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Nurse Practitioners: An Opportunity to Recreate the Art of Nursing

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Abstract

The Australian Public Healthcare system today is complex and fragmented. It is a three-tiered system comprising primary, secondary and tertiary care. The typical hospital structure is a complex web of clinical streams, supported by Allied Health and other administrative functions. The system has created clinical silos without considering how they work together to look after the patient holistically. There is a separation within the system of people with a disability, chronic or complex illness, aged care, mental and social welfare.

Healthcare nursing is both and art and a science. However, the time pressures on nurses have largely reduced their roles to being task driven. They may be mindful that health affects all members of families, that health and illness are family events and that the process and outcome of healthcare is influenced by family support but, they do not have the capacity within their roles to practice this art of nursing.

Experienced nurses are feeling disenchanted and are leaving the profession. One ideal solution is to have a healthcare coach (nurse practitioner) who is available to the patient, for the patient; assists the patient in interpreting the system; understands what the doctor/specialist is looking for; supports communication between providers and patients and has the ability to access a support network.

This role would provide a career pathway for more experienced nurses, retain them in the profession and address many of the communication issues that arise for patients trying to navigate the complexity of the Australian Public Healthcare System.

Introduction

In this discussion we consider a new nurse practitioner model based on generalist knowledge and experience in a similar context as a general physician in medicine, as the highest ideal. A generalist nurse practitioner provides both an understanding of medical care, allied health care and experience in how the healthcare and social welfare system works. Over the years we have attempted many different versions of collaboration between different specialties in the care of our patients including eg. Multi-disciplinary teams. The challenges of working in multi-disciplinary teams is time and cost. We know from experience of nurse practitioner models such as clinical nurse specialists in diabetes, respiratory, cardiac and community nursing that patients feel comfortable and safe. They feel more able to follow treatment protocols but more importantly the experience with the health system is dramatically improved. Unfortunately, we currently have no generalist nurse practitioner model to work with which would improve communication across the specialties (including allied health professions). As the nurse practitioners are currently funded through Medicare this would provide a wider scope for not only improved collaborative care, but also reduced anxiety in the patient with the outcome of less aggression towards healthcare professionals. Both of these outcomes are essential to improve patient outcomes in the healthcare environment and also reduce costs by improved workplace health and safety and also provide a career path for nurses who are no longer able to work because of age and restricted ability. It also ensures that the money spent for their education, training and experience is not lost.

Experience of working in the community has given the author a greater understanding of how important it is to provide whole of person care. Seeing people in their natural environment opens up a greater understanding of the person, their family situation, their environment and their ability to manage preventative treatment. Experience of caring and patient roles has also given the author a greater understanding of how traumatic experiences within the healthcare system can actually be. One of the most important things a patient can experience is the notion of being heard and considered an equal within the care team. The nurse practitioner model provides an ability for interpretation and communication to be addressed in a manner that is less intimidating than dealing with healthcare professionals who by nature of their work are often feeling rushed. Finally, we believe this nurse practitioner role will support a number of current issues that are trying to be dealt with through a number of different pilot programs.

There are two notions that are considered when we are talking about nursing. They are 1) task oriented nursing care which is the science and 2) the art of nursing which encompasses the intuitive side of nursing gained through experience. The art of nursing includes being able to speak to somebody and understand what their needs are outside of and above what is already known. It is where the nurse is able to step into the patient's place in the world and work on understanding what impact the medical condition, that has already being diagnosed, is having on their lives. It is more than just looking at the patient in isolation, it includes their family, their social network and their work environment. It is taking into consideration how long they might be in hospital, what impact that might have, the complexity of their needs and the patient's family situation (eg. do they have

young children that they are caring for). When considering the art of nursing it encompasses people that you remember. They are the people that have sat down and spoken to you about what is happening to you, the patient. We need to re-establish the notion that the patient is the centre of their medical care, they are the ones that get to say 'yes' or 'no' to anything that we do. If we try and do something that they do not want us to do, it is called assault. The exceptions are if they are incapacitated or incompetent (for example, if the patient has just had a car accident, next of kin or medical power of attorney cannot be contacted and it is an emergency).

