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What is the scope of practice of the nurse practitioner as a surgical assistant in Australia?

Abstract

Discussion around the scope of practice of all nurse practitioners (NPs) in Australia was a component of the recent review of NPs' eligibility to have broader access to the Medical Benefits Schedule (MBS). This review process has been prolonged and, while the MBS review officially concluded on the 30 June 2020, no information regarding decisions about expanded NP access to the MBS for patient rebates had been disclosed at the time of publication. It is anticipated that the MBS review will contribute little change to NP access to the MBS.

The MBS is the primary funding process for private-sector medical services in Australia and is a barrier to the scope of practice of Australian NPs. Specifically, in the perioperative setting the lack of access to the 'assistance at operations' MBS item numbers limits the NP's scope of practice as it leaves the private sector surgical patient out-of-pocket when an NP provides surgical assisting services. This discussion paper considers the international non-medical surgical assistant experience and relates this to the Australian context exploring the complexities associated with the term advanced practice nursing, regulation of the NP compared to other clinicians, and the matters of funding and protectionism in the perioperative space.

Keywords: nurse practitioner, non-medical surgical assistant, scope of practice, Australian health care system, advanced practice nursing, anticompetitive government policy

Background

The focus of this paper is the Australian nurse practitioner (NP) who practises collaboratively with other health care professionals to improve access to health care in the perioperative environment[1]. At the inception of the NP role in Australia, a defined scope of practice would have limited many of the models of care used by NPs in the wide array of practice settings in which they provided care[2]. However, the lack of a structured scope of practice has caused some confusion for NPs, their colleagues, their employers[3,4] and regulatory and reimbursement bodies such as the Department of Health, the Department of Veteran's Affairs and Medicare surrounding what the scope of practice for the NP should be and how much public funding patients of NPs should receive. Compounding the confusion is the use of the term 'advanced practice nursing' (APN) for roles which exceed entry-level practice for registered nurses (RN).

The notion held by some that the NP's scope of practice should be predetermined and static is incorrect. The NP's scope of practice is fluid. This is consistent with other health care practitioners' scopes of practice to meet continually developing health care best practice[5], the needs of the health care team, and the needs of the patient. The scope of practice of the NP as a surgical assistant is the responsibility of the NP who collaborates with a surgeon in an individual clinical

practice setting. The NP scope of practice is based on the Nursing and Midwifery Board of Australia (NMBA) 'Nurse practitioner standards for practice', 'Safety and quality guidelines for nurse practitioners', decision-making framework and code of conduct. An NP's scope of practice is reliant on the knowledge, skills, training and experience of an individual NP; state and national legislation; the policies of the health care facilities; and the needs of the patients. As a result of the Hilmer report[6] , strictly defined scopes of practice, including that of the NP, are not dictated by the government or a regulatory body. Federal legislation sanctions the advanced practice of NPs to undertake medical and professional services[7]; however, the government unofficially restricts the NP's scope of practice by requiring formal collaborative agreements and limiting access to MBS item numbers. Limited MBS access negatively impacts on the financial sustainability for NP models of care and reduces access to NP services. These restrictions impact on the perioperative NPs by denying patients an MBS rebate for surgical assistant care provided by an NP which results in the patient incurring an out-of-pocket expense which in turn reduces access to the service. Other restrictions imposed on the scope of practice of the NP relate to protectionism, the exclusion of nurses from health care policy development committees, and the lack of advocacy for and active development of the non-medical surgical assistant role by health care professional and regulatory bodies.

The conundrum of advanced practice nursing

In Australia, it is predominately an RN and NP that undertake the role of non-medical surgical assistant[8]; however, an NP offers many clinical and regulatory advantages over an RN in this role. The NP is the only formally regulated APN role in Australia. To ensure public safety, the NMBA requires NPs to achieve and maintain endorsement as well as registration which enables NPs to apply for a provider number which in turn allows access to the MBS and the Pharmaceutical Benefits System[9,10]. Confusion and discussion continue about interpretation and use of the term 'APN' by others practising in this space[2,11,12].

To practice at entry level as an RN or NP in Australia, the NMBA requires clinicians to conform to a code of conduct and meet the standards of practice for registration and endorsement. There are over 67 titles for nurses practising at various levels in Australia[12]. While some RNs are practising at 'top of license'[13], the continued use in the literature of inconsistent language around the term APN for nursing roles which exceed the foundation level of nursing practice but are not an NP role perpetuates misperception and ambiguity when there is debate on fundamental issues such as scope of practice and government policy concerning MBS patient rebates for the advanced practice of the NP[13–17]. In a recent white paper, the Australian College of Nursing (ACN) proposed a solution to the conundrum around the plethora of nursing titles. The ACN proposes that the RN who works in a specialty practice role could be regulated with the addition of a formally recognised APN title which sits under the NP title[12]. However, the changes suggested by the ACN are extensive and would be expensive to implement. The first point to consider regarding the ACN's proposal is that in contrast to all Australian NP master's degree courses which are standardised and accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC), implementation of the National Clinical Nursing Framework[12] proposed by the ACN would require moderation of specialty-related master's degrees (a level of education stipulated by the ACN for APN) to attain a consistent level of education and practice. The second point for consideration is, would this new APN role meet the requirements to access an MBS Provider Number and public funding? The private sector of the Australian health care system accommodates 67 per cent of all elective surgery[18], so access to the MBS would be a priority for a perioperative APN. Given NPs are currently limited to a total of four time-tiered MBS consultation or telehealth item numbers[19], and no access to procedural item numbers, access that was reduced from this would be of little value to the APN. The third and most crucial point for consideration is the need for a significant shift in ideology by the NMBA who currently relegates the management of specialty nursing practise (other than the NP) to specialty nursing groups[20].

