

# Liability and collaborative arrangements for nurse practitioner practice in Australia

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**Abstract.** The purpose of this paper is to clarify the relationship between medical practitioners (MPs) and nurse practitioners (NPs) in general, and privately practising NPs (PPNPs) in particular, in relation to collaboration, control and supervision in Australia, as well as to explore the difficulties reported by PPNPs in establishing mandated collaborative arrangements with MPs in Australia. In order for the PPNPs to have access to the Medicare Benefit Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) in Australia, they are required, by law, to establish a collaborative arrangement with an MP or an entity that employs MPs. This paper begins by describing the history of and requirements for collaborative arrangements, then outlines the nature of successful collaboration and the reported difficulties. It goes on to address some of the commonly held misconceptions in order to allay medical concerns and enable less restrictive access to the MBS and PBS for PPNPs. This, in turn, would improve patient access to highly specialised and expert PPNP care.

**What is known about the topic?** NPs have been part of the Australian health workforce since 1998, but until 2009 their patients did not receive any reimbursement for care delivered by PPNPs. In 2009, the Federal government introduced limited access for PPNPs to the MBS and PBS, but only if they entered into a collaborative arrangement with either an MP or an entity that employs MPs.

**What does this paper add?** The introduction of collaborative arrangements between PPNPs and MPs seems, in some instances, to have created confusion and misunderstanding about the way in which these collaborative arrangements are to operate. This paper provides clarification of the relationship between MPs and NPs in general, and PPNPs in particular, in relation to collaboration, control and supervision.

**What are the implications for practitioners?** A clearer understanding of these issues will hopefully enable greater collegial generosity and improve access to patient care through innovative models of service delivery using NPs and PPNPs.

**Additional keywords:** interprofessional relationships, private practice.

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## Introduction

The purpose of this paper is to clarify the relationship between medical practitioners (MPs) and nurse practitioners (NPs) in general, and privately practising nurse practitioners (PPNPs) in particular, in relation to collaboration, control and supervision in Australia. NPs are now established in the Australian nursing workforce, with the first NP authorised in 2001.<sup>1</sup> Despite significant opposition in the early days from elements of the medical profession,<sup>2,3</sup> NPs are now endorsed to prescribe medications, initiate pathology and diagnostic imaging investigations and

make referrals to other healthcare practitioners (HCPs). NPs in Australia are well established in clinical areas such as emergency departments,<sup>4</sup> specialist services including cancer<sup>5</sup> and complex care areas such as diabetes<sup>6</sup> and heart failure.<sup>7</sup> The intent has always been that NPs can provide entire episodes of patient care without duplication of services while still working collaboratively with other HCPs.<sup>8</sup> As of September 2018, there were 1745 endorsed NPs in Australia.<sup>9</sup>

In Australia, most NPs are employed in the public sector, with a smaller number working in private settings.<sup>10</sup> Concern that very

few NPs were working in Australian community settings was considered to be due to their ineligibility to provide care subsidised through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS).<sup>11</sup> In 2010, legislative amendments were passed enabling NPs to access the MBS and PBS. Several private community NP services have since developed.<sup>1</sup>

There is strong evidence here<sup>12–22</sup> and in the US<sup>23</sup> demonstrating that public sector NPs are providing safe, high-quality care and improving patient access. Confirmatory outcome measures include waiting and treatment times<sup>12–16</sup> and patient satisfaction.<sup>17–22</sup> There is concern that the comparative research (evaluating NPs as substitute MPs) limits the focus on the work that NPs provide as highly skilled nurses<sup>24</sup> and overlooks the fact that they have their own values and their own unique models of care delivery,<sup>19</sup> complementary to medical models but not necessarily the same. This need to portray NPs as substitute doctors also leads to misperceptions. Moreover, recent experience from one of the authors of this paper (TW) implementing new public sector NP roles as part of a multisite translational research project has highlighted an erroneous belief that NPs must work under the ‘supervision’ of medical specialists, some of whom fear they may be ‘responsible’ for NPs’ decisions. This misunderstanding is discussed further below.

In order for PPNPs to access the MBS and PBS, they are required by law to establish a collaborative arrangement with an MP or an entity that employs MPs (*Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010* (Cth); *Collaborative arrangements for Nurse Practitioners Determination, 2010*). The collaborative arrangement is defined as an arrangement between an eligible NP and a specified MP that must provide for consultation, referral and transfer of care, as clinically relevant. NPs are the only health professionals legally mandated to establish a collaborative arrangement in order to access the MBS and PBS.

