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Nursing Legal Issues in Australia: The Nurse Practitioner

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This paper seeks to review the legal and policy trends facing nurses and, in so doing, indicates the numerous medico-legal and ethical issues confronting the nursing profession. At the same time, it is important to note that many of these developments have a wider impact, affecting not just those involved directly in health care. It is only by way of a collaborative effort that a suitable path will be paved through the many difficult issues surrounding health and health care delivery in this decade.

INTRODUCTION

There is no doubt that we are living in a century in which there have been amazing advances in the fields of medicine and science. Indeed, Edward Shorter, in a 1987 book, described this century as the "health century."[1]

The scientific and medical advances witnessed in this century offer health consumers an enormous array of health care services and, more importantly, choices—choices that were previously nonexistent. This is particularly apparent in Australia in the context of the current consideration given to nurse practitioners.

The focus of medicine and, more importantly, health care and health care delivery has altered dramatically. With the technological developments made in this century, there has, in effect, been a complete change in focus: a change from *care* to *cure*.[2] The proliferation of new technologies, new treatments, and the

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1. EDWARD SHORTER, THE HEALTH CENTURY (1987).

2. *See* ARTHUR H. PARSONS & PATRICIA HOULIHAN PARSONS, HEALTH CARE ETHICS (1992).

increasing professional specialty and practice has posed, and will continue to pose, new and interesting challenges and, equally, dilemmas of an increasingly social and moral kind.

One obvious implication of technological development has been its effect on health care today: the delivery of health care services and, more importantly, the nature of the health care relationship. What is apparent is that decision making in this field is becoming more and more value laden, requiring a consideration of a wide range of issues of a social, ethical, legal, economic, and political nature. These developments are pushing ethical concerns to the forefront; indeed, ethical considerations pervade most areas of health care decision making.

At the same time, the rapid rate of development, particularly evident in the pharmaceutical area with the proliferation of new drugs for illnesses previously untreatable, has served to heighten the expectations that consumers now have of the health care system. Whereas medicine previously had little to offer and patients expected little, patients today are more keenly demanding access to the various products of scientific development as well as making increasing calls upon governments and health providers to provide health services. Health administrators are now confronted with that unenviable task of formulating an equitable basis on which to allocate what are fast becoming scarce resources. The costs of providing health care in the 1990s is an issue that will concern many, and it is an important factor underpinning the current debates in Australia concerning nurse practitioners.

NURSE PRACTITIONERS

There are a number of factors that have precipitated the current formal consideration being given, in New South Wales at least, to the notion of a nurse practitioner. Apart from the more obvious concerns for cost-effective and accessible health care delivery,[3] the consumer movement, together with the heightened claims, expectations, and demands for autonomy in decision making about health care, has been the major basis upon which the current discussions are taking place. With the ever-increasing array of health services, in particular alternative

3. *See* JENNY MACKLIN, THE FUTURE OF GENERAL PRACTICE, ISSUES PAPER 3, NATIONAL HEALTH STRATEGY (1992) (indicating support for the idea that some services may be delivered more cost effectively by nurses rather than medical practitioners).

health services, more options are being generated and, more importantly, sought by health consumers. Nurse practitioners are now being seen as a suitable alternative to the more traditional medical practitioner base of health care delivery.

Presently in Australia, the ability of a nurse to practice as a "nurse practitioner" is significantly limited. A nurse is not able to initiate diagnostic tests or prescribe medication. So, for example, a midwife practitioner cannot legitimately order blood tests or ultrasounds or take swabs without the prior authority of a medical practitioner. Equally, contraceptives cannot be provided by a nurse to clients. Similar restrictions apply to other nurse specialties, such as sexual health and palliative care. Even those nurses working within a health care institution are required to have their decisions to take a specimen or swab validated by a medical practitioner. Those nurses working in the community are equally restrained, there being constant concern to legitimise their professional decisions. These sorts of restrictions currently placed on nurses are being used to demonstrate the enormous savings in time, efficiency, and cost that could be achieved by formal recognition of a broader nurse practice, the nurse practitioner.

The concept of a nurse practitioner, whilst perhaps not new in Australia, is, from a practical point of view, very much in its infancy stage.[4] Only New South Wales, to date, is considering the issue and the practicalities involved in giving formal recognition to such health care professionals.

