A STUDY OF ROLE PERFORMANCE IN SPECIALTY OUTPATIENT CLINICS

Robin Weir and Gina Browne

For 25 years the role of the nurse in clinical practice has been the subject of extensive inquiry, evaluation and recommendations. The emphasis in this particular body of literature has been on defining the rights, expectations and obligations of the nurse's role in a variety of different situations. This is in keeping with the structural-functional orientation of role theory (Banton, 1968; Gordon, 1966). Less attention has been given to determining the conditions under which various types of roles emerge. This type of investigation would be best located within the social-psychological orientation where behaviour is viewed as situationally derived, in part, from the demands and expectations of others (Palmer, 1970; Sarbin, 1966). From this perspective, the enactment of a role is interactive and circular in that it involves persons simultaneously fitting their acts into the ongoing acts of the other, and each receiving some sort of role support by the other (Carson, 1970). Thus, the behaviour of a part of a system (nurse's role) in a situation (clinical practice) can be partly understood in terms of the behaviour of the rest of the system (health care team; health care organization) (Von Bertalanffy, 1968; Ruesch & Bateson, 1951). It is the absence of this perspective in the literature that this study addresses.

The enactment of a role does not occur in a vacuum but is interactive, by definition. Thus, conceivably it could be affected by the individual's educational preparation and experience, the availability and roles of other resources in this situation as well as the organizational structure and complexity of work demands. To test these assumptions, the present study was designed to compare the activities of nurses with different educational preparation (RN and RNA), while assessing the relationship between these activities and the confounding effects of the organizational arrangement and organizational demand. The College of Nurses of Ontario regulates the practice of nursing by establishing standards of practice which are required by each level of registrant, i.e., R.N. and R.N.A. Clear guidelines for practice

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have been developed to indicate the types of procedures and responsibilities for each level of registrant.

The literature on the nurse's role is largely descriptive and can be seen as representing three general conceptualizations of role: prescribed, subjective and enacted. When measured empirically, these three constructs also show a close relationship (Habeeb & McLaughlin, 1977). In other words, when nurse members correctly perceive the social norms that govern their behaviour, such as attending team conferences, following the physician's orders or making nursing care plans, there is a congruence between their subjective role (what they expect of themselves in the work situation) and the prescribed role (how the system expects them to act in their jobs). Similarly, when the professional staff act (real role) according to what they believe is required of them (ideal role) there is a congruence between their enacted and subjective roles (Habeeb & McLaughlin, 1977). In addition, successful role performance depends on the expectations and performance of other persons in the interaction. Activities of nurses are affected by numerous variables, such as economics, other resources and policies. Cost conscious hospital administrators may limit the numbers, types and proportional mixes of registered nurses and registered nursing assistants in particular settings. Given the overlap between RNs and RNAs in defined permissible actions, under certain circumstances, shifts in activities should also occur. Similarly, the availability and accessibility of other members of the health care team also may affect the particular activities of the nurses in the setting. During "off hours" nurses are frequently expected to assume some of the activities or responsibilities of other members of the health care team. Policies and routines in the various settings, such as staffing patterns or procedures for administering medications, also influence nurse activity (Howarth, 1972). Studies do not usually distinguish between the effect of these variables (the context or organizational structure) from the expected role performance. Nurses work as members of health care teams and presumably influence, and are influenced by, both the organizational structure and the types of other health care workers with whom they work. How these variables influence the role performance of the nurse and the implications for nursing practice are largely unknown. To address this gap in understanding, we undertook this study examining the role of the nurse in a specific context. Specifically, this study examined two types of nurses' roles in an outpatient clinic setting, from three perspectives - enacted, subjective and prescribed roles, in order to capture a more complete picture of influences on role performance.

