Challenging the status quo in rural health workforce roles: risks versus benefits

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Introduction

Innovative workforce strategies are vital to providing high quality health care in rural and remote Australia. Examples of effective innovations already exist, such as rural nurse practitioner roles and limited license radiography performed by nurses and general practitioners in locations where radiographers are not available. Other opportunities for innovation exist in advanced practitioner roles for allied health professionals and greater use of assistant practitioners. Of course, new practice models must deliver safe and effective care and isolated practitioners and assistant practitioners should not be expected to perform roles or tasks for which they have minimal training with little mentoring and support.

This paper argues that more needs to be done to support innovative models of health service delivery across Australia, especially to improve access to services in rural and remote areas and to reduce the costs to patients of travelling long distances to receive relatively minor, low risk diagnostic tests or treatments. Flexible approaches to service delivery are often considered a characteristic of rural practice[(1)] and existing models can serve as examples for broader implementation.

Various factors may hinder the implementation of innovative practice roles and this paper considers two important and related issues: (1) legal barriers, including scope of practice and liability concerns; and (2) threats to professional identity. The paper explains how the law influences occupational roles, status and responsibility, integrates current research on the perceptions of professional distinctiveness, and discusses safety and quality concerns that arise when the boundaries between health professions are challenged. Some boundaries exist for sound reasons and there is a need to ensure that practitioners who take on extended scope roles do so with due care and do not pose harm to the health and well-being of the already vulnerable rural and remote population. The paper recommends several priorities for action to help advance innovative rural and remote health workforce strategies.

Health system reform and new practice models

The healthcare system in Australia (and many other developed countries) is facing multiple challenges: an ageing population; a growing chronic disease burden; increasing demands for care; escalating government expenditures; disparities in health service access between urban and rural/remote regions; and demographic changes in the health workforce. These challenges are significant drivers for reform, including shifts to new practice models involving cost-effective deployment of the workforce with potential to improve patient care and health outcomes.

Several recent reports have underscored the imperatives of system-wide workforce reform. The Australian Government review of the health workforce referred to a need to '[break] down traditional professional barriers and silos which impede innovation' and to promote 'role redesign which will allow health practitioners to work at the fullest extent of their scope of practice'[(2)], meaning they spend more time performing work at a higher skill level. The *status quo* is unsustainable and 'it is important that this pressing need for innovation is acknowledged and that sensible, evidence-based change is embraced.'[(2)] The Grattan Institute report contended that '[c]urrent workforce roles were designed in the days of the horse and buggy'[(3)] and the Productivity Commission report on the Australian health workforce noted that '… the introduction of nurse practitioners to Australia — a profession which has existed in some other countries for forty years — has been a drawn out process and is still encountering resistance from parts of the medical profession. Similarly, contested issues in relation to the roles of physiotherapists, radiographers and the various levels of the nursing profession seem likely to remain intractable in the absence of institutional reform.'[(4)]

New models of care are premised on the need to 'ensure people get the right care, at the right time, by the right team and in the right place'[5] and it has been suggested that occupational roles may change in four possible ways[6]:

- *enhancement*, where scopes of practice are expanded to include a broader range of tasks, which is common in remote area nursing practice;
- *substitution*, where a practitioner performs work traditionally done by another profession, such as in specialty nurse practitioner roles;
- *delegation*, where more junior or less qualified practitioners take on work commonly done by, and under the authority of more senior/qualified practitioners, for example in radiological reporting by radiographers; and
- *innovation*, which involves introduction of a new occupational group into the health workforce, such as physician assistants and allied health assistants.

All have potential applications in rural and remote health care in Australia, if they do not already exist in that context.

Legal barriers to new practice models

Macro or system-level factors influence the development and implementation of new models of care beyond the level of health organisations (meso level) and individual workers (micro level). They include health profession regulatory frameworks, legal liability rules, and health system funding and compensation models. It is important to understand how macro factors operate to either promote or impede role changes at the meso or micro levels. For example, health professionals may perceive legal barriers to be the primary impediment to extending scopes of practice.[7]