Specific attention to the concept of a nurse practitioner commenced back in 1990, following the annual Conference of the New South Wales Nurses' Association.[5] The impetus for this came largely from an indication of support from the New South Wales Minister for Health at that time, the Hon. P.E.J. Collins, who subsequently called for a submission on the issue from the nursing profession. The submission was prepared by both the New South Wales Nurses' Association and the New South Wales College of Nursing after wider consultation with the profession. A Health Department task force, the Independent Nurse Practi-

4. Although statistics are hard to find as to current practice nationally, it appears that only 1.3% of all nurses in Australia were performing this role by 1980. Figures indicate that only approximately 100 private and 200 salaried nurses act in this capacity in New South Wales. *See* NURSE PRACTITIONERS IN NEW SOUTH WALES—THE ROLE AND FUNCTION OF NURSE PRACTITIONERS IN NEW SOUTH WALES, DISCUSSION PAPER 3 (1992) [hereinafter NURSE PRACTITIONERS].

5. *Id.*

tioner Task Force, was then set up in September of 1991 by the Chief Nursing Officer of the New South Wales Health Department to examine generally the role and function of independent nurse practitioners and to report back to the Department. Subsequently, a Working Party was formed to review the submissions and develop recommendations. After a review of the joint submission from the New South Wales Nurses' Association and the New South Wales College of Nursing, together with additional independent submissions received from both the nursing profession and medical profession, a Discussion Paper was published.[6]

It is of interest to note that, early in the process, it was decided that the use of the term "*independent* nurse practitioner" was inappropriate, as all health care delivery and practice was seen as requiring the collaboration of all health professionals. Furthermore, a reference to an "*independent* nurse practitioner" was seen as failing to take account of those nurses employed by others, yet still working as nurse practitioners. Practice specialties would be reflected by noting the specialty practice area in parentheses, as in "nurse practitioner (women's health)."

The definition of a nurse practitioner adopted by the Working Party is as follows: "A nurse practitioner is a registered nurse with appropriate accreditation who practises within the professional role. S/he has autonomy in the work setting and has the freedom to make decisions consistent with his/her scope of practice, and the freedom to act on those decisions."[7]

In line with this relatively broad definition, the responses from the profession indicated a wide range of practice areas for those few nurses who considered themselves as coming within its scope and hence practising as a nurse practitioner. The practice areas identified included palliative care; cardiac, orthopaedic, and geriatric rehabilitation; community health management; mental health; rural and remote area nursing; midwifery; women's health; and a variety of specialty education and counseling services.[8]

The Final Report of Stage 2 of the Nurse Practitioner Review concluded that no single definition was suitable. It was, however, agreed that a nurse practitioner is a registered nurse with

6. *Id.*
7. *Id.* at Executive Summary, 4.
8. *See* Mary Chiraella & John Kelly, *Discussion Paper Sparks Debate—Nurse Practitioners in NSW*, 1(2) AUSTL. HEALTH L. BULL. 13, 13-14 (1992).

education for advanced practice, enabling the practitioner to make autonomous clinical nursing decisions within his/her discrete practice specialty.[9]

After reviewing the literature on nurse practitioners, and the different models in place both nationally and internationally, the Discussion Paper proceeds to identify the following specific issues, each with its own legal implications requiring further detailed consideration.

A. Accreditation

The Discussion Paper openly acknowledges the importance of establishing an appropriate system of accreditation.[10] In light of the recent emphasis in Australia upon patients' "rights" and "responsibilities," the issue of accreditation is perhaps the most important issue from the health consumer's perspective. Accreditation is the basis for ensuring accountability and, more importantly, standards of practice. Unless there are specified accreditation criteria and appropriate disciplinary mechanisms in place for the continual oversight and maintenance of professional standards, there is a legitimate concern for the adequate protection of the interests of the health consumer. The profession itself clearly recognises the importance of this issue, as evidenced by the early submissions made to the New South Wales Department of Health.