The obligation for PPNPs to have mandated collaborative arrangements has created significant discussion.<sup>10,25–27</sup> Opponents argue that collaboration is innate to nursing practice, thus NPs naturally collaborate with a range of HCPs, including MPs. Furthermore, the ability for an NP to be eligible to access the MBS and PBS becomes a matter of choice for an MP and a matter of supplication for the NP. Recent research (and experience of the authors) has shown that some MPs do not understand the nature of the collaborative arrangement, reinterpreting it as a supervisory or control relationship.<sup>28</sup> Such an interpretation contradicts the intent of the introduction of NPs initially,<sup>29</sup> and latterly PPNPs,<sup>11</sup> which was to increase access to health services for underserved and marginalised populations through the introduction of a highly skilled nursing workforce that was able to practise autonomously.<sup>30</sup>

The persistence of these misunderstandings among some MPs has led to associated concerns about their liability for the actions of NPs and PPNPs. This paper sets out to clarify the relationship between MPs and NPs in general, and PPNPs in particular, in relation to collaboration, control and supervision in Australia by examining concerns that have been expressed over liability and complaints. In doing so, a clearer understanding of the skills and competence of NPs and the nature of the relationship between an NP and a similarly skilled MP can be achieved.

## Nature of collaborative arrangements

The concept of the collaborative arrangement is a work of complexity. Under the *National Health (Collaborative arrangements for nurse practitioners) Determination 2010* (the Determination) a collaborative arrangement is defined in several different ways under Sections 5 and 6 of the determination (see <https://www.legislation.gov.au/Details/F2010L02107>, accessed 28 May 2019). Under Section 5(1):

- (a) *the nurse practitioner is employed or engaged by 1 or more specified medical practitioners, or by an entity that employs or engages 1 or more specified medical practitioners;*
- (b) *a patient is referred, in writing, to the nurse practitioner for treatment by a specified medical practitioner;*

Under Section 6:

- (1) *An agreement may be made between:*
  - (a) *an eligible nurse practitioner; and*
  - (b) *1 or more specified medical practitioners.*
- (2) *The agreement must be in writing and signed by the eligible nurse practitioner and the other parties mentioned in paragraph (1) (b) [i.e. the one or more specified MPs].*

This indicates that although the NP may be employed by the MP, the NP may also be self-employed or employed by another agency and may be engaged by the MP to work with them. Given that most NPs work in specialist areas, many such arrangements would already have been in place at the time of introduction of the Determination, although probably most the NPs would have been employees at that time. Specialist NPs often work closely with specialist MPs in areas such as chronic and complex care,<sup>10</sup> diabetes,<sup>6</sup> renal disease<sup>31</sup> and mental health.<sup>32</sup> What NPs were unable to do was to obtain independent financial reimbursement for the work they did because, if they were self-employed, they had no access to any forms of payment other than direct out-of-pocket expenses for their clients.

Where the Determination reaches new heights of complexity is in Section 7, the arrangement for the PNP’s written records, which is set out in [Box 1](#). As indicated, Section 7 is extremely detailed and obliges the PNP to record specific details in a patient’s clinical record. The detail required depends on the form of collaboration occurring (e.g. collaboration by referral to another medical professional or consultation with a medical professional). This mandated level of detailed documentation could be considered as overkill. There is no evidence that audit or other forms of surveillance are maintained in relation to PPNPs’ compliance with Section 7. Furthermore, the level of detail in Section 7 is unique and has no equal in any other relationship between any other health professional groups (with the exception of the parallel Determination required for midwives).

Numerous research studies cited above examining NP efficacy have indicated the NP to be a high-performing clinician who has the potential to be a significant asset to an overstretched and maldistributed medical workforce. A recent study demonstrated that NPs practising in the private sector are able to address the needs of underserved areas of the population, thereby creating new and innovative models of healthcare delivery and providing

**Box 1. Arrangement for the Nurse Practitioner's written records (reproduced from <https://www.legislation.gov.au/Details/F2010L02107>, accessed 28 May 2019)**

