EDUCATION AND HEALTH STANDING COMMITTEE

THE ROLE AND INTERACTION OF HEALTH PROFESSIONALS IN THE WESTERN AUSTRALIAN HEALTH SYSTEM

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 23 OCTOBER 2002

SESSION 6

Members

Mrs C.A. Martin (Chairman)
Mr M.F. Board (Deputy Chairman)
Mr R.A. Ainsworth
Mr P.W. Andrews
Mr S.R. Hill

[12.30 pm]

CALLAGHAN, MS ANDREA LOUISE
Advocate, Health Consumers' Council
examined:

DRAKE, MS MAXINE ELIZABETH
Advocate, Health Consumers' Council,
examined:

The CHAIRMAN: For the record, in accordance with the Legislative Assembly's committee procedures, I read the following notes into the record: the committee hearing is a proceeding of Parliament and warrants the same respect that proceedings in the House itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as contempt of Parliament. Have you completed the witness form, and did you read the note at the foot of the form?

The Witnesses: Yes.

The CHAIRMAN: Have you read the "Information for Witnesses" briefing sheets regarding giving evidence before parliamentary committees?

The Witnesses: Yes.

The CHAIRMAN: We have written to you on the basis of the submission that you put in, and we wondered if you could give us some further information. We have some questions, but if there is anything you would like to open with, that you have a passion to place on the table, that would be great.

Ms Drake: The Western Australian community has the benefit of having a generic health consumer organisation, which is the Health Consumers' Council. It is funded by the Department of Health, but it is independent of health service providers and government. This provides an alternative perspective on service delivery in this State, and there is a benefit in creating a third-party perspective on health service delivery. Health services evolve in the interests of patients, but the way they are organised is often in the interests of providers and managers. The Health Consumers' Council seeks to bring the consumer perspective into the planning and decision making about the way health services are delivered. One of the significant areas is in the training and education of health service professionals, so that they are delivering service in a manner that best suits the interests of consumers, who will be the recipients of those services.

We recognise that this is the only State in Australia that has a generic health consumers council, which provides a central point for government to obtain a consumer perspective on health services. In other States, they must rely on individual, disease-specific consumer groups, such as the Cancer Council and the Asthma Foundation. None of those necessarily has an oversight of the way health services are organised, and that is why we are very fortunate that, in this State, the Government supports the existence of this small but feisty consumer group.

Mr R.A. AINSWORTH: I would like to ask a question about something I am particularly interested in. Something we wanted to get some further information on was the use of nurse practitioners as emergency specialists. What scope of practice and what benefits do you see they may have for patients?

Ms Drake: One of the things we say in our submission is that it is not necessarily up to us to decide how health services should be organised, so you should appreciate that point. There may be a level between initial triage and the seeing of a medical practitioner, who may be a trainee doctor, where nurse practitioners can offer a level of expertise that might be based on many years of experience and training. For example, there may be a resident doctor and a registrar in an emergency department with oversight of consultants, but a nurse practitioner would be a nurse who is at an advanced level of practice, so would have years of experience and wisdom, and the capacity to undertake certain actions that would currently be outside the scope of an ordinary registered nurse. So you would have the depth of experience over time that nurse practitioners can offer to an emergency department, and the power to act, which is a significant addition to that. What we often see is a gap between the limited authority that nurses have after many years of experience and junior doctors who have a lot more power. If nurse practitioners can be introduced into that equation, they can have some power, as well as years of expertise, to negotiate with junior doctors. That is one of the benefits that we see.

Mr P.W. ANDREWS: Could you give us a specific clinical example?

Ms Drake: I can give it from an inquest that was held into the death of a baby at King Edward Memorial Hospital, where a young registrar who had been in obstetrics for three months was dealing with a situation with three midwives, who between them had 47 years of experience. The registrar had the power to ring the consultant to inform him of the situation. The midwives were telling the registrar what they thought was necessary to convey to the consultant, but they had no power to go to the consultant over the head of the junior doctor. That is an example that is slightly outside the situation we are talking about, but it does give weight to the fact that many nurses train and practise for many years, and never have the authority they need within the scope of practice allowed to them, to contribute to some of the critical decision making in an acute care setting. The nurse practitioner model in the metropolitan setting, as opposed to endorsing what is currently being done in the rural setting, could be beneficial.