In the literature reviewed, little attention was directed to the study of actual role performance (enacted role) in the variety of clinical situations in which nurses were employed. The notable exception was the nurse practitioner studies of the 1970's (Kergin, Yoshida & Tidey, 1972). More recently, although there is much interest in the role and function of the clinical nurse

Table 1
Literature Review

Author	Sample	Design	Data Collection Method				
			Questionnaire	Self-Report	Interview	Check List	Observation
Lewis, C. et al. (1969)	RN Clinic MD Clinic	Before-after	+				
Kahn, L., & Wirth, P. (1975)	3 NPs and 4 MDs	Before-after					+ MDs only
Bullough, B. et al. (1977)	75 NPs	Survey	+	+			
Gray, J. et al. (1977)	44 graduating seniors of diploma and BScN	Survey	+				
Habeeb, C., & McLaughlin, F. (1977)	15 RNs 15 SWs	Survey			+		
Chaska, N. (1978)	303 RNs	Survey			+		
Levine, J. et al. (1978)	58 NPs 46 MDs	Survey	+	+	+	+	
Christensen, M. et al. (1979)	53 NPs	Survey		+		+	
Weiss, S. (1983)	24 RNs 24 MDs	Descriptive		+			
Yauger, R. A. (1984)	RNs and LPNs	Survey		+			
Kinney, C. K. (1985)	101 graduating BScN students	Survey	+				
Prescott P. & Bowen .S (1985)	1044 RNs 536 MDs	Survey		+	+		
Rustin, J. et al. (1985)	43 hospitals	Survey	+				

RN = Registered Nurse; MD = Medical Doctor; NP = Nurse Practitioner; SW = Social Worker; LPN = Licensed Practical Nurse

specialist, there is a paucity of study (Merritt, Mitchell & Pogel, 1988). Of those studies that did attempt to describe the role of the nurse, the majority employed interview and questionnaire methods to explore the perceptions of nurses and other health care practitioners about the actual and ideal role of the nurse. None of the studies examined the actual (observed) activities of the nurse in clinical practice, nor the variables (context, types of other personnel) in the situation that might have influenced performance. A summary of these studies is presented in Tables 1 and 2.

Table 2
Literature Review: Role description

Author	Outcome			
	Role Description		Method	
	Real	Ideal	Reported	Observed
Lewis, C. et al. (1969)	+		+	
Kahn, L. et al. (1975)	+		+	
Bullough, B. et al. (1977)	+		+	
Gray, J. et al. (1977)		+	+	
Habeeb, C. et al. (1977)		+	+	
Chaska, N. (1978)	+	+	+	
Levine, J. et al. (1978)	+		+	
Christensen, M. et al. (1979)				
Weiss, S. (1983)	+		+	
Yauger, R. A. (1984)	+		+	
Kinney, C. K. (1985)	+		+	
Prescott, P. et al. (1985)	+		+	
Rustin, J. et al. (1985)	+		+	

The dearth of observation studies is hardly surprising given the complexity of the clinical situation and the problems inherent in direct observation. None of the exploratory literature that was reviewed however, offered a comprehensive view of professional role functions.

We chose to conceive of a professional role as, in part, determined by the organizational structure and complexity of the work situation. Given the weakness in the quality of the evidence previously cited, as well as the incompleteness in conceptualizing role function, we undertook the following study.

Purpose of the study

The purposes of this study were to assess the role activities of two types of nurses (RNs and RNAs) under different demand conditions and organizational arrangements.

Organizational demand refers to the number of physicians simultaneously holding clinics in a designated area. High demand was defined as three or more physicians. Low demand was two or less physicians.

Organizational arrangement refers to the type of clinic team structure that resulted from the type of demand or the number of concurrent clinics. A co-ordinative team structure was defined as one in which one nurse related to three or more physicians. A collaborative team structure was one in which one nurse related to one or two physicians.

The major assumptions underlying the design of this study were threefold: a professional's role is in part determined by educational level, organizational structure and complexity of the work situation; the activities of the professional, in turn, determine much of the productivity of the setting; and the degree of productivity of the setting serves to create more or less organizational demand, not to mention more or less cost to the organization. The circular relationship among these factors is displayed in Figure 1.

