



**Ontario Medical Association &  
Registered Nurses Association of Ontario**

**The RN(EC)-GP Relationship:  
A Good Beginning**

Goldfarb Intelligence Marketing  
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## INTRODUCTION

The Ontario Medical Association (OMA) and the Registered Nurses Association of Ontario (RNAO) are interested in defining effective strategies, which can then be used to optimize the working relationships between General Practitioners (GPs) and Nurse Practitioners with the RN(EC) designation RN(EC)s or NPs. (Note: In the report the terms RN(EC) and NP are used interchangeably in all cases the individual has an RN(EC) designation).

In order to gain insight into the overall collaborative practice between GPs and NPs, the OMA and RNAO retained Goldfarb Intelligence Marketing and D. Dave HealthCare Solutions to conduct a qualitative research study that consisted of one-on-one and joint interviews with GPs and NPs.

### Objectives

Specifically, the objectives are:

- To assess the nature and extent of this collaborative relationship
- To confirm the influence of GPs and NPs on each other in a collaborative relationship
- To explore further how the relationship works
- To identify best practices so that the working relationship can be optimized

### Methodology

Goldfarb Intelligence Marketing and D. Dave HealthCare Solutions conducted interviews with GPs and NPs together and separately to achieve the best possible insights. All physicians and nurse practitioners interviewed delivered primary care. The interview period was divided into 45-minute blocks. In total there were three 45-minute blocks as follows:

- |                                |                 |                 |
|--------------------------------|-----------------|-----------------|
| 1. 45 minutes GP <b>or</b> NP  | } Participant 1 |                 |
| 2. 45 minutes GP <b>and</b> NP |                 | } Participant 2 |
| 3. 45 minutes GP <b>or</b> NP  |                 |                 |

Discussion guides were developed with the input of OMA and RNAO personnel. The interviews followed these guides (See Appendix A).

Specific areas of focus in the discussion guides are:

- Roles and responsibilities of NP and GP (including opportunities for growth and frustrations)

- Motivations for working in this type of partnership
- Assessment of relationship (past, present, future)
- Opportunities for improvement
- Catalogue of benefits for NP, GP and patient
- Best practices
- Tools that assist in making the relationship better (including training, computer programs, etc.)

A total of 32 interviews were conducted in Ontario in four geographies (See Appendix B). The research included GPs and NPs from community health centers (CHCs), primary care networks (PCNs), long-term care facilities (LTCFs), GP private offices, solo NP practices and the military (See Appendix C). All interviewees were selected from the list supplied by OMA and RNAO. The timing of interviews and the final mix of locations and types of practices is a function of the lists supplied.

Interviewing was conducted from December 2002 to February 2003.

Note: In this report, reflecting the reality of the professions, RN(EC)s are referred to as “she” and GPs as “he or she”.

## DETAILED FINDINGS

### Optimizing the working relationship

Relationships between NPs and their collaborative GPs are heterogeneous. There are a number of different models and all of them can be effective. Nevertheless, there are certain basic building blocks that, if present, help in the building of a successful working relationship.

1. Mutual respect and trust
2. Recognition of (unique) expertise
3. Understanding of NP's scope of practice
4. Good team structure – but limit the size and number of teams
5. Understanding of legal responsibility
6. Dealing with hierarchy
7. NP practical experience – diagnostic skills
8. Understanding RN(EC) solution is about access not cost
9. Shared values

#### Mutual respect and trust

The RN(EC) designation is still new and doctors are still becoming used to what these nurse practitioners can do. Few doctors trust the designation as such; that is, they do not presume that those with the designation are competent. Instead, they trust the nurse practitioner with whom they work. Indeed, several said that they believe that the NP they work with is exceptional – almost unique. Even doctors who are most familiar with the designation, i.e. those working with an RN(EC), are not completely comfortable with the designation.

This is an issue that needs to be addressed. The RN(EC) program is a regulated professional program with attendant monitoring and controls. However, this is not widely understood by GPs. Notably the reverse is true; RN(EC)s interviewed do not question the integrity of medical training. For the success of the RN(EC) program, GPs need to understand it and therefore approach RN(EC)s with the presumption that anyone with the designation is able and competent, because the license itself means something. Currently GPs are more likely to trust the relationship they have with an individual rather than that individual's training. Of course, individuals will still have to prove themselves but they deserve to be starting from a presumption of competence rather than a 'wait and see' attitude.

A few GPs and NPs believe working with NPs should be part of doctor's training. They suggest, to the extent it is feasible, that interns and NP students cross-train. The training would help GPs better understand the designation.

In terms of individual relationships, trust is established over time. On average, doctors indicate that in three months they know the person is competent. Conversely, they know if the person is not competent much sooner. Therefore, basic trust is established in three months, but as the relationship continues, as with any other relationship, trust and respect

tends to deepen. A potential challenge is that while it takes approximately three months to build a good relationship, it may only take weeks to recognize a bad one.

Clearly there is a need for mutual trust. Doctors, however link trust with technical skills and where there is not trust on the GP's part the collaboration suffers in distinct ways:

- Where the RN(EC) is an employee of the GP she may lose employment
- The GP may retain control over more complex patients so that the RN(EC) does not have the opportunity to practice within the full scope of her practice

Where the RN(EC) does not trust the doctor (although this was discussed on a hypothetical basis as all RN(EC)s interviewed said that this was not a problem) the consequence is more an unhappy relationship and working environment.

### Recognition of (unique) expertise

Doctors who appreciate that the collaborating nurse practitioner is a professional and an expert in her field are most likely to respect and trust the NP with whom they work. Recognition of expertise seems to be built upon personal experience with the NP – that is, there is no predisposition to view all NPs as primary care experts.

For those who believe that nursing has a fundamentally different approach, based on a wellness or health promotion model, there is an acceptance that the NP's expertise is different than the doctor's – yes, there are large areas of overlap but each partner in the relationship has unique areas of expertise (Figure 1). Others see what an NP does as being a subset of what a GP does (Figure 2).

Figure 1

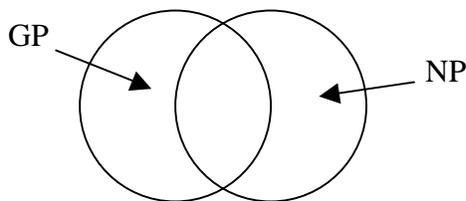
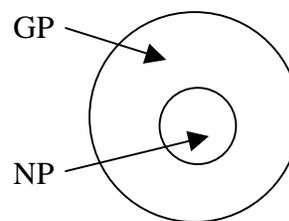


Figure 2



Therefore, there are two distinct ways at looking at RN(EC)s' delivery of primary care, with each perspective being held by some doctors and some nurse practitioners:

1. NP delivery of primary care is essentially *different* than a GP's because the nursing perspective is different
2. NP delivery of primary care is essentially the *same* as a GP's, although limited to the scope of practice

Both of these viewpoints work in collaborative NP-GP relationships. However, for a successful relationship it is better if both partners in the relationship share the same perspective on this issue from the outset.

Out of this perspective other elements of the practice emerge.

Should the NP be taking similar or more time to do patient examinations? If more time, then the practitioner likely subscribes to the view that a nurse's examination (especially a well person physical) is more holistic and deals with more issues, including, for instance, diet and stress. In partnerships where the NP thinks one way and the doctor thinks the other, expectation cannot be met in terms of either volume of patients seen or services delivered to them at each visit.

