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The expected, enacted and desired role of family practice nurses in family medicine groups as perceived by nurses and family physicians

Le rôle attendu, joué et souhaité des infirmières en groupe de médecine de famille : les perceptions des infirmières et des médecins de famille

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Keywords

nurse's role;
family medicine
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Abstract

Introduction: Family practice nurses (FPNs) have been integrated into family medicine groups (FMGs) to improve access to primary care and services. However, FPN workforce development was operationalized without a clear definition of its scope of practice, leading to misunderstandings regarding the achievement of an optimal interdisciplinary teamwork. **Objective:** To describe the perceptions of the expected role of FPNs by FMG nurses and head physicians in order to better understand the influence of such perceptions on the enacted and desired role of FPNs in FMGs. **Methods:** Using a descriptive interpretive qualitative approach (Thorne, 2016), 8 registered nurses and 4 head physicians in FMGs were interviewed individually between December 2018 and February 2019. Data were analyzed using the Miles, Huberman and Saldaña's (2014) method. **Results:** Both groups believe that the expected role of FPNs is to facilitate access to care, as FMGs are one of the entry points into the healthcare system. While several nurses and head physicians perceive that they work collaboratively, hierarchical organizational relationships still continue to shape the enacted role of nurses. Task delegation and subordination activities are more prevalent than integrated collaboration and complementary activities within the interprofessional team. Both groups express different strategies to promote a more effective interdisciplinary teamwork. **Discussion and conclusion:** All stakeholders must support an optimal interdisciplinary teamwork and maximize the contribution of FPNs to increase patient access to primary care and services.

Résumé

Introduction : Les infirmières ont été intégrées dans les groupes de médecine de famille (GMF) pour faciliter l'accès aux soins et services de première ligne. Cependant, l'absence de définition du champ de pratique de l'infirmière en GMF a compliqué le déploiement de son rôle et celui d'un travail interdisciplinaire optimal. **Objectif :** Décrire les perceptions associées au rôle attendu des infirmières en GMF par les infirmières et les médecins responsables des GMF afin de mieux comprendre l'influence de ces perceptions sur le rôle joué et souhaité de ces infirmières. **Méthodes :** Une recherche qualitative descriptive interprétative (Thorne, 2016) a été réalisée pour recueillir les perceptions des infirmières et des médecins. De décembre 2018 à février 2019, 8 infirmières et 4 médecins responsables en GMF ont été interrogés. Les données ont été analysées selon Miles, Huberman et Saldaña (2014). **Résultats :** Les deux groupes perçoivent que le rôle attendu des infirmières en GMF est de faciliter l'accès aux soins, puisque les GMF sont l'une des portes d'entrée du système de santé. Bien que plusieurs infirmières et médecins responsables rapportent avoir l'impression de collaborer, les relations hiérarchiques continuent de façonner le rôle des infirmières. La délégation d'activités de soins des médecins aux infirmières est plus fréquente que les activités professionnelles complémentaires. Les deux groupes ont exprimé différentes stratégies afin de promouvoir une collaboration interprofessionnelle plus efficace. **Discussion et conclusion :** Toutes les parties prenantes doivent soutenir un travail d'équipe interdisciplinaire optimal et maximiser la contribution des infirmières en GMF pour accroître l'accès des patients aux soins et services de première ligne.

Mots-clés

rôle infirmier;
groupe de
médecine de
famille;
collaboration
infirmière-
médecin; soins
primaires;
recherche
qualitative

INTRODUCTION

In recent decades, different types of primary care settings have been created across the world, forcing the emergence of new professional roles (Aggarwal et Hutchinson, 2012). In the early 2000s, family practice nurses (FPNs) workforce—also known as primary care nurses (Canadian Family Practice Nurses Association, 2019) or general practice nurses (Aerts et al., 2020; McCarthy et al., 2012; McInnes et al., 2016)—was powered by financial incentives offered by governments to private medical clinics to increase their capacity to provide primary care (Breton et al., 2011; McInnes, Peters, Bonney, & Halcomb, 2017a). Nevertheless, FPN workforce development was planned without a clear definition of its scope of practice (Halcomb et al., 2016; Martin-Misener & Bryant-Lukosius, 2014; Poitras, Chouinard, Fortin, Girard et al., 2016b). Existing literature describing nursing activities in primary care medical settings in Canada and abroad (including Australia and the United Kingdom) suggests that the role of FPNs remains misunderstood (Bauer & Bodenheimer, 2017; McInnes et al., 2016; Oelke et al., 2014) and that role enactment varies from one setting to another (Halcomb et al., 2014; Norful et al., 2017; Poitras, Chouinard, Gallagher et al., 2018b), resulting in the underutilization of FPNs.