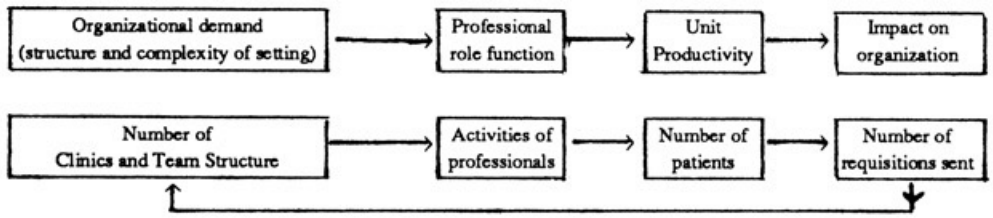

Figure 1
Circular relationships concerning the situational factors that influence role enactment

The above purposes and assumptions guided the following study questions.

(1) Are the activities of RNs and RNAs independent of clinic demand?
(2) In similar demand situations, are the activities of the nurses independent of educational preparation?
(3) Is clinic productivity (number of patients seen) independent of types of nurse activities?
(4) Is the impact on the organization (number of requisitions sent), independent of clinic productivity?
(5) What is the degree of agreement (role clarity) between nurses' and physicians' expectations of the role of the nurse and these same nurses real and ideal role function?

The variables and their measures are summarized in Figure 2.

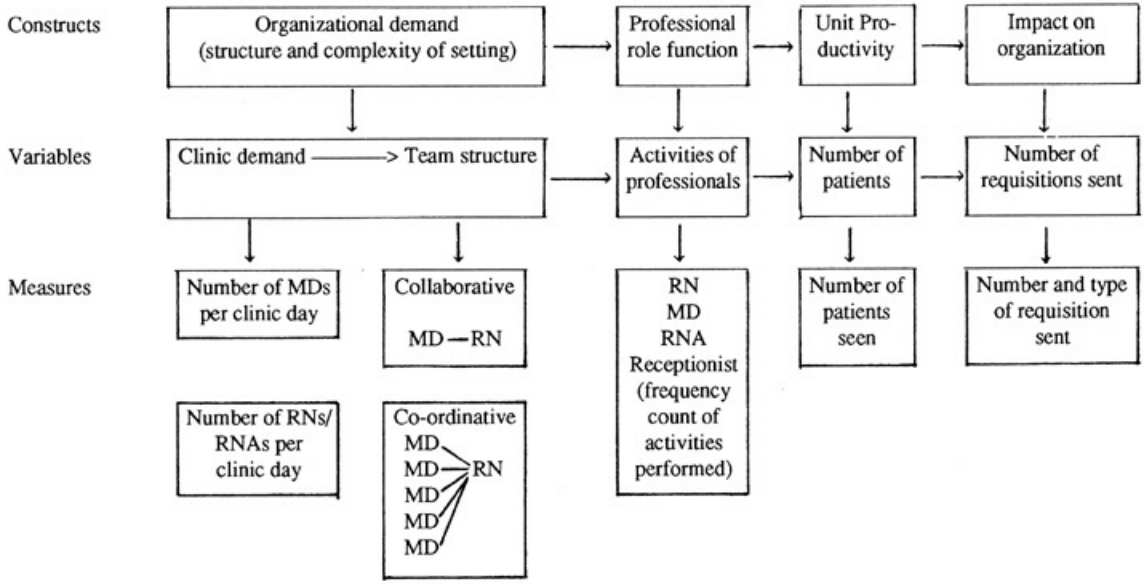

Figure 2
Study Variables and their Measures

Method

Research setting

The study setting was a 350 bed urban teaching hospital in which two outpatient specialty clinic areas (A and B) were purposefully selected for this study. Physicians who were internists with specialization in cardiology, diabetes, general medicine and gastroenterology paired with two different types of nurses (RNs and RNAs) worked together in these settings in various combinations during more and less demanding (number of physicians) clinic days. Data gathered from such an actual setting about role function and situational demand was judged to be suitable to answer the study questions.

Study sample and sampling procedures

In clinic Area A, nurses worked with physicians in both a co-ordinative and a collaborative team structure. Some of the same physicians who held clinics in the mornings in Area A and who were part of the high-demand situation, also held an additional clinic on another day and were part of the low-demand situation. These physicians are identified as "same" type. In contrast, in Area B, the physicians who constituted the high-demand situation were different from the physicians who constituted the low-demand situation. These physicians are identified as "different" types.