According to the NMBA, APN is not a job title, pay grade or specific scope of practice but rather a level of practice[13,21]. Despite that, clear direction, such as the Safety and Quality Guidelines for Nurse Practitioners[22] as set out by the NMBA, is required to guide these roles. Rather than a structured, limiting scope of practice, these guidelines sit within a framework for practice which is able to be individualised[23]. O'Connell and Gardner[24] suggest that while competency standards act as a benchmark for entry to practice, they are inadequate to address the expert practice of the NP role. They suggest that context specificity and situated cognition, which enable flexible parameters and address

real-world health care situations, are more important when defining the NP role[24]. The NP role combines specialty clinical knowledge with advanced practice; demonstrates independence, autonomy and complex decision-making; and can holistically care for the patient in all phases of the perioperative episode of care[14,25–27]. Task divergence exists between the RN and NP in all stages of the patient's perioperative journey. This task divergence is related to patient assessment skills and ordering investigations, diagnostic decision-making skills and critical thinking, initiation of appropriate treatment options, and the contribution to joint decision making in the intra-operative setting[8].

The international non-medical clinician as surgical assistant and scope of practice

Similar to colleagues in the United States of America (USA) and the United Kingdom (UK), the Australian NP as a surgical assistant has a standardised, accredited master's level of education and a fluid scope of practice as well as being sanctioned by federal legislation[28] to undertake an interventional, complex level of surgical care and authorised to provide medical and professional services.

The non-medical clinician as a surgical assistant is well established internationally. This role has been practised in Australia for over 30 years[28]. Non-medical clinicians can undertake an active role in the preoperative, intra-operative and post-operative phases of the patient's perioperative journey[8]. They are particularly valuable as intra-operative surgical assistants in geographical locations or surgical specialties where the number of medical practitioners to fill the role of the surgical assistant is limited, when the skills required to perform the role of the intra-operative surgical assistant are highly specialised, or when the surgeon needs a consistent, experienced assistant[29–31]. The literature outlines that patients find care that is traditionally offered by a medical practitioner acceptable when provided by non-medical clinicians when access to care is improved[32–38]. Studies have also found a significant improvement in access to surgical care is achieved by incorporating non-medical advanced practice clinicians as surgical assistants into the surgical team[29,31,39–42].

The broad concept of advanced practice incorporating both nurses and other non-medical clinicians as a level of practice rather than a specified scope of practice is outlined in recent literature from the UK which elaborates that tasks do not define advanced practice[31,43,44]. This definition leads to a flexible and responsive role that is not bound by a rigid scope of practice. In this way, the NP role gains a fluidity that meets the needs of the patient and, in the perioperative environment, the needs of the surgical team in which it functions[31]. This fluidity was evident and considered an advantage in a report by the Royal College of Surgeons of England (RCSE) on the role of the surgical care practitioner (SCP) in the extended surgical care team[31]. The SCP is a non-medical clinician in UK surgical teams who functions as an intra-operative surgical assistant[45]. As the NP role in the UK is not regulated, and in order to standardise titles in surgical teams, the RCSE, the Perioperative Care Collaborative, the Association for Perioperative Practice and the medical, nursing and health care councils of the UK have taken an active stance on providing a framework and guidelines for the practice for the non-medical clinician as a surgical assistant in the UK. The SCP sits at the top of this hierarchy and is trained and educated to provide interventional assistance[46]. Similar input by the Royal Australasian College of Surgeons (RACS), the Australian College of Perioperative Nurses (ACORN), the NMBA and other nursing professional bodies would add clarity to the roles of RNs and NPs as surgical assistants in Australia and could guide discussions related to eligibility of the NP for MBS patient rebates to reduce patient costs. It would be anticipated that the Australian NP would be at the top of this hierarchy, trained and educated to provide interventional assistance and gain access to MBS 'assistance at operation' funding with their MBS provider number.

This notion of a fluid scope of practice is also reflected in the role of the physician's assistant (PA) in the USA. The PA is a non-medical clinician who has a presence in many specialties. There are more than 44 000 PAs in the USA[47]. As opposed to the NP in the USA, the PA has a significant surgical presence, and one of their functions is as an intra-operative surgical assistant[40]. While some minor variations exist, almost all states in the USA have halted a requirement for the regulatory body to determine a blanket scope of practice for the PA and instead defer to a system where an individual PA's scope of practice is decided on a practice level and in collaboration with a medical professional[48].