In fact, Canada was lagging behind other countries in terms of defining family practice nursing competencies at the national and provincial levels (Lukewich et al., 2018). While the Canadian Family Practice Nurses Association (CFPNA) was established in 2008 (Lukewich et al., 2018), it is only in December 2019 that the National Competencies for Registered Nurses in Primary Care was published. This document lays out a defined set of competencies to provide role clarity and to facilitate collaboration within primary care teams (Lukewich et al., 2020). Across jurisdictions in Canada, there is also variability in the integration of FPNs and guidance for their practice. Registered nurses in primary care have completed either a college diploma or baccalaureate degree. To practice in family medicine groups (FMGs) in Quebec, Canada,

nurses must have a bachelor's degree in nursing, as in all provinces/territories (Lukewich et al., 2018). The integration of registered nurses in FMGs dates back to the early 2000s. However, only in September 2019 was the *Guide pratique à l'intention des infirmières cliniciennes qui travaillent dans un groupe de médecine de famille ou un groupe de médecine de famille universitaire* (i.e. guidelines for the expected practice of nurses in FMGs) actually published (*ministère de la Santé et des Services sociaux* [MSSS], 2019b). Both documents suggest that FPNs function as generalists: in partnership with family physicians, nurse practitioners and other health professionals, they provide a broad range of primary care and services, including health promotion and disease prevention (Canadian Family Practice Nurses Association [CFPNA], 2019). Also, FPNs contribute to follow-ups for episodic and chronic conditions of individuals of all ages and families across the life span (CFPNA, MSSS). FPNs take care of and follow-up on patients according to health needs, but medical assistance does not fall within their role (MSSS).

A scoping review by Roy (2015) identified that in order to promote the scope of practice of nurses, it is necessary to better understand the roles and responsibilities of each professional in the team to achieve an optimal interdisciplinary teamwork. It is known that FPN role enactment is negotiated through interactions between nurses and family physicians, and that role perception has a major impact on the professional nursing practice, on task sharing in interdisciplinary teamwork settings and, consequently, on public-oriented care and services (Aerts et al., 2020; Karimi-Shahanjarin et al., 2019). However, limited attention has been given to understanding the organizational components and the socio-professional and socio-political dynamics that enhance or limit role enactment of FPNs in FMGs.

OBJECTIVE

The objective of this study was to describe the perceptions of the expected role of FPNs by FMG nurses and head physicians in order to better understand the influence of such perceptions on the enacted and desired role of FPNs in FMGs.

METHODS

STUDY DESIGN

This qualitative research used an interpretive descriptive design as described by Thorne (2016). The interpretative dimension of the design lies in seeking explanations in order to understand the significance of the phenomenon of interest (Thorne, 2016; Thorne et al., 1997; Thorne et al., 2004). By exploring personal experiences, this design helps clarify the meaning of the phenomenon by highlighting the points of view of the various actors involved in it (Gallagher, 2014).

SETTING

This study focuses on the FMGs of the province of Quebec (Canada). Before the early 2000s, primary medical care was delivered through a network of private clinics across the province. FMGs were later created following lengthy negotiations between family physicians and government officials (Breton et al., 2011). FMGs use a traditional fee-for-service payment model and receive a population-based supplement to enable family physicians to employ FPNs and, when it is the case, other healthcare professionals. All healthcare professionals, except family physicians, are salaried employees of the healthcare organization in their FMG's local jurisdiction (Breton et al., 2011; Pomey et al., 2009). Also, the government has imposed the co-management of such professional resources: the hierarchical authority comes from the public healthcare system managers working in the healthcare organization (management of professional and financial resources) whereas the functional authority emanates from the FMG head physician (management of the daily activities of professionals) (*ministère de la Santé et des Services sociaux* [MSSS], 2016). There are over 350 FMGs across the province of Quebec, Canada (*ministère de la Santé et des Services sociaux* [MSSS], 2019a). The number of health providers varies from one FMG to the next, as does the number of registered patients (*ministère de la Santé et des Services sociaux*, 2017b).

SAMPLE AND RECRUITMENT

We used a non-probability purposive sampling method to fully understand the phenomenon as lived by the participants presenting various experiences and characteristics (Gallagher, 2014). In addition to the FMG nurses, FMG head physicians were targeted to participate in this study given their functional authority over the practice of nurses, as explained above. A total of 12 participants (eight nurses and four head physicians) were recruited in a remote and rural region of the province of Quebec, Canada. The number of registered patients in FMGs is ranged from 2,589 to 31,137, and the FMG network covers 57,337 km² with a population of 147,542 registered patients (2.6/km²) (Institut de la statistique du Québec, 2020).

