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Review

Reframing professional boundaries in healthcare: A systematic review of facilitators and barriers to task reallocation from the domain of medicine to the nursing domain

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ABSTRACT

Aim: To explore the main facilitators and barriers to task reallocation.
Background: One of the innovative approaches to dealing with the anticipated shortage of physicians is to reallocate tasks from the professional domain of medicine to the nursing domain. Various (cost-)effectiveness studies demonstrate that nurse practitioners can deliver as high quality care as physicians and can achieve as good outcomes. However, these studies do not examine what factors may facilitate or hinder such task reallocation.
Method: A systematic literature review of PubMed and Web of Knowledge supplemented with a snowball research method. The principles of thematic analysis were followed.
Results: The 13 identified relevant papers address a broad spectrum of task reallocation (delegation, substitution and complementary care). Thematic analysis revealed four categories of facilitators and barriers: (1) knowledge and capabilities, (2) professional boundaries, (3) organisational environment, and (4) institutional environment.
Conclusion: Introducing nurse practitioners in healthcare requires organisational redesign and the reframing of professional boundaries. Especially the facilitators and barriers in the analytical themes of 'professional boundaries' and 'organisational environment' should be considered when reallocating tasks. If not, these factors might hamper the cost-effectiveness of task reallocation in practice.

1. Introduction

Various healthcare settings (e.g. within primary care, child healthcare and hospitals) are facing shortages of medical staff and specifically physicians. Simultaneously, there is an increased demand for healthcare in general and for more specific and more intensive patient treatments [1–3], while the explosive growth of healthcare expenditure continues to dominate many policy agendas [4]. One of the innovative approaches to dealing with the anticipated shortage of physicians and/or attempting to control healthcare expenditure is to introduce new nursing roles, such as the nurse practitioner (NP) [5]. NPs are registered nurses specially educated to take on tasks previously performed by professionals of the medical domain. This implies that tasks are shifted from the traditional professional domain of medicine (cure) to the domain of nursing (care).

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Several studies have demonstrated that appropriately trained nurses can deliver as high quality care as physicians and achieve equally good outcomes in terms of patient health, care processes, use of resources and economic variables [6–10]. Reviews by Horrocks et al. and Laurant et al. on NPs in primary care settings yield numerous indications that NPs can deliver equivalent quality of care as physicians, hand in hand with patient satisfaction, although the cost-effectiveness of NP delivered care remains somewhat unclear [7,9]. Similarly, Bissinger et al. and Sakr et al. show that NPs can provide safe and high quality care in neonatology and emergency care settings, respectively [6,8].

Nevertheless, debates on workforce changes demonstrate that introducing new roles in healthcare practices is not a straightforward process [6,11,12]. For one, workforce changes often put pressure on workforce boundaries. Traditional workforce boundaries become dynamic due to the identification of new work areas or by adopting new roles normally fulfilled by other professionals [6]. In response, however, established professionals may seek to protect and maintain boundaries or to expand their areas of control via institutional work (e.g. the creation of rules that facilitate, supplement and support institutions) [11]. Consequently, the newly introduced roles, against the background of (anticipated) physician shortages and/or the reduction of healthcare costs, generate fundamental questions concerning professionalism and the provision of public services such as healthcare. In other words, the changing position of professionals not only raises power and privilege issues at the individual level of professionals, but also involves context and social transformations at the professional, organisational and institutional levels [13].

Introducing new nursing roles in healthcare practices thus often implies redesigning the organisation and raises discussions on workforce change and professionalism. This applies especially when these roles operate in between, and in the overlap of, the traditional professional domains of medicine and nursing. This paper focuses on the introduction of new nursing roles that cause or warrant interdisciplinary workforce change. The disciplinary boundaries of nursing are expanded by taking on work that is traditionally performed by other disciplines, particularly physicians [6]. Before redesigning health organisations to enable the introduction of NPs, it is important to understand what facilitators and barriers may be expected in task reallocation. If these factors are not taken into account they might hamper the (cost-)effective execution of task reallocation in actual practice [14].

This review explores what facilitators and barriers have been found in earlier evaluations and studies of task reallocation from the professional domain of medicine to the domain of nursing. The questions addressed in this review are: (a) What forms of task reallocation can be observed in healthcare? (b) What barriers and facilitators are perceived when task reallocation occurs – specifically in relation to the ability of NPs to perform their role? and (c) How are the different types of task reallocation and perceived facilitators/barriers related?

The multi-layered concept of professionalism by Brandsen et al. is used to explore task reallocation from one professional to another professional domain [13]. The professional is first deconstructed in terms of essential components: (a) relying on specific knowledge and expertise; (b) belonging to a closed community of people with similar knowledge and expertise characterised by shared norms and values, institutions for socialisation and regulation; (c) this closed nature of the community is considered legitimate by society at large; and (d) discretionary or professional autonomy are allowed at both an individual and community level. Task reallocation and the specially trained NPs challenge the boundaries of the specific knowledge and expertise these closed communities rely on. According to Brandsen et al., professionalism should therefore be considered multi-layered, with the professional challenged at different levels of analysis: (1) at the individual level, (2) within his/her professional community, (3) within his/her organisational community and (4) at the level of the general public or society [13].

Using the multi-layered concept of professionalism enabled the emergence of a networked model. This networked model describes the internal and external structures positioning the NP in relation to the facilitators and barriers in task reallocation. This model might contribute to the organisational redesign processes and successful adoption by stakeholders (e.g. hospital managers, NPs) to meet future requirements of access to and quality of care [15].

The next section describes our research methods. The Results section presents the different categories of facilitators and barriers in task reallocation, followed by a Discussion of how the networked model, positioning the NP in relation to the facilitators and barriers in task reallocation at different analytical levels, answers our research questions, and of the restrictions of the presented review.

2. Materials and methods

2.1. Design

We conducted a systematic literature review to identify facilitators and barriers to reallocating tasks from the traditional domains of medicine to nursing. This "vertical substitution involves the delegation or adoption of tasks across disciplinary boundaries where the levels of training or expertise (and generally power and autonomy) are not equivalent between workers" [5, p. 909]".

Inclusion criteria for literature consisted of: population, intervention/topic of interest, study design and outcomes. We included articles that discuss the role of specially trained nurses adopting new tasks that previously belonged to the medicine domain. These nurses are referred to as either nurse practitioner (NP), advanced practice nurse (APN), nurse specialist (NS), or general nurses specially trained for a new task. APN is an umbrella term containing both the NP and NS, although they have varying levels of authority. APN can be defined in different ways, yet most studies seem to use the definition used by the International Council of Nurses or a definition with similar content.

> A **Nurse Practitioner**/Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and