For sampling purposes, clinic health care teams within the two clinic Areas (A and B) were selected in a manner which controlled for the type of physician ("same", or "different") associated with type of nurse, and for the type of nurse (RN, RNA) working with either type of physician.

Two diploma RNs and two RNAs, each with an average of five years of clinical experience, plus eight specialist physicians in internal medicine, agreed to participate in the study.

The following eight team situations were identified through the sampling procedure.

1) Co-ordinative team, as defined by high organizational demand, were sampled under conditions in which:

    a) i) RNs were working with the same physicians (Area A)
       ii) RNs were working with different physicians (Area B)
    b) i) RNAs were working with the same physicians (Area A)
       ii) RNAs were working with different physicians (Area B)

2) Collaborative Team, as defined by low organizational demand, was sampled under conditions in which:

   a) i) RNs were working with the same physicians (Area A)
      ii) RNs were working with different physicians (Area B)
   b) i) RNAs were working with the same physicians (Area A)
      ii) RNAs were working with different physicians (Area B)

A random schedule of observations was developed to guide trained research assistants' data collection. Three randomly-selected half hour periods, in each clinic, each week, for each team situation, were observed for four weeks. This yielded a sample of thirty-two clinic half days and forty-eight hours of direct observation.

Each research assistant was regularly assigned to the same health care worker for each observation period. At the beginning of the sample time, the raters synchronized their stop watches in order to have simultaneous observations of the various members of the team. Using the stopwatch as the guide, the activities of each of three or four health care workers, depending on the clinic, were rated each minute. This rating generated one-minute counts of professional activities, which were subsequently summed and averaged for each health care worker.

The rater assigned to the receptionist also tallied the number of patients scheduled for the clinic day as well as the number of requisitions completed during the sample time. The observed professionals exercised their discretion in allowing the raters into the examining room during the observation period.

Following the four week observation period, each health care worker was requested to complete the activity rating form and to indicate what activities were most appropriate (ideal role function) for what health care worker in the clinic. These ratings were compared to the observed (real) activities.

Instrument

For purposes of this study, the observation activity form was designed by the investigators from direct observation in the clinics. Random one-hour periods of time were sampled during which every discrete activity was recorded. Following the sampling period, the activities were summarized into the following categories.

Discrete Categories	Broad Categories
Clerical (includes scheduling appointments and paperwork associated with tests and procedures) Recording (includes dictating and writing notes, reports and mail) Teaching (includes teaching students or other health professionals)	Professional Collateral
History taking (includes interviewing patients re problems) Examination (includes physical, taking specimens) Treatment (includes procedures and assisting and preparing for same)	Patient Centered
Scheduling (includes telephone calls and moving patient from waiting room to office) Information Exchange (includes getting and giving general information directly to MD, patient, family, other team members, or indirectly [phone, records])	Co-ordinative Clerical
Housekeeping (includes cleaning equipment, getting laundry or supplies)	Housekeeping
Errands/Personal/Team Exchange (includes going out of department, socializing, miscellaneous)	Personal/Errands

Figure 4
Categories for observation of activities

The developing instrument was tested in the same clinics for the mutual exclusiveness and exhaustiveness of categories. The investigators achieved 100% agreement in classifying the activities in the above discrete categories, and 98% agreement in an item-by-item comparison within each discrete category. Research assistants were then trained in observation by the investigators. One investigator served as the standard to test the inter-rater agreement of the research assistants in classifying activities. The percent of agreement ranged between 90 and 95% with a Kappa of .86. This was judged to be acceptable for study purposes.

Results

For purpose of analysis, the eight team "types" were collapsed to four team "types"; they included co-ordinative (high demand) and collaborative (low demand) team structures with two nurse types (RN and RNA). Because of the small sample size, no attempt was made to determine the effect of "the same" or "different" physician variable.

The proportion of time spent by the RN and RNA in the various categories of activities was derived from the total minutes of time spent by all team members. The following results are primarily a report of nurse activities in each category under the different demand conditions. Chi-square analysis was used to compare the frequency of activities between the RN and RNA subjects, under the different team structures.

