

# COLLABORATIVE PRACTICE BETWEEN REGISTERED NURSES AND MEDICAL PRACTITIONERS IN AUSTRALIAN GENERAL PRACTICE: MOVING FROM RHETORIC TO REALITY

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## ABSTRACT

Collaborative practice between medical practitioners and nurses is purported to improve patient access to services, improve health outcomes, provide a more 'seamless service', increase efficiency of care, reduce health care costs and improve practitioner job satisfaction. Therefore, it is important to understand what hinders and what facilitates this type of interdisciplinary functioning. This paper will examine these factors in the context of the Australian general practice setting. It is timely because recent Government financial incentives have been provided to increase the number of nurses employed in this sector and also to expand their role. Awareness of these factors may enable nurses in general practice, both individually and collectively, to better understand the dynamics of role expansion in order to move towards collaborative partnerships with their medical colleagues. Recommendations to advance collaborative practice are given and a model of practice proposed that identifies possible autonomous, collaborative and dependent functions for nurses in general practice.

## INTRODUCTION

Collaborative practice between registered nurses and medical practitioners has been the subject of discussion, debate and research for decades. However, despite purported positive outcomes from such interdisciplinary functioning, it has been the exception rather than the dominant pattern in health care. This paper will present some of the known facilitative and hindering factors to collaborative practice and examine these in the context of the Australian general practice setting. Awareness of these factors may enable practice nurses (PNs), both individually and collectively, to better understand the dynamics of their relationships with general practitioners (GPs) in order to move from a role that is predominantly dependent towards one that is more collaborative in nature. This is important because of the recent release of substantial amounts of money in the 2001-2 Commonwealth Budget to employ more nurses in general practice settings and to expand their current role.

### Collaborative practice

The terms collaborative practice, joint practice, associated practice, interprofessional working, transprofessional care, shared care and partnership are often used interchangeably in the health field, yet their definitions are at times vague and highly variable (Baggs and Schmitt 1988; Henneman, Lee and Cohen 1995; Jones 1992; Stichler 1995; Taylor 1996). This lack of clarity and a contention that collaboration between nurses and medical practitioners is a key variable in explaining patient outcomes, led Baggs and Schmitt (1988) to undertake a literature review of the use of the term 'collaborative practice'. Their review identified the critical attributes to be: sharing of planning, goal setting, decision making, problem solving and responsibility; open communication; cooperation; coordination; and, recognition and acceptance of separate and combined areas of activity.

Henneman et al (1995) also addressed collaboration, undertaking a concept analysis to create operational definitions of the term and provide the basis for tool

development and evaluation. They identified additional defining attributes as shared power and authority based on knowledge or expertise as opposed to role or function, and non-hierarchical relationships. However, these authors assert that before collaboration can take place, a number of personnel and environmental antecedents must occur. Personnel factors include readiness to engage in the process, understanding and acceptance of levels of expertise and role boundaries, confidence, and effective group dynamics. These must be combined with environmental factors which include flat organisational structures that encourage participation and interdependence between its members and leaders, who foster individual creativity and autonomy in decision-making while facilitating unified direction.

Taylor (2002) concurs, adding several fundamentals of collaborative practice. She lists the following as the behaviours that characterise autonomy: knowledge of current trends and issues in nursing; engagement in collective activity with other nurses to improve patient care and advance the profession; competence in both medically dependent and medically independent nursing activities; assertiveness in initiating, documenting and articulating nursing actions and their outcomes and willingness to take risks on the patient's behalf or to preserve the integrity of the profession.