In this respect, the Discussion Paper identifies the various parties responsible for accreditation and their respective roles. First, the responsibility for seeking accreditation to practice as a nurse practitioner, as well as reaccreditation and any continuing education and peer review requirements, is to lie with the individual nurse, in much the same way as nurses generally are responsible for seeking and maintaining registration to practice under the relevant state or territory nursing acts. The responsibility for establishing and enforcing the appropriate criteria for accreditation is said to lie with those professional organisations responsible for the areas of specialty practice. In addition, such bodies are seen as the appropriate bodies to undertake accreditation and, more importantly, notify the registration boards if an individual's accreditation lapses. The Discussion Paper acknowledges that much work has already been done by the pro-

9. NEW SOUTH WALES HEALTH DEP'T, NURSE PRACTITIONER REVIEW (STAGE 2), WORKING PARTY DELIBERATIONS 5 (1993).

10. NURSE PRACTITIONERS, *supra* note 4, at 10.

fessional bodies in developing professional practice standards, which could provide the basis for the future development of formal accreditation guidelines.

The third party identified as having a role in the accreditation process is the Nurses Registration Board. Specifically, its recommended role is "to establish accreditation guidelines and to officially register accredited nurse practitioners."[11] It was further recommended that an accreditation committee be established by the Registration Board to "develop standards for accreditation and criteria for the subsequent approval of professional colleges and professional groups by the Nurses Registration Board."[12] Each nursing specialist association will be required to recommend the minimal education requirements for its specialty area. In this respect, although post graduate degrees in the various specialty areas are not uniformly available at present in Australia, demand will likely prove to be a driving force for tertiary institutions to respond accordingly.

In order to facilitate the establishment and practice of nurses as nurse practitioners, the Discussion Paper identifies a number of necessary legislative amendments to the Nurses Act 1991 (NSW). Specifically, the legal branch of the New South Wales Health Department made a number of recommendations regarding amendments to the legislation to accommodate the proposed accreditation process. These amendments would require the Nurses Registration Board to register the additional qualifications for and give recognition of the status of nurse practitioner. Those legislative amendments recommended are as follows:

> (i) Part 2 of the Nurses Act 1991 (NSW) would require amendment to include a provision "that a person must not claim or hold out to be a nurse practitioner unless accredited as such";
> (ii) The inclusion of a specific provision "allowing for nurse practitioner particulars to be included in the register"; and
> (iii) A specific provision "allowing for the Board to authorise a person to act as a nurse practitioner."[13]

An important concern identified by the legal branch of the New South Wales Health Department was the availability of suitable mechanisms to ensure accountability and, more particu-

11. *Id.*
12. *Id.*
13. *Id.* at 15.

larly, disciplinary action relating to breaches of professional standards. In this respect, it was noted that the Nurses Registration Board, under the existing legislative provisions, can "only take disciplinary action if a nurse is shown to have breached standards of professional conduct as defined in the Act."[14] As presently drafted, the professional standards make no differentiation of the different types of "nurses." It was noted that "any violation of accreditation would only be actionable by the Board if it also amounted to professional misconduct."[15] Thus, although the relevant professional association would be empowered to withdraw accreditation of an individual nurse practitioner or indeed expel that individual from the association, there is presently no power to prevent a particular nurse from continuing to practice as and hold him/herself out as a nurse practitioner. From the perspective of the health consumer, there would be some means of redress via the lodging of a complaint with the New South Wales Health Care Complaints Commission.[16] There would, however, still be a problem of enforcement, and more particularly an absence of any suitable mechanism for preventing an individual nurse practitioner from continuing to practice. Unless the Nurses Act itself identifies the different professional standards of practice for a nurse practitioner, there will be no adequate mechanism available to prevent continued substandard practice by any one individual nurse practitioner. This is a fundamental issue in the process of giving recognition and legitimacy to nurse practitioners. As such, the legislation must be specifically amended.

B. Professional Accountability

Directly related to the issue of accreditation is the issue of professional accountability. The Discussion Paper acknowledges the importance of professional accountability so as to ensure acceptable professional standards of practice. The major concern here lies not only with the formal establishment of standards of practice for each discrete specialty of nurse practitioner, but, more importantly, the educational requirements for nurse practitioners so as to legitimize their position with both

14. *Id.*
15. *Id.*
16. The Health Care Complaints Commission is an independent statutory body established under the Health Care Complaints Act 1993 (NSW) to which health consumers may make a formal complaint about the provision of health care services.

their peers and clients. In this respect, the Task Force acknowledged that the various professional associations were in a suitable position to set such practice standards.