Does the nurse practitioner have a one-on-one client-teaching role backed by expertise beyond that of the doctor (independent of any group education role) because her discipline is wellness or health promotion focused? If so, the nurse practitioner is seen as someone who excels in client education and should be doing it and should be allocating time for it. The contrary view is to the extent it gets done, the NP will do it as she likely has more time to do so.

Many (but not all) NPs believe taking more time leads to better care; GPs do not necessarily believe this to be so; however, those who work with NPs generally see the benefit of NPs taking some additional time.

Nurse practitioners refer to the people they see as clients; doctors refer to them as patients. When asked, both say it is semantics but it underlies a different approach to delivering primary care. The doctor frequently sees a person requiring treatment services, the nurse more likely sees a person requiring a variety of services from her including treatment and health promotion.

#### Understanding of NP's scope of practice

NPs believe that the relationship works best when both partners have a thorough understanding of the scope of practice. This helps doctors understand what the NP can and cannot do and alleviates a potential source of tension in the relationship. This is not a panacea: some aspects of the scope of practice are judgment calls.

On the other hand, most doctors do not believe that understanding the RN(EC) scope of practice in detail should be their responsibility. They expect the NP they are working with to work within her scope of practice and that therefore they do not need to figure out what the scope is in any great detail.

#### Good team structure – but limit the size and number of teams

The best team environment for NPs and GPs is to have a one-on-one relationship. Some note a relationship of 2:1 (going either way, depending on the practice environment) could also work. If an NP (according to the NPs/GPs interviewed) works with more than one or two doctors the continuity required to run an efficient practice is lost. It also takes much longer

to cement the relationship and develop the trust required. If a doctor works with more than one or two NPs, then the doctor is unable to give the consultative time required to optimize the NP's practice.

If too many professionals on a team see the same patient there is a danger of not delivering the best possible care. The patient may be told different things. Unless charting and note writing is perfect, the next caregiver may not be fully aware of all that has gone before. This was identified as an issue particularly where there were high need, transient patients (i.e. refugees in one CHC).

In situations where an NP is working in more than one environment, for instance at two or more Long Term Care Facilities (LTCFs), each with its own physicians, one team is nearly always compromised. The NP cannot give the time and attention required for best results in multiple work environments.

#### Understanding of legal responsibility

Doctors are insecure about this issue. They understand that the nurse practitioner carries her own insurance and is responsible for her own actions. However, there is a lot of uncertainty over whether or not once they see the patient (even once on a consult on a particular issue) they take on the legal responsibility for the patient's care. Others are concerned that they take on liability because of the shared physical environment. In circumstances where an NP sees the GP's patients (i.e. she does not have her own roster) the GP believes he or she has ultimate responsibility.

For some GPs this is a back of mind concern but for others it is something they worry about. A few have called the CMPA to try to come to a clearer understanding of their liability but have not been able to get a clear answer from the CMPA. Additionally, the recent OMA paper has heightened, and in some cases created, concerns about the extent of doctor liability for consultation and the issue of nurse practitioners' coverage. For the NP-GP relationship to evolve positively this issue must be clarified.

NPs also need to communicate the extent of their coverage and be clear about what is covered and how much coverage is appropriate. Any deficiencies in coverage should be addressed and any new coverage terms communicated. GPs are particularly interested in understanding NP coverage in terms of continuation of coverage after an NP leaves a practice.

Some doctors feel uncomfortable with the level of consultation – they would prefer to be seeing more of the NP's patients, more often, especially those with more complex health issues. This is because of both legal responsibility concerns and a perspective that complex patients likely need medical consultation.

This dynamic can create tension in the relationship: doctors want to see more patients, nurse practitioners feel that they consult where appropriate and that these additional consultations are duplicative rather than additive to patient care.

There is a difference of opinion between some NPs and GPs regarding referral to specialists. Some experienced NPs and a few GPs say that scheduling a GP visit can be a bureaucratic inefficiency imposed by the system.

While not as big an issue in CHCs it is still of concern.

### Dealing with hierarchy

The traditional doctor-nurse relationship is hierarchical. NPs clearly view themselves not as a supporting member of a team that delivers primary care; but as a deliverer of primary care, albeit, in a team environment. As such, they view the doctors they work with as partners.

Certain doctors, particularly those who work in CHCs and LTCFs view the nurse practitioner they work with as a partner as well. Others, especially those who believe they are ultimately legally responsible for what the NP does, still see a hierarchy existing. They can (although they usually do not) override an NP decision, giving them the ability to accent the hierarchical potential.

Many NPs say that the partnership could not work out if they were the employee of the doctor. That would give the doctor an additional lever in an already unbalanced relationship. In situations where the NP and the doctor have the same boss (i.e. the institution's administrator) this potential cause of tension is absent.

Two nurse practitioners we interviewed worked in an employer-employee environment. As with any employer-employee, personality issues aside, this can and did work. However, the parameters of the relationship need to be established up-front. In one relationship the NP focused on three distinct areas: diabetic education, prenatal education and palliative care. She had relative autonomy within the delivery of services in those areas; she had limited involvement in decision-making about the practice but was free to make recommendations to the doctors, who had final decision-making authority. Both the doctor and the nurse were satisfied with the quality of the relationship.

One sign of hierarchy is how the two address each other. This issue has layers of tradition and power relationships built into it: doctor, nurse; male, female; and often, older, younger. NPs prefer to call the doctor with whom they work by first name (even if they do not refer to the doctor that way in front of patients or others). Clearly, there are occasions when this is not happening and there is still a very successful relationship. However, when they can, it helps them feel like equal partners.

### NP practical experience – diagnostic skills

New practitioners, whether they be GPs or NPs have a period of adjustment to the realities of practice. Having the self-confidence to be sure of clinical skills, when a patient is depending on that practitioner, takes time and experience.

GPs go through this period of uncertainty but report that through medical internship and residency they have had enough patient exposure to be fairly self-confident upon graduation.

Several nurse practitioners and doctors (including those who are the biggest supporters of the RN(EC) designation) say that graduates from the course who do not otherwise have clinical experience in an extended practice (say, through outpost nursing) are frequently not fully confident in practicing as a primary care provider. Several RN(EC)s indicated that they would like to see more emphasis on clinical training in the RN(EC) program. The perceived variability of RN(EC) programs by both RN(EC)s and GPs, adds to this concern.

Some doctors are prepared to invest in helping a nurse practitioner hone clinical skills for a period of three to six months, knowing that in the long run this investment will pay off.

However, other doctors do not believe that this should be required and are therefore not prepared to take on this role. Graduating RN(EC)s should, ideally, be fully capable of, and confident in performing the job, or at least exude the same degree of confidence and demonstrate the same degree of capability as new GPs do. Because some experiences with new RN(EC)s have not worked out well, some doctors now say they do not trust the nurse practitioner they work with until after a 3-6 month de facto probation period. Of course, trust is built over time and there will always be a period of solidifying a new collaborative relationship.

The collaborative relationship begins on day one. Both NPs and GPs say it evolves over time. For instance, at the beginning when each practitioner is learning the other's style and preferences, more consultation occurs. Once a mutual understanding has been established, consultation diminishes to the level appropriate that is within the comfort zone of the collaborating professionals. Nevertheless the faster the foundation for trust is established the better the prospects for long term success. Demonstrating clinical acumen within a supportive, collaborative relationship is a basic building block for establishing trust.