If the two groups adhere to this type of approach, it is likely to lead to improved patient outcomes in the form of decreased mortality (Knaus et al 1986; Rubenstein et al 1984) and improved functional status (Alpert et al 1992). Biggs (1993) claimed that interprofessional collaboration in community care resulted in improved clarity of objectives for the client, and a more 'seamless service' due to a reduction in duplication of assessments. Vautier and Carey (1994) found that patients who were collaboratively case-managed rated their care more positively than did other patients. Further, the benefits of team and collaborative care to underserved populations have been documented by Baldwin (1996) and include enhanced patient compliance, greater patient satisfaction, reductions in broken appointments and decreases in hospitalisation and use of physicians. In ambulatory care, collaboration has resulted in increased patient access to and choice of provider, a greater focus on preventive care, increased community involvement and increased patient self-care (Dunevitz 1997).

Collaborative practice has also rendered positive outcomes for the professional participants. Alt-White, Charnes and Strayer (1983) and Alpert et al (1992) reported a significant correlation between nurses' job satisfaction and engagement in collaborative practice. Baggs and Ryan (1990) found a statistically significant correlation between nurses' perception of collaboration and satisfaction with decision-making.

Clearly, collaborative practice has the capacity to lead to enhanced health care. However, despite all

these documented benefits, it remains the exception rather than the norm (Dower and O'Neil 1997; Evans 1994; Henneman 1995; Keleher 1998; Kendrick 1995; Taylor 1996; Willis, Condon and Litt 2000). The reasons for this become apparent when the educational and socialisation processes that nurses and medical practitioners have experienced are compared to the antecedents that are necessary for collaboration to take place. Many of the antecedents are dependent on the individual's readiness to engage in this type of interpersonal process. Education that prepares a person for an interdependent role and prior collaborative experiences are important factors in facilitating readiness (Henneman et al 1995).

A particular barrier to nurse-medical practitioner collaborative practice has been identified as a lack of understanding on the part of medical practitioners and nurses of each other's roles and responsibilities (Bradford 1989; Evans 1994; Stichler 1995). Professional competence is the essential component that creates the respect and valuing necessary for entitlement and the development of truly collaborative relationships. Each member of the partnership brings a specific set of skills, talents, information or resources to complement the other. A collaborative relationship cannot evolve if team members do not value one another and respect one another's competencies and this is impossible without a clear understanding of what they are (Stichler 1995; Taylor 2002).

### **Interdisciplinary functioning in ambulatory care**

Hastings (1997) contrasts two models of interdisciplinary functioning that can be used to describe current approaches to ambulatory (or primary) health care; the Provider Substitution Model (PSM) and the Collaborative Practice Model (CPM). The PSM is based on the oldest and most common form of ambulatory care - the medical practitioner's office visit. It assumes that medical diagnosis and treatment are the primary purpose for the visit and that, theoretically, the medical practitioner could provide all the necessary care. Implicit in this model is the assumption that the medical practitioner has the authority to delegate tasks to other licensed and unlicensed assistive personnel (UAP) up to their maximum scope of practice. Hastings contends that this model emerged from the fact that practices are owned and managed by medical practitioners as small businesses. The primary purpose of employing other providers is to increase 'throughput' and thereby reduce costs and increase profits. In this model other providers, like nurses, are viewed as substitutes for the medical practitioner.

In contrast, the CPM is based on the premise that a team of health professionals is required to provide patient care; each professional licensed with a unique but overlapping scope of practice (Hastings 1997). The purpose of the patient visit can vary from visit to visit and the involvement of specific team members is dictated by

patient requirements. However, it is assumed that medical practitioners are generally the leaders of the team, have the largest scope of practice and retain the authority to refer to or direct the care of other disciplines. In this model, specific disciplines delegate work to, and supervise UAPs. According to Hastings, this model forms the basis of care for chronically ill patients requiring long-term therapy and is most commonly associated with hospital-based outpatient programs or large group practice medical centres.