**7 Arrangement – nurse practitioner's written records**

- (1) An eligible nurse practitioner must record the following for a patient in the nurse practitioner's written records:
  - (a) the name of at least 1 specified medical practitioner who is, or will be, collaborating with the nurse practitioner in the patient's care (a *named medical practitioner*);
  - (b) that the nurse practitioner has told the patient that the nurse practitioner will be providing services to the patient in collaboration with 1 or more specified medical practitioners in accordance with this section;
  - (c) acknowledgement by a named medical practitioner that the practitioner will be collaborating in the patient's care;
  - (d) plans for the circumstances in which the nurse practitioner will do any of the following:
    - (i) consult with a medical practitioner;
    - (ii) refer the patient to a medical practitioner;
    - (iii) transfer the patient's care to a medical practitioner;
  - (e) any consultation or other communication between the nurse practitioner and a medical practitioner about the patient's care;
  - (f) any transfer by the nurse practitioner of the patient's care to a medical practitioner;
  - (g) any referral of the patient by the nurse practitioner to a medical practitioner;
  - (h) if the nurse practitioner gives a copy of a document mentioned in subsection (2) or (3) to a named medical practitioner – when the copy is given;
  - (i) if the nurse practitioner gives a copy of a document mentioned in subsection (4) or (5) to the patient's usual general practitioner – when the copy is given.
- (2) If the nurse practitioner refers the patient to a specialist or consultant physician, or if the nurse practitioner requests diagnostic imaging or pathology services for the patient, the nurse practitioner must give a copy of the referral, or the results of the services, to a named medical practitioner if:
  - (a) the nurse practitioner:
    - (i) consults with the named medical practitioner; or
    - (ii) refers the patient to the named medical practitioner; or
    - (iii) transfers the patient's care to the named medical practitioner; and
  - (b) the named medical practitioner asks the nurse practitioner for a copy of the referral or results.
- (3) Also, the nurse practitioner must give a named medical practitioner a record of the services provided by the nurse practitioner to the patient if:
  - (a) the nurse practitioner:
    - (i) consults with the named medical practitioner; or
    - (ii) refers the patient to the named medical practitioner; or
    - (iii) transfers the patient's care to the named medical practitioner; and
  - (b) the named medical practitioner asks the nurse practitioner for the record.
- (4) If the nurse practitioner refers the patient to a specialist or consultant physician, or requests diagnostic imaging or pathology services for the patient, and the patient's usual general practitioner is not a named medical practitioner, the nurse practitioner must give a copy of the referral, or the results of the services, to the patient's usual general practitioner.
- (5) Also, if the patient's usual general practitioner is not a named medical practitioner, the nurse practitioner must give the patient's usual general practitioner a record of the services provided by the nurse practitioner to the patient.
- (6) However, subsections (4) and (5) apply only if the patient consents.
- (7) In this section:

*usual general practitioner*, for a patient, includes a medical practitioner nominated by the patient.

support, infrastructure and expertise to the healthcare workforce.<sup>33</sup> The proportion of NPs working privately and reaching out to underserved populations is low compared with those working in the public health setting.<sup>34</sup> Privately practising nurse practitioners do practise in rural and remote locations, where there may be few MPs with whom to collaborate.<sup>34</sup> It has been reported that some PPNPs have experienced difficulty identifying MPs who are willing and available to collaborate with them, and this has been an impediment to the establishment of their private practice.<sup>33,35</sup>

In a national survey of PPNPs, it was reported that establishing a collaborative arrangement was dependent on the personality of the MP in terms of their willingness to collaborate and their perspective on collaboration.<sup>33</sup> The success of collaborative arrangements was highly dependent on the MP's level of understanding of both the NP's role and the legislation. However, where there was a good understanding of the expertise of the PPNP, especially where the PPNP and MP were working in the same speciality and/or the same location, this made a significant

difference to the nature of the relationship and was related to more frequent communication.<sup>35</sup> The benefits of collaboration are well documented and, when effective, collaboration supports mutual learning between NPs and MPs<sup>35</sup> and can improve prescribing practice,<sup>36</sup> reduce patient waiting times<sup>37</sup> and reduce cost of care.<sup>38</sup> When collaboration worked well, it reportedly facilitated mutual learning and enhanced patient care because it provided opportunities to discuss treatments, particularly medications.<sup>35</sup>