Doctors' concerns over NPs' clinical acumen are at least partially shaped by the relative newness of the RN(EC) designation and the relative newness of doctors working with this type of nurse. Nevertheless, to the extent that mixed experience with graduates is impacting how doctors feel about the profession, this natural tendency is exacerbated.

The RN(EC) training does not explicitly address the LTCF environment. RN(EC)s without prior geriatric experience report having an additional learning curve to achieve success in the LTCF environment.

*Understanding RN(EC) solution is about access not cost*

Almost all GPs and NPs say the addition of the NP into a setting is about delivering value-added care or care to more people. It is not about delivering less expensive care. Doctors and NPs who were interviewed worry that the government thinks that utilizing more RN(EC)s is about savings and that its success or failure will be measured on this basis.

Cost is one source of potential concern between GPs and NPs and indeed a concern shared by NPs and GPs about the model in which they work. There are cost impacts in the various settings in which NPs and GPs work together for instance in:

- LTCFs residents are receiving services that enhance their quality of life that they did not receive before, and
- CHCs well baby exams take 40 – 60 minutes

Cost arises as an issue. RN(EC)s generally see fewer patients per day as each interaction is generally scheduled for a longer period. This reflects a difference in approach to care.

Doctors in a fee-for-service environment also note that the RN(EC)s with whom they work are paid salary and benefits by the government (as are doctors in the CHC environment). For similar cost, different approaches are adopted by the two professions and by the government, as demonstrated by the way in which the two professions are paid.

RN(EC)s and usually their collaborating GPs are convinced of the validity and value-add of their approach; however some feel that there is not yet a good metric to measure the true value of their care.

### Shared values

For there to be mutual respect the partners must share a vision of how they want to deliver primary care. That is, they must share certain values. Often, doctors and NPs who have worked together for a long period of time say that they have become personal friends. While they share values in their professional lives, they find that they also share personal values, which leads to friendship. Liking the person is not a prerequisite to a successful relationship; yet, it certainly helps. Having a mutual understanding on how care is to be delivered is (for instance, in one practice both partners stressed punctuality as a fundamental practice principle which is not the case in others who may value other things such as an holistic approach).

### **Role Definition**

There needs to be a clear understanding of roles. Both the legal RN(EC) scope of practice and the desired scope of practice of the GP and NP who are working together must be taken into account. There are a number of possible solutions that work. However, some practices have become defined by default or by following the desire of one party only. Unless both parties agree on who does what, there is likely to be dissatisfaction. Possible models in a shared physical environment (CHC, community clinic or private office) include:

1. NP takes all new clients until her practice fills up. New clients with issues beyond her scope of practice are referred elsewhere. Doctor retains existing client base.
2. NP takes all clients (new and existing) within her scope of practice. Doctor's practice becomes restricted to more complex cases.
3. NP restricts her practice to more straightforward issues, for instance well women and well babies. Doctor has a more varied practice.
4. NP and Doctor both take on varied patients. Consultation as required.

The first option works in under-serviced communities and is the best option in those communities needing to extend care to more people.

The most efficient option is the second. If doctors want a more complex practice (as many in CHCs do) this works; however, often doctors want a varied caseload to add balance and enjoyment to their day. Some doctors also worry about deskilling – if they stop doing certain things they will lose the skills to do them. Others worry that if they give up well examinations they lose the reference point to confidently identify when someone is not well.

Some nurse practitioners like the third option; others find this becomes boring and limiting.

The last option is usually the most satisfying for both parties. To make this work, good triage is required. Best practices have an RN doing triage amongst her other duties; in other instances a receptionist works at prioritizing patients. While the latter is not the optimal solution, in time and with training and nursing supervision receptionists are reported as able to function well in this capacity.

Within each model, there are two ways that patients are allocated. In most practices, the NPs have their own patients, and in others all patients are part of the doctor's roster, and the NP handles certain issues on certain of those patients.

## **Acceptance**

Both GPs and NPs say that there is resistance to NPs by some doctors. This is based, they believe, on the fear that NPs will take work away from GPs. This is seen as fear, based on uncertainty about what NPs truly do; moreover, it is seen as completely groundless in underserved communities. Most people seen by the NPs we spoke to, do not have a family doctor and have no possibility of getting one. For instance, in Sudbury some say 30,000 to 40,000 people do not have a family doctor.

There are other barriers to acceptance, which are clarity about medicolegal issues, confidence in the skills associated with the designation and knowledge of financial models that make collaborative practice beneficial to doctors.

Nurse practitioners say that the current relationship is consultative. They would like to see it evolve into a collaborative one. This change will require doctors to appreciate the unique expertise of nurse practitioners and to see them as adding a unique skill set into a primary care practice.

GPs and NPs report that a collaborative practice is one without hierarchy. It is one in which both the GP and the RN(EC) are equally involved in planning for the practice and planning for more complex patients' care. It is one that builds in time for the free exchange of ideas, meaningful discussion and mutual consultation.

## **Learning**

The NP-GP relationship is a teaching and learning one. And, most believe the teaching goes both ways. Most obviously the NP learns from the doctor through the consultative process.

The medical perspective focuses more on treating illness. Many of the NPs interviewed say a distinct aspect of the nursing perspective is health promotion and wellness. Many of the GPs interviewed, especially those in the CHC environment, appreciate the historical difference in the perspectives of the two disciplines and view the opportunity to learn about these health promotion and wellness issues as a key benefit of working with an NP. On the other hand, some doctors see the learning process as more one way – they teach, and enjoy teaching, and the NP learns.

There are common learning opportunities. Some GPs have the NP they work with attend their meetings with drug representatives. In CHCs, frequently whichever primary care provider attends a conference, presents to the rest of the team after the conference. Sometimes, subject matter experts present to a CHCs primary care team.

The opportunity to learn from each other, to collaborate on complex cases and issues is a key benefit in working in this type of relationship. Doctors who do it acknowledge they are giving up power/autonomy but they believe they are achieving better patient care: ‘two brains are better than one’.

In one partnership, the CHC’s consulting physician was a retired specialist who was extending his practice life by going back to family medicine. This physician was learning a lot about family medicine, including the basics of well person care (for instance, how to inoculate a baby) from the NP with whom he worked. In this model, the specialist said, a specialist and an NP working together provided the same quantity and quality of primary care as two GPs, thereby stretching the resources of the system.

## **Consultation**

Consultation is key to the NP-GP relationship. Doctors have two, somewhat inconsistent, perspectives on consultation. On the one hand, they worry that they are not being consulted enough. They want to know what is going on in the nurse practitioner’s practice and they want to be comfortable that the right decisions are being made, especially in cases where they share patients and liability. On the other hand, they have busy practices of their own and they do not want to be consulted about issues that fall squarely within the nurse practitioner’s scope of practice.

At the beginning of a relationship doctors want and expect to be consulted more frequently than as the relationship goes on. Indeed, as the nurse practitioner gains confidence in her role (if she is a new graduate) and as both the NP and the GP gain confidence in the relationship, consultations appear to appropriately decrease. If this does not happen this is a sign of a relationship in difficulty.

There is a qualitative aspect to consultation as well. A “bad consult” can significantly undermine the GP’s confidence in the NP’s diagnostic and management skills, possibly more so than non-consultation.

