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RESEARCH PAPER (ORIGINAL)

Perceptions of portuguese family health care teams regarding the expansion of nurses' scope of practice

Perceções de equipas de saúde familiar portuguesas sobre o alargamento do campo de exercício da enfermagem

Percepciones de los equipos de salud familiar portugueses sobre la extensión de competencias de la enfermería

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Abstract

Theoretical framework: Expanding primary health care nurses' scope of practice is a strategy that has been used in various health systems to good advantage. Its feasibility depends on the health professionals' consensus as to its suitability.
Objective: To find out the perceptions of Portuguese family health care teams regarding the expansion of primary care nurses' scope of practice.
Methodology: Focus groups.
Results: The team perception is that citizen expectations, the shortage of nurses and the need for specific training are the main issues to be faced. The teams discussed various roles that the nursing profession could take on in Primary Health Care (PHC) via a work reorganisation included in the regulatory framework.
Conclusion: The assignment of wider clinical roles to PHC nurses is not unanimously approved of, since it is perceived by some doctors and nurses as inappropriate and unfair. Some health care teams expressed their willingness to take part in this option, due to its potential contribution to improving the response to care needs not currently being met.

Keywords: primary health care; advanced nursing practice; perception; patient care team.

Resumo

Enquadramento: O alargamento do campo de exercício do enfermeiro de cuidados primários tem constituído uma estratégia utilizada em diversos sistemas de saúde com ganhos conhecidos. A sua exequibilidade depende do consenso dos profissionais de saúde sobre a sua adequação.
Objetivo: Conhecer as perceções de equipas de saúde familiar portuguesas sobre o alargamento do campo de exercício do enfermeiro de cuidados primários.
Metodologia: Grupos focais.
Resultados: Na perceção das equipas, as expetativas dos cidadãos, a escassez de enfermeiros e a necessidade de formação específica são os principais problemas a enfrentar. As equipas discutiram vários papéis que a profissão de enfermagem poderia assumir em Cuidados de Saúde Primários (CSP), mediante uma reorganização do trabalho, enquadrada normativamente.
Conclusão: A atribuição de papéis clínicos mais vastos ao enfermeiro de CSP não reúne unanimidade, por ser percebida, por alguns médicos e enfermeiros, como desajustada e iníqua. Algumas equipas de saúde manifestaram disponibilidade para aderir a esta opção, face ao seu potencial contributo para melhorar a resposta a necessidades assistenciais atualmente não satisfeitas.

Palavras-chave: atenção primária à saúde; prática avançada de enfermagem; percepção; equipe de assistência ao paciente.

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Resumen

Marco contextual: La extensión de la práctica de enfermería en atención primaria ha sido una estrategia utilizada en diferentes sistemas de salud con beneficios conocidos. Su factibilidad depende, en particular, del consenso de los profesionales de salud sobre su idoneidad.
Objetivos: Comprender las percepciones de los equipos de salud familiar portugueses sobre la extensión de la práctica de enfermería en atención primaria.
Metodología: Grupos de enfoque.
Resultados: La investigación reveló que, para estos equipos, las expectativas de los ciudadanos, la escasez de enfermeras y la necesidad de formación son los principales problemas a enfrentar. Los equipos discutirán varios papeles que la profesión de enfermería en atención primaria podría asumir, a través de una reorganización encuadrada normativamente.
Conclusión: La asignación de funciones clínicas más amplias a la profesión de enfermería en atención primaria no congrega unanimidad, puesto que, algunos médicos y enfermeras, la interpretan como desplazada e inicua. Algunos equipos manifestaran disponibilidad para adherirse a esta opción, por su contribución eventual a la mejora de la respuesta a necesidades asistenciales actualmente desatendidas.

Palabras clave: atención primaria de salud; enfermería de práctica avanzada; percepción; grupo de atención al paciente

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Introduction

The improved efficiency resulting from the combination of human resources is one of the most important challenges that health systems face. Modifying the skill mix between physicians and nurses, particularly by extending the professional scope of practice of PHC nurses, has been one of the options most widely discussed in this context. Countries like Canada and the United Kingdom have vast assessment experience in this matter. A number of systematic literature reviews on the replacement of doctors by nurses in specific activities in a PHC context revealed that, under appropriate conditions, nurses can provide care of a quality equivalent to the care provided by doctors, with gains in terms of patient satisfaction but with higher consumption of resources (Delamaire & Lafortune, 2010; Laurant et al., 2009). Some studies have even reported that 30% to 70% of the work performed by doctors could be done by nurses; however, it was emphasised that the feasibility of task transfer should not be confused with its cost-effectiveness based solely on the idea that nursing work costs are lower than medical work costs, as it is necessary to assess the time and the amount of resources consumed by both groups, as well as the possible need for additional training and supervision (Richardson & Maynard, 1995).