An initial contact by the first author (AB) was established with the Assistant Director of Nursing responsible for primary care and services, and the head physician of each FMG, to explain the study and obtain their approval to recruit nurses and head physicians. Then, a cover letter was then sent to all nurses who met the inclusion criteria to inform them that they would be contacted for recruitment. Upon contact, the first author (AB) explained the different stages of the study as well as the expected involvement of the participants. This study garnered a great deal of interest among FMG nurses and head physicians; the number of positive responses exceeded the number of targeted participants. That said, 12 participants were selected based on several characteristics (age, years of experience, size of the FMG) in order to achieve a highly diverse sample.

STUDY FRAMEWORK

The study framework combines two components: the theoretical framework of Kahn, Wolfe, Quinn and Snoek (1964), referred to as "Role Episode" and the professional practice schematization of Poitras, Chouinard, Fortin, and Gallagher (2016a).

First, the Role Episode model recognizes that the enactment of a role is influenced by several members in an organization. All members express role expectations, explicitly or implicitly, based on their perceptions and available information (e.g.,

legislation) (Kahn et al., 1964). This is followed by an enactment of the role that can be compliant or not (i.e., desired role) generating member feedback and, therefore, creating subsequent expectations (i.e., role episodes) (Kahn et al.). The components known to impact interactions between members and shape role enactment are threefold: personal, organizational and relational (Katz & Kahn, 1978). The Role Episode diagram along with a breakdown and explanation of the connections between its components are available in Katz and Kahn (1978).

Second, the professional practice schematization as defined by Poitras et al. (2016a)

allows for the inclusion of the conceptual and operational dimensions of the role in a structure for describing nursing professional practice (Figure 1). The main concepts of the hierarchical representation are role (function assumed by the nurse), domain (group of activities of the same nature) and activity (interventions or tasks undertaken by the nurse) (Poitras et al.). For this study, these three concepts were used to operationalize the enacted role of nurses.

Table 1 provides the definitions of the concepts used. They are drawn from the combined frameworks of the study.

