to collaboration. Therefore, the findings of this study support efforts to identify more “creative ways of funding” primary health care services in order to enhance NP – physician collaboration. Models of funding that move away from fee-for-service compensation of physicians support and encourage team-based collaborative practice (CNA, 2006). The MOHLTC has commenced remunerating physicians for their time in consulting and collaborating with NPs. This is a step in the right direction, however, recommendations to provide incentives for practicing in an interprofessional way need to be further explored and developed for all health professionals (Interprofessional Care Steering Committee, 2007).
Implications for Future Research

This inquiry focused exclusively on the collaboration between the NP – physician dyad from the perspective of the NP. A complementary inquiry to this one would explore qualitatively physicians’ perspectives and experiences in collaborating with NPs. Moreover, inquiries including clients’ perspectives and experiences within the NP – physician – client triad would be valuable to fully elucidate the collaborative process. The 2007 Canadian Health Services Research Foundation (CHSRF) synthesis entitled *Interprofessional Collaboration and Quality Primary Healthcare* asserts that definitions of collaboration have not included the patient’s perspective and this is indicative of a poor conceptualization of the patient’s role in the collaborative process.

As the NP workforce continues to grow and interprofessional collaborative practices providing primary health care become established, research-investigating outcomes of collaborative care will be appropriate. Moreover, research aiming to develop and evaluate interventions to strengthen collaboration is also necessary. For example, education initiatives aimed at fostering interprofessional collaboration are currently underway across Canada. As these health professionals, educated in new ways, are integrated into practice environments research designed to evaluate levels of collaboration and their impact on practice would further the knowledge of interprofessional collaboration.

Conclusions

NPs are a growing workforce within primary health care in Ontario. Their work with individuals, families and communities and their expertise in health assessment, health promotion, illness prevention, rehabilitation and community development has the
power to improve the health of Ontarians. However, NPs do not work in isolation; they function to their full scope only in collaboration with other primary health care professionals, specifically, physician partners. A focus on primary health care reform nationally and provincially has garnered political and societal support for NPs as well as for interprofessional collaboration. Integration of NPs into Ontario primary health care practices has been an endeavor undertaken in a milieu of practice settings over the last decade. Since interprofessional collaboration between NPs and physicians is essential to primary health care reform, a qualitative descriptive study was undertaken to investigate this phenomenon.

A qualitative descriptive study and content analysis were used to explore NPs’ experiences and perceptions of interprofessional collaboration with partnering physicians in Ontario primary health care practices. Six NP participants were interviewed and seven themes describing their experiences and perceptions of interprofessional collaboration with physicians were identified. Additionally, a diagrammatic representation was developed to visually represent the collaborative relationship between the NP – physician dyad. The diagrammatic representation also served to organize the seven identified themes. Five of the themes identified were reciprocal in nature and required mutual effort and input from NPs and physicians. These themes included: quality of communication, maintaining and establishing relationships, investing time and energy, complementary vision, and mutual trust and respect. Alternatively, the theme described as NP competency and expertise was found to be solely the responsibility of the NP while the theme of physician remuneration method related exclusively to the physician.
The findings of this investigation provide support for education initiatives aimed at fostering interprofessional collaboration and practice initiatives aimed at improving collaboration between health professionals working in the provision of primary health care. Moreover, future research on collaboration within primary health care must include the client’s perspective as part of the health care team.
References


Appendix A: Queen’s University Health Science Research Ethics Approval

QUEEN’S UNIVERSITY HEALTH SCIENCES & AFFILIATED TEACHING
HOSPITALS RESEARCH ETHICS BOARD

Queen’s University, in accordance with the “Tri-Council Policy Statement, 1998” prepared by the Medical Research Council, Natural Sciences and Engineering Research Council of Canada and Social Sciences and Humanities Research Council of Canada requires that research projects involving human subjects be reviewed annually to determine their acceptability on ethical grounds.

