Editor's key points

- Much has been written about the development and implementation of the primary health care nurse practitioner (PHCNP) role. However, limited information exists about how family physicians view their own role relative to that of these professionals. Family physicians in this study identified the following main themes that influenced their views: the nature of follow-up possible with patients, sharing the scope of practice for which they are accountable, the patient profile, and new positive work experiences.
- Several physicians reported that their specific role tended to be squeezed between the respective roles of PHCNPs and other specialist physicians. Physicians also questioned their accountability for the care provided to patients by other professionals.
- For many physicians, collaboration with PHCNPs has meant that their own case loads have included more medically complex patients, while less medically vulnerable patients are being directed toward the PHCNPs. Some participants were comfortable with this evolution, while others had reservations.
- The challenges associated with effective collaboration with PHCNPs highlight the importance of the collaborator and leader competencies for family physicians.

Advanced practice nursing

Qualitative study of implications for family physicians' perceptions of their own work

Nancy Côté PhD Andrew Freeman PhD
Emmanuelle Jean RN PhD Jean-Louis Denis PhD

Abstract

Objective To explore family physicians' perspectives on how best to exercise their role relative to that of primary health care nurse practitioners (PHCNPs).

Design Qualitative case study.

Setting Three Quebec health care regions.

Participants Sixteen physicians participated. To be eligible, family physicians were required to have worked with at least 1 PHCNP for a minimum of 6 months.

Methods Semistructured individual and focus group interviews.

Main findings The implementation of the PHCNP role can be associated with considerable redesign of family physicians' habitual ways of functioning and with important transformations in their role within primary care teams, which can lead these professionals to reflect upon the meaning of their work. The physicians identified the following 4 elements that influenced their views: the nature of follow-up possible with patients, sharing the scope of practice, the patient profile, and new positive work experiences.

Conclusion The evolution of family physicians' role in the face of the PHCNP role must be situated within a discussion about the overall organization of care provision to patients and is not as straightforward as simply defining task division. This implementation also must take into account the frequently highly demanding context in which family physicians practise. Greater understanding is needed about contextual conditions that will facilitate physicians' practice within multidisciplinary teams, including the nature of, and interaction among, micro-, meso- and macro-level elements.

Pratique avancée en soins infirmiers

Étude qualitative de ses répercussions sur la façon dont les médecins de famille perçoivent leur propre travail

Nancy Côté PhD Andrew Freeman PhD
Emmanuelle Jean RN PhD Jean-Louis Denis PhD

Résumé

Objectif Explorer les points de vue de médecins de famille sur les meilleures façons d'exercer leur rôle par rapport à celui des infirmières praticiennes en soins primaires (IPSP).

Type d'étude Étude qualitative de cas.

Contexte Trois centres régionaux de santé au Québec.

Participants Seize médecins ont participé. Pour être admissibles, les médecins de famille devaient avoir travaillé avec au moins 1 IPSP pendant au moins 6 mois.

Méthodes Entrevues structurées individuelles et en groupes témoins.

Principales constatations La mise en œuvre du rôle des IPSP peut être associée à une restructuration considérable des façons habituelles de fonctionner des médecins de famille et à une transformation importante de leur rôle au sein des équipes de soins primaires, ce qui peut inciter ces professionnels à réfléchir à la signification de leur travail. Les médecins ont cerné les 4 principaux éléments suivants qui ont influencé leurs points de vue : la nature du suivi possible auprès des patients, le partage du champ de pratique, le profil du patient et de nouvelles expériences de travail positives.

Conclusion L'évolution du rôle des médecins de famille par rapport au rôle des IPSP doit être située dans le contexte d'une discussion au sujet de l'organisation globale de la prestation des soins aux patients, et il ne s'agit pas seulement d'une simple division des tâches. Cette mise en œuvre doit aussi tenir compte du contexte souvent très exigeant dans lequel exercent les médecins de famille. Il faudrait mieux comprendre les conditions contextuelles qui faciliteront la pratique des médecins au sein d'équipes multidisciplinaires, y compris la nature de ces éléments et les interactions entre eux aux niveaux micro, méso et macro.