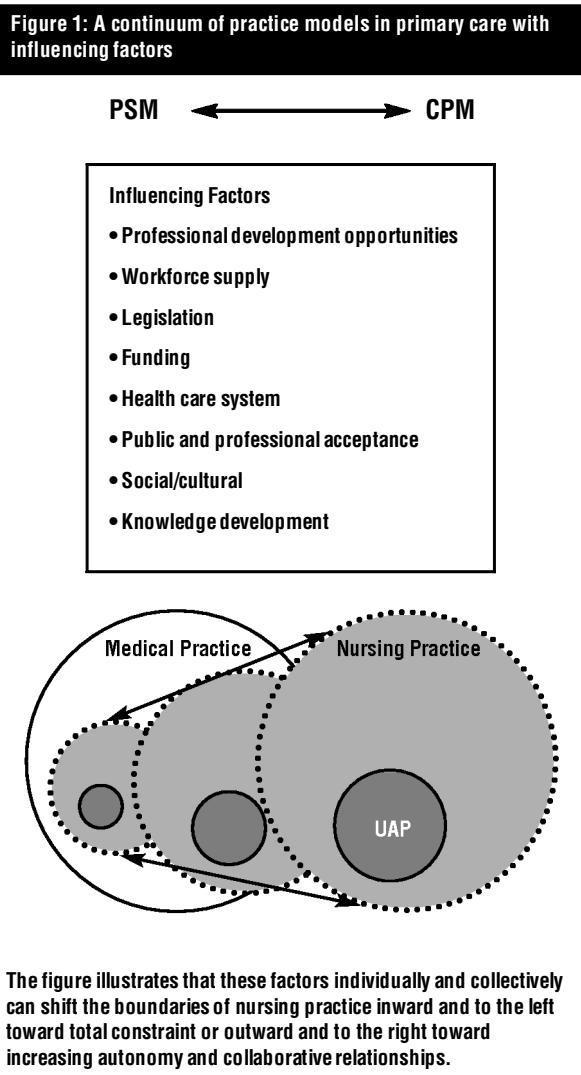
Hastings (1997) asserts that where there is a clear and universally accepted requirement for nursing care, collaborative practice between medicine and nursing has the potential to evolve, based on mutually dependent but distinct, if overlapping, areas of work. This is most likely to occur in inpatient acute care and extended care settings where patients are unable to care for themselves due to illness, disability or the nature of their treatment. However, when the patient is managing self-care the nursing role is not so clearly defined and professional boundaries can become blurred. In this context, expansion of the traditional or universally accepted nursing role may be viewed, by different groups, as medical substitution, role encroachment, or the rightful claim of nursing territory.

We would argue that, rather than there being just two contrasting models to conceptualise the boundaries of nursing practice, there may be a continuum of models (see Figure 1). At one end, nursing practice is totally constrained, not only by its legislated scope of practice, but by medical authority and control of reimbursement for services. The PSM is situated at this end of the continuum. While cooperation may exist between nurses and medical practitioners, there is no evidence of collaboration in this model, as described in the theoretical literature. Towards the other end is Hastings' CPM in which nursing has recognised and accepted autonomous functioning but is still constrained, somewhat, by the medical practitioner's authority to refer to or direct nursing care. This model still reflects a hierarchical relationship between nursing and medicine where power rests with medical authority rather than knowledge and expertise. This negates any claim that it is truly collaborative in practice.

At the extreme end of this continuum, we propose, is a model that better reflects the attributes of collaboration, where nursing and medical practice retain unique elements but have areas that overlap. The scope of each discipline's practice and team leadership and case management are dictated by patient need and practitioner competence. Practice roles, therefore, change from one patient context to another as determined by the team. This model acknowledges the possibility that a nurse may assume the broadest scope of practice, lead the team and refer to other practitioners, including doctors, when their knowledge, expertise and/or competence is more appropriate to the patient's needs than is the nurse's. The boundaries of nursing practice, in this model, are limited only by professional accreditation standards and

government legislation and not by medical 'gatekeeping'. At this end of the continuum, nursing's contribution to health care has the potential to be fully realised. This type of arrangement also may reflect patient centredness rather than any professional scope of practice. In this respect, the roles revolve around ensuring quality patient care, rather than expediting managerial throughput.

