

NURSE PRACTITIONERS' EXPERIENCES OF WORKING COLLABORATIVELY WITH GENERAL PRACTITIONERS AND ALLIED HEALTH PROFESSIONALS IN NEW SOUTH WALES, AUSTRALIA

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ABSTRACT

Objective:

The study aimed to explore contemporary collaborative experiences of nurse practitioners (NPs) in providing care with general practitioners (GPs) and allied health care professionals.

Design:

A qualitative descriptive, exploratory design was considered the most appropriate to achieve the study objectives. This allowed the researcher at first hand to gain a thorough understanding of the nurse participants' experiences.

Setting:

The study was conducted in urban, rural and remote clinics and hospitals throughout New South Wales, Australia, where the NPs were authorised to care for the community.

Participants:

Nine authorised NPs were the key participants in the study.

Results:

Analysis identified one main theme of *Collaboration* and three sub themes that were named as *Total Collaboration*, *Partial Collaboration* and *Non Collaboration*.

Conclusion:

In this study, most NPs reported dissatisfaction from working in ineffective collaborative relationships with medical and allied health care professionals. Total collaboration did not automatically occur and was

identified as the exception. Sustainable collaborative partnerships should be developed with all health care providers by acknowledging each others unique, valuable contribution. Despite this challenging and complex situation, NSW NPs remained determined to provide advanced nursing care for patients and to establish and maintain effective collaboration with all health care professionals.

INTRODUCTION

Previous international researchers indicated that collaborative practice between doctors and nurses resulted in positive outcomes for patient care. According to the Macquarie Dictionary (1989) collaboration is defined as 'to work, one with another, cooperate'; it also connotes teamwork, coaction, consilience and synergy. In this paper, collaboration related to health care is referred to as a joint communicating and decision making process with the expressed goal of satisfying patients' wellness and illness needs whilst respecting the unique qualities and abilities of each professional (Coluccio and Maguire 1983). However, authors such as Chaboyer and Patterson (2001) assert that collaborative practice appears to be the exception, rather than the dominant pattern, within health care. The act and art of effective collaboration appears challenging to health care professionals for a variety of reasons. It requires sharing of information and expertise among disciplines who have typically worked independently.

Traditionally, hierarchical and competitive relationships which typify many nurse-physician interactions, do not exist in a true collaborative environment, where instead, power is shared, and is based

on knowledge and expertise rather than on titles or roles (Henneman 1995). Hallmarks of collaborative practice appear to be based on effective communication and include: mutual trust, respect, use of conflict resolution skills, use of humour and negotiation (Taylor and Seehafer 1998). In the health care arena, doctors in particular tend to see themselves as the leaders of teams and may insist on their views having precedence (Begley 2003).

Examination of existing literature from MEDLINE and CINAHL spanning more than 20 years revealed diverse international perspectives concerning nurse practitioners (NPs) collaborative role and caring experiences, especially between nurses and physicians. While on one hand this partnership has been positively linked to patient outcomes in adult acute care (Curley et al 1998), on the other hand the introduction of NPs into the NSW health care system has been fraught with opposition by some health care professionals, such as doctors (Courtney 2001). Despite such opposition the state government enacted legislation authorising NPs to practice in NSW.

In contrast, authors such as Baggs and colleagues (1992) identified a good correlation between patient outcomes and collaboration as reported by nurses. Other authors have suggested that NP practice can enhance interdisciplinary collaboration (Britton 1997; Sidani and Irvine 1999).

In the NSW context, there are now more than 35 authorised NPs providing care in urban, rural and remote areas of the state. In addition there are over 30 more advanced nurses in transitional positions throughout the state (Henderson and McMinn 2004). However, there has been little contemporary research undertaken concerning collaboration of NSW NPs with GPs and other health care professionals in Australia. Consequently, this study aimed to address this imbalance by identifying collaborative experiences of the NPs providing care for local communities in NSW.