Points de repère du rédacteur

- Beaucoup d'encre a coulé à propos de l'élaboration et de la mise en œuvre du rôle des infirmières praticiennes en soins primaires (IPSP). Par ailleurs, il n'existe pas beaucoup d'information sur la façon dont les médecins de famille envisagent leur propre rôle par rapport à celui de ces professionnelles. Dans cette étude, les médecins de famille ont cerné les principaux thèmes suivants qui ont influencé leurs opinions : la nature du suivi possible auprès des patients, le partage du champ de pratique pour lequel ils sont responsables et de nouvelles expériences de travail positives.
- Plusieurs médecins ont signalé que leur propre rôle avait tendance à être coincé entre les rôles respectifs des IPSP et ceux des autres médecins spécialistes. Les médecins remettaient aussi en question leur imputabilité pour des soins prodigués aux patients par d'autres professionnels.
- Pour de nombreux médecins, la collaboration avec des IPSP s'est traduite par une augmentation des patients plus complexes sur le plan médical dans leur charge de travail, tandis que les patients moins vulnérables sur ce plan sont davantage dirigés vers les IPSP. Certains participants étaient à l'aise avec cette évolution, alors que d'autres avaient des réserves.
- Les défis associés à une collaboration efficace avec les IPSP mettent en évidence l'importance pour les médecins de famille de posséder des compétences en collaboration et en leadership.

Family physicians practise within a complex health care environment in which governments are endeavouring to ensure citizens have access to high-quality primary care services while simultaneously controlling costs.[1] Contemporary health services increasingly rely on interdisciplinary teams[2]; in recent decades, the inclusion of advanced practice nursing roles—for example, primary health care nurse practitioners (PHCNPs)—is one of the important initiatives that has been explored in several jurisdictions.[3,4] A growing number of family physicians have, therefore, had to determine how best to exercise their role relative to that of these health professionals.

Much has been written about the development and implementation of the PHCNP role,[5-9] including some discussion within medicine.[10-15] However, limited information exists about how physicians view their role relative to that of PHCNPs. Family physicians experience a number of well documented pressures (eg, large case loads, increasingly complex cases)[16,17] as they endeavour to provide high-quality services while also maintaining a satisfying professional life. In this context, it is important to understand their perspectives regarding the increased presence of PHCNPs with respect to their overall representations of, and the meaning attributed to, their work. The purpose of this article is to present the findings from an investigation conducted in the province of Quebec regarding family physicians' perspectives in particular about their role relative to that of PHCNPs (in Quebec, *infirmière praticienne specialisée en soins de première ligne*). The research question being addressed was the following: How do family physicians perceive their role relative to that of PHCNPs?

Methods

The theoretical framework underlying our investigation was Giddens' structuration theory,[18] which facilitates understanding of the dynamic between structural constraints and actors' actions. We worked in close collaboration in the collection (interviews) and analysis of the data.

Study design

We used a qualitative research case study design,[19] which is appropriate for the exploration of a phenomenon within its context. In our investigation, the cases were 3 health care regions (Capitale-Nationale, Bas-Saint-Laurent, Laurentides) owing to their distinguishing characteristics (eg, population, services, administrative structures) and diverse conditions in which the PHCNP role was being implemented.

Study setting, sample, and recruitment

Our investigation was carried out during 2016 and 2017 across a range of demographic (eg, urban, semiurban, rural) and administrative (centre local de services communautaires, groupes de médecine de famille, groupes de médecine de famille universitaires, groupes de médecine de famille–clinique réseau Québec) structures.

To participate in the study, the family physicians were required to have worked in collaboration with at least 1 PHCNP for a minimum of 6 months. To recruit physicians, we were assisted by regional directors of general medicine, who agreed to forward information about the project by e-mail to the family physicians. We also used the snowball[20] approach, whereby physicians encouraged other physicians to participate in the study.

In total, 16 physicians participated in individual or focus group interviews; 2 physicians participated in both formats. Physicians from all 4 administrative structures participated. Several physicians had collaborated with more than 1 PHCNP, up to a maximum of 6 PHCNPs.

We created 2 advisory committees to support the rigour of our study by providing advice regarding recruitment, data collection, and analysis (**Table 1**).