Both Australian and overseas studies reveal that the nurse's role in primary care is influenced by many different factors. These include the funding and local arrangement of health services, national and local health priority goals, professional medical and nursing organisations, health-related policies and legislation, the availability of educational programs and professional support bodies, the supply of GPs, and the beliefs, attitudes and values of individual medical practitioners and nurses. These factors individually and collectively have the power to shift the boundaries of nursing practice inward toward total constraint or outward toward increasing autonomy and collaborative practice arrangements (see Figure 1).



## Practice nursing in Australia

General practice is perhaps the only health care setting in Australia where medical practitioners currently have almost complete control over the employment of nurses and their scope of practice. The majority of general practices in Australia function without nursing input (Bonawit and Watson 1996; Le Sueur and Barnard 1993; Patterson, Del Mar and Najman 1999a). Of those practices that do employ nurses, nearly all fund their positions from the income generated by the GPs. A few PNs are employed by divisions of general practice for specific projects and a few are employed in publicly funded medical clinics. Therefore, most PNs in Australia are employees of medical practitioners.

Findings from studies conducted in Western Australia (Le Sueur and Barnard 1993), South Australia (Willis et al 2000), Victoria (Bonawit and Watson 1996; Keyzer et al 1996) and Queensland (Patterson et al 1999a) illustrate that, to date, the PN's role has been primarily that of assistant to the GP to facilitate the efficient running of the practice. The PN performs this role in three ways: one, by undertaking basic physical assessment tasks to aid the medical diagnosis; two, by carrying out delegated therapeutic procedures to facilitate management of the medical condition, and three, by contributing to the administrative functioning of the practice. The PN appears to be predominantly task or condition oriented and dependent on medical delegation or direction. Autonomous nursing initiatives are confined to immediate first aid pending medical attention or are incidental to other prescribed activities. In many cases, independent activities are limited to providing emotional support to patients and clarifying medical instructions given to them. Thus, GP-PN functioning resembles that of Hastings' (1997) PSM.

The Medicare Benefits Scheme (MBS) in Australia does not have a fee structure that includes independent nursing services in general practice; only fees that are medically initiated attract a rebate as part of the overall medical consultation. Because of this, medical practices are restricted in their ability to generate income from nurse-initiated activities. This arrangement severely restricts nursing autonomy but encourages the involvement of nurses in medically delegated tasks to speed up the throughput of patients. However, recently, as part of the Commonwealth Government's Enhanced Primary Care initiative, new MBS items were introduced for annual health assessments of individuals over 75 years (over 55 years in Aboriginal and Torres Strait Islander people). These health checks are to include assessment of the person's health and physical, psychological and social function (Byles 2000). Although GPs are central to the process, the schedule allows for other health professionals (including RNs) to conduct these assessments 'on behalf' of the registered service provider (Sims, Kerse, Naccarella and Long 2000). Anecdotal information indicates that the introduction of these new MBS items has stimulated the

employment of more nurses in general practice and a perceived increase in autonomy.

The 2001-2002 Federal Budget provided funding of \$104.3 million over four years for general practices in areas of high workforce pressure, particularly in rural and remote areas, to employ more nurses ([www.health.gov.au/budget2001/index.htm](http://www.health.gov.au/budget2001/index.htm)). The funding, to be provided to eligible practices through the Practice Incentives Program (PIP), is available through Divisions of General Practice for mentoring and training of PNs and in the form of scholarships for rural nurses to assist in their re-entry to the nursing workforce. The Government envisages that PNs will contribute to better management of chronic diseases and be involved in population health activities. Whether their role will continue to be merely supportive of GPs or evolve to be collaborative will depend on GPs' and PNs' readiness for such functioning and future funding arrangements.