METHOD

The study utilised a qualitative, descriptive exploratory design (LoBiondo-Wood and Haber 1998). This method was considered highly appropriate because it allowed at first hand, and for the first time, valuable description and insights concerning authorised NPs. This day-to-day caring practice with patients was negotiated both with GPs and allied health professionals. Data for this paper was part of a larger study conducted in NSW.

PARTICIPANTS AND SETTING

A purposive sample (Schneider et al 2003) of nine authorised NSW NPs were the key participants in this study. These voluntary participants were from urban, rural and remote clinics and hospitals where the primary goal

was to provide quality care to individuals and local communities.

The NPs were recruited using the following process. Firstly, the researcher obtained a list of authorised NSW NPs from the state health department. Secondly, the researcher telephoned each NP to discuss and provide information about the study and invite them to participate. Finally, the researcher made a follow-up telephone call to each NP to finalise arrangements and answer any questions that may have arisen. In order to maintain confidentiality and anonymity names and urban, rural and remote clinical locations of these study participants, have not been more clearly identified.

DATA COLLECTION

As this was a multi-site study, ethics approval was obtained from the human research ethics committee of the Australian Catholic University and eight area health services across NSW.

Each participant provided written consent for an in-depth interview which typically lasted from one to two hours using a semi-structured format (Minichiello et al 1995).

Examples of questions asked during the interviews included: *What skills and qualities do you believe are essential in order to be a nurse practitioner? How do you provide care to patients in collaboration with other healthcare professionals? From your clinical practice, what barriers have you experienced in your role?*

All interviews were audiotaped and conducted at a mutually convenient time and place, which was usually the clinic where the NP was employed. Criteria for judging the scientific rigour of the research was evidenced by the credibility, auditability, fittingness and confirmability of the findings (Schneider et al 2003).

In order to have confidence in the truth of the findings, the researcher returned the thematic analysis of the data to three of the NPs. When a NP agreed with a statement made by another NP it was assumed the statement was indeed credible (Chenitz and Swanson 1986, p.229; Schneider et al 2003).

DATA ANALYSIS

Interviews were transcribed verbatim. Initial analysis of the data included reading and rereading the data and subsequent sorting of the responses from the data into categories, whilst looking for patterns. Three coders were involved in the analysis process with regular team meetings enabling intercoder reliability and consensus for the development of themes (Coulon et al 1996).

The method of analysis used was line by line coding (Strauss and Corbin 1990). Following the development of codes, themes and sub themes were identified. Once the themes were identified, these provided an overview and

synthesis of the participants' experiences. Systematic review using the constant comparison method of analysis (Strauss and Corbin 1990) enabled the analysis process to reveal new themes embedded within the data that may have been missed during the previous analysis process.

FINDINGS

From an in-depth analysis of NPs day-to-day working patterns, one main theme emerged and was named Collaboration. This theme embraced three sub themes of Collaboration. These were: *Total collaboration*; *Partial collaboration*; and, *Non collaboration*.

For the purposes of this study *Total collaboration* was defined as a dynamic transforming process of creating power sharing partnerships for pervasive application in health care practice and organisational settings for the purposeful attention to patients' needs and problems in order to achieve likely successful outcomes (Sullivan 1998).

Partial collaboration was referred to as, professional interactions with GPs and allied health care teams who only supported NPs in select clinical circumstances.

Non collaboration referred to the non-engagement and total rejection of professional health care partnerships and refusal to acknowledge the contribution of NP care.

In this study, only three NPs described their caring practice as being in *Total collaboration* with GPs and allied health care teams. Each study nurse identified that they were autonomous practitioners, and they were part of the local multidisciplinary health care teams. These nurses considered that successful quality health care environments were influenced by collaborative practices among team members.