A Research Ethics Board composed of:

Dr. A.F. Clark  Emeritus Professor, Department of Biochemistry, Faculty of Health Sciences, Queen’s University (Chair)
Dr. S. Burke  Professor, School of Nursing, Queen’s University
Rev. T. Deline  Community Member
Dr. M. Evans  Community Member
Dr. M. Green  Assistant Professor, Department of Family Medicine, Queen’s University
Mr. C. Kenny  Community Member
Ms. T.C. Knott  Research & Evaluation, Southeastern Regional Geriatric Program, Providence Continuing Care Centre – St. Mary’s of the Lake Hospital Site
Dr. J. Low  Professor, Department of Obstetrics and Gynaecology, Queen’s University and Kingston General Hospital
Dr. H. Murray  Assistant Professor, Department of Emergency Medicine, Queen’s University
Dr. W. Racz  Professor, Department of Pharmacology & Toxicology, Queen’s University
Dr. B. Simchison  Assistant Professor, Department of Anesthesiology, Queen’s University
Dr. A.N. Singh  WHO Professor in Psychosomatic Medicine and Psychopharmacology Professor of Psychiatry and Pharmacology Chair and Head, Division of Psychopharmacology, Queen’s University
Dr. S. Taylor  Director, Office of Bioethics, Queen’s University and Kingston General Hospital; Associate Professor, Department of Medicine, Queen’s University
Dr. K. Weisbaum  LL.B. and Adjunct Instructor, Department of Family Medicine (Bioethics)

has examined the protocol and consent form for the project entitled “Nurse Practitioner Perceptions and Experiences of Interprofessional Collaboration with Physicians in Primary Health Care Settings” as proposed by Ms. Catherine Faria and Dr. Marianne Lamb of the School of Nursing at Queen’s University and considers it to be ethically acceptable. This approval is valid for one year. If there are any amendments or changes to the protocol affecting the subjects in this study, it is the responsibility of the principal investigator to notify the Research Ethics Board. Any unexpected serious adverse event occurring locally must be reported within 2 working days or earlier if required by the study sponsor. All other adverse events must be reported within 15 days after becoming aware of the information.”

Chair, Research Ethics Board  Date
March 5, 2005

NURS-164-05
EX
Appendix B: Description of NP Participant’s Practice Setting

*Family Health Team (FHT)*

FHTs provide team based primary health care through a range of providers which depending on local need may include physicians, nurses, NPs, social workers, dieticians, pharmacists and/or other allied health care providers. FHT governance can be provider-based, community-based or a mix of provider and community based. Through collaboration with team members, FHTs offer direct health care including after hours care, chronic disease management, disease prevention and health promotion services to clients enrolled with physicians on the team. Once enrolled, clients can receive the services of other health providers within the team. NPs are funded via salary and physicians are remunerated based on capitation in which the FHT receives funding for each client enrolled to the team.

*Primary Care Network (PCN)*

PCNs consist of groups of physicians and other health care providers, primarily NPs, in the provision and co-ordination of primary health services to clients. Clients enrolled with the PCN have access to their physician as well as the other health professionals within the network. NPs are funded via salary and physician remuneration is based on capitation in which funding is provided for each enrolled client of the PCN. In Ontario, FHTs have replaced the older model of PCNs.

*Community Sponsored Clinic*

A community clinic consisting of two NPs with a collaborating physician off – site was commenced with a grant from the Primary Health Care Transition Fund. NPs provide primary health care to clients within their community. They primarily service clients
whom do not have a family physician. The clinic is sponsored by the community and has a governing board. The NPs are remunerated via salary and their collaborating physician receives a $10 000 annual stipend per NP with whom she collaborates.

*Corporate Sponsored Community Clinic*

A community clinic housed in an adult living facility consists of one NP with a collaborating physician spending a half-day per week at the clinic for collaboration. This clinic was commenced with a grant from the Primary Health Care Transition Fund and is sponsored by the corporation of the adult living facility. The NP services the clients living in the building, elderly clients in the community without a family physician and young women in the community. The NP is remunerated via salary and her collaborating physician receives a $10 000 annual stipend.

*Community Health Centre (CHC)*

CHCs consist of teams of physicians, NPs, nurses, dietitians, social workers, health promoters, community workers and other allied health care providers. Teams provide a range of primary health care services including primary care, illness prevention and health promotion to individuals, families and communities. CHCs are governed by community boards and are not-for-profit organizations whose health professionals are remunerated via salary. CHCs serve a specific community and individuals living within that community can access the services offered within their local CHC.
Appendix C: Introductory Letter and Study Proposal Summary

Queen's University
School of Nursing
90 Barrie Street
Kingston, Ontario
K7L 3N6

February 15, 2005

Dear,

Thank you for taking the time to speak with me regarding my research on interdisciplinary collaboration within primary health care. As per our previous conversation please find attached a summary of my proposed study. A copy of my full proposal and Queen’s University Ethics Approval will be available for your review if required.