The art of nursing is looking at the person holistically. You have more time to get to know the patient. The doctor only gets a short amount of time and they are dealing with a specific issue. The nurse looks at the whole picture and they are the most likely to understand the whole picture. They have a little bit of knowledge about a lot of different things. By necessity, they have to because if you were working in a remote area, you need someone who can work independently of others, that is financially viable, and is able to say "I know where my limits are, I know when to send you off to a medical or allied health care specialist in this area"

Nurse practitioners will look at all of the areas that go into making up a person, including their cultural and religious background, their understanding of English and whether they need to have an interpreter to come in. It might be just once during their stay in hospital or at the beginning of the process of diagnosis. This one step may allow the patient to make better, more educated decisions and allow them to feel like they are part of the discussion.

Life experience, as well as experience working in different areas of nursing would be required for a generalist nurse practitioner. This can be seen when patients have the experience of working with their diabetes nurse, their cancer nurse or their district nurse. These nurses have developed knowledge over time and they have become better at it. They are the ones people remember because of their passion and experience in their nursing role. When nursing in the hospital system, the acute setting tends to have a lot of younger nurses. There are some older nurses, but because of the physicality required in nursing a lot of the older nurses tend to work towards shifts that they can do during the day or they focus on a particular area of nursing so that they feel they can be better nurses in their area of expertise. Examples might include cardiac nurses, respiratory nurses or nurses who work in infectious diseases. These are nurses who have usually done further study in the area of their expertise. The reason you remember them is because they are so passionate about what they do, they do give you the time, and they become very skilled at managing their time well. This then gives them the time to sit down with the patient at some stage and ask "What's happening?"

Context for nurse practitioners

We do have nurses in general practice. Again some of them are good, as they provide patients with someone to speak to and support them in their plan of treatment however, some of them are more task orientated by necessity due to time constraints. The author means that they are able to spend more time with the patient than the GP to talk about their story, their life. Generally speaking because the nurse in that position is able to illicit a lot more information about what the patient needs to manage at home safely.

If you have somebody in a hospital 500km away from their family unit because they happen to live in the outback then how do you manage that? This is particularly relevant for communities in the remote or rural areas of Australia. Telehealth or video conferencing programs can support communication but it is not the same as having human contact. Again it is about understanding more about what that person is going through, how much it is affecting their life in general, and making sure that they are getting the right care at the right time. As an example, if a patient is having orthopaedic surgery, the doctor will almost always consider rehabilitation because there is a necessity to build up enough muscles around the new knee or the pin or whatever it might be. There are other things that might come into play. If the patient has had a disease or traumatic injury and it has affected their stability and movement then the nurse might suggest to the doctor that an Occupational Therapist and/or a Physiotherapist is required to look at this person before they go home. We need to make sure they go home and they know they need to see the GP, OT and physio. There might be an impact on their work life. A social worker might need to look at getting them assistance with Centrelink payments or seeing what kind of programs there are for them, whether it is Worksafe or TAC or whatever it might be.

A knowledge base that comes with lifelong skills and not just new graduate skills unless the nurse happens to be a graduate who already has life experience that included a caring role or they have almost adjacent to a caring role. For example, the nurse might the eldest daughter who is looking after the grandmother or the eldest daughter of a family where children are a generation apart and they are the one looking after the babies. Another example might be a nurse who has parents who need care. Alternatively the nurse who is learning may have gone through the health and welfare system already. They may have a condition which causes them to see lots of specialists and lots of other allied health professionals. Everybody has had a different life experience and therefore may come out of university with greater understanding of the needs of the patient over and above their education.

Having an understanding of cultural differences, language differences, and knowing that the current illiteracy rate of adult Australians (according to Australian Bureau of Statistics) is 1% who are not able to read any pamphlets that the nurse may give them, or the new migrant who comes in and asks the doctor about something

and then says 'yes' to everything because that is an expectation. The most likely treatment plan that is not followed is the preventative one. "Why would I do this if I'm healthy and I feel fine? I don't want to put chemicals in my body if I don't have to. I don't want to follow a diet because I like the food it eat. How dare you tell me to do that. I don't have time to make meals, I don't have time to go for a walk". All of these things that we think as healthcare professionals, as preventative measures, are often the ones that are least likely followed. Therefore, having a nurse practitioner following up with the patient would support both the GP and the cost of further treatment due to the recurrence of the original diagnosis.