The SCP in the UK and the PA in the USA are not considered roles limited to nurses[45]; however, the advanced and interventional nature of their intra-operative practice is comparable to the practice of the Australian perioperative NP[46,49]. The scope of practice of the SCP in the UK, the PA in the USA and the NP in

Australia, in which each undertakes the role of intra-operative surgical assistant, is based on knowledge, skills, training and capabilities, policies of the health care facilities, and the needs of the patients in the individual clinical setting[50,48]. For the PA programs in the USA, SCP programs in the UK and NP programs in Australia a master's degree is the standard level of education which is administered by the respective national regulatory entities[10,48,50,51].

Protectionism in the perioperative space

Despite the reforms that arose from the Hilmer report, medical practitioners as surgical assistants enjoy public funding in the form of a patient rebate from the MBS while NP surgical assistants are not afforded the same privilege. Similarly, medical practitioners are able to gain health care facility credentialling as a surgical assistant with no further qualifications than a bachelor degree, while the NP with a master's degree is unable to secure credentialling as an NP at many private sector health care facilities.

As a result of protectionism from other health care professionals working in this space, it was hypothesised that restricting the scope of practice of the NP may ensure a higher quality of care. The differences in NP and medical practitioner training can be the source of some concern of medical practitioners regarding the quality of care and hence the limitations or restrictions[52,53]. However, evidence from the USA highlights that the NP delivers a high quality of care regardless of whether practice is or is not restricted and that implementing a full scope of practice improved access to health care and demonstrated cost savings[52–55].

The move away from a wholesale and rigorously demarcated scope of practice in Australia was instigated in 1993 following the release of the Hilmer Report. This report recommended the implementation of a national competition policy[6]. A government-dictated standardised scope of practice unwittingly served to protect the monopoly some professionals had on specific tasks[52,56]. While government regulation is an essential feature of health care to protect consumers and public health and safety, regulations of this nature impose anticompetitive restrictions on some clinicians[6]. An example of this is the NP in the intra-operative role of the surgical assistant who meets the criteria for this role as set out by peak professional bodies including the RACS[28] and ACORN[57]. The NP is effective in the intra-operative role[58] and is a legitimate clinician to undertake the role[28]. Still, due to government regulations, the NP's patients are unable to access a patient rebate for intra-operative surgical assisting services as this is restricted to medical practitioners by the wording of the highly medico-centric government-dictated MBS[29].

The undefined scope of practice for the NP is the same for medical practitioners in Australia. If a medical practitioner holds unconditional general registration the Australian Medical Board does not define a scope of practice[59]. Both medical practitioner and NP training requirements are dictated and supervised by their respective accreditation councils[60–62]. As is the case for the NP, the medical practitioner applies for credentialling at health services and hospitals. This credentialling process will investigate if the clinician has the appropriate training to perform the proposed role for which credentialling is sought. Medical practitioners requiring health care facility credentialling to perform the intra-operative role of surgical assistant do not need any qualifications other than their bachelor's degree. This is also the case for the master's degree qualified NP in public sector health care facilities and some private sector health care facilities[63]. However, discussion continues in Australia about the NP credentialling process which is currently inconsistent in the private sector, with some corporate health care groups or individual facilities not credentialling the NP in any capacity.

Restriction of access to an MBS rebate, and limiting the ability to gain health care facility credentialling as an NP, is anticompetitive and contravenes the essence of fair trading by limiting the NP's ability to practise and negatively impacting their financial sustainability[64]. It is the role of the Australian Competition and Consumer Commission (ACCC) to uphold fair trading, encourage competition and regulate national infrastructure[65].

Conclusion

The recent ACN white paper noted that the NP role in Australia was well established and it was now time to focus on 'optimising the service potential of advanced practice nursing'[12]. It is suggested here that the NP role in Australia is not well established as it lacks the government infrastructure required to place the patient at the centre of the health care model. Lack of government funding confers inequitable out-of-pocket expenses on the patient despite the fact that the NP acting as a surgical assistant increases access to surgical care, thereby contributing to equity. The inability to fully access MBS funding limits all NP's scope of practice.

Similarly, the continued protectionism by others in the health care space limits the ability of the NP to gain credentialling at health care facilities which in turn, limits the capability of the NP to work at their full scope of practice. As is the case in the UK, input is required by both the medical and nursing professional and regulatory bodies to allow the NP to practice to their full scope and uphold the spirit of fair trading and the role of the ACCC.

The NP should enjoy a fluid scope of practice that conforms to the NMBA 'Safety and quality guidelines for nurse practitioners' and sits within the NMBA decision-making framework and the Australian NP metaspecialty framework. However, the lack of support by the government, regulatory and peak professional bodies limits the NP's scope of practice.

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