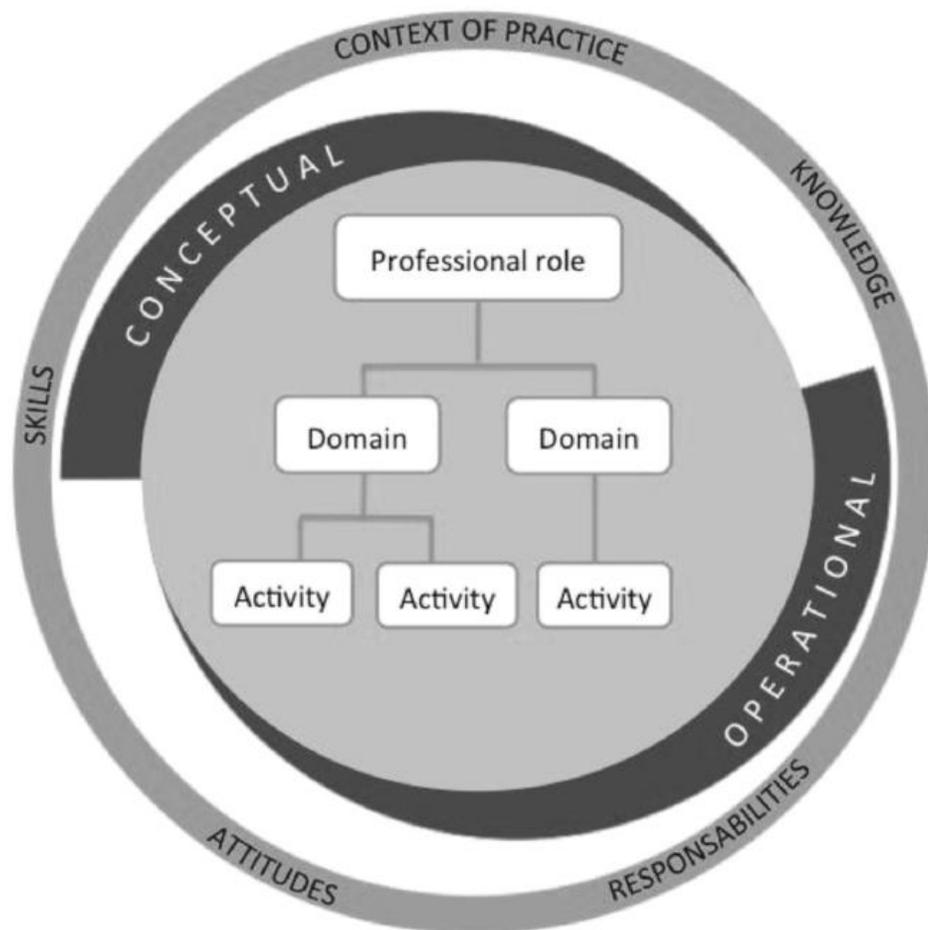


Figure 1. Structure for the description of professional practice in nursing (Poitras et al., 2016a)

Table 1

Concepts definitions drawn from the Khan et al. (1964) and Poitras et al. (2016a) frameworks

Concepts	Definitions
Expected role	Role defined as a function (i.e., conceptual definition) to be performed in a given position within an organization according to professional standards, legislative frameworks, scope of practice and social systems.
Enacted role	Role defined by domains (set of activities of the same nature) of activity falling within a position in an organization (i.e., operational definition) in adequacy or not with the expected role.
Desired role	Role that is wished to be enacted, arising from personal and professional expectations, needs and aspirations in adequacy or not with the expected and enacted role.

DATA COLLECTION

Between December 2018 and February 2019, individual semi-structured interviews were conducted with participants. For each group, guides were developed following a literature review on the existing role of FPN and supported by the study's specific framework. The recorded interviews were conducted in French and lasted 45 to 60 minutes.

DATA ANALYSIS

Verbatim transcripts were thoroughly analyzed in order to extract the dominant themes and understand their meaning. Three major steps were used following Miles, Huberman and Saldaña's (2014) approach: data condensation, data display and conclusion drawing/verification. The first author (AB) developed a mixed coding grid based on the study's framework (Miles et al., 2014). On the one hand, the model of Kahn et al. (1964) made it possible to compare the perceptions of FMG nurses and that of head physicians, and to assess the influence of such perceptions on the role that nurses should perform (expected), the role they perform (enacted) and the role the participants would like them to perform (desired). On the other hand, the Poitras et al. (2016a) framework made it possible to link the list of activities to the operational definition of the role (i.e., enacted role). Then, grouping the activities by domain allowed the creation of a conceptual definition to identify the expected role.

The grid was validated by all the authors and a multiple coding exercise was performed (Miles et al., 2014). Then, a schema inspired by the combined frameworks was developed (Miles et al.,

2014) to draw connections between the concepts and go beyond descriptive investigation.

Follow-up validation interviews were conducted to corroborate the interpretation of the data (Grove et al., 2013). Through an iterative process, a graphic representation of each interview was emailed to each participant who was asked to comment or propose edits as needed. Then, a short telephone discussion was conducted with each participant to collect any comments and/or modifications. Seeking feedback from the participants ensured that verbatim analyses reflected the expressed perceptions. Moving back and forth between the raw data and the analyzed data ensured the consistency of the conclusions (Miles et al., 2014). Finally, for this paper, verbatim transcripts were carefully translated into English to maintain their meaning.

ETHICAL CONSIDERATIONS

The research project was approved by the research ethic committee of a *Centre intégré de Santé et de Services sociaux* and that of a university part of the network of the *Université du Québec*.

RESULTS

SAMPLE CHARACTERISTICS

Eight nurses and four head physicians from five different FMGs took part in the interviews. The number of nurses in each of the FMGs varied (two to seven nurses) according to the number of registered patients. The majority of FMGs were integrated into a University family medicine group.

Table 2 presents the characteristics of the participants.

The study shows similarities and differences in perceptions between FMG nurses and head physicians regarding the role of FPNs in FMGs. The reported perceptions were grouped under three concepts inspired by the study's combined framework: expected role, enacted role and desired role. Table 3 presents a schematic synthesis of the perceptions expressed by FMG nurses and head physicians regarding the role of FPNs.

EXPECTED ROLE

Nurses reported the absence of a clearly defined nursing role and practical guidance. For some nurses, this misunderstanding regarding the role definition is due to the lack of clear recommendations regarding the activities dedicated to nurses. "Honestly, we were left to

ourselves. We didn't know what to do and we didn't know where to get the information," said Nurse 6. The expected role is also influenced by a lack of knowledge of the way family physicians work with nurses. Many family physicians used in admitted that they had difficulty considering how to develop teamwork with nurses: "We didn't really know whatever we got into [with the FMG], it was a change of [solo] practice [...] and the role [of the nurses] was not clear, so neither were the expectations nor what we do" (Head Physician 2).