Why do people get aggressive when they come to see the doctor or go to a hospital? The simple act of going into someone's clinic or emergency department is traumatic in itself. They are already sick, they have already been injured, and then they find themselves in this weird environment that smells like detergent, with all this noise and all these lights. It is not conducive to feeling comfortable. To be able to find that space where somebody feels comfortable to talk to a professional about their innermost fears and their worries about how they are going to manage in the future, only comes with a development of trust. Doctors coming through quickly are not going to be the people that the patient will trust. The doctor who comes in, sits down and actually talks to the patient, will be the one the patient not only trusts but will remember. There are not many of those anymore. Everybody is in a rush. This includes nurses. Health professionals are always in a rush to next thing they have to do.

Who contacts the general practitioner to tell them that one of their patient's have been in hospital? They have an automated system that faxes or emails through discharge letters, sometimes it works and sometimes it does not, even in the private sector. We would think that there is a system where they can pay for the better machines and have it monitored…there is not. How then does the GP know that the patient has been in hospital unless the patient goes to the GP to tell them. But they are not going to go to their GP after a hospital visit if they do not think they need to. It might be three months down the track that they go to the GP and tell them that they have been in hospital a few months ago and had a problem with "something – it might have been sugars – I'm not sure". It is only then that the GP can follow up. The problem is they have lost three months of treatment which might mean the patient has already gone back to the original baseline before they went into hospital.

On the other side of the coin is the fact that our experienced nurses are leaving the profession for a number of reasons. One of those might be because nursing care is very physical, shift work is very hard to maintain for a long period of time (especially if they have children) and we are so busy now that some nurses feel like they do not have time to do what they did nursing for – which is to give the patient a sense of safety and trust, to give the patient a chance to say what is on their mind, to actually elicit some of those issues that might come up during that conversation.

There is an argument within multi-disciplinary care teams as to who should be the team leader. Always the team leader is the person who makes the decision at the end of the day. At the end of the day, the person who makes the decision is not the surgeon, or the GP, or the social worker, it is the patient. We have to remember that they are in control of what happens to them. If we do not give them the information in a way that they understand then they are going to be scared. They are going to feel like things are moving at a pace that they do not understand and they are going to get more distressed and this comes out as aggression.

Take the time before you walk out the door to ask "Is there anything else I can do for you?" Not doing so means you have lost the chance for them to express their distress. The patient may become aggressive. Then the family may also become aggressive because they are getting information from the patient. The patient is saying "they're not doing this, they're not doing that"

We need to look at the art of nursing as a specialised part of our care. We have nurse practitioners already but they are clinical specialists. For example, they go down the track of cardiac nursing, diabetes nursing or respiratory nursing. We have got clinical specialists in nursing, clinical specialists in medicine, but in medicine we also have physicians who have a general understanding of what is happening in other areas of the patient's care. Why don't we have a place for nurses who have a generalist knowledge, whose specialist knowledge is about the healthcare systemand how it can support somebody, not just in the clinic, or in the hospital or for a short time in the community, but across a longer span of time until that person feels like they can actually be safe to manage on their own.

We have developed these silos in our healthcare system which are much specialised. Understanding some of the history of the Australian healthcare system helps to explain how this has come about.

The Australian healthcare system

The Australian healthcare system began with medical services provided only to people who could afford to pay or who were covered by charity. As a result, many Australians ended up bankrupt and destitute due to illness. Families gave up everything in order to pay for the care of a loved one. If that person also happened to be the main breadwinner, it was even harder for the family to manage financially.

Prior to the introduction of universal healthcare, families had to find a way to pay for everything on their own. Private health insurance was available, but it was something people opted into on their own, not something provided by their employers. The introduction of Medicare enabled many more people to have access to affordable healthcare,

but earlier regulations meant that not all medical professionals were required to participate in the program.

In 1946 (after World War II), the Australian constitution was amended to ensure the prohibition of any federal law authorising medical and dental services in a manner that would result in 'any form of civil conscription' of the practitioners. This meant that doctors or dentists could not be forced into working for the government.

The Federal Labor Government lead by Gough Whitlam established community health centres in the 1970s so GPs would receive the support they needed to provide health services to people at home. Community health services allowed allied health professionals to work alongside GPs to offer improved care for patients in the community. They were initially funded by a mix of federal, state/territory and local governments. However, the majority of care was still provided in hospitals. People could also have private health insurance, but the premiums were high and out of reach for many.

Medibank (the first attempt to provide a universal healthcare scheme) was established in 1975. Medibank Private became available only to paying customers when the Liberal Party led by Malcolm Fraser was elected in 1975.