The analyses of the composition of the workforce in the Portuguese health system (a 1.5 nurse/doctor ratio) suggest an inefficient combination of human resources, with strong dependence on medical work and a limited scope of practise of the nursing profession (Dussault & Fronteira, 2010). This situation is particularly visible in the PHC field, the basis of the public health care system, which is reflected in access and quality constraints which, in 2013, translated into approximately one million Portuguese people without a family doctor and an unbalanced consumption of hospital care by the most prevalent chronic illnesses. The future need to strengthen PHC sphere of intervention (e.g., epidemiological changes) enable us to estimate that these imbalances between supply and demand will tend to increase.

The development of the PHC nurse's role, and specifically of the family nurse, can help solve some of the issues that have been identified. In 2000, Portugal was one of the European states who signed the Declaration of Munich, which is committed to supporting the creation of a family nurse role, as defined by the World Health Organization (World Health Organization, 2000). In 2011, the Nursing Board established the specific skills profile of a nurse specialised in family health and, in 2012, the Ministry of Health set up a work group to prepare legislation on the action methodology of family nurses. The results of this initiative were reflected later in the publication of a legal act assigning to the General Directorate of Health the task of identifying the areas of shared responsibility in the provision of health care among the family nurse and other professionals; this legal act also assigned to the Regional Health Administrations (RHA) the task of implementing these professional activities by means of pilot experiments to be carried out in the second half of 2014. In early 2015, the 35 NHS functional units were chosen where these experiments will be carried out.

At this time, it is unknown whether the responsibilities to be assigned to family nurses will involve greater clinical autonomy, like what the International Council of Nurses refers to as advanced nursing (International Council of Nurses, 2003). In any case, the discussion about the potential assignment of greater clinical autonomy to PHC nurses is not limited to the nurses who are family health specialists.

But the decision to expand PHC nurses' scope of practice, which many countries have resorted in order to improve the performance of their health systems, may not be feasible in the Portuguese context. Each country needs to find the solutions that best fit its health needs and the appropriate provision of services to respond to those needs (Dussault & Fronteira, 2010), taking into account its characteristics, its political, cultural and economic context (Dolowitz & Marsh, 2000) and even its path dependence (Greener, 2002). In Portugal, research on the subject is scarce (Buchan, Temido, Fronteira, Lapão, & Dussault, 2013; Temido & Dussault, 2014). Still, it suggests there is a favourable environment for this type of initiative in the field of PHC, where the reform dynamics resulting from the model of organisation into Family Health Units (FHU) have encouraged teamwork.

This study, therefore, seeks to contribute to assessing the suitability of a model that gives PHC nurses a practice scope at advanced nursing level according to the perception of Portuguese family health care teams.

Its purposes are to understand these perceptions with respect to: (i) care needs which the expansion of PHC nurses' clinical roles could potentially fulfil; (Ii) issues to be faced and objectives to be achieved with this expansion; (iii) new ways of working that such an expansion might involve.

Background

As it has been emphasised by several authors, social acceptability is one of the determining factors for the feasibility of human resources policy in health (Dussault & Fronteira, 2010). As such, policy makers who contemplate bringing about a change in the skill mix of the workforce – like the change involving the expansion of the nursing profession scope of practice by placing it at the level of advanced practice (International Council of Nurses, 2003) – should evaluate the recognition stakeholders give it, by involving them in the process (Buchan, Temido, Fronteira, Lapão, & Dussault, 2013). The PEPPA model, Participatory, Evidence-based, Patient-centred Process for APN nurse development, implementation and evaluation (Lukosius & DiCenso, 2004) aims precisely to guide the development, implementation and evaluation of advanced nursing practices. This model is based on the idea that the transition from a paradigm of illness-focused care to a different patient-focused paradigm oriented towards integrated care and prevention involves a significant change that requires the consensus of stakeholders regarding the alignment of goals in health, care models and nurses' advanced practice roles. The original model uses a complex approach based on stages. The first five stages involve needs assessment and matching the development of advanced nursing practices to the context: i. describing the current care model and the user population; ii. identifying stakeholders and selecting participants for the method application; iii. determining the need for a new care model; iv. defining key issues to be faced and goals to be achieved; v. determining the new care model and the role of advanced practice nurses. The subsequent steps assume a positive response to those needs and matching, and involve: vi. establishing the implementation strategy; vii. implementation; viii. assessment of results; ix. long-term assessment. This study consisted of an exploratory analysis of steps three to five, since they represent the part of the process where stakeholders' perceptions are analysed. These stakeholders are considered here as being family health care teams, i.e., doctors and nurses working at FHUs.