I would like to schedule a meeting with you to further discuss this investigation. Please contact me, at your earliest convenience, at 416 – 504 – 8215 or by email at fariacatherine@hotmail.com. You may also contact my thesis supervisor Dr. Marianne Lamb, at ml24@post.queensu.ca, if you have any questions or concerns.

Thank you,

Catherine Faria
RN, BSc, BNSc, MSc student
School of Nursing
Queen's University
Nurse Practitioner Perceptions and Experiences of Interprofessional Collaboration with Physicians in Primary Health Care Settings

Study Proposal Summary

Purpose

The purpose of this study is to explore nurse practitioners’ experiences of collaboration with physicians while working in a primary health care setting. More specifically, the research question guiding this inquiry is: How do nurse practitioners working in primary health care settings describe their experiences and perceptions of collaboration with physicians? An investigation of interdisciplinary collaboration within primary health care is timely and appropriate for many reasons. Firstly, primary health care is currently on the national agenda as a means of revitalizing the health care system and achieving better health for Canadians. Moreover, there is widespread agreement in both the research literature and recent policy documents that interdisciplinary collaboration is necessary to achieve the objectives of primary health care reform. Specifically, collaboration between health professionals is believed to improve both the delivery and health outcomes of primary health care services. Secondly, although a large body of literature on interdisciplinary collaboration exists, the majority of this research has been undertaken within acute care settings. To date, there is limited research exploring interdisciplinary collaboration within primary health care settings. Furthermore, since interdisciplinary collaboration is a central tenet of primary health care, it is reasonable to assume that nurse practitioners and physicians working within interdisciplinary primary health care teams would have significantly differing attitudes and perceptions regarding collaboration than their acute care counterparts.

Method

In order to explore primary health care nurse practitioners’ experiences of collaboration with physicians a qualitative study utilizing naturalistic inquiry method is proposed. This method was chosen with the aim of fully exploring collaboration from the perspective of nurse practitioners currently working in the field of primary health care.
care. Data collection will include interviews with nurse practitioners regarding their experiences with collaboration.

Several ethical considerations have been taken into account to protect the individuals participating in this study. First, data collection will not commence until approval from the Queen’s University Health Sciences Human Research Ethics Board is obtained. Second, the name of the participants will not be identified by the research, nor will they appear in any written material resulting from this study. Pseudonyms and disguising information will be used, as required, to protect anonymity. Raw data will only be available to the researcher and thesis supervisor and will be stored in a locked cabinet. Participants in the study will receive a final report on study completion.

Researcher

I am a Masters student in the School of Nursing at Queen’s University. The proposed study is being supervised by a committee led by Dr. Marianne Lamb and will fulfill the requirement for my thesis research. I am a Registered Nurse and I currently work part time as a Public Health Nurse for the City of Toronto.

Catherine Faria
Appendix D: Interview Guide

**Demographic Questions**

How long have you been a nurse practitioner?

How long have you worked in this position?

What is your previous experience in health care?

Describe your education preparation.

**Open-ended Questions if Probe Required**

What has been your experience with physician collaboration?

How important is collaboration with physicians to your work?

Describe how collaboration with physicians occurs.

How does collaboration with physicians impact patient care?

Describe factors you believe foster or facilitate collaboration.

Describe the challenges you face in collaborating with physicians
Appendix E: Draft Summary of Findings

Seven themes were identified by the investigation. The themes were: Communication, complementary vision, physician compensation, NP – physician relationship, time and energy, competency and expertise, and trust and respect. Below follows a description of each theme.

NP participants utilized various methods of communication when collaborating with their partnering physicians. Regardless of the method utilized, NP participants perceived communication as essential to the collaborative process. Communication was perceived to be vital to patient care and safety as it is through communication that NPs and physicians kept informed about their patients. NP participants identified clear, concise and direct communication skills as an asset to collaboration. Participants generally felt their NP – physician dyad had good communication that facilitated collaboration, however, participants also provided examples in which collaboration has been negatively affected by substandard communication.