Nurses and head physicians found the role was still unclear for them and still developing according to the evolving expectations of the health authorities surrounding primary care organizations. Nevertheless, considering that FMGs are one of the population's entry points into the healthcare system, nurses and head physicians described the overarching role of nurses in FMGs as facilitating access to primary care.

Table 2

Characteristics of FMG nurses and head physicians

Characteristics	Participants (n = 12)			
	Nurses (n = 8)		Physicians (n = 4)	
	n	(%)	n	(%)
Age group				
20-29	1	(12.5)	0	(0.0)
30-39	2	(25.0)	1	(25.0)
40-49	3	(37.5)	1	(25.0)
50-59	2	(25.0)	2	(50.0)
Years of experience as a nurse or a family physician				
5-10	1	(12.5)	1	(25.0)
11-15	2	(25.0)	0	(0.0)
16-24	3	(37.5)	2	(50.0)
25 and more	2	(25.0)	1	(25.0)
Years of experience as a nurse in the FMG or as a FMG's head physician				
≤ 4	3	(37.5)	2	(50.0)
5-7	0	(0.0)	0	(0.0)
8-10	2	(25.0)	1	(25.0)
11-15	3	(37.5)	1	(25.0)

Table 3

Schematic synthesis of the perceptions expressed by FMG nurses and head physicians regarding the role of FPNs

Nurses	Common perceptions	Head physicians
<p>Expected role</p> <ul style="list-style-type: none"> • Absence of clearly defined nursing role and job descriptions • Health care accessibility <p>Enacted role</p> <ul style="list-style-type: none"> • Collaborative or supportive role within the medical team • Broad range of activities; can lead to comparisons and tensions between nurses • Patient consultations by medical reference mainly • Need to meet the expectations of physicians to promote collaboration <p>Desired role</p> <ul style="list-style-type: none"> • Inclusion in the management collaborative team • Greater involvement and autonomy in patient care 	<p>Expected role of FPNs in FMGs</p> <p>Facilitate accessibility to primary health care and the health system</p> <p>Enacted role of FPNs in FMGs</p> <p>Organization of the practice of family medicine</p> <p>Government requirements</p> <p>Domain: Prevention and health promotion</p> <p>Domain: Assessment and care planning</p> <p>Domain: Communication and coordination of care</p> <p>Desired role of FPNs in FMGs</p> <p>Need a common understanding of the role</p> <p>Enhance full enacted scope of practice</p> <p>Effective collaboration</p>	<p>Expected role</p> <ul style="list-style-type: none"> • Integration of nurses represented a change in family medicine • Contribution to the accessibility of care provided by the physician <p>Enacted role</p> <ul style="list-style-type: none"> • Collaborative role in the medical team • Opportunity to fill gaps in continuity of care and compensate physician work overload • Lack of nursing resources to meet the demand for care <p>Desired role</p> <ul style="list-style-type: none"> • Switch to a more generalist practice instead of being limited to disease-centred practice • Increase the appointments throughput to facilitate access to care in the FMG

On the one hand, for nurses, the notion of accessibility referred to facilitating accessibility for the patient. As these nurses reported, FPNs hold a strategic position in referring patients to the right professionals or services in the healthcare system according to their health needs, thus enabling a judicious use of resources. “Nurses can do a lot for most patients, so that each patient is placed in the right place, so that physicians can see patients when it is really needed, essentially so that access is better for healthcare,” explained Nurse 1. “So it’s us who will start to refer our patients to the right professionals to help them,” expressed Nurse 7. On the other hand, for some head physicians, the notion of accessibility seemed to refer to the nurse’s contribution to the accessibility of care provided by the family physician. “The biggest added value is that patient services have improved. Accessibility with [our nurses] [...] because they can’t reach me when I’m in the hospital,” said Head Physician 1. “The overload that physicians have right now does not allow us to offer this continuity of care too [...] when physicians cannot see their patient because they are elsewhere, busy or all that, the nurses are there,” described Head Physician 3.

ENACTED ROLE

Nurses and head physicians identified two organizational factors explaining the influence of the context on the professional practice of nurses in FMGs. First, nurses and head physicians reported that the activities of nurses depend on the fact that many family physicians also have a hospital practice which limits the number of days spent in the FMG office:

What physicians found difficult was that not only did they have office consults, but they also work in hospitals, emergency departments and long-term care facilities for the elderly. [...] So what’s been put in place is that everything that can be referred to the nurse is referred to the nurse (Nurse 2).