Research question

This study aims to answer the question: what are the perceptions of Portuguese physicians and nurses working in Family Health Units (FHUs), regarding the option of extending the clinical roles of primary health care (PHC) nurses as a way of improving the response to care needs?

Methodology

In order to meet the objectives set out above, we designed a qualitative study with data collected by means of the focus group technique (Morgan, 1996). The choice of this technique resulted from its recognised advantages when you want the discussion among the participants to bring out divergent perspectives, encouraging individuals to justify their opinions and the group to resolve conflicts. This decision was also made because we intended not only to know *what* the group thought about the theme, but also *how* and *why* they thought so as a result of their interaction (Kitzinger, 1994). This technique would also enable us to get the participation of the team in designing the possible solutions for the redistribution of work argued for in the PEPPA model (Lukosius & DiCenso, 2004).

The family health teams participating in the study were B-model FHUs, chosen because of their higher degree of organisational autonomy and better remuneration incentives when compared to A-model units. In the design phase, these aspects were considered a stimulus for innovative forms of work distribution like the one we wanted to discuss. The choice of FHUs was conducted by intentional non-probability sampling, with the selection of one unit in each of the five RHAs in mainland Portugal in order to enable us to capture possible geographical variability. With five groups we expected to obtain data saturation. Since we intended to capture the perception of family health care teams on the theme, we opted for the

heterogeneity of focus groups, including, in the same technique, doctors and nurses working together (pre-existing groups). We also decided not to exclude the medical coordinator since, among other functions, he/she represents the FHU. The potential biases of having members in the same group with virtual professional ascendance were prevented, as far as possible, by carefully planning and conducting the technique, and assumed given the predominant aim of revealing the opinion of the working team while they interacted. Administrative workers were excluded because they are not direct care providers. With this exception, all team members were invited to participate. The research team formally contacted the coordinator of each FHU, presenting the study and requesting participation in the project. For the collection of data, authorisation was obtained from the coordinator of each FHU; after informing them about the study objectives and guaranteeing anonymity, all participants signed an informed consent. None of the participants in the focus groups were previously known to the researchers.

In the case of the Alentejo and Lisbon and Tagus Valley RHAs, we had to submit a collaboration request to several model-B FHUs before getting any acceptances. At the Alentejo RHA, only one participant showed up on the scheduled dates, and we carried out a semi-structured interview based on the focus group script. At the Lisbon and Tagus Valley RHA, recording permission was denied. The Centre RHA proposed to the research team the additional formation of a second focus group with only intern physicians (excluded by the study design). In the focus groups that took place, it was not always possible to gather the entire team on the scheduled day and time (Table 1). Each focus group had an average duration of 90 minutes; the semi-structured interview had an approximate duration of 40 minutes. Except in the case of the Lisbon and Tagus Valley RHA, where notes were written, focus groups and interviews were recorded.

Table 1
Participation in focus groups

FHU	Team of doctors	Team of nurses	Focus group date	Doctors present	Nurses present	Team present	
						No.	%
1	8	8	16.07.2014	5	6	11	69%
2	6	6	18.07.2014	6	3	9	75%
3	7	7	12.09.2014	6	4	10	71%
4	9	9	22.09.2014	1	0	1	6%
5	7	7	15.10.2014	5	5	10	71%
Total	37	37	_	23	18	41	_

To conduct the focus groups, we used a script that included a warm-up theme and two scenarios intended to stimulate discussion (Table 2). Prior to the application of the script, we collected the participant sociodemographic data (e.g., gender, age group, professional group, education level).