While some studies (Patterson et al 1999b; Willis et al 2000) have identified that most medical practitioners are reluctant to accept autonomous nursing function in their practices, the nurses' 'readiness' is also questionable. According to George and Davis (1998), distinct generations in the nursing workforce are wedded to different sets of values and of what is important at work, some seeing little advantage in the new 'professionalism' proposed by nursing leaders. These nurses, they assert, are generally the older, least ambitious nurses who have other commitments and interests. The demographic characteristics of PNs reported in the previously cited Australian studies indicate that the typical PN is a female, middle-aged, hospital-trained RN who is not engaged in further education. In addition, George and Davis (1998) assert that the dominant-subordinate relationship between individual medical practitioners and nurses is often accommodated because the relationship has been built up over time and is based on trust, personal loyalty and mutual recognition of specific areas of expertise. This typically rules out challenge and conflict. Again, this assertion has been substantiated in the cited Australian studies about PNs.

Patterson et al (1999a; 1999b) assert that PNs' isolation from the wider nursing profession has been a constraining influence on their role development. They found that many PNs work in a situation where they are the only nurse on the premises so they do not have the opportunity to exchange ideas with other nursing colleagues or support from peers to initiate new ventures. As previously noted, the vast majority of PNs studied in Australia had no tertiary nursing qualifications nor were currently undertaking tertiary nursing study so they were unlikely to be exposed to contemporary nursing ideals of practice or challenges to their own practice.

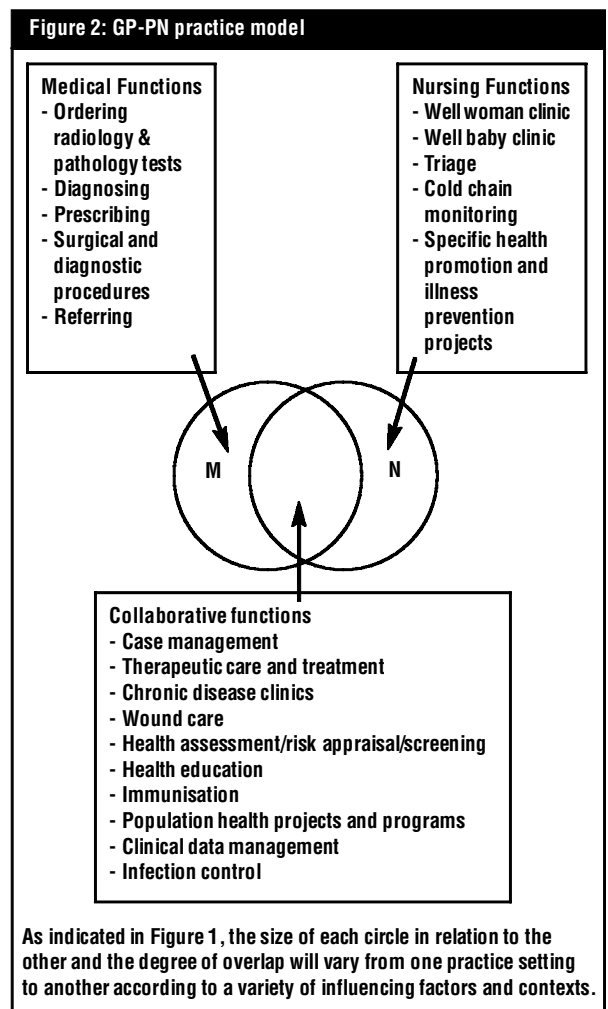
Le Sueur and Barnard (1993) and Patterson et al (1999a) also found that a lack of opportunities for further education was a barrier to the expansion of the PN role in Australia and this was consistent with the situation in the

United Kingdom (UK) prior to the introduction of accredited courses for PNs. These studies indicate that some PNs are availing themselves of opportunities to increase their knowledge and skills about particular aspects of their clinical practice (eg. wound care) resulting in acknowledged expertise (albeit without legitimate power). However, as identified in the UK (Atkin, Hirst, Lunt and Parker 1994), this form of further education only addresses specific shortcomings in knowledge and skills and does not address the overall development of the role. In contrast, a case study presented by Pearson, Hegney and Donnelly (2000) demonstrates that, despite economic and legislative restrictions, PNs in Australia can achieve significant role expansion when they are adequately and appropriately educated.