In each relationship, more than one mode of consultation is used. Depending on the relationship, different modes were more prevalent. In CHCs, informal, hallway consultation is common given the physical proximity and the CHC funding model. This is true of some private offices as there is also physical proximity, but in others the demands of a fee-for-service practice made consultation more likely to occur at lunch or the end of the day. In practices where there is little physical overlap (i.e. LTCFs) written consultation becomes more important. And, in environments where the doctor is being paid on an hourly basis to consult, a more formal in-person approach is favoured.

Whatever the method, a successful consultation is one in which the NP should:

- Clearly know why she is consulting and, as per above, the consult is a “good consult”, properly worked up but obviously outside the legal scope of practice or the particular NP’s expertise/experience.
- Have specific questions to ask the doctor
- Have all she needs with her (chart, patient, referral request, etc.)
- Ensure the consultation is (later) documented

And the consulting GP should:

- Be available as required
- Listen respectfully and attentively
- In front of the patient, demonstrate confidence in the RN(EC)
- Not expand the scope of the consultation to redo the NP’s work

Consultation methods are:

### In person

#### *Hallway*

In CHCs and shared office practices this is often the most frequent form of consultation. NPs use this type of consultation to discuss ideas, to update doctors on shared patients, and when necessary, pull the doctor in to examine her client. In a CHC this may occur throughout the day, between patients; in a private office the NP may speak to the doctor between patients but tries to save up questions for natural breaks in the day such as during lunch.

#### *Planned meeting*

This occurs in CHCs and contracted consultation. These are scheduled periodic meetings. At CHC meetings, practice planning and development is also discussed. In both settings more complex patients are discussed, as well as learning opportunities for the practice and any required procedural issues. In CHCs and in some private offices planned meetings will involve education with outside resources being brought in (such as an expert speaker on an

issue). Planned meetings lend themselves to practices that are not fee-for-service. In fee-for-service environments, doctors say there is no time.

### *Patient Examination*

Sometimes there is an issue that requires the doctor to see the patient. Often the NP makes this determination and requests a consultation. Sometimes, in a shared environment the doctor will see the patient on the spot – fitting the patient in between his or her own patients. At other times, the patient is scheduled to come back and see the doctor.

The other way a patient sees the doctor is if, on an oral or written consultation, the doctor decides it would be better for him or her to see the patient.

A salaried doctor has more flexibility in making this determination. A fee-for-service doctor also has to struggle with the competing issue of managing caseload. This doctor will either have to work longer hours or decide to see fewer patients in a day. Additionally, the only way a fee-for-service doctor can get paid for a consultation is if the patient is seen by the doctor.

## Telephone

### *Scheduled*

Some partnerships have regular scheduled telephone consultations or discussions; where there is not physical proximity this works well in some instances. Of course, it cannot replace all face-to-face meetings or requirements.

### *Emergency*

In LTCFs and settings where the NP does not practice with a physician on-site, she will, if required, call the doctor to deal with an emergency, out-of-scope problem. This happens rarely, with NPs reporting they can count on their hands the times it has happened in the past year. Generally, their clients do not need emergency care and if they do they are told to go to a hospital emergency room.

## Written

### *Binders*

In LTCFs, especially where doctors and nurse practitioners share patients yet are frequently not on-site at the same time, formalized written methods of communication have been worked out. These include having binders with lists of residents for the doctor to see on his or her visit, and lists of questions for the doctor to answer regarding patients as well as tests, prescriptions and referrals that need to be ordered (usually attached to the chart) and require the doctor's signature.

### *Charts*

The chart is the basic tool of communication about patient care and is essential in shared practices. It is through the chart that one practitioner finds out what the other practitioner has done in the absence of a discussion. Even where there is a face-to-face meeting, the chart is the primary tool in discussing a patient and in documenting decisions.

Charting is almost always done in the format that the doctor prefers. Nurse practitioners who work with more than one doctor accommodate different doctors' preferences in their charting.

Only one interviewed practice used computer charting and all members of the practice interviewed were very satisfied with it. Most do not believe the PC based software currently endorsed by the Ministry is at a point where computerized charting would actually be useful. Even if it were, many do not have the budget to buy the hardware and software required to make computerized charting a real option. And, even if that were in place many admit that they are not personally comfortable with using the computer for charting.

### *Notes*

The chart is the basic document used to communicate – notes and questions are generally inserted in the chart by one partner for the other partner. The chart is left in an 'in-box', the other writes back a response and care proceeds accordingly. Requests for referrals, prescriptions or tests are often appended to the chart. This is often used where there is less face-to-face or hallway opportunity for consultation.

Sometimes a straight note is left – without being appended to a chart. This happens much less frequently.

The system for notes is often developed by the NP as it is the NP who has the requirement to consult.

### *Referrals/prescriptions/tests*

Because of the parameters of their practice, nurse practitioners need to consult with a physician when they believe that a patient needs a referral to a specialist or certain prescriptions or tests ordered. Generally, the GP decides if an oral consult or chart review is sufficient or if he or she needs to see the patient before any further action is taken.

For some prescription renewals (in a stable patient with a chronic condition) or certain conditions that are frequently seen in a particular practice or certain specialist referrals (most notably Obstetricians) some nurse practitioners work under medical directives. Most of the RN(EC)s we interviewed do not have any medical directives in place. For those who do, they have almost always initiated the process. NPs say the standard format available is quite useful and

a good place to start. The directives themselves are very detailed, appropriate for the specific practice and thoroughly thought about before they are put into place.

Most of the doctors we interviewed and all of the NPs believe that the NP's inability to refer to specialists is about money: specialists do not make the same amount of money on an NP referral as they do from a GP referral. While clearly most referrals would still go through a GP, most say there are clear-cut cases when this should not be so and that the OMA or the province needs to deal with this issue. The "quality" of the referral in terms of appropriateness of the specific specialist consulted was mentioned as an issue by some GPs in areas serviced by tertiary care/teaching centers. In these areas, specialists have often developed highly specific areas of sub-specialty, and there is concern that NPs may not be aware of this or be able to make the appropriate referral. As well, some GPs believe that the NP they work with makes more referrals than is required. Sometimes, the GP can solve the issue without a specialist referral.

Most NPs and GPs note that some of these issues will be alleviated with the new drug list coming (perhaps this spring).

## **Work Environments**

### **CHC**

Doctors who work in a CHC environment have chosen this environment for the following reasons:

- They like working in a multidisciplinary team
- They like the collegial atmosphere
- They like spending a lot of time with a patient; many note that they could not practice the way they wanted to when they were in a fee-for-service environment
- They like serving complex patients (e.g. geriatric, palliative, refugee, Native) and find dealing with their medical issues intriguing
- The salaried model gives them security and allows them to make a living practicing how they want, in the manner in which they are most comfortable

Nurse practitioners choose CHCs for complementary, but not identical reasons:

- CHC provides one of the best job opportunities for them, in terms of hours of work, benefits (including vacation time and professional education), job security
- They like working in a team environment
- They like the various components of the job, including education, client care, outreach/off-site visits and education/public health
- They like the security of having a consulting physician on the premises

In most CHCs new clients are seen by NPs. Reception or the NP clearly explains the NP role. Most clients are comfortable with seeing a nurse practitioner and are generally glad to be receiving any care at all. CHC employees report that if a person requested to see a doctor instead of an NP they would accommodate the request, but that this rarely, if ever, happens. Triage is done by the receptionist or sometimes by a designated RN. Both approaches can work, however when triage is done by reception training is important, and nursing staff are more involved in supervision. Clearly the process runs more efficiently and effectively when an RN is responsible for the function.