They also explained that family physicians have different expertise and nurses saw patients mostly by referral:

But there are clinics that do more perinatal care, this nurse will do more pediatrics. There is one clinic that has less pediatrics but was

taking care of more new patients. [...] They were saying, “But you can help me by updating his file, collecting it, collecting data, and then the list of problems.” [...] So the role is somewhat modulated by the needs of each clinic (Head Physician 3).

Second, given that the provincial government demands that family physicians provide more primary care in exchange for subsidies, nurses and head physicians noted the use of medical assistance as a strategy for fulfilling these obligations, which unfortunately does not adequately support the role enactment. “It was [the walk-in clinic, i.e., taking vital signs] that was prioritized because there were government standards for the FMG to be reappointed or renewed,” reported Nurse 7. In addition, head physicians noted that the ratio of nurses funded in each FMG was not adequately compensated to meet the demand for care. “The gaps are in terms of availability and time, because we can’t hide the fact that we don’t have a nurse assigned to each physician... They are completely overloaded,” said Head Physician 3.

To describe the enactment of the role, nurses and head physicians listed a broad range of activities. For example, it was said that all nurses contribute to the management of chronic diseases (diabetes, hypertension, dyslipidemia), the assessment of cognitive disorders and the triage of the walk-in clinic. Few nurses contribute to the follow-up of pregnant women and babies, screening for sexually transmitted diseases and family planning. Also, some nurses help with minor surgery and perform blood tests and blood pressure monitoring. All activities were grouped under three domains: prevention and health promotion, assessment and care planning, and communication and coordination of care. This variability was perceived negatively by nurses because it leads to comparisons and creates tensions between them. “I’m afraid the physicians will make us compare ourselves. You know, how many patients she has on her schedule and everything. But I think it’s also a question of the physicians’ demand,” reported Nurse 6. While several nurses and head physicians perceived that they work together collaboratively, hierarchical relationships still continue to shape the role of

nurses in the organization. Task delegation from family physicians to nurses is more prevalent than integrated interprofessional collaboration. Nurses disapprove of being excluded from the management team and not being consulted for decisions regarding their own practice. “But it’s certain that if, in the executive management, they do not see this need, [...] it may not develop as much. Of course, perhaps when [...] others take their place, maybe the vision will change too,” said Nurse 2. Also, nurses reported that they felt they had to submit to the family physicians’ expectations (often heterogeneous) to stimulate their desire to work collaboratively. “It seems that we have to adapt our work to each physician with whom we may collaborate so that they’re satisfied and they trust us, and finally, we can develop a good bond,” explained Nurse 8. Thus, some nurses described themselves as having a support role rather than a defined professional role with their own scope of practice: “Supporting physicians. We’re really there to support them, to lighten their workload,” mentioned Nurse 5. That said, some nurses and head physicians talked about working together to provide care. “I see it as a collaborative role in the medical team. Basically, this collaboration is about providing the most care to our patients,” said Head Physician 3. Indeed, these narratives highlight the inconsistencies between subordination activities and complementary activities within the interprofessional team.

On the one hand, some nurses assess and determine the most appropriate care for patients with acute problems:

If, for example, it's uncontrolled diabetes, we could set up an appointment with an FMG nurse [...] If we judge that the person needs to see a physician, [...] we will schedule it with a physician. If, on the other hand, an external resource is needed, [...] we will contact the community health centre referral (Nurse 4).

On the other hand, some nurses are underused for medical assistance activities, which leads to a high rate of professional dissatisfaction:

I don't think I'm being used to my full potential. I note the reason for the consultation, I take the vital signs, if it's a child I weigh him, I take one's temperature, [...] and

then the physician takes over. So, it's much faster (Nurse 3).

DESIRED ROLE

Nurses and head physicians acknowledged that they did not really grasp the full scope of practice of nurses. Yet, regarding delegation of responsibilities, nurses felt they could extend the use of their scope of practice. “It would be to increase my functions, in terms of common health problems. Adding tasks, physicians delegating a little more,” described Nurse 5. Furthermore, nurses stressed wanting to develop a better common understanding of their role, which would support interprofessional collaboration. “Perhaps it would be clearer, what our role is, clearer [...] How far we can go. Well, maybe we wouldn't have to fight to create that trust relationship [with physicians] either,” said Nurse 8.