From the findings, two key characteristics emerged which supported the *total collaborative* process. These were the length of time the NP had worked in the hospital or community, and the rapport established before the NP was authorised by the NSW Nurses' Registration Board. The three NPs who enjoyed *total collaboration* identified that they had an extensive employment history within their health area. For example: all were employed within their local health service for over ten years. This included working in a number of different departments with various health practitioners and local GPs. Also, their authorisations were welcomed and publicly acknowledged by professionals in this area.

Heather said: *I have been working in this area for ten years, everyone knows me* (one year experience as an NP).

Lorraine said: *Because I have been in the area for so long, people know what I am doing, what I can do and what I am capable of* (18 months experience as an NP).

Heather remembered: *The CEO came and congratulated me on my authorisation* (one year experience as an NP).

Lorraine: *The rapport I have with the local GPs allows me to phone them up and request a script for Erythromycin for this person without the GP having to see them* (18 months experience as an NP).

Total collaboration was also demonstrated through diverse forms of professional support. For example, various members of the multidisciplinary team were sometimes involved in the development of the NP position and provided ongoing encouragement. Two NPs reported that colleagues were concerned there was not enough support available for them in their role. Some local doctors advocated for adequate support for the local NP. According to Lorraine: *The main concern of the doctors was I was not going to get enough support and backup. They were looking at it from a caring attitude as opposed to how can we get rid of her attitude* (18 months experience as an NP).

About half the NPs identified that they worked in *Partial collaboration* with a variety of doctors and allied health care professionals and reported that some doctors shared their clinical work on a day to day basis. However, their professional respect for NPs was not always evident. This lack of respect may have resulted from a poor understanding of the role, or a personal belief that NPs were not essential to the health care delivery system. Clare stated that from her experience, educating other health care professionals did not always result in *total collaboration*, but rather *partial collaboration* with some support.

She pointed out that: *Once the GPs understand the role and can see what we are trying to do and it's a supportive role and that we do need collaboration, they are fairly supportive* (two years experience as an NP).

One NP who reported experiencing *partial collaboration* worked in a community where one of the local GPs was very active in that community. This GP was known to have expressed grave concerns in the community about the advent of NPs.

Olma explained: *We have a very community active medico in town who is wary of the whole nurse practitioner thing and who is really concerned about prescribing and test ordering, he has expressed concerns* (13 months experience as an NP).

According to Olma, this situation forced her to rely heavily on scientific knowledge and extensive clinical experience when treating patients. Her advanced care for patients had to be delivered in alternate ways to avoid GPs raising further concerns about the NPs' extended skills.

Olma later explained: *I have avoided confrontation by getting things done in other ways. I am still doing the prescribing and ordering tests when I need to and making*

it up with good rationale and working within guidelines (13 months experience as an NP).

Some GPs were concerned that these NPs would take patients away from the doctor's practice.

Olma's example highlighted this issue: *I am very careful not to be seen to take patients that would be patients accessing the surgery and that is an issue we have identified... I have got three doctors surgery's open, it means I have to access another population so that means another time of day until I establish nurse clinics then I can pick the times for those clinics* (13 months experience as a NP).

Although there was open disapproval expressed by some local doctors with collaboration remaining minimal, there was one time when a local GP chose to collaborate with the NP. This occurred when a patient required emergency care at the local hospital.

Clare illustrated this in the following example: *If I ring any of the doctors and I don't get them straight away the receptionists know that if I am ringing and I say its about a clinical issue I don't give names or anything, within two minutes the doctors are back on the phone, they know there is a problem, a significant problem* (two years experience as an NP).

According to Olma, one of the GPs main concerns was the loss of income as a direct result of patients accessing the NP instead of the doctor. This possibly fuelled the doctors' refusal to collaborate in a professional and effective manner.

Olma said: *With the extended primary health care and incentives that general practitioners have got in their practices...there is quite a significant financial remuneration for general practitioners...All the doctors see me in terms of pinching the Medicare stuff, [and] that I am pinching their patients* (13 months experience as an NP).

