

Medical role substitutions and delegations — overcoming the fear

Brendan Murphy

Abstract

This paper outlines the increasing need for new health care practitioners to work under delegation or as substitutes for medical practitioners to resolve the Australian health workforce crisis. The personal experience of the author and common issues for medical practitioners related to the introduction of these new roles are discussed.

Aust Health Rev 2007; 31 Suppl 1: S20–S24

IT IS NOW READILY ACKNOWLEDGED, by all levels of government and most professional groups, that a clinical workforce crisis is looming — a crisis that will affect all countries, covering the full economic and social spectrum. In Australia, the health workforce problem has been well summarised by the recent report of the Productivity Commission.¹ There are well documented shortages of nurses, medical practitioners and allied health practitioners, which are clearly worse in rural and regional areas. The shortages have appeared despite significant growth in the overall health workforce, and falling workforce participation is a significant part of the problem. Despite much recent government attention, the problem is set to get worse in Australia over the next 5 years.

While part of the solution will be to train more of the traditional clinical practitioners, it is clear that a “more of the same” strategy is unsustainable and would eventually result in a tertiary educa-

tion sector almost exclusively devoted to producing traditional health professionals. A sustainable solution to the health workforce problem requires substantial clinical role delegation or substitution, with the introduction of new roles and the legitimisation of a number of competencies already in the workplace. Many new roles of this kind, such as nurse practitioners and certificate-trained health care workers, have been implemented successfully in the United Kingdom and other countries. These roles will evolve in Australia, despite the resistance of some professional groups. The figure in the Box demonstrates the likely direction of role delegation and substitution.

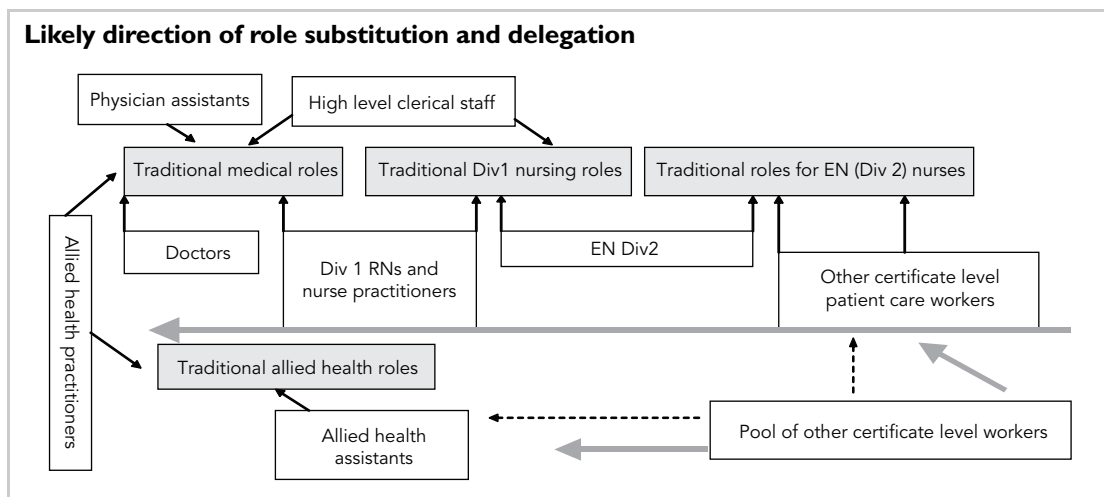
For most of my own professional life, I have worked as a consultant physician in a teaching hospital environment. More recently, I have been confronted with the workforce problem in my management role and in the work of the Victorian Health Service Management Innovation Council. As a result of this professional experience, and some personal exposure, I have developed a strong interest in medical role substitution/delegation, and the reasons for the continuing high level of anxiety and resistance to such changes, in the public hospital context.

It appears to me that the introduction of new roles should be seen as offering many benefits to doctors in the hospital environment. In addition to the obvious outcome of relieving acute shortages, the introduction of new roles can improve the quality of hospital-based clinical work of existing medical practitioners. These roles can also protect and justify improved income and working conditions for medical staff, as they take on a broader supervisory role.