In a CHC there are several doctors and nurse practitioners. Each has his or her own practice style. In terms of consultation, different doctors have different expectations. Some are more likely to ask more questions; some prefer to do their own examination on certain issues.

While there is a lot of interaction amongst the full team, certain relationships develop. Sometimes they are based on physical proximity, with the NP going to the office next door for a quick consultation; sometimes they are based on shifts, with those who work more hours together developing stronger relationships; and sometimes, the NP picks the doctor she consults with by issue. For instance, in one CHC one doctor is known for trusting the NP's diagnosis for certain conditions and will sign a prescription order after a hallway consult; another doctor will likely want to examine the patient. The one who wants to examine the patient is therefore not consulted unless there is no one else available.

Some GPs have concerns about aspects of their relationship with the NP they work with but do not say anything. The fear of saying anything, of causing hurt feelings, seems to be a CHC phenomenon. Those doctors who express this concern and who have conquered this fear, have found that after they speak up the whole relationship improves as a source of anxiety is resolved.

Call remains an almost exclusive domain of the doctor. Call is generally delivered through a network of CHCs – few offer call on a CHC-specific basis. Only a few NPs we spoke with had call responsibilities. Doctors remain the sole providers of call in most centres for three reasons:

- Most believe that there is no way for an NP to be paid for call
- Doctors rely on the income from call and do not want to give it up
- Most believe NP call will still require physician backup, thereby duplicating services

Conversely, where NPs have call responsibility it works well and services are not duplicated. The back-up physician is called rarely if ever; but nevertheless, still has to be available.

### LTCF

In many ways this is an ideal situation for a nurse practitioner practice. Clients in an LTCF have chronic (versus acute) conditions. They are a stable population and they benefit from regular primary care.

Nurse practitioners in LTCFs report needing to first gain the trust and confidence of their co-workers including administration, other RNs and RPNs. In a cooperative environment each health practitioner is working to his or her highest and best potential. That is, frequently by watching the nurse practitioner the RNs' and RPNs' skills are improved so that the RN(EC) is freed up to work fully within the scope of her practice. Doctors are then consulted on issues that truly require medical care on their (often weekly) visits to the facility.

Each nurse practitioner we spoke to, spent time at more than one facility. In no case did the relationship work equally well in both facilities. This is especially true when she worked with different physicians in each facility. In one instance, the same doctor was the medical director at two facilities and this resulted in fewer imbalances in the relationships at the two facilities. Upon introduction of the RN(EC) service to a facility, the nurse practitioner needs a champion for optimal results. The administration and a doctor with a large percentage of the patient load need to demonstrate support for her work in order for her to be most effective. Where this does not happen, she tends to be used more as a resource of last resort, a fall back when all else fails or no one else is available. She does not become involved in the planning of the client's care.

When the NP is funded to work at two or more facilities, and one facility welcomes her and the other merely puts up with her, she understandably tends to put her best efforts into the facility that values her. This perhaps perpetuates the problem at the second facility, but on the other hand, 'you fight the battles you can win.' This occurred in the LTCF practices we interviewed.

The key is to ensure administrative and medical support up front for the job to be fulfilling and patient care to be optimized. Nurse practitioners who have received this report say the following factors were instrumental for success:

- Meeting with administration and medical staff before the job begins
- Taking time to learn the current routines of the LTCF facility before implementing changes
- Finding a champion – administrative or medical – to educate others on the benefits the NP will bring to the institution

Doctors and nurse practitioners identify acute care follow-up as an area where the nurse practitioner role can be extended. That is, where patients of the NP are transferred to a hospital, both GPs and NPs state that the NP should have privileges at the hospital so she can be prepared to treat the patient appropriately when the patient comes back home. As well, she can be a familiar face for that patient in the hospital.

Doctors generally prefer to handle death certification, although it is within the RN(EC) scope of practice. In one LTCF, if the NP was there and a doctor was not, she would do the certification. In another, the doctor would be called. This was identified as an income issue for the doctor as well as the agreed upon practice in these facilities.

## Private Office

This is a model that is more prevalent in smaller and northern centres. The nurse practitioner sets up practice in space that is rented from a doctor or doctors. She has her own clients, and the GP agrees to consult as required. In the event that the client needs a doctor's care, the doctor usually does not agree to take those people on. The GP's practice is closed and remains closed. These partnerships are about extending primary care in communities where there are shortages of primary care physicians.

From an economic perspective, the doctor at best breaks even but is likely losing money. The nurse practitioner funding includes \$10,000 to pay for overhead (rent and administrative support, usually the doctors' employee). This does not truly cover the cost. The NP is also likely using certain of the medical practice's supplies like tongue depressors, syringes, etc. without cost to her. Additionally, the doctor's consultation time is free, unless the doctor sees the patient.

The GPs in private practice who can most afford to work collaboratively with an NP are doctors who are fee-for-service but who also have other sources of income, such as receiving income from a hospital or university. We interviewed few doctors who depend solely on fee-for-service income who share offices with a nurse practitioner.

Doctors in private offices decide to work with NPs to extend care in their community. They may also do it because they enjoy collaboration and having someone else in the office. To some extent the nurse practitioner is there to back up the doctor – if the doctor is running behind on a particular day, she might take some of the people booked with the doctor.

An evolution of this practice in rural and northern communities has occurred. Nurse practitioners have set up practices, without having a doctor on-site. Their sponsoring organization has contracted with a doctor to provide one or two hours of consultation per week, at a set hourly remuneration. As part of the contract the doctor agrees to be available for a telephone consultation in the event of an emergency. These weekly consultations take place outside of the doctor's office and the nurse practitioner decides how she wants to spend the time and therefore money she is accountable for: it may involve the doctor seeing a few patients about specific issues that the NP would like to consult about; it may involve chart review and written consultation; it may involve review of tests and prescriptions that the NP thinks are needed but are beyond her scope of practice to order or prescribe. It clearly does not involve the doctor taking on more patients; the consultation is limited to the identified issue and the person does not enter the doctor's practice.

Some NPs work within the framework of the doctor's practice often as employees, particularly in private practices. Doctors apply for funding for these NPs in communities where improved service is required. In one PCN example the NP allowed for extended and Saturday hours in a non-urban area where medical access was limited. In another private practice, the NP played a role in health promotion that resulted in much improved health in the practice – e.g. more blood work coming back normal. The NP was also used to provide

home visits that otherwise could not occur. Collaboration is equally as successful in these practices.

Administration, that is the actual administration required by the province to report on the activity of the funded NP position, is identified as a huge burden in these practices. Clearly administration is a burden for the profession generally but in these practices there is neither the dedicated administrative staff nor the NP increased comfort with administrative tasks found in other environments. The NP is required to file logs that specify exactly how she is spending her time. While some indicated that they report at a high, more summary level, others file very detailed reports. These reports are time consuming and at least some are concerned that they raise patient confidentiality issues.

### **Physical Environment**

Office design can help or hinder the collaborative relationship. Some newer environments were designed specifically to enhance collaboration. Features of these workspaces include:

- In a CHC, GPs and NPs sharing an office
- In a private office, offices physically near each other and around examination rooms
- In a CHC, patient rooms in a semi-circle around a central area, facilitating communication and oversight
- Adequate IT and clerical support, including computer resources for all primary care providers

In other environments collaboration occurred almost in spite of the physical space. For instance, collaborating personnel were on different floors.