RN team in high- and low-demand situations
(Co-ordinative vs Collaborative Team Structure)

There was a significant difference ($x^2 = 152.88$, df = 11, $p < .001$) in the proportion of time spent in the various categories of activities (discrete categories) of the same RNs in the same setting between high- and low-demand conditions. The results are shown in Table 3.

Table 3

Proportion of Time Spent by the Same RNs in High- and Low-demand Situations

Category	High (%)	Low (%)
History Taking	2	6
Examining	3	9
Treating	6	12
Scheduling	13	8
Information Exchange	26	30
Clerical	18	16
Recording	6	10
Teaching	.2	.1
Housekeeping	.2	0
Errands/Personal	9	5
Team Exchange	18	4
	100	100

$x^2_{11} = 152.88$, $p<.001$

In the co-ordinative team structure or high-demand situation determined by the number of physicians seeing patients, the RN spent a greater proportion of time "scheduling" (12.5%), "clerical" (18%), "going out of the department on errands" (9%) and "team interaction" (18%). In contrast, in the collaborative team structure or conditions of low organizational demand, these same nurses spent a greater proportion of their total time "taking patient's history" (6%), "giving information" (13%), "examining" (9%), "treating" (12%) and "recording" (10%). In addition, it appears that when these nurses *increased* their "examining" and "recording" activities under conditions of low organizational demand, the same physicians *reduced* their activity in these areas. On the whole, on RN teams, receptionists moderately increased their "scheduling" and "information exchange" activities under conditions of high organizational demand, but there was little difference in their roles under the two demand circumstances and two team structures.

RNA team in high- and low-demand situations
(Co-ordinative vs Collaborative Team Structures

There was a significant difference ($x^2 = 197.29$, df = 11, $p < .001$) in the proportion of time spent in the various categories of activities of the same RNAs in the same setting between high- and low-demand conditions. The results are shown in Table 4.

Table 4

Proportion of Time Spent by the Same RNAs in High- and Low-demand Situations

Category	High (%)	Low (%)
History Taking	0	4.5
Examining	.1	3.5
Treating	13.5	5.5
Scheduling	14	15
Information Exchange	13	19
Clerical	10	18.5
Recording	5	10
4mand, Teaching	0	3
Housekeeping	0	1.2
Errands/Personal	20	7
Team Exchange	24	13
	100	100

$x^2_{11} = 197.29$, $p<.001$

Under conditions of high organizational demand (co-ordinative team structure), the RNA spent a greater proportion of time "assisting with treatments" (13.5%), "errands" (20%) and "team interaction" (24%). In contrast, under conditions of low organizational demand (collaborative team structure), these same RNAs expanded the proportion of time spent in "history taking" (4.5%), "information exchange" (19%), "examining" (3.5%), "clerical" (18.5%) and "recording functions"(10%).

As with the RN teams, under conditions of low organizational demand, when the RNA expanded the "examining" and "information giving" functions, these functions were proportionally reduced by the physicians. In addition, similar to the RN teams, the receptionist moderately increased the "giving information", "scheduling" and "clerical function" activities under high organizational demand conditions, but there was little difference in role activities under the two team structures.

RN and RNA teams compared in high-demand situation
(Co-ordinative Team Structure)

There was a significant overall difference ($x^2 = 137.10$, df = 11, $p < .001$) between the RN and RNA in the proportion of time spent in the various activities performed under similar high-demand conditions (co-ordinative team structure). The RN spent a greater proportion of time "taking histories" (2% vs 0%), "information exchange" (26% vs 13%), "examining" (3% vs 0%) and "clerical work" (18% vs 10%). In contrast, the RNA spent a greater proportion of time "assisting with treatments" (13.5% vs 6%), "errands" (20% vs 9%) and "team interaction" (24% vs 18%). Receptionist activity on the two types of teams appears similar; no pattern in physicians' activities can be detected. Although the physicians working with the RN and RNA teams are different, the number and type of physicians are similar between groups.