This research project received ethics approval from the Research Ethics Committee of the Centre intégré universitaire de santé et de services sociaux de la Capitale-Nationale.

Data collection

The individual interviews (average 1.25 hours' duration) were conducted either face-to-face or by Skype, as requested by the participants. The semistructured interview guide comprised open-ended questions that elicited a description of the work milieu and the characteristics of the catchment area in which the services were being provided; the evolution of physicians' role and their overall professional practice; the effects on professional autonomy; and previous experiences of interprofessional collaboration and the supports necessary for optimal collaboration. The focus group interviews (average 1.5 hours' duration) were carried out following the initial analysis of the individual interview data, with the objective of validating these initial findings but also of pursuing some of these findings in greater depth. For example, we sought to better understand how the collaboration with the PHCNPs affected physicians' perspectives regarding their own role and the meaning of their work. With the participants' consent, both the individual and focus group interviews were audiorecorded.

Data analysis

The audiorecorded interviews were transcribed and anonymized. A comprehensive summary of each individual interview was prepared; these summaries were structured according to the interview guide elements and the themes that emerged. Subsequently, a matrix was constructed to organize the global themes as they emerged; this information constituted the first level of analysis.[21] We used this information to develop the interview guide for the focus groups. The focus group interview data were

Table 1. Committee composition

TYPE OF COMMITTEE	MEMBERS
Strategic Committee	1 representative of the Quebec physicians' professional regulatory college
	1 representative of the Quebec nurses' professional regulatory college
	2 representatives from the Quebec Ministry of Health and Social Services
	The DNS from the CIUSSS de la Capitale-Nationale
	The DPS from the CIUSSS de la Capitale-Nationale
	The president of the Quebec association of PHCNPs
Work Committee	1 family physician with experience working with PHCNPs
	1 PHCNP from each of the 3 regions
	2 regional directors of general medicine
	1 regional DNS and 1 assistant DNS
	1 regional DPS
	1 patient partner recruited by means of the Réseau de soutien de recherche axée sur le patient

CIUSSS—Centre intégré universitaire de santé et de services sociaux, DNS—Director of Nursing Services, DPS—Director of Professional Services, PHCNP—primary health care nurse practitioner.

coded using NVivo software and organized in a matrix to reveal the subjective experience of the participants and the actions that they recommended. Over the course of the investigation, the emerging findings were presented to the members of the Strategic Committee and the Work Committee. These members' questions and reflections were used to clarify the analysis of the data.

Findings

The implementation of the PHCNP role can be associated with considerable shifts in family physicians' habitual ways of functioning. This altered work dynamic can lead to important transformations in physicians' roles within their teams and can lead these professionals to reflect upon the meaning of their work. By *work meaning,* we are referring to the overall sense of congruence experienced by individuals with the various elements that constitute their work. Work is considered meaningful by individuals when the tasks and the context in which they are carried out are consistent with their identity.[22] The physicians identified 4 main elements that influenced their perceptions of the effects of their practice reorganization on their sense of meaning in their work: the nature of follow-up possible with patients, sharing the scope of practice, the patient profile, and new positive work experiences. **Table 2** provides examples of direct quotations (translated from French) from participants that capture the perspectives expressed.

Nature of follow-up possible with patients

Collaborating with PHCNPs has an important influence upon the nature of physicians' follow-up with some patients. The traditional model, in which family physicians were often the sole or primary providers of care over the patient's lifetime, appears to be evolving. Several physicians reported that their specific role is tending to be squeezed between the respective roles of PHCNPs and other specialist physicians. These changes not only influence the specific tasks performed by family physicians but also these professionals' overall way of thinking about their practice in family medicine. Health promotion, a holistic long-term perspective of patients, continuity of care through a single provider of services, and the possibility of establishing a long-term relationship with patients are important elements of family physicians' professional identity that play an important role in the meaning that they attribute to their work. Some physicians expressed strong misgivings about the dilution of these dimensions of their practice in the face of the redefinition of their role within the collaboration with PHCNPs. They sometimes wondered about the evolution of their profession and what would become of family medicine.