### **Personality**

Many of the RN(EC)s we interviewed shared certain traits and indeed, these traits are likely important for the success of their collaborative relationship. Given the variety of their practices, the GPs we spoke with had a wider variety of traits. Nevertheless, those in the most successful collaborative relationships also exhibited these traits:

- Confident
- Knowledgeable
- Forthright
- Good communication skills
- Comfortable with scope of practice
- Flexibility
- Organized
- Realistic
- Good clinical skills, or the ability to acquire them quickly

*Confident:* Primary care providers need to be confident in their own abilities in order to instill confidence in their clients and in the other professionals with whom they work. GPs interviewed are generally confident in their skills. Some NPs, especially those with less

clinical experience, are still developing the confidence they will need as their career advances.

*Knowledgeable:* An NP's knowledge has to cover all of the areas in which she practices within the scope of practice. This is also true of physicians. As well as basic primary care issues, a nurse practitioner's knowledge can include specific areas of public health (i.e. smoking cessation, sexual health, etc.). Practitioners' knowledge must include a good understanding of each other's scope of practice generally, and particularly the RN(EC) legal scope of practice. This is a basic building block – having it and communicating that you have it is not the same thing; but both are required.

In many relationships, this attribute includes the desire to gain more knowledge and expertise. Many nurse practitioners and doctors take team teaching, and learning, seriously and believe the opportunity to teach and learn from each other is a key benefit of the collaborative relationship.

*Forthright:* Doctors and NPs agree that they need to be open with each other and feel free to express their own views. In the event of a disagreement, both need to feel secure enough to talk about the issue and do so in a calm, professional manner. The Ontario College of Family Physicians' May 2000 paper "*Implementation Strategies: Collaboration in Primary Care – Family Doctors and Nurse Practitioners Delivering Shared Care*" identifies assertiveness as a necessary trait for a successful relationship. However, many view assertive as too strong a word to describe a successful relationship. Indeed, they see assertive as contrary to being a good team player. On a continuum aggressive is clearly an overstatement, likely so is assertive, and forthright is accurate. In CHCs especially, assertive is not always seen as a positive as it, to some, is contrary to the team approach.

*Good communication skills:* GPs and NPs both indicate that communication is key to the success of the relationship. As issues arise both partners must feel secure enough in the relationship to deal with them tactfully yet honestly; openly but discretely and as equals who respect each other. In situations where issues have not been dealt with the whole relationship suffers. Once the issue has been cleared up (by communicating) the relationship has been able to grow. The RN(EC) role is new and any one practitioner's success is ultimately based on her ability to win allies and build confidence in the role among clients, doctors, other RNs, administrators, pharmacists, social workers, etc. The first way for her to do this is to build support up-front through open dialogue about her role, what it means for the community and what she can and cannot do. It is important to set expectations accurately.

As the NP develops a client roster and relationships with one or more consulting GPs open and friendly lines of communication are critical. The fact is that it falls more on the NP to carry the burden of the doctor-NP relationship.

*Comfortable with scope of practice:* The NPs who are the most satisfied with their job and who have the best relationships with their physician partners with (as assessed by both themselves and the physicians) are those who are comfortable with their scope of practice. These are people who enjoy practicing in an extended role but who clearly see and are

comfortable with the boundaries. They want to consult; they do not want to be doctors nor do they view what they do as being a “mini” doctor.

A danger that some doctors identify is ‘how do you know what you don’t know’; that is, there is a fear that NPs will not always recognize situations in which a consultation is required. Doctors expressed that they are most comfortable working with NPs who they believe demonstrate good judgment and consult appropriately. The single largest issue of concern for doctors is NPs who do not consult frequently enough. The challenge can be that consultation is wanted from a theoretical perspective, but practically it can result in some frustration unless the system for consultation is well organized and both doctor and NP are flexible. Where a doctor’s practice is also busy, NPs understandably are careful to consult, only when they truly think it is necessary if it is during patient hours.

*Flexibility:* This is the attribute most consistently identified by NPs as being important. Flexibility arises in several circumstances:

- Seeing patients not booked for you if another person becomes backed up
- Working certain hours and locations in order to offer more opportunities for care
- Flexibility in thinking in order to diagnose appropriately when dealing with high needs patients (i.e. homeless, refugees)

Flexibility also was identified by some doctors. Flexibility is key to successful coordination. A flexible approach helps balance the need for autonomy with collaboration.

*Organized:* The NP is carrying on a practice often without the administrative support that a doctor takes for granted. And, in many circumstances the NP has additional administrative reporting responsibilities to the provincial government. Without superior organizational skills success is more difficult.

Because of the role consultation must play in her practice she needs to keep records that will allow the consultative process to flow smoothly. Clearly it is the responsibility of both the GP and the NP to keep records, however, in the practices we visited the NP has the primary responsibility for doing so. For NPs who do not have the luxury of having a doctor on premises, they need to make the best possible use of the scheduled time they have with a physician. This requires organization.

*Realistic:* Doctors – both GPs and specialists – RNs, administrators, pharmacists and patients are all learning what the RN(EC) designation means. Some NPs have a sense of impatience; they want to be fully accepted now. More however understand that it will take time before everyone understands and appreciates them and their role:

- 1) Presently, many (especially older) doctors still treat them in a hierarchical way. Hierarchy manifests itself both in issues of form and substance. Most NPs do not see hierarchy (especially issues of form) as a big issue.

- 2) Doctors spend little time strategizing how best to communicate with the NP they work with; NPs consider more carefully how they approach the doctor they work with. (This is somewhat less true in the CHC environment, which appears to be a more truly collaborative, equal setting).

While NPs might wish this were not the case, those who are happiest say they are realists – they know that progress is being made, focus their efforts where they can make the most difference, and accept that it will take time for the role to fully evolve and gain acceptance. They believe that over time cooperation will result in each other acknowledging and respecting each discipline’s approach to care.

*Good clinical skills, or the ability to acquire them quickly:* At the heart of the extended role is the ability of the nurse practitioner to function as a primary care provider. She needs to have good diagnostic and other clinical skills. Stating the obvious, without them she cannot succeed.

Some say they did not have as strong clinical abilities as they would have liked, when they first graduated. This first resulted in both themselves and the doctors they work with lacking sufficient confidence in their clinical acumen. Since graduation, their clinical abilities have strengthened. The key is working with a doctor who is willing to assist them in honing these skills. As long as they are able to hone these abilities within a year they are demonstrating the acumen required. In the beginning of collaboration, especially for those NPs who feel their clinical skills need honing more consultation will be required and thus it is important to be in a job that allows this to happen.

She also needs the self-confidence to trust her instincts in this area. Many say that at the beginning they thought they knew what the answer was but that they called the doctor in for a confirmatory consult. As they gained experience this type of consultation was eliminated.

### **Structural Observations**

The structure of the delivery of primary healthcare in this province remains predominantly fee-for-service. Almost all noted (on an unprompted basis) that the RN(EC) program does not make sense in a fee-for-service model. Fee-for-service physicians are not remunerated for the informal consultation that is the hallmark of the best collaborative relationships and this is reflected in the relatively small number of wholly fee-for-service physicians who work with nurse practitioners.

Nurse practitioners are making their mark in serving under-served communities by providing care to individuals who would not otherwise receive consistent primary healthcare. They are succeeding in CHCs, generally serving the urban poor, and in rural and northern communities. They are also succeeding at LTCFs, where stable residents tend to be under-served.