### Moving from medical substitute to collaborative practitioner

The concept of collaborative practice and the nature of nursing have been the subject of discussion and debate for many years, particularly in relation to extending and/or expanding the range of nursing responsibilities (Percival 2001). Nursing has undergone a process of growth in its scope of practice through medical delegation, technological advances, physician shortages, reforms in health care delivery and the growth of nursing research and knowledge. Pressure for change has often resulted in legitimisation of the status quo rather than an actual expansion of role.

While some local areas or states in Australia may have been active for a time in trying to promote and develop practice nursing, it has only been since the beginning of this century that significant national activities have taken place. The Australian Practice Nurse Association (APNA) and the National Steering Committee on Nursing in General Practice have been established while postgraduate courses specific to practice nursing have been implemented. Practice nursing in Australia now stands poised for an exciting future, not just in terms of a new specialty area within nursing, but in terms of its potential contribution to population health. Overseas studies (see for example Atkin and Lunt 1996; Charlton, Charlton, Broomfield and Mullee 1991; Dent and Burtney 1997; Drury, Greenfield, Stilwell and Hull 1988; Hibble 1995) have indicated that PNs, with appropriate education and experience, can and do practice effectively across a range of activities from medically prescribed to autonomous. Findings from these studies provide some indication of how GPs and PNs can function collaboratively (see Figure 2). However, it must be noted that Australia has different funding arrangements from those in the UK where these studies were undertaken. In Australia, the current fee-for-service funding of general practice would not easily facilitate such functioning. In addition, it is likely that variations in GP-PN functioning will occur from one practice setting to another due to location (urban, rural or remote), community profile (age, ethnic origin, socio-economic status, identified health targets), supply of doctors/nurses, access to



professional development opportunities, and professional and community acceptance or readiness.

After reviewing the theoretical and empirical literature about collaborative practice (in general) and practice nursing (specifically) we make the following recommendations that may help to advance collaborative practice between GPs and PNs in Australia from rhetoric to reality:

- That PNs undertake regular self and/or peer assessment and take appropriate action to improve competence in identified areas of need.
- That PNs identify and articulate areas of expertise within their practice and negotiate with their employer to fully utilise this expertise.
- That PNs seek out and access available educational resources and research data to improve their practice.
- That PNs join a professional interest group, like APNA, to provide a collective 'voice' for their issues and needs, to facilitate the sharing of knowledge and skills and to promote their professional identity.
- That PNs, with GPs, seek out funding to support specific projects that enhance the potential for collaborative practice for specific population groups.
- That APNA encourage its members to engage in

education that promotes and facilitates comprehensive role development in addition to any that addresses specific shortcomings in skills.

- That providers of nursing and medical education investigate and utilise shared educational opportunities for nursing and medical students/practitioners in order to promote a better understanding of each other's knowledge and skills and more collaborative relationships.
- That further research is conducted to evaluate different practice models involving PNs with respect to defined patient outcomes and cost effectiveness.

## CONCLUSION

This paper has brought into focus factors that have constrained or enhanced collaborative practice between PNs and GPs. It has identified that constraining forces have outweighed those that are facilitative, resulting in a nursing role that has been limited in scope and function. Identifying and highlighting these forces may enable PNs, both individually and collectively, to better understand their role in the wider context of health care. Greater awareness can be instrumental in empowering nurses to strive for an enhanced role if they choose. While nurse academics and others in positions of influence can provide the potential for PNs to expand their roles through advanced education and lobbying government, there has to be a considerable degree of intrinsic motivation on the part of the PNs to change. The extent to which this motivation will lead to a different reality in future depends on widening the circle of collaborative practice, both inter and intra professionally.

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