Why then are many current medical staff afraid of this evolution? It is clear that fear underlies opposition to clinical role substitution/delegation.

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This fear is, I believe, totally irrational. The opposition is often disingenuously marketed as concern about quality of care, when the fears are really about unfounded risks to job security, income or status of existing clinicians.

Evolution of medical roles

As background to addressing these fears, it is instructive to look briefly at the evolution of medical roles in larger public hospitals over the last 30 or so years. There have been a number of changes in hospital medical staff practice, in the three main groups.

Full-time specialists

There are increasing numbers of full-time senior staff with a greater service focus than in the past, when full-time staff had a stronger leaning to the “academic”. The evolution of new specialties, such as emergency physicians, greater subspecialisation, and restrictions on the unsupervised tasks of trainees have combined to create a proliferation of specialists with a long-term commitment to a largely service life in the public hospital system. These doctors have an expectation of incomes approaching those of their colleagues in private practice. Despite this, they are not particularly attracted to the somewhat repetitious “throughput orientated” practice, which is typical of the

private sector and which managers and governments believe should now be delivered in a productive public sector. As a result, many full-time senior medical staff seek to limit their clinical contact time, ostensibly to do teaching and research, with quite variable output. Those who do develop a successful academic side to their practice will often be well satisfied with their clinical roles and be seen to enhance the reputation of their hospitals; others, who are less academically productive, may become disaffected and industrially focused.

Visiting Medical Officers (*part-time or fractional specialists*)

These doctors have made a major transition from “Honorary” to now having an expectation of appropriate pay for the time worked, including teaching and other non-patient-care tasks. As a result, management and governments are asking them to provide higher throughput clinical services in their hospital time, in exchange for their new pay rates. In the main, these doctors are not motivated to spend more of their public hospital time doing routine clinical work; rather, they seek from the public hospital:

- High-end, novel, complex work, and help with difficult problems
- Collegiality and continuing medical education
- Exposure to teaching and training and research

- Somewhere to treat their uninsured patients
- A sense of belonging, pride, and loyalty to the institution
- An outlet for a sense of social justice and altruism.

Many have become increasingly frustrated at the “managerial approach”, which values routine service work above these other less tangible parts of what they see as their hospital life.

Junior medical staff (largely doctors in specialist training programs)

Traditionally, the junior medical staff role in public hospitals has been a highly successful mix between service and training. This apprenticeship model was successful when junior doctors worked very long hours, providing 24-hour service cover and gaining a broad range of clinical experience. With much reduced and safer working hours, it is becoming increasingly difficult to provide the service cover from the junior medical staff pool. The few junior doctors on duty after hours are less experienced and less confident than their peers of a previous era. Junior doctors can find work anywhere and have education debts to repay. Their institutional loyalty is much less, and ad hoc vacancies and gaps in rosters are common; these are now seen as a management problem rather than a collective problem of the junior medical staff. The increasing shortages have focused attention on the large number of non-clinical, particularly clerical, tasks that are traditionally undertaken by these doctors.

If one accepts that there is significant disaffection with public hospital working life for many medical practitioners, a new perspective in which to market inevitable role substitution/delegation emerges. Role substitution/delegation is more than just a solution to vacancies. Rather it can and should be seen as a major strategy to improve the job satisfaction of the existing medical staff.

A new perspective

There are many well-established medical role substitutions/delegations that would be applic-

able to Australia's public hospital system. Many of them have worked very well in the United Kingdom, United States and other countries. Nurse practitioners or advanced practice nursing roles are the most obvious and have been proven to be successful in a range of collaborative routine diagnostic, procedural and ongoing patient management settings. Some examples include sedation nurses, endoscopy nurse practitioners, diabetic nurse practitioners and emergency department nurse practitioners. In general, if implemented in partnership with the relevant medical practitioner groups with defined protocols, they have been very successful, even in situations where initial opposition was significant.