With the return of the Australian Labor Party (ALP) headed by Bob Hawke in 1983, the universal health scheme changed its name to 'Medicare'. This was considered a major social reform that aimed to produce a simple, fair and affordable insurance system that provided basic health cover for all Australians.

Medicare is now Australia's national health insurance scheme, which subsidises many medical and allied healthcare services for Australian citizens, permanent residents and those from countries which have reciprocal agreements with Australia. Medicare commenced on 1 February 1984, following the passage of the Health Legislation Amendment Act 1983.

Conservative government policies have changed the nature of funding for Medicare over the years. In 1999, the then government (under John Howard) introduced the Private Health Insurance Rebate to encourage people back into the private healthcare system and reduce the pressure on the public healthcare system. Middle income families were required to pay a Medicare levy if they did not take out private health insurance. This has had the effect of reducing the funding of the public healthcare system and further weakening the welfare state in Australia.

Private corporations have increasingly pushed into the public health sphere, which has had an overall negative impact on the quality of healthcare in Australia. The costs of private health insurance continued to increase, despite the Medicare levy and rebate, which reduced the ability of middle-class families to afford private health insurance. The big winners in this policy change have been private health insurance companies and their stakeholders.

These days, GPs and other medical specialists commonly resent the impact of the corporatisation of their patient care into what is essentially an American-style managed care system. It erodes their historical role as arbiters of the cost and degree of medical care. Although there has been an increase in the care of chronically ill patients in the community, most healthcare funding is still targeted at the acute care setting – that is, funding is aimed at curative measures rather than the improvement of the ongoing care of these patients (or prevention and management).

Australia is unique because the social services amendment of the Australian constitution is largely a product of the federal government's assumption of responsibility for health insurance after World War II, as part of a wider program of social welfare reforms. Prior to this amendment, healthcare provision was largely the responsibility of the states.

There is now a complex mix of private/public funding and state/federal funding of the Australian healthcare system. Essentially though, the federal government has required states and territories to continue to fund a large portion of the population's healthcare. This has led to distinct differences in funding arrangements across Australia's states and territories. This does, in part, explain the significant differences in care provision across state and territory boundaries.

The system has created specialised silos. We did not have a very good system for talking across those silos. This includes talking about issues around cost and the impact that might have on the family. It includes issues about what happens when the patient goes home. The patient may not be the same person going home that they were before they left. The patient may have been diagnosed with a lifelong condition that means they have to change the way they work and the way they do things. The patient may not be able to go back to work. The patient may come in to the hospital and then have to go to a different home? They may come into hospital as an active person and they end up going home to an aged care facility because they can no longer care for themselves eg. after a serious car accident. Imagine the trauma of that and who would you pull in to make sure that the healthcare system actually works in a way that doesn't cause the whole family to become aggressive and angry towards the healthcare professional.

Having a generalist nursing specialist or a nurse practitioner would actually bring in a role that we are missing at the moment. We are expecting social workers to do this kind of work. Social workers do not have medical knowledge. They do not understand what multiple sclerosis or diabetes does to somebody. They are specialised in the social welfare system. We could name any medical condition and

they would not have the understanding about what the diagnosed condition or ongoing medical treatment would do to someone. That is not what their expertise is in. Their expertise is helping the patient manage their financial and social situation at home. They have a different specialty. This role would not cut across that. It would simply be understanding that the patient needs a social worker or an occupational therapist. It is not about who is fighting for what position, it is giving the healthcare system somebody who can be the interpreter, the communicator across the different specialties, across the different streams of care. It is not only financially viable, they are actually able to speak to the specialist at the specialist's level without missing a beat and then being able to interpret that back to the person who has no idea what treatment was just discussed and explaining it to them in a way that they can understand what has actually happened. Some medical personel and allied health care workers are very good at this but most are not. This is why people are getting so angry with the healthcare system. They are not enabled to be part of the healthcare decision making and often do not understand the information they are given.