Funding from the province for NP positions is based on proposals. In the ideal situation, the NP who will do the work is involved in the proposal. This ensures a fit of skills and interests. Where there have been issues at LTCF facilities, it has been because the administration did not fully support the proposal. Good support constitutes advocating for the RN(EC) within the facility. Many are still not familiar with what an RN(EC) does and how this position is different from an RN's position. Without administrative support and direction staff (medical, nursing and other) are sometimes resistant to welcoming this new role in the institution. Where there has been administrative support the NP has been able to do the job she wants to do more quickly and more easily.

Provincial administrative requirements are onerous and reporting takes a lot of work and time. There is limited administrative support for RN(EC)s. Therefore, the "paperwork" takes NP time, time that could be spent seeing additional patients. Provincial paperwork required can include a log of patients seen and also a variety of statistics (that the NP collects) including on patient load and outcomes. One NP noted that she had "binders" of data collected for purposes of provincial reporting.

## SUMMARY AND CONCLUSIONS

Almost all of the NP-GP pairs we interviewed said they have a good working relationship. The RN(EC) program has been very successful throughout the province in Long Term Care facilities and Community Health Centres and, in more remote communities especially, private offices. The structure of the delivery of primary healthcare in this province remains predominantly fee-for-service. Almost all noted (on an unprompted basis) that the RN(EC) program does not make sense in an unmitigated fee-for-service model.

There are two distinct ways at looking at RN(EC)s' delivery of primary care, with each perspective being held by some doctors and some nurse practitioners:

- NP delivery of primary care is essentially *different* than a GP's because the nursing perspective is different, as it includes a focus on wellness and health promotion
- NP delivery of primary care is essentially the *same* as a GP's, although limited to the scope of practice

Responsibilities within a collaborative practice need to be clearly thought out. Where there has been discussion over who does what there was general satisfaction. Where it has happened haphazardly there has been some level of dissatisfaction by both NPs and GPs over the complexion of their patient load.

Possible models for patient allocation in a shared physical environment (CHC, community clinic or private office) include:

1. NP takes all new clients until her practice fills up. New clients with issues beyond her scope of practice are referred elsewhere. Doctor retains existing client base.
2. NP takes all clients (new and existing) within her scope of practice. Doctor's practice becomes restricted to more complex cases.
3. NP restricts her practice to more straightforward issues, for instance well women and well babies. Doctor has a more varied practice.
4. NP and Doctor both take on varied patients. Consultation as required.

The last option is usually the most satisfying for both parties. To make this work, good triage is required. Office design can help or hinder the collaborative relationship. Some newer environments were designed specifically to enhance collaboration.

Consciously developing and evolving the relationship is important for success. We have identified nine themes that need to be explicitly dealt with if the relationship is to work:

1. Mutual respect and trust
2. Recognition of (unique) expertise of NP
3. Understanding of NP's scope of practice
4. Good team structure – but limit the size and number of teams
5. Understanding of legal responsibility

6. Dealing with hierarchy
7. NP practical experience – diagnostic skills
8. Understanding RN(EC) solution is about access not cost
9. Shared values

Given the newness of the designation and the fact that the success of the professional relationship is usually more important to the NP than the GP (as she needs a collaborating physician to practice), it is up to the NP to carry the relationship.

The most successful collaborative relationships involve partners who display the following traits:

- Confident
- Knowledgeable
- Forthright
- Good communication skills
- Comfortable with scope of practice
- Flexibility
- Organized
- Realistic

The most frequently identified areas for improvement by NPs and GPs are almost all under the control of the provincial government:

- Funding for program enhancement or continuation
- Funding for administration
- Amendment of the scope of NP practice to update the list of drugs that RN(EC)s are authorized to prescribe
- Amendment of referral policy so that specialists are paid the same whether the referral comes from a GP or an NP

The second type of improvement identified was mostly mentioned by NPs and involves, at a minimum enabling NPs to practice to their full scope. These identified improvements would address sources of frustration in their practice. NPs and GPs both enjoy the consultative nature of their work. However, some NPs sometimes feel that the system requires them to consult more frequently than their practice judgment dictates. To deal with this issue some identify putting in place medical directives and moving to more hallway or written consultation and less patient examination by the GP.

Doctors who work with RN(EC)s are supportive of the role and believe working in this type of relationship has enhanced their practice and the delivery of primary care to their patient population. Nevertheless, many report two issues of concern that they would like to see addressed. Firstly, they do not have a clear understanding of GPs' legal responsibility and liability when they work with an NP. This is at least partially a communications issue.

Secondly, (and this is concern is linked to the first concern) GPs also worry about the extent of consultation and frequently say they would prefer to be seeing more not fewer of the NP's complex patients. They want to know what is going on in the nurse

practitioner's practice and they want to be comfortable that the right decisions are being made, especially in cases where they share patients and liability. This is clearly the case where the relationship is new, but remains something some think about even in longstanding relationships. At the same time, they have busy practices of their own and they do not want to be consulted about issues that fall squarely within the nurse practitioner's scope of practice. Over time, as trust develops consultation generally appropriately diminishes.

Consultation occurs in many different ways:

- In person: hallway, planned meeting, patient examination
- Telephone: scheduled, emergency
- Written: binders, charts, referrals/prescriptions/tests, notes

Different practices rely on each of these methods to a different extent. Collaborating partners work together to determine what mix is right for them.

It must be remembered that the RN(EC) designation is relatively new and models to optimize the role, from a practice perspective, are still being worked out. It seems that the early graduates of the program were often very mature, very experienced RNs, many of whom had outpost experience. As this pool of candidates goes through the program, thought needs to be given as to how other younger, less experienced candidates can perform confidently. They will need to select jobs in which their collaborating physician(s) is willing to assist them in honing skills in their first year of practice.

The NP-GP relationship is a teaching and learning one. And, most believe the teaching goes both ways. The opportunity to learn from each other, to collaborate on complex cases and issues is a key benefit in working in this type of relationship.

Nurse practitioners say that the current relationship is consultative. They would like to see it evolve into a collaborative one. This change will require doctors to appreciate the unique expertise of nurse practitioners and to see them as adding a unique skill set into a primary care practice.

A collaborative practice is one without hierarchy. It is one in which both the GP and the RN(EC) are equally involved in planning for the practice and planning for more complex patients' care. It is one that builds in time for the free exchange of ideas, meaningful discussion and mutual consultation.

**APPENDIX A**  
**Discussion Guides**

## **Discussion Guide Notes**

1. Each participant will only hear the introduction once. For the first group of doctors or nurses it will be given at the beginning of the 45 minute discussion. For the second group of doctors or nurses, who participate in a joint discussion first, the introduction will be completed in advance of the joint discussion. Quick introductions also will take place at the beginning of joint discussion so all are familiar with each other.
2. There is some repetition in questions for the doctors/nurses guides, and the joint guide. The intent is to fully probe on collaboration. Speaking with GPs and NPs without their working partner on collaboration is essential in order to understand their profession-specific issues of making the partnership work, including potential challenges. Interviewing together on collaboration will not only provide an understanding of their interaction, but also will enable a productive interactive discussion.
3. Emphasis will be placed on questions as appropriate for NPs and GPs.