Mr R.A. AINSWORTH: I would like to follow that a bit further with the second area, because I see some overlap. You mentioned in your submission the exclusion of general practitioners from roles in public hospitals. It would seem to me that there is a gap between what the nurses, particularly the experienced nurses, are allowed to do, and what the inexperienced doctors can do. Could you give us some more details about the exclusion of general practitioners from the public hospital system, and whether they could help to fill that gap, if that is the way to look at it?

Ms Drake: The scenario we are talking about most in relation to the exclusion of general practitioners is in the peripheral hospitals, the secondary hospitals in the metropolitan periphery, where general practitioners are relied upon to provide medical care. Their involvement in public hospitals gives consumers the opportunity to receive care closer to home. We see that at times there is an organisation of the medical marketplace between the three parties - the state health system, which is purchasing the services from the doctors, the general practitioners and the specialists -

that operates against the interests of consumer, where the specialists appear to have some powers to exclude general practitioners and to strike deals with the Department of Health that exclude general practitioners from having access to health services.

One of the frustrations for consumers is that they are so often outside any of these negotiations. The visiting medical officer agreement that is struck between the Australian Medical Association and the Department of Health never has a consumer perspective feeding into it, other than by proxy, meaning the Department of Health. Similarly, these agreements that can be struck in peripheral hospitals can exclude the primary care level of intervention and leave the consumer without the choice of receiving care closer to home. We do not have any power to influence those negotiations. All we can do is tell those with the power, the impact it has on consumers, and that means that they travel into the tertiary hospitals in the metropolitan area when they could receive the care closer to home. This is particularly the case with obstetric care and minor surgery, and things that are within the scope of what should be happening in those hospitals. We do not understand the power that goes on behind the scenes and the negotiations. We can only reflect on the effect it has.

[12.45 pm]

Mr P.W. ANDREWS: I have probably a couple of sequential questions. I am interested in the role of the nurse practitioner in that situation. What is the difference between what you were calling the nurse practitioner, and the clinical nurse specialist in an emergency setting? Can you tell us what extra training would be needed, if any? What have you in mind? Let us say that someone is a clinical nurse specialist working in an emergency situation.

Ms Drake: It is outside the scope of our knowledge to comment. If I were on a selection panel looking for somebody who might be stepping up from one to the other, hypothetically, I would want to see a capacity for autonomous decision making, recognition of boundaries of their scope of practice and the opportunity for referral. You would be asking me as a citizen, because I do not have the expertise to comment.

Mr M.F. BOARD: You represent the consumer, who is the most important person in the whole equation. The reason the State Government spends about $2.5 billion, and the Commonwealth spends about the same in this State, is because people are sick, and yet they are often left out of the entire equation. Things are driven by clinical considerations, administration, bureaucrats and funding. Your role is critical to the equation, because if we spend more and more money on health each year, but we do not get a better outcome, or we do not get satisfied "customers", then there is not much point in the way we are going. The latest surveys have shown people feel less and less satisfaction with the public hospital system. The percentages are going down by one or two per cent every year. The latest survey I have seen indicates that people are still satisfied overall, but the situation is deteriorating, and their primary satisfaction level is down to about 65 per cent in some instances. Obviously we need to start looking at that. This is a long question, but it probably gets to your representation. If you ask the patients what sort of care they need, who should be standing by their bed, and whether they should have eight different specialists compared to one or two people they can relate to throughout the process, I suspect that the answer would be the latter. Do the representations that you get indicate that patients are looking for more time with a particular individual, familiar faces next to the bed, someone they can relate to and who knows their circumstances and not a

different person every day? Are you getting the feeling that there is too much specialisation and not enough patient time for nurses and health professionals generally?