A third sub theme was identified as *Non-collaboration*. According to two NPs, Sarah and Jenny, collaboration with health care professionals such as doctors in their local area was non-existent. This disappointing situation arose from battles with local GPs and resulted in the doctors' refusal to have any professional relationship or dealings with the nurses, which led to a policy of *Non-collaboration*.

Sarah received a letter from the local doctors which outlined: *We feel were a nurse practitioner to practice at We would have no option but to withdraw from ... as the definition of roles and responsibilities, mindful of the conditions that prevail at the moment, would be impossibly complicated and unworkable from our point of view.*

Threats from the local doctors to withdraw their services from the local community, where Sarah had provided care for many years, made her feel responsible

for the reduction in medical services available to the community.

This experience forced Sarah and Jenny to reconsider whether they should have an NP position in their respective community. An integral part of their experience included personal examination and reflection of this volatile situation. They explained this during their interviews with the researcher and indicated they knew the fight would be tough. To their professional credit, they remained committed to providing advanced care for their patients.

Sarah's final correspondence from the local GPs was a letter stating: *We wish to advise you, that if you wish to discuss a patient with us for whatever reason, or if you are in doubt about the best management of a patient, do not contact us, always refer them directly to the base hospital'.*

Sarah and Jenny approached the state government clearly stating that their local community should have authorised NPs available. They informed the NSW Health Department about their professional problems with the local GPs. The issue became deadlocked, with the local GPs giving the NSW health department the ultimatum of choosing either NPs or GPs. The health department supported the NPs.

According to Jenny, the essence of the conversation between the doctors and NSW Health was as follows: *Their trump card then of course was, well if you put this nurse practitioner position in then we will leave, we won't come out to this community once a fortnight or once a week, we will leave if you put this in and New South Wales Health said, you are a private practitioner you can do what you like* (One years experience as an NP).

Without regular community consultation with a GP, Sarah and Jenny were forced to establish nurse led clinics without medical assistance. The area health service allocated funding to give Sarah and Jenny the best opportunity to establish their clinic.

Sarah explained: *I think if we work within appropriate guidelines and we are ethical and we are courteous in our dealings with our colleagues, if they don't like it, well, it's law now, and we're able to practise, we're able to provide care, if they want to be unscrupulous and unethical in the way they relate to us, well, that's their problem. I am not going to let it worry me* (11 months experience as an NP).

DISCUSSION

Findings from this study identified three different models of clinical collaboration engaged in by the study nurses with local healthcare professionals: *Total collaboration*, *Partial collaboration* and *Non collaboration*. Despite state legislation authorising NPs to practice, only three NPs were described as being engaged in Total collaboration with medical and allied health care professionals.

However, there were two factors which clearly facilitated the establishment of total collaboration. These were the length of time the NP was employed in that hospital or local community. For instance, the longer the time working in the area, the more it enabled a sense of trust and respect to be built with the local health care professionals. Further, the degree of rapport built up and established with allied members of the health care team prior to the NPs authorisation made a difference to their on-going relationship and the resulting model of collaboration.

Lorraine conceded that her success in collaboration as a NP was: *because I have been in the area for so long, people know what I am doing [and] what I can do and what I am capable of.*

It is postulated that the employment of a nurse who had an extensive history of working in the local area was more successful in gaining acceptance as an NP than the appointment of a nurse new to the area, who had not developed a network of professional health colleagues.

Consequently, it may be more prudent to appoint a nurse who has successfully achieved an advanced practice role over a period of time and who has developed an appropriate level of collegiality. All three NPs who identified they were engaged in total collaboration had a previous extensive employment history where they were appointed. Each reported establishing excellent rapport with other health practitioners, managers and patients. It is recognised that there were a few GPs who openly supported these three NPs, and that not all local doctors opposed the concept of NPs. Winson and Fox (1995) considered that American NPs were successful in becoming established in health care teams. However, this required effective communication and negotiation with other health care professionals in order to initially determine the NPs' agreed scope of practice. This suggests that establishing collaboration requires effective communication as an on-going dynamic process mutually and consistently undertaken across multidisciplinary health care teams.