Sharing the scope of practice

Collaborating with PHCNPs raises questions for family physicians specifically where there is some potential role overlap. Physicians question their accountability for the care provided to patients by other professionals. In part because in Quebec patients are only registered in the physician's name, several physicians expressed unease, believing that they were accountable for all care provided. Even if this interpretation of their legal accountability is not necessarily accurate given PHCNPs' own clearly defined accountability obligations for the services they provide, the physicians' misgivings were not only linked with their legislative understanding but also with an overall sense of ethical accountability; in essence, they feel a strong sense of responsibility for the overall quality of the care provided to the patients on their list. Collaboration with PHCNPs similarly raised concerns about physicians' definition of their professional autonomy, in that the joint management of the same patients might imply a certain loss of overall control regarding the services provided.

Patient profile

For many physicians, collaboration with PHCNPs has meant that their own case load has included more medically complex patients (eg, individuals with comorbidities or undiagnosed conditions), with the less medically vulnerable patients being directed toward the PHCNPs. This situation has tended to evolve family medicine toward a more specialized practice in which the physicians primarily treat patients who require their exclusive expertise. The physicians expressed divergent

Table 2. Quotations that illustrate the key elements from the findings

ELEMENT	QUOTATIONS
Nature of follow-up possible with patients	• "You have some nurses who, on the one hand, have advocated for many years for new roles, claiming that they have the competencies to carry them out. We have family doctors who have a role and we have specialists who have a role .... My area is becoming more and more squeezed because, basically, the part that touches health promotion, follow-up, the knowledge, the global perspective, the continuity of care that I do with a patient, I'm being told, 'Listen, when we'll have the advanced nurse practitioners, it's them who'll do these things.' What do I become as a family doctor? My strengths are the continuity, the global perspective on health, my knowledge about the individual. What will happen to the relationship, what will the doctor have, if he becomes simply a 'walk-in clinic doctor' who only sees individuals with serious problems?"
Sharing the scope of practice	• "There are many, many overlaps between our roles; where does one begin and the other begin? This seems risky" • "Will we, the doctors, lose power, prestige, and the capacity to practise autonomously?" • "In my opinion ... I have some concerns about the loss of power, some concerns about what will happen to the patient. Will we be making decisions with negative consequences for our patients?" • "Before, it was just us, the doctors; however, over time we've been learning how to work with other professionals, like the PHCNPs, with the physios, and so on. I have to know how to do this now, to figure out how to integrate this in my practice"
Patient profile	• "The PHCNPs see my patients, but when they're too sick, she sends them to me. Yes, they're the same patients, but I see them when they're more ill, and when they enter my office, I won't just check their blood pressure like before .... it takes much longer. For sure it's like that for some doctors ... yes, it's more demanding; I'm telling you" • "You know, the 300 patients that she follows, if she leaves tomorrow because ... whatever the reason, I already have 1900 patients, OK. What do I do with the 300 patients? Not everyone seems to have understood .... this agreement with the PHCNPs; their patients are our patients. If the PHCNPs leave, we're left with their 300 patients"
New positive work experiences	• "It's more agreeable, less onerous, to arrive at the office in the morning when I see that my waiting room is full; I have 20 messages from patients who want to see me and so on. It's less onerous than being all alone in my practice all day. Having someone with whom I can talk, working in partnership. I find it very satisfying. Firstly, there's the pleasure of working as a team rather than working all alone in my corner. It's satisfying to know that there are 2 heads reflecting together about the patients" • "I have the impression that I'm more satisfied with my work and that I have a bit more time" • "At an intellectual level, as well .... it's helped us to ask more questions, to be involved in teaching. When you teach, you're obliged to check things because of the questions you'll receive. It helps to improve our knowledge"

PHCNP—primary health care nurse practitioner.

perspectives about this situation. Some individuals were comfortable with this evolution, believing that it made sense for them to be concentrating on treating cases that clearly required their competencies, as well as seeing it as a recognition of the important and distinct role of family medicine. However, other individuals expressed reservations, believing that it was contributing to making their already demanding practice even more so. Being able to include some more straightforward patients in their case load permitted them to better balance their workload. These latter comments were situated within the context of overall concerns about the highly demanding nature of their practice as family physicians, in which they were endeavouring to provide high-quality services while maintaining a satisfying professional and personal life (eg, avoiding burnout). In a related vein, the fact that the patients being followed by the PHCNPs are registered on the physician's list could also be anxiety provoking given the potential considerable implications for the physician's case load should the PHCNP be away on parental or sick leave.