RN and RNA teams compared in low-demand situations
(Collaborative Team Structure)

There was a significant overall difference ($x^2 = 136.52$, df = 11, $p < .0001$) between the RN and RNA teams in the various activities performed under similar low-demand conditions (collaborative team structure). RNs spent proportionally more time than RNAs in "history taking" (6% vs 4.5%), "information exchange" (30% vs 19%), "examining" (9% vs 3%) and "treating" (12% vs 6%). RNAs on the other hand spent a greater proportion of time "maintaining the schedule" (15% vs 8%), "clerical" (19% vs 16%), "teaching" (3% vs 0%) and "errands/team interaction" (21% vs 9%).

Summary of RN and RNA teams frequency of activities

The eleven categories of activities of RNs and RNAs were summarized into five broader categories to facilitate discussion and description. The categories were: patient centered activities; professional collateral activities; clerical co-ordinative activities; housekeeping; and personal/errand activities. In general, the RN and RNA increased professional collateral (clerical, recording, teaching) activities under conditions of low organizational demand (collaborative team structure). In addition, whereas the RN increased patient-centered activities (history taking, examination and treatment), the RNA increased co-ordinative clerical activities (scheduling, getting information, giving information) under this same low-demand situation. In high-demand situations, i.e. co-ordinative team structure (more physicians holding clinics simultaneously), both the RN and RNA increased their errand and team interaction activities with that of the RNA being close to two thirds more than that of the RN (44% vs 27%). The results are shown in Table 5.

Table 5
Minutes of Time Spent by RNs and RNAs in Clinic Activities in High- and Low-demand Situations

Demand	Role	Professional (Indirect Patient Care)	Direct Patient Care	Clerical	Housekeeping	Errands or Personal
High	RN	171	69	268	2	184
	RNA	107	94	186	0	303
Low	RN	182	193	265	0	61
	RNA	206	89	221	8	135

High RN vs Low RN $x^2_4 = 122.77$, $p < .000...$
High RNA vs Low RNA $x^2_4 24 = 106.24$, $p < .000...$

Clinic Efficiency (number of patients treated)
and Organizational Impact (number of requisitions sent)

There was no significant difference ($x^2 = 1.457$, $df = 1$, $p > .05$) in the number of patients seen under the two organizational conditions by RN and RNA teams. This lack of difference in the number of patients seen in high- and low-demand situations is similar to the lack of difference in the number of requisitions sent under the same conditions.

Expected/observed role comparisons

Two RNs, two RNAs and eight MDs completed the activity sheet rating which health professional each expected to perform the various indicated activities.

There was a general consensus between the two RNs that their expectation was to be involved in all the activities composing the eleven categories, with the exception of arranging hospital admissions, sorting mail, and billing. In addition, they were in agreement as to what activities they thought appropriate for the RNAs, MDs and receptionists. Both RNs agreed that history taking, recording orders and medications were inappropriate for RNAs but they disagreed that information exchange was a part of the RNA role. They agreed that maintaining supplies was appropriate for the RNA role.

The two RNAs, on the other hand, were divided in their expectations of both the RN and RNA. One RNA expected that both the RN and RNA should be involved in all categories of activities with one exception: medications, IVs and teaching nursing students, were considered appropriate for the RN, whereas housekeeping activities were appropriate for the RNA. The other RNA saw the categories of activities predominantly within the RNA role, other than some collateral clerical work, teaching students and IV management.

Interestingly enough, the physicians generally expected the RN to be involved primarily in teaching students and in the assisting activities (information exchange, assisting in physical patient care). In contrast, the physicians expected the RNA to be involved in housekeeping, scheduling, clerical and assisting with physical patient care. On the whole, however, physicians appeared to expect a greater variety of functions from the RNA than RN.

The discrepancy between these "ideal" role expectations and observed (real) role performance is interesting to note, in light of the literature on role function studies. The comparison between "real" (actually observed) and "ideal" is rarely done in other studies of role performance. Traditionally role studies are done using self-reports of what the professionals "think" they do or descriptions of what they expect or would like to do. While a comparison of the reliability of self-report versus direct-observation methods is beyond the scope of this study, the disagreement about role definition is congruent with other role function studies (Habeeb & McLaughlin, 1977). The effect of these differences on morale and work satisfaction remains a question.