Ms Drake: When patients are lying in a hospital bed, they are processing constantly what goes on around them. They are making assumptions and judgments, and assessing the dynamics of what is going on around them. They can trade off a lot of things. They can trade off some areas of attention, as long as they get a response when they ring the bell. If they do not get a response when they ring the bell, and they are also not getting attention, they start to interpret this as meaning that they are not important, or they can see that the nursing staff are working very hard, and they know it is not the fault of the nursing staff, but rather the system around the nursing staff. Patients can accommodate a lot of things, but one of the things they ultimately cannot deal with is not being given information, and being left in the dark. The consumer cannot know what questions to ask. The practitioner has the responsibility to know the information that must be imparted. It is fundamentally a question about the professional standards and professional ethics of any health practitioner. That is what patients cannot tolerate - people not necessarily recognising their professional obligations to the patient and letting things slide.

The other thing that we say is that the community has possibly not come to terms with how much the health system has contracted to a fundamentally acute system. You can no longer go in and convalesce for any period of time. People are expected to be discharged sicker and quicker. We are not necessarily told this as a community, other than by default, through the human interest stories in the paper, and various other editorials. We are not told that that is the situation. When people are told those things, when the community is informed, they are in a much better position to make those adjustments. I probably have not answered your question very specifically, but we do not necessarily get a complaint about multiple providers, as long as the providers behave responsibly towards people, and give them the information it is their duty to provide.

Mr M.F. BOARD: Is there a need for more enrolled nurses who spend more time with patients, allowing registered nurses to get on and be involved in more specialty type activities, or do you think that you must continue the process? In this inquiry we are trying to look at the emerging model point of view. Is the current model of the professions and the hierarchy the right model for us to pursue, and to continue to put more resources into, or can we develop a better model for delivery? That is one of the areas we are keen to pursue.

Ms Drake: One of the things that patients know is that the element of nursing care that is hardest to quantify but is most missed is attention, nurturing and the caring bedside contact. You cannot put a unit cost to that. When you put it into somebody's job description, how do you quantify it? What people hope for is that the nursing staff have the capacity to give the time that is needed to attend to their individual needs. What they are seeing is that nurses do not have that capacity. I will give you an example. An elderly woman was admitted to a hospital for assessment of dizziness. She needed to go to the toilet. A nursing staff member came and got her, took her to the toilet and then went off to tend to other patients. The woman tried to get back to her bed, and fell and broke her hip. It is a classic scenario. When we followed this through the system, the health service admitted that previously nurses would have been able to stay by the room until the patient had finished and lead her back to the bed safely. Because of the pressures on nursing staff from having to

attend to too many patients, they felt compelled to tend to another patient in the interim period and then come back. In this case, maybe the nurse was distracted, then the patient got impatient and tried to get back to bed, and suffered a broken hip, which is another episode of care for the hospital system to deal with. If that capacity to attend to the patient's needs is included, then it is addressed in the way staffing is organised. That is what we need. If it is written into the job description of an enrolled nurse, that could possibly be reasonable. The question is, would it be cost effective to do that with nurses, or with another professional group?

Mr M.F. BOARD: It is probably not your area of expertise, but because you represent consumers, I wonder what issues they are bringing forward. There is a school of thought - and I know the Australian Nursing Federation would say this - that the better solution is to have more registered nurses, or to close beds until you get the right ratios. We are trying to explore what alternatives there might be to that, and what patients are bringing forward. A patient may not be the best person to be able to make that call. If eight out of 10 representations you are getting are about relationships with people, then time is obviously a major factor.

Ms Drake: The Health Consumers Council has been on the steering committee for the scope of nursing practice decision making framework. Does that ring a bell for you?

Mr M.F. BOARD: Yes.

Ms Drake: We do not necessarily have a contribution to make to that, other than to know that it is occurring and to understand that there is now a shift in thinking about nursing, so we can address issues like career structure and autonomous action within certain professional groupings. We support that process, and we would be willing participants in any discussion about issues of scope of practice for enrolled nurses, as opposed to registered nurses and advance practice nurses. That is what we can offer.

The CHAIRMAN: Thank you very much for your time. We must move on. Before we conclude I need to let you know that you will be receiving a copy of the Hansard transcript in the mail. If you need to alter or correct anything, please do so. The information package tells you how to do that. If you could have it back to us within 10 working days we would appreciate it. I would also like to take this opportunity to thank you for coming in and giving us this information. We really appreciate it.

Proceedings suspended from 1.00 to 1.10 pm.