Most NPs in this study explained their experience of working in *Partial collaboration* with other health care professionals. A major contributing factor to this limited professional relationship was the resistance expressed by some doctors. According to these NPs, the doctors were concerned that they may lose their patients to the NP. In effect, they were concerned about a reduction in their income.

This was pointed out by one participant Olma who said: *all the doctors see me in terms of pinching the Medicare stuff, that I am pinching their patients.*

This suggests that the inception of NPs has the capacity to reduce country doctors' income. However, most NSW NPs provided extended nursing care with only four or five approved clinical practice guidelines. Thus, it is a questionable assumption that the introduction of NPs

would greatly reduce GPs incomes. In addition, 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 (Patterson and McMurray 2003). Furthermore, from these nurses' accounts, it is worth noting that many NPs in rural and remote NSW provide advanced care to patients, where there were no doctors for hundreds of kilometres.

In NSW, NPs have been subjected to political attack, which, only serves to remind the wider community that for some NPs they will most likely remain engaged working in the often stressful situation of partial collaboration. While the concept and role of NPs was never going to be welcomed by all involved, it remains concerning that professional respect for health colleagues is not forthcoming or indeed valued by some members of health care teams.

The urban NPs reported that from the start they had total support for their role. In contrast, most NPs in rural and remote areas reported that barriers existed from the beginning. This may have been the result of inappropriate education strategies which failed to inform the wider health care community about this new nursing role. In addition, it is suggested that underlying political, environment and economic influences played a part in the poor reception of the NP positions. For example one area health service collapsed two registered nurse positions classified as eighth year and thereafter to fund the new NP role. This decision by management had the potential to put further pressure on the individual NP and the health care facility where the nurse was employed.

This study's findings concurred with those of Chaboyer and Patterson (2001) who indicated that a collaborative relationship cannot evolve if individuals do not value and respect each others competencies. This was evident in the reflections of two NPs who were forced into a non-collaborative relationship because the local doctors showed disregard for the NP positions.

Although some doctors openly questioned the role of NPs, all the withdrawal of medical services would achieve is to disadvantage isolated communities where access to health care remains limited. It is recognised that by expanding the traditional nursing role it may be viewed by some community groups as medical substitution, or role encroachment, or alternately they may consider it a rightful claim of the nursing profession. As Professor Judy Lumby (2000) explained, 'they will not be working as GPs, but as expert nurses'.

As illustrated in this study and supported by Patterson and McMurray's research (2003), a particular barrier to nurse-medical collaborative practice has been a lack of understanding on the part of medical practitioners and nurses concerning each other's roles and responsibilities. With improved innovative educational strategies and effective communication, specifically targeted toward

doctors and allied health care professionals, this issue of non collaboration may be overcome and consensus reached with most health care industry professionals.

CONCLUSION

This study identified that total collaboration between NPs, GPs and allied health care professionals remains complex and does not automatically occur. The process of effective collaboration needs to be, consciously constructed, learned and once established protected.

In contemporary health care, it is now time to set aside differences and work harmoniously with colleagues from all disciplines toward the common goal of quality care, which will provide the necessary shared identity (Begley 2003). This opportunity may increase in Australia once there are more NPs appointed and authorised to provide effective care.

It is recommended that a national study be undertaken to explore the contemporary challenges embedded in health care partnerships and the forces that facilitate or negate collaboration. Findings from such studies may provide a clearer understanding of the dynamic complex collaborative relationships existing in urban, rural and remote areas. In the future, sustainable collaborative partnerships need to be developed with more health care providers recognising the valuable contribution that can be made by NPs in improving patients' health outcomes.

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