Discussion and Conclusions

This study of role performance of health team members in two specialty outpatient clinics has demonstrated that some differences in role enactment and role emphasis occurred on the part of physicians, nurses and receptionists, under differing amounts of organizational demand and different organizational structure.

Under conditions of high organizational demand (co-ordinative team structure), both types of nurses became involved in clinic maintenance activities as the physicians were attending to the patients. When the number of physicians was reduced (collaborative team structure) but the number of patients did not differ, the RNs expanded into direct patient-care functions, while the physicians reduced their activity in this area and the RNAs increased their co-ordinative clerical activities. Receptionist activity appeared constant across organizational demand conditions and various team compositions.

In this study setting, in response to differing practice conditions, the RN and the MD appear to exhibit the most flexibility in role function with an apparent ability to respond to the different demands and expectations of the situation. While the RNAs did respond to differing organizational conditions and team structure with increased clinic maintenance activities, their direct patient-care activities did not change. The number of patients treated by the two different types of teams (RN and RNA), did not differ significantly under the two organizational conditions and two team arrangements. It may be that the greater number of physicians did not increase their number of patients because of their educational responsibilities to residents, and, that the similar number of patients seen by fewer physicians might have been possible because of the different responsibilities assumed by the nurses.

In summary, this study has demonstrated the influence that situational demand and organizational arrangement played on the role performance of team members in one study setting. Caution in generalizing these findings to other similar study settings should be applied because of the selected and small sample size. Respondents represented professionals in clinics in a tertiary care setting within one geographic segment of a national health care system. Findings may not be applicable to other geographic segments within the same systems. Within study limitations the implications for administrative practices should be noted. Increased attention may be paid to matching the role to the task and organizational arrangement. It was the RN who assumed more clerical functions under conditions of high organizational demand (co-ordinative team). Under reverse conditions, and different from the RNAs, RNs were able to assume more direct patient-care activities. When the task of outpatient clinic care can predictably escalate, it may be more appropriate to have clerical staff to free the RNs from these functions in order that their talents may be used, and system productivity realized. Alternate settings may be more appropriate to the talents and productivity of the RNA.

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RÉSUMÉ

Une étude de la performance professionnelle dans les consultations spécialisées externes

Cette étude approfondit les différences observées au niveau de la performance professionnelle des membres de l'équipe de deux consultations spécialisées externes d'un hôpital d'enseignement en milieu urbain. A dessein, on a identifié et choisi différentes équipes de professionnels dans le but de tenir compte du type de médecin appelé à oeuvrer avec deux catégories d'infirmier les jours où la consultation était très fréquentée et les jours où elle l'était peu. Deux adjoints de recherche formés à cette fin suivaient un calendrier d'observations établi au hasard pour évaluer simultanément les couples infirmier-médecin tout au long d'une période d'observation de quatre semaines.

Les résultats de l'étude indiquent que les activités professionnelles des deux différents types d'infirmier (infirmier autorisé et infirmier auxiliaire autorisé) étaient fonction à la fois des exigences de la consultation et de la formation des intéressés. Aux heures où la consultation était très fréquentée, les infirmiers et les infirmiers auxiliaires passaient davantage de temps à assurer le bon roulement de la consultation alors qu'aux heures plus calmes ils consacraient plus de temps aux malades. Abstraction faite des exigences administratives, l'infirmier passait plus de temps auprès des malades que l'infirmier auxiliaire. Cette différence était encore plus manifeste aux heures calmes de la consultation. En outre, les différentes activités des infirmiers prévues selon les différentes conditions n'étaient pas associées aux mesures d'unité de productivité telles que nombre de patients vus en consultation ou nombre de demandes de consultation reçues.

Pour être efficace, la dotation en personnel des consultations spécialisées externes doit tenir compte de l'adaptabilité apparente de l'infirmier autorisé aux exigences de différentes circonstances comme en témoigne sa performance professionnelle.