However, not all collaborative arrangements have worked well. PPNPs have reported misinterpretation of the collaborative arrangement legislation, with MPs perceiving collaboration as a supervisory role with concomitant legal responsibility.<sup>35</sup> Twenty-five per cent of participants in the national survey reported challenges with their collaborative arrangement;<sup>35</sup> analysis of these data revealed six themes: understanding of collaborative arrangements, understanding of PPNP role, resistance, accessibility, reciprocity and difference in clinical opinion. Evidence indicates that mandated collaborative arrangements and the

current design of the MBS and PBS are two significant barriers to NPs establishing and working in private practice, and thus improving access to underserved populations.<sup>27,35</sup> The recently published report of the NP MBS reference group,<sup>39</sup> part of the MBS review taskforce, recommends the removal of the mandated requirement for PPNPs to form collaborative arrangements. The report states that collaborative arrangements are an impediment to the growth of the PPNP role and their capacity to improve access to care.<sup>39</sup>

### NPs: education and practice preparation

The Nursing and Midwifery Board of Australia (NMBA) has developed standards for practice for NPs in Australia.<sup>40</sup> The standards are deliberately stringent to ensure that those endorsed as NPs have the necessary skills, knowledge and experience to practise safely. The educational requirement for endorsement in Australia is a Master's Degree and 5000 h or 3 years full-time experience at clinical advanced nursing practice level. This requires the registered nurse (RN) applying for NP endorsement to be skilled and specialised in their clinical field before endorsement, with similar experience by the time of endorsement to a Fellow in a professional medical college. In addition, the NP must have completed an approved Master's qualification that is recognised by the Australian Nursing and Midwifery Accreditation Council (ANMAC) demonstrating that the NP is able to meet the NP standards for practice.<sup>41</sup> These stipulations are designed to ensure that NPs can function to the full scope of their practice and are capable of managing patient episodes of care, collaboration, referral for investigations, referral to other HCPs, medication management and interpretation of investigations, to name but a few of their everyday functions.

### Complaints and notifications about NPs

Liability is defined as 'the legal responsibility for an action'.<sup>42</sup> Professional liability is described as those 'legal obligations arising out of a professional's errors, negligent acts, or omissions during the course of the practice of his or her craft'.<sup>43</sup> Where patient care is concerned, most remedies that a patient may seek usually relate to some sort of treatment-related harm or the outcomes of poor care. Healthcare-related remedies fall into several categories and, following an adverse event, a patient may choose to seek redress in several ways, depending on the outcome they seek.

Patients may go directly to the healthcare provider, be that an employer or an individual practitioner, and state their grievance. The remedy that is required may be as simple as an explanation and an apology. Nowadays, when an adverse event occurs, it is best practice to explain to people what has happened when things go wrong, although this is not necessarily considered to be an admission of liability.<sup>30</sup> This process is referred to as 'open disclosure'<sup>42</sup> and is described as:

*...an open discussion with a patient about an incident(s) that resulted in harm to that patient while they were receiving health care. The elements of open disclosure are an apology or expression of regret (including the word 'sorry'), a factual explanation of what happened, an opportunity for the patient to relate their experience, and an explanation of the steps being taken to manage the event*

*and prevent recurrence. Open disclosure is a discussion and an exchange of information that may take place over several meetings.*<sup>42</sup>

If the patient or family is concerned about patient safety, because they believe the HCP to be unsafe or perhaps unwell, they may take their grievance to a regulatory or healthcare complaints authority. In such cases, the focus is on the protection of the public,<sup>44</sup> rather than on the punishment of the HCP *per se*. This type of liability is sometimes referred to as 'professional liability' because it relates to the HCP's professional status and registration.

If the person has suffered current or future financial loss as a result of the harm incurred by the HCP, they may sue the HCP or the HCP's employer in negligence in order to obtain compensation for their loss. This type of civil liability relates to a financial remedy, which may be far more than the HCP is able to provide, unless they are appropriately ensured. Under Section 38(1)(a) of the *Health Practitioner Regulation National Law 2009 (Qld)*, each National Board has to set a registration standard in relation to professional indemnity insurance (PII) requirements for the profession (see <https://www.legislation.qld.gov.au/view/pdf/2017-10-11/act-2009-hprnlq>, accessed 2 June 2019). All practising registered nurses<sup>45</sup> and all practising MPs<sup>46</sup> have to declare annually that they will not practise their profession unless they have PII arrangements in place. Thus, there is an expectation that the HCP will be able to provide a financial remedy through their PII arrangements.