Complementary vision or similar practice styles and philosophy of health care was seen as important to the collaborative NP – physician relationship. NP participants described their experiences in collaborating with physicians that have similar visions of health care provision as themselves as, “positive”, “ideal” and “exemplary”. Conversely, NP participants identified that differing visions of health care provision and practice philosophies can cause difficulty within the collaborative relationship.

All NP participants discussed physician compensation. Those NPs working in NP-led clinics and a CHC believed that physician compensation had been adequately addressed within their practice settings and did not negatively impact NP – physician collaboration. In contrast, some participants described how other models of practice such as fee – for – service and family health teams due to their funding structures could negatively impact the NP – physician collaborative relationship and ultimately patient care.

The NP – physician relationship was seen as important to the collaborative process. NP participants perceived their current relationships with their primary partnering physician to be well established and collaboration to be positive. Participants described personalities and interpersonal aspects of the NP – physician relationship to be important in the establishment of relationships and collaboration. Additionally, NP participants outlined how difficulties in developing relationships with physicians can lead to challenges in collaborating.

Time and energy was required in order to develop good NP – physician collaboration. Trust and respect, clinical competence, developing and maintaining the NP – physician relationship, best practices and communication are all areas that NP participants perceived as necessitating time and energy.

NP participants felt that proving their clinical competencies and areas of expertise to their collaborating physicians was necessary for effective collaboration. It was perceived that NPs must prove that they have an adequate baseline of knowledge and are able to demonstrate that knowledge to their partnering physicians. Moreover, NP participants perceived that they had areas of strength and expertise beyond baseline competencies that they demonstrated to their partnering physicians. It was also identified
that determining the interests and strengths of partnering physicians was important to team functioning and patient care.

The importance of physicians trusting and respecting the NP and the NP role was perceived as necessary to the NP – physician collaborative relationship. Some NP participants identified trust and respect as elements of collaboration that take time to develop. Additionally, NP participants perceived that physicians demonstrate trust and respect either through public acknowledgment of the NP and the NP role or by accepting their assessment and clinical suggestions. In the absence of physician trust and respect NP participants identified challenges to collaborative practice.
Appendix F: Researcher’s Experiences and Perceptions of Interprofessional Collaboration in Primary Health Care

In both my private and professional life I have had difficulty accessing timely and appropriate primary health care for myself and for my clients. As a public health nurse working with families with young children in a large urban center I have encountered many challenges and felt the frustration of my clients when they are unable to access a family physician. In addition, language barriers and lack of health coverage due to immigration status make accessing family physicians near impossible for several of my clients. For these clients, there are limited options for primary health care. CHCs are often the only setting in which primary health care can be accessed without an Ontario Health Card. I have found myself on many occasions advocating for my clients as they are placed on long waitlists to see a primary health care practitioner.

Through the course of my work I have had very positive experiences with CHCs and specifically, NPs working in CHCs. It is my feeling that NPs are the key to revitalizing primary health care in Ontario. Their focus on health promotion and disease prevention and their holistic perspective of the client place them in an optimal position to positively affect the health of their clients. Moreover, it has been my experience that NPs often look beyond the health services they can provide and are able and willing to assist their clients in accessing other health and social services they may need.

I believe that family physicians’ method of compensation plays a large role in how they provide services to clients and how receptive they are to NPs and collaboration with other health professionals. In my opinion, the fee-for-service method of compensation is not conducive to collaborative practice or patient focused practice. This
method of compensation offers little time for either of these. Moreover, I feel that physicians that choose to work in settings such as CHCs, in which they are compensated via salary, are more likely to want to work collaboratively with other health professionals.

I believe that the NPs currently employed in primary health care settings in Ontario have faced many challenges, as they are pioneers in their field. I feel that physicians that have not had experience with a NP may feel threatened by their expanded scope and may not realize the value they can bring to a primary health care practice. Similarly, clients that have not had experiences with NPs may be wary of this new provider. However, it has been my experience that both physicians and clients upon interacting with NPs are very satisfied with their knowledge, skill and the quality of care they provide.