Table 2
Summary of discussion scenarios

1. Portugal was one of the countries that committed to supporting the creation of the family nurse role. Recently, the Ministry of Health set up a work group to prepare legislation on the action methodology of these professionals [in August 2014, the principles and the framework for the activities of a family nurse (*) were established]. One of the aspects that could be considered is giving the family nurse a wider scope of practice. If the team were in the position of the ministry's counselling group, what would they recommend regarding these professional scope of intervention so as to improve response to health needs?
2. In the early 1980s, a pilot project was carried out at a health centre in the UK with the support of the University of Birmingham. A nurse with 14-year experience received specific training to be able to work with greater autonomy (e.g. initial examination of patients, chronic illness management); all her work processes were protocolled. On admission to the health centre, patients were asked whether they wished to be attended by one of the doctors or by this nurse. While working, the nurse always had support from doctors. Supposing we proposed that the team take part in a project like this, which aspects would they be most enthusiastic about?

(*) Description used in the last two focus groups and in the semi-structured interview.

The focus groups and the interviews were carried out at the premises of each FHU, having assured the necessary conditions for privacy. The empirical part of the research involved two of the three authors of the study; the first two focus groups were conducted by the second author of the study, given her training and experience in the application of the technique; the others and the interview were carried out by the first author. The recorded focus groups and the interview were fully transcribed; each participant was assigned a code that enabled us to identify the FHU and the professional group (nurse – E; Doctor – M). Data were analysed according to the content analysis method (Bardin, 2007), manually processed by researching the perception of the teams regarding the research themes defined and set out in the Results section, although some emerging themes were identified.

Results

The demographic and professional characterisation of the study participants revealed that from a total of 41 individuals, 62% were women and the predominant age group was ≥40-<45. fifty-six percent of participants were doctors, and 11% of the nurses were specialists. Of all the participants, the most representative groups were those working for 15 or more years in PHC (50%) and between four and six years at FHUs (52%).

General perceptions

Assessment of nursing work in an FHU context

In the opinion of one FHU, reflection on extending the family nurse's role should be preceded by the assessment, still to be done, of nursing work in FHUs. The perception was expressed that, since FHUs started their activity, the population has increasingly trusted the role of this professional: "Many users now accept our view. . ." (E-FHU2).

The impact of FHUs in professional relationship paradigms

The understanding that the reform of the PHC and the FHU model modified the relationship paradigm and reinforced the collaborative model of care, and that the role of the family nurse is their natural consequence, was emphasised: "When this primary care reform was implemented, it substantially changed the relationship between doctors, nurses and secretaries." (M-FHU3).

Nurses working at FHUs as family nurses

We obtained the perception that nurses working at FHUs consider themselves family nurses: "our role within the unit is already that of a family nurse. . ." (E-FHU3). However, at one FHU it was noted that, formally, the family nurse title derives from having a speciality yet to be established and that the current nursing career path does not even include a level for specialist nurse (E-FHU5).

The expansion of PHC nurses' scope of practice in the field

In two FHUs, it was emphasised that in the field there are initiatives to assign to PHC nurses broader scopes of practice that are not clearly assumed and consequently do not allow for assessment: "At the FHU there are acute situations where the population goes home and is only seen by a nurse. Yes, they are rare. But they already happen" (M-FHU2); "managed to get the executive director to authorise a pilot experiment in that area. To take some users with no family doctor, low-risk pregnant women. . . monitor those pregnancies. . . There are two or three experiments like that, a bit hidden. . ." (M-FHU3). At the interview a similar result stood out: "There are nurses here who do smear tests with the help of the doctor, with supervision or delegation, whatever you want to call it" (M-FHU4).

Making the most of the nursing workforce skills

In one FHU, the team stressed that it does not make sense to discuss the assignment of wider powers to nurses when their current skills are not fully utilised: "What we need is more respect and more autonomy. . . autonomy in what we do and in our responsibilities" (E-FHU1).

Theme: *Care needs that the expansion of PHC nurses' clinical roles could potentially fulfil*

Different care needs

In one of the FHUs, there was mention of the need to tailor responses to different needs: "it is important

to see if the population needs have changed. . ." (M-FHU2). In another, the team highlighted the need for increased availability of PHC nurses to work on prevention. One FHU and the interview emphasised the risk of neglecting the response to currently established needs because of potential new models: "What I'm afraid of is that, by wanting to cover more functions, we will underrate others that are already defined. . ." (E-FHU3); "So who will do what nurses do now?" (M-FHU4).