However, a large employer is considered to be in a better financial position, better able to plan and ensure for such losses and better able to distribute such losses through their financial system. In determining liability in such situations, the courts will consider whether the liability for an individual's negligent act can be transferred to another person. This is known as the doctrine of vicarious liability.<sup>30</sup>

Where two employers or two groups of HCPs are involved, the determination of liability will go to the facts of the case, particularly where there is disagreement between HCPs as to whose act incurred the liability.<sup>2</sup> For example, in two Australian operating theatre cases (*Langley and Warren v Glandore Pty Ltd and Thomson* [1997] QCA 342; *Elliott v Bickerstaff* [1999] NSWCA 453) where there were retained swabs, the surgeons successfully made the case that the RNs were responsible for the swab count (and thus their employers were liable for the related damages).<sup>30</sup>

Both professional and criminal liability are always personal: each individual HCP is expected to be answerable for his or her own actions, and even in civil liability the allocation of fiscal liability (be it vicarious or personal) is dependent on the level of culpability of the individual HCP and the standard of care that could be expected. An extensive review of case law where both medical and nursing staff were under scrutiny demonstrated that MPs gave evidence (accepted by the courts) that they relied on the expertise of their nursing colleagues.<sup>2</sup> If this were the case for an RN, arguably the defence would be more cogent were the MP to be relying on the greater expertise of an NP.

The Australian Health Practitioner Regulation Agency (AHPRA) complaints databases were searched to try to identify the type and number of complaints about NPs since 2010.



However, the AHPRA annual reports do not provide specific information about NPs. The tables of panel and tribunal hearings also did not reveal any specific complaints about NPs, despite providing greater detail about the nature and location of certain complaints.

A search on the Australasian Legal Information Institute website (austlii.edu.au, accessed 2 June 2019) in the health practitioner database found 47 references using the search term 'nurse practitioner'. However, of these, only four tribunal decisions related to NPs. One was a professional boundary issue (*Nursing and Midwifery Board of Australia v Buckby* [2015] WASAT 19), two were sexual misconduct issues (*Nursing and Midwifery Board of Australia v Stephenson* [2016] SAHPT 6; *HealthCare Complaints Commission v Stone* (No 2) [2016] NSWCATOD 150) and one was an appeal from a finding of unsatisfactory professional performance, which was allowed (*Ropciuc v Nursing and Midwifery Board of Australia* [2015] WASAT 77).

A recent New South Wales (NSW) study examining initial complaint data from the NSW Nursing and Midwifery Council's database revealed no performance complaints against NPs.<sup>47</sup> In that study, 978 complaint files (July 2010–June 2015) were 'hand searched': 266 files related to a health or conduct complaint and were therefore excluded because they did not assist with the understanding of performance or competence, leaving 712 complaints that were eventually analysed, none of which identified the respondent as an NP.

Were one to make comparisons about the risk profile of receiving a complaint about an NP, as opposed to an MP, the 2015–16 AHPRA annual report identified that 53.3% of notifications were about MPs, who make up 16.3% of total practitioners.<sup>48</sup> The 2015–16 subreport of the NMBA identified that, on a national basis, the percentage of registered health practitioners with notifications received during the year was 1.5%. The percentage of all nurses with notifications received was 0.5%.<sup>49</sup> It is acknowledged that the number of endorsed NPs is small, compared with RNs, and there is no evidence to support that there is any cause for MP concern about NP performance.

## Conclusion

This paper has set out to address concerns raised by some MPs about their collaborative relationships with NPs and PPNPs. The concern regarding collaboration and its legal implications has recently been raised in both the public sector in relation to funded translational research and in the private sector through misunderstandings about the mandated collaborative arrangements. These medical concerns are reportedly related to liability, risk and their relationship as 'supervisors' of these highly skilled clinicians. The purpose of this paper has been to clarify the relationship between MPs and NPs in general, and PPNPs in particular, in relation to collaboration, control and supervision in Australia, as well as to explore the difficulties reported by PPNPs in establishing mandated collaborative arrangements with MPs in Australia. The paper has laid out the educational and clinical preparation of NPs and identified that the current record of performance complaints about NPs in Australia is negligible. It is hoped that this paper will facilitate an improved understanding that will encourage more MPs to establish collaborative

arrangements with PPNPs and NPs. A better outcome would be the recognition that there is no requirement for this unique mandated collaboration at all and that the recommendations of the MBS NP reference group to remove collaborative arrangements are upheld.

## Competing interests

The authors confirm there are no competing interests.

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