Some head physicians recognized the potential of promoting a more optimal scope of practice of the FPN's role and suggested that nurses switch from a limited disease-centred practice to a more generalist practice:

There are many things they could potentially do, follow-ups for healthy 0 to 5-year-olds, for women and men, integrated with chronic disease follow-ups. As long as the patient is healthy, it doesn't take a physician, and a nurse is totally competent to organize this (Head Physician 3).

However, in the context of overwork afflicting family physicians and facing the pressure from governments to increase primary care, some head physicians said they would like nurses to see more patients. “I would like it to be faster to be able to meet demand. Would they be able to see a little more?” (Head Physician 4).

Nevertheless, both groups perceived the need to initiate a true collaboration through shared responsibilities, decision-making and effective communication methods with a view to deliver high-quality care. “The ideal would be for us to be close, to look each other in the eye, to work together. Where precisely we would improve our partnership, we would improve our relationship and the quality of care... outcomes!” explained Head Physician 4.

Also, nurses feel strongly about wanting to work on the implementation of clinical tools such as collective prescriptions. “I see that collective prescriptions are implemented much elsewhere... We want to expand [our role], but we will be patient,” expressed Nurse 5. In their opinion, these clinical tools would increase their level of autonomy. “Being more independent in practice when you want to do anything... Health problems you can fix, but your hands are tied,” described Nurse 6.

DISCUSSION

The objective of this study was to describe the perceptions of the expected role of FPNs by FMG nurses and head physicians to better understand the influence of such perceptions on the enacted and desired role of FPNs in FMGs. The results highlight a lack of common understanding of the role of FPNs arising from role ambiguity. This gives rise to role conflicts through inconsistencies in nurses’ activities and practices sharing between nurses and family physicians. The results point to the need for enhancing collaborations to develop an optimal primary care interprofessional practices.

ROLE AMBIGUITY

The conceptual definition of the role refers globally to behaviours and expectations associated with a function in an organization (Katz & Kahn, 1978) which is operationalized by domains of activities (Poitras et al., 2016a). The use of the Poitras et al. (2016a) schematization in this study made it possible to structure the definition of the role while allowing the integration of its conceptual (scope) and operational (enactment) definitions in order to understand its multiple facets. When nurses themselves as well as family physicians tend to describe the nurse’s role based on the activities they perform every day without a clear definition of the role within the team, it fosters role ambiguity and does not allow the optimization of the nurse’s contribution through interprofessional collaboration (Al Sayah et al., 2014; Freund et al., 2015). This can be explained by the fact that the

interviews were conducted between December 2018 and February 2019, but guidelines for the standards of practice of nurses in FMGs were released only in September 2019 (MSSS, 2019a). Role ambiguity stems from a lack of information needed to adequately perform one’s role (Katz & Kahn, 1978), and, in the context of nurses, results in the development of a role oriented towards the accomplishment of ad hoc activities rather than the engagement in an optimal interprofessional collaboration (McInnes et al., 2016; Norful et al. 2017; Poitras et al., 2018a). A clearly defined role of FPNs is needed to allow the transition from simple task delegation towards a more optimal collaboration within interprofessional teams (Aerts et al., 2020).

ROLE CONFLICT

The use of the theoretical framework of Kahn et al. (1964) helped to better understand the influence of perceptions resulting from interactions with various actors (nurses and head physicians) regarding the role of nurses in FMGs. The results suggest that nurses in FMGs are experiencing inconsistencies, referred to as “role conflict” by Kahn et al. (1964). Role conflict occurs when incompatible expectations are raised, making it difficult or impossible to exercise a role (Katz & Kahn, 1978).

Given the organization of the primary care medical setting, new models of collaboration with other primary care health professionals are leading family physicians to redefine their practices (Côté et al., 2019). These changes are viewed positively by some, and negatively by others, and require the development of new collaborative and leadership skills (Côté et al.). This in turn translates into a source of role conflict because nurses do things that may be accepted by some, but not by others, or that could be done in different ways (Rizzo et al., 1970 cited by Lachance et al., 1997). In addition, the performance criteria imposed on family physicians in the restructuring of the primary care system have influenced the sharing of activities with nurses (*ministère de la Santé et des Services sociaux*, 2017a) and has contributed to the current insufficient involvement of nurses in patient care (*Commissaire à la santé et au bien-être*, 2017). Indeed, this study has found that the

underutilization of nursing within a setting focused on supporting medical practice and family physician needs is another source of role conflict; nurses work on things they consider irrelevant to their level of expertise (Rizzo et al., 1970 as cited in Lachance et al., 1997).