Response potential of the expansion of nursing roles

Disagreement about the option of expanding the clinical scope of practice of the nursing profession was evident in the case of some members of one FHU team: "maybe the main solution is to create conditions that will make it possible for unemployed family doctors. . . to be able to work" (M-FHU1); "In Africa, I think it is justified. Here in Portugal, I don't think so" (M-FHU1). The same position was obtained in the semi-structured interview: "I see no need to expand more, in formal terms" (M-FHU4); it was expressed that the preference would be different: "To assign more responsibilities to nurses in order to relieve doctors, that's only if we want to turn doctors more and more into bureaucrats" (M-FHU4). Yet, even within that FHU where part of the team expressed disagreement with the strategy, its unsuitability was not unequivocally understood: "I think that a nurse with education and training for certain situations can do certain things" (M-FHU1). In two other FHUs, the suitability of expansion was clearly expressed: "There is no medical resistance" (M-FHU2); "It does not bother me at all whether certain acts are performed by a nurse or by a doctor" (M-FHU3). The explanation for this position was clearly stated: "it ends up freeing the doctor for the core of the profession. . . given the Portuguese context of a shortage of doctors, especially family doctors, and a population that increasingly. . . makes use of the NHS" (M-FHU3). References were made to the individual experience of working with models where the exercise of broader clinical duties by PHC nurses has been instituted: "We already have this in Spain, so for me it is not strange. My private opinion? Neither good nor bad, I mean, it's one more function" (M-FHU3); "As an intern I did an internship in Denmark, which is a country where this already exists. . . actually, it's a model that works. . . So maybe here we also have something to learn at this level" (M-FHU3).

In another FHU, there were wide gaps between the team positions – some physicians said they understood the expansion of nursing roles as being appropriate due to the medical work time it would free up for other activities, others saw it as a dishonest strategy since it aims to assign more work and responsibility without monetary compensation; some nurses were radically opposed to this option because it represents a way for "the Ministry of Health to have nursing specialists without paying a penny" and were not interested "in working more for the same money". (E-FHU5)

Theme: *Issues to be faced and objectives to be achieved with the expansion of PHC nurses' clinical roles*

Citizen expectations

In the view expressed in one of the FHUs, one of the issues that this discussion raises is that of citizen expectations of PHC: "Users do not always believe that the service they are receiving is the best for them. . . when it is low-complexity care, which is what we, as primary care professionals, have to offer" (M-FHU2). The resolution of this difficulty was perceived as implying a cultural change, especially because "if nurses don't feel there is social recognition in order to go ahead. . . I also don't believe they have the ambition of being able to do it. . ." (M-FHU2). In this perspective, "the first thing you should do is to assess the perception of health care users. It is society that must be called upon to give its opinion" (M-FHU2). In another FHU, someone expressed the conviction that people expectations are clear: "When patients have a problem, it is the doctor that they seek" (M-FHU1); once again, there were differing views: "how can they not accept a nursing prescription but accept a prescription from a pharmacist?" (M-FHU1).

Shortage of nurses

In three FHUs, it was noted that the shortage of nurses is an obstacle to different ways of working: "I can't see how the nurses I work with at the moment, with the workload they have, can take this on as well" (M-FHU1); "We have so much work, how will we also be able to. . . ?" (E-FHU3). However, within one of

these FHUs, there was no consensus when assessing the theme: "I actually disagree with another thing that was said here, that we need more nurses. I think that, before that, is it necessary for the staff to be organised. . ." (M-FHU3).

Specific training

In three FHUs, participants mentioned the need to provide PHC nurses with the appropriate skills to respond, as part of the multidisciplinary team, to the FHU range of services: "We need a speciality of family nursing, of primary health care nursing" (M-FHU2); "The courses have to be reworked for the needs we have and for the work we are doing." (E-FHU3); "If we have nurses with higher basic training. . . we will of course have a healthier combination in the distribution of tasks" (M-FHU2). The interview results revealed the same understanding: "the general practice speciality gave future family doctors security and quality of care. . . that is what the family health nursing speciality can give nurses" (M-FHU4). At the same FHUs, there was the perception that if it is true that nurses currently working in an FHU context acquired a lot of expertise during their practice, it is necessary to have it validated and "from a certain point onwards, only nurses who have previously acquired skills can be family nurses" (M-FHU2). There was a suggestion to use a practice certification process for nurses already working at FHUs, "as was the case in the 80s, with family doctors" (M-FHU3). The participants noted the need to upgrade skills in the areas of promotion, prevention and intervention in general and family medicine, and stressed the importance of a specific approach to nursing care provision: "The thing is that we are very much oriented towards a biomedical area, we were trained in that area" (E-FHU2).