Law influences occupational status and roles

The legal history of health professional regulation sheds light on contemporary cultures of health care practice and how laws have entrenched traditional hierarchies in healthcare. In Australia, the Constitution does not set out specific federal powers over health matters and states and territories have developed legal frameworks for health practitioner regulation. However, interjurisdictional variations prompted calls for a national scheme and, in 2010, the *Health Practitioner Regulation National Law Act* came into effect. Arguably, the National Law provides a legal framework that enables innovations in practice roles, one of the objectives being 'to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by health practitioners.' [National Law, s3(2)(f)]. Moreover, the Law does not prescribe the scope of practice of each profession, thus avoiding rigid statutory definitions that enforce role boundaries. Instead, professional practice scopes are articulated through various sources, including registration standards and clinical protocols[8]. The National Boards for each registered health profession develop Professional Practice Frameworks and may include scope of practice statements and rules for additional training and experience needed to work in an expanded or extended role. State and territorial laws (*e.g.* laws governing drug prescribing authority), health department directives, enterprise agreements and employer policies may also establish scope of practice rules. A central repository of practice scopes for registered and unregistered practitioners has been recommended to provide clarity on existing rules and identify areas for reform.[9] It would also be helpful to adopt consistent definitions of terms such as expanded, extended and advanced scopes of practice. Confusion over such terms may fuel misunderstanding about whether one is acting within or beyond an appropriate scope.

Health practitioners' knowledge of the laws may also impede change. Some practitioners believe that scopes of practice are statutorily defined and may resist role innovations they believe are not legally permissible.[10] For example, this has been an impediment to implementing radiographer reporting in Australia, where radiographers themselves, as well as radiologists, have argued that it is not legally permissible for a radiographer to provide a written opinion about possible radiological abnormalities. Misinformation can fuel professional 'turf' disputes, which are common barriers to change, and it is

important that practitioners understand one another's roles and responsibilities, as well as limitations, when transitioning to a new practice model.

Law determines standards of care

The law imposes duties on health practitioners to deliver care in accordance with a legally determined standard. In adjudicating negligence, courts expect *reasonable* and *diligent* performance of duties by a *prudent* practitioner. Courts do not expect perfection and recognise the complexity of team-based healthcare where practitioners must rely on others to perform their roles appropriately.

Fear about increased liability is a barrier to new models of care. For instance, a recent Queensland taskforce on expanding health practitioner scopes of practice reports: 'The issue of liability and indemnity was repeatedly raised by medical practitioners and a small number of allied health professionals as a barrier for changes in scope of practice, particularly in relation to allied health professionals being first contact professionals and undertaking extended scope tasks.'[10] Whilst medical practitioners may worry that they will be held ultimately accountable for the actions of other care providers, this is generally a misperception.[11] The doctor does not sit at the top of a healthcare hierarchy where legal liability automatically flows upward. Where skill or task sharing occurs and a patient is harmed, courts will consider evidence of each practitioner's actions and responsibilities in determining a fair apportionment of legal liability. In the case of delegation, however, the professional who delegates a task is responsible for the delegation and retains overall responsibility for the management of the patient/client. The delegatee is responsible for carrying out the task(s) to the expected standard (e.g. that of a reasonably prudent allied health assistant).

In all situations, practitioners must have a clear understanding of roles and have effective communication strategies in place. It is prudent to negotiate clear role definitions – such as through collaborative care practice agreements – especially when new service delivery models are implemented that involve practitioners working in extended scope. Healthcare organisations also have legal obligations to support practitioners in working safely and effectively in approved new practice models. In turn, those new models should help improve timely access to appropriate care, potentially improve patient outcomes and, consequently, reduce clinical error and overall liability risks for both the practitioner and the organisation. Nevertheless, all registered health professionals must have their own professional liability insurance to supplement indemnity cover from their employer.

Professional identity-related barriers to new practice models

Professions are principally defined in terms of distinct bodies of expert knowledge, skills and abilities[12]. These capabilities are usually not shared across professional boundaries and, indeed, there is evidence that members of one profession will actively construct barriers to the sharing of expertise to any other profession [13-15]. Threat to professional identity, or *distinctiveness threat* [16], emerges from the perception that the defining attributes and characteristics of one profession are not unique or distinctive from other professions.

Distinctiveness threat is a salient aspect of the development of new or expanded healthcare roles because such initiatives typically involve the acquisition of knowledge and skills that were hitherto only held by one extant profession [17, 18]. Blurring the interprofessional boundary [19, 20] triggers distinctiveness threat but it has also been demonstrated to increase professional solidarity [21, 22] and motivate strong defence of the distinguishing factors between professions. Indeed, distinctiveness threat has been shown to increase aggression towards the professions or occupations perceived as encroaching or impinging on a jurisdiction or interprofessional boundary [23]. Typically, members of the threatened profession seek to strengthen the characteristics that distinguish them from their perceived rival profession, leading to the intensification of stereotypes [24, 25].

While new practice models can provoke actions designed to obstruct their implementation [22, 26], there are many examples to evidence the effectiveness of new practice initiatives [see, for example, 8, 27, 28]. For example, it has been shown that radiographers can acquire the knowledge and skills to perform at a similar level to radiologists in some examinations and procedures, with patient satisfaction maintained. Similarly, extended scope physiotherapists with the capacity to request X-rays, refer to specialists and perform limited procedures have been found to increase throughput and reduce waiting times, also while maintaining patient satisfaction[29]. There is some evidence that rural

workforce shortages and distance-related challenges create a context that potentially increases the patient-related and organisational benefits of such practice models [30].