A personal example

It is useful to cite a personal example. In my former clinical life as a hospital nephrologist, the routine management of haemodialysis patients took up a big part of the clinical day. Such management is often tedious, with many monitoring, regulatory, investigation and prescribing functions, and results in diminishing time available to apply the direct holistic skills of the consultant physician to the dialysis patient. This has been cited as one of the reasons for a lack of attraction of physician trainees to this specialty. At the same time, haemodialysis units were largely run by experienced registered nurses, arguably with training in excess of the routine patient-care tasks required. These nurses spend up to 16 hours a week with their patients, know the patients and their specialty but usually have little by way of a formal or legitimised role in making decisions about treatment, prescribing and general patient management. In this context it seemed to me that these experienced and competent nurses should be further trained to take on the routine management of dialysis patients in a nurse practitioner role. This highly successful model now sees these nurses prescribe and monitor the routine aspects of dialysis including pharmaceuticals, investigations and referrals.

It was, to me, fascinating to observe the transition of some nephrologist colleagues during the

evolution of this haemodialysis nurse practitioner project. Initial concerns about the impact on their practice and on the training of junior doctors proved to be completely unfounded. More importantly, the nephrologists universally rated the quality of their own clinical practice to be much higher in the shared care model with the nurse practitioners. The nephrologists found they were functioning as physicians again and dealing with the complex aspects of dialysis together with the many general internal medical issues affecting these patients. The impending departure of one of the nurse practitioners led to serious concern from the nephrologists, who insisted on a replacement strategy.

The same sort of practice improvement is readily envisaged in other settings such as:

- An endoscopy centre where nurse practitioner endoscopists work beside a gastroenterologist, allowing the gastroenterologist to focus on the interesting and complex cases and further development of the nurse practitioners
- An anaesthetic department that provides sedation services (for example, endoscopy and radiology) via sedation nurse practitioners, who have an anaesthetist available on campus to assist if required
- An Emergency Department where the emergency nurse practitioners and advanced physiotherapists do a number of routine lower acuity consultations in partnership with ED physicians
- Surgical wards where a critical care-trained nurse practitioner shares the responsibility for postoperative care in partnership with junior medical staff.

Overcoming the fear

If medical role substitution/delegation is introduced in partnership with medical practitioners in this way, I believe that resistance will disappear when the real improvement in quality of work is evident to the medical practitioners. The challenge is to overcome resistance and fear for long enough to gain this practical experience. To do this we need medical clinical champions and we

need to address the irrational fears that block early implementation. Some of these fears and an appropriate response are listed below.

Will these newly delegated roles put doctors out of a job?

Given the time taken to develop a significant delegated workforce, the existing and projected medical vacancies and continued reduction in working hours, it is inconceivable that existing practitioners would ever be displaced. New roles can take up growth and cover the existing gaps in service provision.

How will the high salaries and status of doctors be justified if there is a cheaper alternative?

These roles are not an alternative; rather they are part of a new team that will require experienced medical practitioner leadership, training and direction. These new supervisory roles for medical practitioners will actually strengthen the case for higher salaries appropriate for the complex and supervisory nature of the new work.

If you provide advanced practice roles for nurses and allied health, will this simply create other shortages in the clinical workforce?

This would be true were this strategy in isolation of the many other role substitution/delegations that are necessary and shown in the Box. It is clear that enrolled nurses and allied health assistants will need to take on new tasks in partnership with RNs and allied health practitioners. Certificate-trained carers will have an increasing role in some care settings with a sustainable balance between graduate and certificate workforce.

Could these new roles compete for medical private practice income if they move outside of the public hospital setting?

This is a possibility, but only with a major overhaul of funding policy. In the unlikely event that funding policies were substantially changed, the best protection for the medical profession is to ensure that the roles are established in a delega-

tion/partnership manner, with a key requirement for medical practitioner involvement.

Conclusion

It is clear that role substitution/delegation will progress in response to impending shortages. Opposition by the medical profession will likely result in conflict with other clinical colleagues and initial dysfunctional implementation processes. Engagement and leadership by doctors is certain to result in greater job satisfaction for doctors and further resolution of the workforce

shortages. It is time for new medical clinical champions to show leadership and increase the pace of change.

Competing interests

The author declares that he has no competing interests.

References

- 1 Australian Government Productivity Commission. Australia's Health Workforce [research report]. Canberra; Commonwealth of Australia, 2005.
(Received 13/02/07, accepted 13/02/07)

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