Training and professional self-regulation paradigms

The issue of the health professionals' training paradigm was highlighted in two of the FHUs, who emphasised the need for universities and schools to adopt a teaching model that better encourages teamwork. In two of the FHUs, participants also stressed the need for professional bodies to take on a different role. Some changes were considered essential: "But until there is academic change, a change in the mind-set of academics and in professional bodies, I think we're going to have a long struggle" (M-FHU2).

Improving the response to care needs

The primary objective of changing the way of working which was identified in one FHU was to improve the response to care needs: "We are focusing on professions, not on the citizen best interests. You have to demand results from the teams, but we continue to demand results from professions" (M-FHU2).

Theme: *New ways of working that the expansion of PHC nurses' clinical roles could take*

Acute illness situations

Greater accountability of nurses in response to acute illness situations has emerged as an aspiration of the doctors in two FHUs, in order to free up time for other care functions: "Personally I support that, vigorously, for doctor visits due to acute illness. . . Not only a good idea but a necessity" (M-FHU3); "Too-easy access to a professional of complexity can be against the patient's best interests. . . The response could be disproportionate" (M-FHU2). We perceived some reluctance on the nurses' part to take on more tasks in this area without further training. However, it also became clear that teams are not all organised the same way and that, in some cases, nurses perform triage of acute illness situations under medical supervision. In another FHU, it was reported that for some time the triage of acute illness had been assigned to nurses, but they had backtracked due to the lack of a framework. In yet another FHU, this possibility was absolutely rejected by the nurses: "I think that the front line must have someone competent to do triage, to facilitate, and someone who has no basic training directed at the pathology. . . What are they going to do, waste the patient's time?" (E-FHU1).

Referral to other health professionals and levels of care

Also regarding the role of nurses in referrals to other health professionals, there were different perceptions among FHUs. In one FHU, it was argued that a nurse, just like a doctor, should not be allowed to make referrals alone outside the unit; in order to maximise the PHC response capacity, this should be a team decision. In another FHU, referral by nurses to other professionals within the Health Care Cluster was regarded as an asset: "having to tell the doctor to

refer to the nutritionist, to refer to the psychologist. . . when that's where I had my absolute competence to intervene!" (E-FHU1). Nurses' referrals to acute health care in specific emergency situations was also identified as an area to be expanded: "we can't do that. But we can say to the patient: Look, call an ambulance and go to the hospital" (E-FHU1).

Drug prescription

In two FHUs, drug prescription was described as being understood as a field where, under specific conditions, it is possible to redefine intervention boundaries. However, in another FHU, this possibility was ruled out by most doctors and by the nurses, based on the idea that nurses' basic training does not prepare them sufficiently, that it is not an actual need and that, even for doctors, prescribing is a complex activity; even so, this team position was not unequivocal: "Can't nurses see if the tonsillitis has pus or not? And they could perfectly well prescribe an antibiotic!" (M-FHU1). In the interview, the possibility of nursing staff being responsible for drug prescription was also rejected: "Of course I'm not going to ask the nurse to write out prescriptions, right? That is intrinsically mine!" (M-FHU4).

Other specific technical and care areas

Nurses' monitoring of low-risk pregnancies, healthy children and chronically ill patients were other examples of areas pointed out as worthy of further autonomous intervention by nurses in two of the FHUs. In one of these FHUs, the performance of specific techniques by nurses with appropriate training was also seen as possible and desirable: [suturing] "is a technique to be learnt!" (M-FHU3); in the interview that option was rejected: "I can get nurses to do sutures, but suturing is something I enjoy." (M-FHU4).

