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Commentary

Commentary on "The Clinical Nurse Specialist as the Manager of the Family Medicine Clinic: A Hybrid Solution Between Four Major Commonwealth Realms"

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Description

Karczewski and colleagues' (2025) description of Cranston Ridge Medical Clinic's family medicine model comes at an important time for primary care redesign **[1]**. Provider shortages, burnout, and increasing patient demand have created challenges to access in primary care in jurisdiction after jurisdiction. The Cranston Ridge model both describes and prescribes an alternative to physician-centred hierarchical models of family medicine practice. By flattening hierarchy to create a linear team structure with leadership from a Clinical Nurse Specialist in clinical care, management, education, and quality-improvement, Cranston Ridge is addressing access and provider satisfaction in innovative ways.

A strength of this article is the acknowledgement that changes to primary care access will not come by continuing to ask physicians and nurse practitioners to do more clinical and administrative work. Moving the Clinical Nurse Specialist into the role of practice manager and clinical support allows for redistribution of work based on the unique training, scope, and abilities of team members. Other clinics and networks should look to the improvements to same-day access, decreased inappropriate emergency department visits, improved physician availability for complex care, and improved provider satisfaction described in this article as a potential model for reducing clinical burden.

Another strength of this article is the clear connection between service redesign and required training and supports for clinic staff. The emphasis on formal training for RN prescribers, medical office assistants, and other clinical staff is what distinguishes this model from informal task shifting, which can create more risk in primary care. In addition to flattening hierarchy, CRMC creates expanded roles and prescribes the training, supervision, and quality control to support them.

It will be interesting to see if, with further study, the CRMC model can be adopted in other clinics and networks. The authors note that this has been successfully implemented at one clinic. Further evaluation should focus on whether similar results can be achieved at clinics of varying sizes, funding methods, patient populations, and in rural and urban communities. Consistent reporting of outcomes for patients (access, safety indicators, patient experience), providers (satisfaction), and payers (cost-effectiveness) would allow regulators and policymakers to better understand and implement this model.

Conclusion

The authors make an important point by positioning the Clinical Nurse Specialist as a leader in primary care, rather than a supplement to the care provided by physicians. This article should be read by not only family physicians and nurse practitioners, but also policymakers and regulators. Changing the model of primary care clinic organization to allow for expanded scope of practice and team-based care is the future of family medicine. With further study at multiple sites and consideration of the various regulatory environments across the country, there is the potential for the CRMC model to be used at scale to improve access and provider experience while reducing pressure on our primary care clinics.

Reference

1) Karczewski D, Stephens JM, Karczewski T. The clinical nurse specialist as the manager of the family medicine clinic: a hybrid solution between four major commonwealth realms. Healthc. 2025, 13:524