New positive work experiences

Despite the challenges identified, many physicians also identified various positive outcomes that have emerged from their collaboration with PHCNPs—for example, the teaching role that they have needed to play with their PHCNP collaborators. Some physicians also noted the improvement in their practice because of their access to the up-to-date knowledge of their PHCNP partners and a related harmonization of quality practices in the clinic. Also mentioned by some individuals was a better, and highly satisfying, use of their expertise. In a point highlighted by many participants, working with a PHCNP helped to decrease the isolation that sometimes characterizes family physicians' practice—for example, by holding discussions about clinical questions and sharing responsibility for patients' care. Thus, for many physicians, collaboration with PHCNPs was associated with new sources of satisfaction that enriched their subjective experience of work, including the meaning attributed to this work. This collaboration also could lead to tangible changes, for example, in managing their case load, which in turn could help them to have a better work-life balance.

Some physicians remarked that this effective collaboration evolves over time. This process can require a substantial investment of time and energy at the start; however, once this new way of working becomes more established, there are clear rewards that tend to outweigh the difficulties.

Discussion

Our study has found that the implementation of the PHCNP role can be associated with considerable shifts in family physicians' habitual ways of functioning and with important transformations in their role within primary care teams. These changes can lead physicians to reflect upon the meaning of their work.

Although strong arguments exist for using family physicians' competencies in the most efficient and effective manner possible,[23] our findings have revealed that achieving this goal must take into account practitioners' subjective perspectives regarding their work. Moreover, for workers such as family physicians whose job it is to provide services to others, a sense of duty and of being able to make a meaningful contribution to those who are in need are important motivating factors.[24,25] Therefore, the evolution of physicians' roles in the face of the implementation of the PHCNP role is not as straightforward as simply defining task division; this evolution must be situated within a discussion about the overall organization of care provision to patients, which recognizes that both family physicians and PHCNPs share an underlying motivation to make a meaningful contribution. This lesson is most likely equally applicable to the global organization of interprofessional teams.

Our findings have illustrated that the integration of the PHCNP role must take into account the overall context in which family physicians practise, which for many includes tremendous pressures that can be accompanied by negative outcomes (eg, burnout). Although the implementation of PHCNPs appears to have positively contributed to some physicians' experiences, others perceive this development to have represented yet another demand on top of what is already a highly demanding reality. The results have illustrated the challenges associated with effective collaboration with PHCNPs. These challenges suggest that the effective implementation of the PHCNP role requires certain competencies in family physicians—for example, the collaborator and leader roles[26]—that they have not all necessarily had the opportunity to fully develop. Physicians must be provided with sufficient support as they negotiate the changes taking place—for example, training in the competencies necessary to work in interprofessional teams; clear information about the PHCNP role, including areas of potential overlap; and clear administrative channels for resolving difficulties.

Also, the implementation of the PHCNP role must be situated within a broader discussion about the role of family medicine. Some physicians' reluctance to embrace the PHCNP role might not in fact reflect a resistance to this role per se, but rather a broader concern about the role of family medicine within the continuum of care that is provided to patients, including that provided by other specialist physicians. This point is congruent with recent reflections about creating the conditions for family physicians to succeed (eg, supporting their motivation to be involved within emerging primary care models).[27,28] In turn, this point highlights the perspective that in order for front-line clinicians to efficiently and effectively harmonize their actions, congruence of understanding of roles, with accompanying structural supports, is necessary at the micro (eg, organization of clinics), meso (eg, regional coordination), and macro (eg, Ministry of Health policies, congruence between the 2 professional regulatory colleges) levels.

The introduction of the PHCNPs has important implications for work organization, which in turn has potential ramifications for family physicians' role, their collaboration with other professionals, and their workload. Of importance, various positive elements in addition to challenges have been identified. In order to optimize both the collaboration between physicians and PHCNPs and the emergence of new care models that are better adapted to contemporary health system challenges, it is essential to focus on the effects of these transformations on work organization and professional practices, including that of physicians.