Regulatory framework and work protocols

In three of the FHUs, the teams alluded to the concern of any change to the scope of practice of the nursing profession always being included in the regulatory framework for proper clarification and accountability: "It is not clear, we do not have a legal basis that helps to clarify our competences. . . " (M-FHU2); "I have worked in many places and I have sutured. But the thing is, I sutured, I learnt, someone taught me, I learned initially. It is a technique that is practice, isn't it? But what if something goes wrong?" (E-FHU1). In one of these FHUs, the need for an appropriate regulatory framework and the intervention of professional bodies dominated the discussion (E-M-FHU5). However, in another FHU, it was noted that a regulatory framework does not guarantee any kind of implementation, for example the skills of a nurse specialised in maternal and obstetric health care in prescribing some tests: "Portugal needs to comply with some things that were signed long ago" (M-FHU3). The need to precede changes with the definition of work protocols was emphasised by one of the teams; however, it was stressed that "the keyword is communication and flexibility", that "protocol does not mean inflexibility" and that "the spirit of teamwork has to prevail" (M-FHU3).

Discussion

Results suggest that in the teamwork model that supports the operation of FHUs there tends to be an environment that favours the allocation of further clinical roles to PHC nurses as a way of improving response to the welfare needs of the population, as had been indicated in a previous study (Buchan, Temido, Fronteira, Lapão, & Dussault, 2013). However, this is not a cross-sectional view the board because it is perceived by some physicians and nurses as inappropriate and potentially unfair. The gap of care needs unmet by the current provision model did not seem to be homogeneously recognised, since the focus is more on supply than on demand (Nelson, Turnbull, & Bainbridge, 2014). Professional experience in health systems where the practice of wider clinical duties by PHC nurses is already established has emerged as a factor that predisposes the favourable consideration of this option, in line with the results of other studies (Aquilino, Damiano, Willard, Momany, & Levy, 1999). The existence, in the field and at the initiative of health care teams, of new forms of work distribution in order to improve response to the population needs has arisen as confirmation that many changes in professional roles happen incrementally (Temido & Dussault, 2014), and it is necessary to assess them.

The health care teams identified several issues that would need to be faced, in the Portuguese context, with the option of expanding PHC nurses' clinical

roles. The need to equip nursing staff with specific skills that enable them to work with more safety and quality within all programs of general and family health generated ample consensus among FHUs, physicians and nurses, as well as among supporters and opponents of the expansion of PHC nurses' roles; in this way, nurses would gain greater self-confidence, which would reflect on how the health care team and their users perceive them. This perception reiterates the findings of studies that have identified trust in one another's competence as one of the main drivers for greater collaboration (Schadewaldt, McInnes, Hiller, & Gardner, 2013).

Health care teams also identified and discussed a wide range of options regarding the new ways of working that the expansion of PHC nurses' clinical roles could involve; perceptions varied widely as to the appropriateness of each option, with health professionals taking different positions among the FHUs and within the same FHU. They emphasised the need to base potential changes on a clear legal framework and on work protocols, revealing concerns similar to those felt in other health systems (Delamaire & Lafortune, 2010).

The results of the focus group carried out at one of the FHUs, outside the study design, with interns specialising in general and family medicine, did not produce very different perceptions from the others, suggesting that the new generation will probably not advocate the change even if they feel overworked, due to a fear of losing territory. This reaction is in line with what initially occurred in other countries where the expansion of the nursing profession roles is now at a more advanced stage (Wilson, Pearson, & Hassey, 2002).

The limitations of the technique used are acknowledged, especially when it is used as the only method, as was the case. The group dynamics and the addition of members with virtual professional ascendance may have influenced the opinions expressed; the recording of one of the sessions solely by using discourse extracts may have biased the content analysis; the number of focus groups may have been insufficient to bring out all the perceptions on the issue, and in one health region we could only perform one interview – a sign that can reflect that the topic under discussion was considered of low relevance in some locations. We also acknowledge that the method used does not allow us to generalise the results, knowing that the perceptions we collected only represent the interaction between the health care teams that agreed to collaborate. Still, we think that the study contributed to a better understanding of perceptions about the appropriateness of extending PHC nurses' scope of practice in the Portuguese context, providing the basis for the development of more systematic research.

Conclusion

The assignment of wider clinical roles to PHC nurses is not unanimously approved of because it is perceived by some doctors and nurses as inappropriate and unfair. Some health care teams expressed their willingness to take part in this option, due to its potential contribution to improving response to care needs not currently being met. Given that contact with care systems which assigned wider clinical roles to PHC nurses suggested greater readiness for this type of model and that the specific training of PHC nurses was perceived as essential to gain confidence in a more autonomous performance, it is important to assess the future impact of establishing a speciality in family health and of pilot experiments for the implementation of family nursing.

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