Role ambiguity and role conflict have a negative impact on organizations including decreased productivity, high staff turnover and decreased job satisfaction (Kahn et al., 1964; Katz & Kahn, 1978). Déry et al. (2018) demonstrated that role ambiguity significantly limits role enactment and linked the scope of practice of nurses to job satisfaction. When nurses perceive that they offer lower quality care, they feel professional dissatisfaction and they are more inclined to consider leaving their work (Déry et al., Halcomb et al., 2018). This, in turn, affects the contribution of nurses to improve the performance of the health system (Déry et al., 2015).

The findings of this study allow understanding that the integration of nurses in FMGs was done without necessarily being accompanied by a process of organizational change. Adding new professionals such as nurses in FMGs forces other professionals to renegotiate their roles so as to ensure that each expertise is judiciously used (Al Sayah et al., 2014). Accordingly, research is needed to find strategies to resolve role conflicts arising from a lack of common understanding of the role, and to foster interdisciplinary teamwork within primary care settings. While interprofessional collaboration can also be seen as the complementary integration of the professional skills and practices of different health professionals, resulting in optimal use of healthcare resources (Supper et al., 2015), it is obvious that the delegation of activities described in this study did little to develop optimal collaboration. A review of teamwork practices in FMGs, involving all professionals, should be initiated to ensure a better complementarity of practices. In the short term, we suggest that stakeholders (nurses, family physicians, managers and decision makers) become acquainted with the recent professional guides from the MSSS (2019a) and the CFPNA (2019), and that the proper conditions be implemented to facilitate their application in order to reduce role ambiguity and

role conflicts. Moreover, it should be noted that a transition from subordination to complementarity and interdisciplinary teamwork is limited by the legislative and financial frameworks (i.e. government-led funding program and performance monitoring, remuneration schemes of professionals) in primary care (Matthys et al., 2017). Policymakers must reassess the relevance of such frameworks in order to further support the progression of the role of FPNs (Bauer & Bodenheimer, 2017; Matthys et al., 2019).

STRENGTHS AND LIMITATIONS

This study differs from other FMG studies as most previous studies focus on describing nursing activities in FMGs. Interpretative qualitative descriptive research was appropriate in this case to allow the understanding of a phenomenon in a particular context with the people involved (Thorne, 2016). The strength of this study lies in the fact that it focuses on the perception of nurses and head physicians in FMGs. This study garnered great interest among nurses and head physicians in the region where it was conducted, partly reflecting its social relevance.

In terms of limitations, it appears from the findings of this study that the phenomenon of role enactment of FPNs in FMGs is multifactorial, multidimensional and evolving. Thus, individual interviews cannot seize its complexity. Indeed, the addition of methods such as observation or focus groups could have complemented our process, allowing us to describe interactions between professionals or contexts that contribute to shape the role. Also, because the mandate of the FMG head physician as a lead manager is to develop and support interprofessional collaboration in the FMG (MSSS, 2016), it is a possible source of bias as the perception of a head physician may not reflect the perception of all the family physicians within a FMG. Finally, as the FMG structure includes a model of co-management with health centres (MSSS), we could have interviewed nursing managers to learn more about their views of this model of co-management and how they think it could affect FPNs role as well as the interdisciplinary teamwork within this specific collaborative management FMGs' structure.

CONCLUSION

The results of this research highlight the contrasted perceptions of nurses and head physicians regarding the expected, enacted and desired roles of FPNs in FMGs. They shine a light on a certain ambiguity surrounding the role of nurses in FMGs, which limits the common understanding of the role, thus contributing to the variability of its implementation and the presence of role conflicts. All stakeholders must work to support a more sustainable integration of FPNs by establishing a clearly defined role and revising legislative and financial frameworks in primary care. Considering these findings, nurses, family physicians, decision makers, managers and researchers must work to find strategies to resolve role conflicts among FMG nurses in order to enhance the full enactment of their role and thus increase the efficiency and effectiveness of primary care.

Authors' contribution: AB wrote the first draft of the research protocol. All authors were involved in the final draft. AB planned and carried out the data collection. MC, ML and MEP were responsible for supervising and verifying the data analysis and results. AB wrote the first draft of this article. MC, ML and MEP commented the first draft of the manuscript and reviewed it, making substantial contributions. All authors have read and approved the final version of the manuscript.

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Québec (2018-10). The names of the institutions that provided the ethics are not stated in full to ensure the confidentiality of the participants. Also, please note that the participating FMGs are not revealed, since the participants could have been identified.

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