Limitations

The generalizability of our conclusions might be limited by our focus on family physicians' experiences in one jurisdiction (Quebec). Nevertheless, the broad trends to which these experiences appear to be linked (eg, increased productivity pressures) suggest that our findings might have broader applicability.[29] The comprehensive nature of the individual and focus group interviews that were conducted, as well as the ongoing validation of the findings carried out with the 2 committees over the course of the research, lead us to feel confident that we have accurately understood some important trends despite the limited number of interviews in a single jurisdiction.

Conclusion

Although our research has provided some insights into certain challenges and possibilities for family physicians that are associated with the evolution taking place in the organization of primary care services, it is clear that further research is required to better comprehend certain elements. For example, a more detailed understanding is needed about contextual conditions that will facilitate family physicians' practice within multidisciplinary teams, including the nature of, and interaction among, micro-, meso-, and macro-level elements.

Dr Côté is Assistant Professor in the Department of Sociology at Laval University in Quebec city, Que, and a regular researcher with the Centre de recherche sur les soins et les services de première ligne de l'Université Laval. **Dr Freeman** is Associate Professor in the Department of Rehabilitation at Laval University and a regular researcher with the Centre de recherche sur les soins et les services de première ligne de l'Université Laval. **Dr Jean** is Professor in the Department of Nursing Sciences at the Université du Québec à Rimouski. **Dr Denis** is Professor in the Département de gestion, d'évaluation et de politique de santé at the University of Montreal in Quebec and Canada Research Chair in Transformative Keys for Health System Redesign and Improvement.

Acknowledgment

This research was supported by the Ministère de la Santé et des Services sociaux du Québec and the Ordre des infirmières et infirmiers du Québec.

Contributors

Drs Côté, Freeman, and **Jean** participated in all stages of the research project, including project development, participant recruitment, data collection and analysis, and preparation of the manuscript. **Dr Denis** participated in the project development and in the preparation of the manuscript.