## **Discussion Guide (Nurse Practitioners)**

### **Introduction (5 minutes)**

- Introduce self, research process including confidentiality
- Name, kind of practice you are in, length of time in collaborative practice, how many people do you work with/how many sites?

### **General (15 minutes)**

- How did you end up working together?
- What are your responsibilities as an NP? What are the responsibilities of the GPs you work with?
  - Does the division make sense? Why? Why not? Probe on scope of practice, skills.
  - What are your areas of exclusive practice?
  - Are there clear delineations of responsibility? Probe on types of care (curative and rehabilitation care, disease prevention, supportive care). Probe on triage.
  - Is there overlap in what you do? Has it been worked out? If yes, how? If no, what are the barriers to a successful solution?
- What motivated you to work in this type of partnership?
  - Probe on benefits - lifestyle, practice-style benefits (opportunities for growth), better care for patients, IT, income, share call and coverage for absences, disease management v. patient care
  - Probe on challenges - administrative demands, IT, patient rostering, dealing with the Ministry (*benefits and challenges to be reviewed*)
- What do you think joint responsibility means? - Probe for specific examples
- Probe to determine structural differences

### **Practice Particulars (10 minutes)**

- How do patients get assigned?
  - How is this communicated/explained to the patient?
  - What does it mean to share patient responsibility? Probe on medicolegal responsibilities. Are patients linked primarily with one or the other? If so, how does it work?
- What are the on-call patterns?
  - Has this changed overtime? If yes how?
  - If you are not doing on-call patterns, why not? Probe on interest.
- What is workable ratio for the setting you are in?
- How should collaboration be funded? Probe on current funding mechanism.
- Probe to determine structural differences.
- How does the practice work with other professionals in your office?

## Collaboration (15 minutes)

- What constitutes successful collaboration? (Probe on communication, mutual trust, respect, collegial aspect of relationship, supervision) (Also Probe on Seven Essential Elements of Collaborative Practice – responsibility/accountability, coordination, communication, cooperation, assertiveness, autonomy, and mutual trust)
- What constitutes unsuccessful collaboration?
- I'd like to focus on specific examples: What has worked? Why? – Probe for specific example
- What has not worked? Why? – Probe for specific examples
- How is planning done for the practice? How has it evolved? How much time do you spend per day with your GP? How do you spend that time? Is the process formal or informal? Is there joint planning? What should the process be?
- How has the relationship evolved?
  - What is different now from when you first began working in this relationship?
  - What would you like to see happen in the next year?
- Probe to determine structural differences.

## **Discussion Guide (General Practitioner)**

### **Introduction (5 minutes)**

- Introduce self, research process including confidentiality
- Name, kind of practice you are in, length of time in collaborative practice, how many people do you work with/how many sites?

### **General (15 minutes)**

- How did you end up working together?
- What are your responsibilities as a GP? What are the responsibilities of the NPs you work with?
  - Does the division make sense? Why? Why not? Probe on scope of practice, skills.
  - What are your areas of exclusive practice?
  - Are there clear delineations of responsibility? Probe on types of care (curative and rehabilitation care, disease prevention, supportive care). Probe on triage.
  - Is there overlap in what you do? Has it been worked out? If yes, how? If no, what are the barriers to a successful solution?
- What motivated you to work in this type of partnership?
  - Probe on benefits - lifestyle, practice-style benefits of working with nurse practitioners (opportunities for growth), better care for patients, IT, income, share call and coverage for absences, disease management v. patient care
  - Probe on challenges - administrative demands, IT, patient rostering, dealing with the Ministry,
- What do you think joint responsibility means? - Probe for specific examples
- Probe to determine structural differences

### **Practice Particulars (10 minutes)**

- How do patients get assigned?
  - How is this communicated/explained to the patient?
  - What does it mean to share patient responsibility? Probe on medicolegal responsibilities. Are patients linked primarily with one or the other? If so, how does it work?
- What are the on-call patterns?
  - Has this changed overtime? If yes how?
  - If you are not doing on-call patterns, why not? Probe on interest.
- What is workable ratio for the setting you are in?
- How should collaboration be funded? Probe on current funding mechanism.
- How does the practice work with other professionals in your office?

## **Collaboration** (15 minutes)

- What constitutes successful collaboration? (Probe on communication, mutual trust, respect, collegial aspect of relationship, supervision) (Also Probe on Seven Essential Elements of Collaborative Practice – responsibility/accountability, coordination, communication, cooperation, assertiveness, autonomy, and mutual trust)
- What constitutes unsuccessful collaboration?
- I'd like to focus on specific examples: What has worked? Why? – Probe for specific example
- What has not worked? Why? – Probe for specific examples
- How is planning done for the practice? How has it evolved? How much time do you spend per day with your nurse practitioner? How do you spend that time? Is the process formal or informal? Is there joint planning? What should the process be?
- How has the relationship evolved?
  - What is different now from when you first began working in this relationship?
- Probe to determine structural differences.

## **Discussion Guide (Joint)**

### **Introduction (5 minutes)**

- Introduce self, research process including confidentiality
- Name, kind of practice you are in, length of time in collaborative practice, how many people do you work with/how many sites?

### **General (15 minutes)**

- What are your responsibilities of GP and NP in a joint practice?
  - Are there clear delineations of responsibility? Probe on types of care (curative and rehabilitation care, disease prevention, supportive care)
  - Is there overlap in what you do? Has it been worked out? If yes, how? If no, what are the barriers to a successful solution? How can these barriers be overcome? (Probe on medicolegal responsibilities)
- What is workable ratio for the setting you are in?
  - What makes that ratio workable? – Probe fully on what is best and why
- Probe to determine structural differences.

### **Collaboration (25 minutes)**

- What constitutes successful collaboration generally and in your practice?
  - What are the key components of successful collaboration – probe on joint planning, sharing of joint responsibility, organization of practice, funding communication, mutual trust, respect, collegial aspect of relationship, on-call patterns
  - (Also Probe on Seven Essential Elements of Collaborative Practice – responsibility/accountability, co-ordination, communication, cooperation, assertiveness, autonomy, and mutual trust)
- What constitutes unsuccessful collaboration generally and in your practice?
  - What are the key components of successful collaboration – probe on joint planning, sharing of joint responsibility, organization of practice, funding communication, mutual trust, respect, collegial aspect of relationship, on-call patterns
- I'd like to focus on specific examples: What has worked? Why? – Probe for specific example
- What has not worked? Why? – Probe for specific examples
- How is planning done for the practice?
  - How has it evolved?
  - Is the process formal or informal?
  - Is there joint planning?
  - What should the process be?
- What is different now from when you first began working in this relationship?
  - Assessment of relationship (past, present, future)
- What are the opportunities for improvement?

- Are there tools that assist in making the practice better? (Probe on training, computer programs, etc)
- What constitutes an “ideal” collaborative group
  - What do you believe constitutes a success story? – Probe on access, quality and continuity of care, patient and provider satisfaction, and increased cost-effectiveness of health care services, collegial aspect of relationship, supervision
- Probe to determine structural differences.

**APPENDIX B**  
**Interviewees – by Geography**

### INTERVIEWEES – BY GEOGRAPHY

	Toronto & Area	Kingston & Area	London & Area	Sudbury & Area
TOTAL	11	9	8	4

**APPENDIX C**  
**Interviewees – by Practice Type**

**INTERVIEWEES – BY PRACTICE TYPE**

	CHC	PCN	LTCF	Private Office	Other
TOTAL	11	4	5	5	5