A new opportunity

We are suggesting a new role within the system which is utilising the experience of nurses who would otherwise have to leave nursing. If you want to do anything in nursing, you either specialise in a clinical area or you become a manager or you become a researcher. They are the options, that is it. What if you actually want to do more than that? You want to be able to walk on to the ward and say to the patient "what is happening – tell me about what is happening for you". Then be able to talk to the specialist and be able to say to them, this patient has this condition but they have also got this other condition and they are having an impact on each other. Most specialists would know this but not always. They don't necessarily get told the medical history to the extent that a nurse might get from the patient because nurses typically spend more time with the patient. The issue is about time and developing that trust that engenders a feeling of being able to talk freely without 'feeling like an idiot'. If there happened to be a member of the church or any kind of club that nurse might be able to contact the club and say 'did you realise, such and such has ended up in hospital, they haven't seen anyone for a few days, is there someone that could come in and talk to them?'

The recommended education pathway for the generalist nurse practitioner would include a written thesis on what the person has actually done to deserve to be called a nurse practitioner in this area. It might be that they have worked within different areas of the healthcare system, that they have travelled, they have had a family, may have looked after a disabled child, or a child with a serious respiratory illness, may have looked after a family member with a cancer diagnosis and had to look after them for years on end. These might be indicators to show that this person has an understanding of the different areas of the healthcare system. They may have had to take someone they care for from the hospital, to the rehabilitation, to the primary care system. Alternatively, there might be somebody who is studying their Masters in Public Health and they have learned about how the healthcare system works. In this case it would be the social system as well. It would be good to have a post graduate option where there would be more discussion around understanding different cultures, the need for interpreters and around the need to look at the family as a whole, to make sure the family is financially viable and that the patient is not going home and living in poverty because they do not know how to access Centrelink, or they run the risk of losing their house following a serious incident. There are areas that are covered in different programs that could be brought into AHPRA's graduate degree which would then allow a general nurse to become a nurse practitioner in this role. The nurse may need to study epidemiology and then they might do a research paper. Then you could get your masters just like any other specialised area of care. The beauty is that we already have this information. It is not new, it is bringing together those things that are over and above what we have time to learn in the nursing degree as an undergraduate. It is a simple change and would sit under Health Sciences. There would not be a need to go looking for people who are specialised in a particular area because we would already have them within our University system.

We believe this would be a really positive way to improve communication between the different clinical specialties and allied health professionals. It has the potential to reduce readmission rates and reduce the aggression toward the healthcare profession. We are desperately trying to figure out how to do that and it would not be a difficult transition. It would not solve the problem of drug induced aggression, so there would remain some need for security guards, but hopefully at a lesser rate. Having someone whose only responsibility is to speak to the patient and find out what their current situation is, how this trauma or illness is affecting their situation today and if it lasts because we cannot fix it, what will be the ongoing impact. This nurse practitioner could come and see the patient in Emergency, or on the ward or see them in the GP clinic so that they could talk to the patient and ask what is going on. Instead of the doctor getting a two hour download, the nurse can get it. Then when they do see the doctor they can go in with fairly directed conversation because the nurse will be able to bring out what needs to be said. Afterward they can speak again to the nurse who can help them organise appointments if they need it. There can be a phone followup program or if more concerned they may go out to the home. As an example, in Engineering, to become registered by the Institute of Engineering you have to submit a 10,000 word document stating what you have done to deserve to be registered with the Institute.

Conclusion

In conclusion, we consider a nurse practitioner model as the highest ideal, providing both an understanding of medical care, allied health care and experience in how the healthcare and social welfare system works. Over the years we have attempted many different versions of collaboration between different specialties in the care of our patients including eg. Multi-disciplinary teams. The challenges of working in multi-disciplinary teams is time and cost. We know from experience of nurse practitioner models such as clinical nurse specialists in diabetes, respiratory, cardiac and community nursing that patients feel comfortable and safe. They feel more able to follow treatment protocols but more importantly the experience with the health system is dramatically improved. Unfortunately, we currently have no generalist nurse practitioner model to work with which would improve communication across the specialties (including allied health professions). As the nurse practitioners are currently funded through Medicare this would provide a wider scope for not only improved collaborative care, but also reduced anxiety in the patient with the outcome of less aggression towards healthcare professionals. Both of these outcomes are essential to improve patient outcomes in the healthcare environment and also reduce costs by improved workplace health and safety and also provide a career path for nurses who are no longer able to work because of age and restricted ability. It also ensures that the money spent for their education, training and experience is not lost.

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- Successes and challenges for future program developments for general practitioners working in residential aged care

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- The Case for Optimism: The Optimist's Voices 2nd Edition (Contributor)

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