Competing interests

None declared

Correspondence

Dr Nancy Côté; e-mail **nancy.cote@soc.ulaval.ca**

References

1. Allin S, Guilcher S, Riley D, Zhang YJ. Improving health system efficiency: perspectives of decision-makers. *Healthc Q* 2017;20(1):10-3.
2. MacDonald-Rencz S, Bard R. The role for advanced practice nursing in Canada. *Nurs Leadersh* (Tor Ont) 2010;23(Spec No. 2010):8-11.
3. Delamaire M, Lafortune G. *Nurses in advanced roles. A description and evaluation of experiences in 12 developed countries* (OECD Health Working Papers No. 54). Paris, Fr: OECD Publishing; 2010.
4. Donald F, Martin-Misener R, Bryant-Lukosius D, Kilpatrick K, Kaasalainen S, Carter N, et al. The primary healthcare nurse practitioner role in Canada. *Nurs Leadersh* (Tor Ont) 2010;83(Spec No. 2010):88-113.
5. Kurtzman ET, Barnow BS, Johnson JE, Simmens SJ, Infeld DL, Mullan F. Does the regulatory environment affect nurse practitioners' patterns of practice or quality of care in health centers? *Health Serv Res* 2017;52(Suppl 1):437-58.
6. Sangster-Gormley E. Prescribing patterns of nurse practitioners in Canada. *CMAJ* 2016;188(3):173-4. Epub 2015 Sep 21.
7. Lovink MH, Persoon A, Koopmans RTCM, Van Vught AJAH, Schoonhoven L, Laurant MGH. Effects of substituting nurse practitioners, physician assistants or nurses for physicians concerning healthcare for the ageing population: a systematic literature review. *J Adv Nurs* 2017;73(9):2084-102. Epub 2017 May 2.
8. Bonsall K, Cheater FM. What is the impact of advanced primary care nursing roles on patients, nurses and their colleagues? A literature review. *Int J Nurs Stud* 2008;45(7):1090-102. Epub 2007 Oct 1.
9. DiCenso A, Paech G; IBM Business Consulting Services. *Report on the integration of primary health care nurse practitioners into the province of Ontario. Final report.* Toronto, ON: Queen's Printer for Ontario; 2003. Available from: **www.health.gov.on.ca/en/common/ministry/publications/reports/nurseprac03/nurseprac03_mn.aspx**. Accessed 2019 Jul 12.
10. Schadewaldt V, McInnes E, Hiller JE, Gardner A. Views and experiences of nurse practitioners and medical practitioners with collaborative practice in primary health care—an integrative review. *BMC Fam Pract* 2013;14:132.
11. Way D, Jones L, Baskerville B, Busing N. Primary health care services provided by nurse practitioners and family physicians in shared practice. *CMAJ* 2001;165(9):1210-4.
12. Donelan K, DesRoches CM, Dittus RS, Buerhaus PI. Perspectives of physicians and nurse practitioners on primary care practice. *New Engl J Med* 2013;368(20):1898-906.
13. Fletcher CE, Baker SJ, Copeland LA, Reeves PJ, Lowery JC. Nursing practitioners' and physicians' views of NPs as providers of primary care to veterans. *J Nurs Scholarsh* 2007;39(4):358-62.
14. Bailey P, Jones L, Way D. Family physician/nurse practitioner: stories of collaboration. *J Adv Nurs* 2006;53(4):381-91.
15. Schadewaldt V, McInnes E, Hiller JE, Gardner A. Investigating characteristics of collaboration between nurse practitioners and medical practitioners in primary healthcare: a mixed methods multiple case study protocol. *J Adv Nurs* 2014;70(5):1184-93. Epub 2013 Oct 20.
16. Katerndahl D, Parchman M, Wood R. Perceived complexity of care, perceived autonomy, and career satisfaction among primary care physicians. *J Am Board Fam Med* 2009;22(1):24-33.
17. Moore M, Gibbons C, Cheng N, Coffman M, Petterson S, Bazemore A. Complexity of ambulatory care visits of patients with diabetes as reflected by diagnoses per visit. *Prim Care Diabetes* 2016;10(4):281-6. Epub 2016 Jan 12.
18. Giddens A. *The constitution of society: outline of the theory of structuration.* Cambridge, UK: Polity Press; 1984.
19. Baxter P, Jack S. Qualitative case study methodology: study design and implementation for novice researchers. *Qual Rep* 2008;13(4):544-59.
20. Patton MQ. *Qualitative research & evaluation methods.* 4th ed. Thousand Oaks, CA: Sage; 2014.
21. Miles MB, Huberman AM, Saldaña J. *Qualitative data analysis: a methods sourcebook.* 3rd ed. Thousand Oaks, CA: Sage; 2013.
22. Grint K, Nixon D. *The sociology of work.* 4th ed. Cambridge, UK: Polity Press; 2015.
23. Nelson S, Turnbull J, Bainbridge L, Caulfield T, Hudon G, Kendel D, et al. *Optimizing scopes of practice: new models of care for a new health care system. New models of care for a new health care system.* Ottawa, ON: Canadian Academy of Health Sciences; 2014.
24. Beaulieu MD, Rioux M, Rocher G, Samson L, Boucher L. Family practice: professional identity in transition. A case study of family medicine in Canada. *Soc Sci Med* 2008;67(7):1153-63. Epub 2008 Jul 20.
25. Jones L, Green J. Shifting discourses of professionalism: a case study of general practitioners in the United Kingdom. *Sociol Health Illn* 2006;28(7):927-50.
26. Frank JR, Snell L, Sherbino J, editors. *CanMEDS 2015 physician competency framework.* Ottawa, ON: Royal College of Physicians and Surgeons of Canada; 2015.
27. Denis JL, van Gestel N. Leadership and innovation in healthcare governance. In: Kuhlmann E, Blank R, Bourgeault I, Wendt C, editors. *The Palgrave international handbook of healthcare policy and governance.* Basingstoke, UK: Palgrave Macmillan; 2015. p. 425-40.
28. Denis JL, van Gestel N. Medical doctors in healthcare leadership: theoretical and practical challenges. *BMC Health Serv Res* 2016;16(Suppl 2):158.
29. Adler PS, Kwon SW, Heckscher C. Professional work: the emergence of collaborative community. *Organ Sci* 2008;19(2):359-76.

This article has been peer reviewed.
Cet article a fait l'objet d'une révision par des pairs.
Can Fam Physician 2019;65:e356-62