There is also some evidence that extended scope of practice models or introduction of new roles may not diminish the reputation or perceived distinctiveness of the extant profession [see, for example, 31, 32]. Indeed, the perception of distinctiveness threat does not necessarily reflect the actual experience of healthcare professionals directly involved in the implementation of new practice models. Rather, if well managed, such models can enhance professional status where a task or role is delegated or passed to across an interprofessional boundary but with the profession to which the task or role traditional belongs taking responsibility for some aspects, such as education and training or safety and quality assurance.

What are the safety and quality risks?

There is surprisingly little research on how new practice models may impact (either positively or negatively) on service quality, patient safety and health outcomes. The risk of harm rather than good arising from such models is a genuine concern for some professions.[33] For example, while generally supporting the delegation of tasks to other health professionals, the Australian Medical Association recognises the need for more research, with the aim of assessing the quality of care and 'the impact on other health professions, costs, efficiency and patient satisfaction'.[34] These are highly pertinent issues and health workforce reform should prioritise the quality of care and patient safety well ahead of the aspirational goals of professions or of governments eager to change the status quo.

It has been argued elsewhere that task transfer or substitution should only take place in the context of team-based care[33] where those who are adopting an extended scope of practice are supported by members of the health profession from which the role or task has been adopted. Thus, nurse practitioners trained to perform specific minor procedures in primary care, for example, would be educated and subsequently mentored by experienced practitioners in that particular procedure or field of practice. Further, they would be guided by protocols and competency requirements to work within the renegotiated practice boundaries.

An example of the perceived risks exists in the field of limited licence general radiography by some rural and remote nurses and GPs in locations where there is no radiographer available.[35] This seems simple enough and surely the risks cannot be too great in extremity and chest examinations. However, diagnostic accuracy (sensitivity and specificity) depends on how well the examination is performed and all radiation exposure carries a quantifiable risk in terms of induced cancers and chromosomal damage. The radiographs of some limited-licence X-ray operators, however, shows evidence of poor image quality and inadequate radiation protection. Qualitative research has shown that limited licensees construct radiography quite differently to radiographers[35], with some informants acknowledging that, if unsatisfied with their own attempts at an examination, they would then refer the patient to a site where they could get a 'proper x-ray'. Several informants commented that they were providing a lesser service, as a 'stop-gap measure'. In the same study, occasions of 'fringe practice' were identified, where licensees knowingly performed examinations that were outside their regulator conditions, adding to the risks of misdiagnosis and unjustified radiation exposure.

Limited-licence GP and nurse X-ray operators are a valuable asset in some smaller rural and remote communities. In most instances they provide an excellent service and save patients having to travel long distances for examinations that may turn out to be normal. However, that particular case study perhaps illustrates how a lowering of practice standards might occur in other new models of practice as more roles and tasks are transferred or delegated from one health profession to another.

Consideration should also be given to other risks, such as the risk that filling service gaps by substitution may promote a belief that 'stop-gap measures' are good enough, potentially leading to stagnation and lost service development opportunities. Budget-conscious health service managers may opt *not* to employ health professionals who have specialised knowledge, skills and abilities in particular fields if local needs can be partially met by extending the scope of practice of some other local health professionals. Unless there are high educational and training standards, supportive mentoring programs, and close practice scrutiny there is a risk that task or skill transfer could deprive rural and remote populations of the same quality of care as is available in the cities. While rural

people are known for being inventive and developing alternative ways of doing things, often out of necessity, rural health services should not be testing grounds for lesser-quality services that lead to poorer health outcomes than might otherwise be expected.

Conclusions and recommendations

Some perceived barriers to the implementation of alternative practice models are not real impediments. Therefore, an important recommendation is that accurate information regarding legal liability and scope of practice is provided both in pre-registration and continuing education programs. Furthermore, new models of care that involve extended or expanded scopes of practice should be based on reliable information and minimise professional self-interest on either side of the interprofessional boundary that is to be renegotiated.

Productive outcomes can be achieved with collaborative renegotiation that focuses in the needs and rights of patients for high quality care no matter where they live. However, as has been highlighted, as well as the potential benefits, there is a need to be alert to the potential risks. It is essential to provide appropriate education and training, mentorship and support, as well as quality control measures to help ensure optimal outcomes in terms of service quality and patient safety. Consequently, it is strongly recommended that alternative practice models are introduced as part of a coherent service delivery plan and never simply as cost-cutting responses to budget constraints.

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Presenter

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