There is no doubt that in establishing professional standards of practice (or Codes of Practice, as they are often referred to), such documents do serve an important purpose in law, delineating acceptable professional practice and the "base line for competence"[17] by which any one individual nurse practitioner's conduct would be judged. Of major concern here, as expressed by various members of the medical profession, is that nurse practitioners clearly recognise the limitations of their own competence and areas of practice and exercise their legal duties of care to their clients by referring to other specialist health care professionals where necessary. This is an important issue, but is not unique to the concept of a nurse practitioner, and applies equally to all health care professionals.

C. Professional Indemnity Insurance

The issue of professional indemnity insurance is closely associated with the issues of accreditation and accountability. The Discussion Paper acknowledges the importance of the existence of appropriate levels of professional indemnity insurance, recommending that all nurse practitioners be required to hold appropriate professional indemnity insurance and that this be a criterion for accreditation. This is a relatively new area for insurance brokers and underwriters in Australia. However, as acknowledged in the Discussion Paper, it is an issue that has recently been addressed in the context of midwife practitioners, resulting in more formal and standardised policies being offered by insurers to nurses. As noted by Chiraella and Kelly, the recent review of professional indemnity arrangements for health care professionals generally, undertaken by the Commonwealth Department of Health, Housing and Community Services, impacts equally on the issue of indemnity insurance for nurse practitioners. Specifically, they state that nurse practitioners must (i) be willing to have their practice examined; (ii) encourage a multidisciplinary approach to the development, examination, and review of practice standards; and (iii) have a clear commitment to ongoing quality assurance.[18]

17. NURSE PRACTITIONERS, *supra* note 4, at 11.
18. Chiraella & Kelly, *supra* note 8, at 24.

D. Reimbursement

It is acknowledged in the Discussion Paper that the development of and recognition attributed to nurse practitioners requires the establishment of suitable reimbursement mechanisms within the general context of the Australian health insurance scheme. Under the current Medicare arrangements, access to diagnostic tests, such as radiology and pathology, and reimbursement for services are prohibited unless initiated by a medical practitioner. In this respect, a number of different models for reimbursement are considered.

1) Employment by a Hospital or Other Health Service

This model is acknowledged as being the most restrictive in terms of the practice and autonomy of a nurse practitioner, as it "still subrogates the role of the nurse practitioner in relation to other health care providers by requiring a referral to the nurse practitioner before services may be initiated."[19] From another perspective, this model equally impacts upon liability issues. Clearly, if the nurse practitioner works as an employee, then (depending upon the clarity and scope of practice protocols) the employer health care institution or health service could well be found vicariously liable for any adverse outcomes resulting from the negligence of an employed nurse practitioner.

2) Fee-for-service Reimbursement by Private Insurers

This model would require nurse practitioners to negotiate suitable arrangements with the various health insurance providers to accept and offer rebates for nurse practitioner services. As noted in the Discussion Paper, such a model already exists with respect to other health care professionals, such as psychologists and physiotherapists. It is, however, acknowledged that within the context of the two levels of health insurance that exist in Australia (that is, public and private), there is a possibility that consumers may be financially discouraged in accessing nurse practitioners unless they are able to afford private health insurance coverage.[20]

19. *Id.* at 22.

20. NURSE PRACTITIONERS, *supra* note 4, at Executive Summary, 12.

3) Group Practice Arrangements

This model is based upon other models and initiatives in place elsewhere that allow nurse practitioners working in conjunction with general medical practitioners. There are currently some initiatives (by way of practice grants) offered by the Commonwealth Government to assist in improving the quality of health care provided in general practice. In this respect, the Discussion Paper acknowledges the possibility of practice grants equally providing for reimbursement of nurse practitioner fees.

4) Employment Contracting

In effect, this model envisages area health services or other health care institutions contracting for the services of nurse practitioners. The fee for services would be negotiated between the nurse practitioner and the area health service or health care institution. There are, however, considerable problems with such a model. Under the Australian health care system, it is the Medicare Agreement that regulates the payment for the admission of patients, whether public or private, in recognised hospitals within a state or territory. As noted by Chiraella and Kelly, the Medicare Agreement

> focuses on recognised hospitals, treatment rights and categories of eligibility of patients, and all necessary medical, nursing and diagnostic services are meant to be included. Services are to be provided by the recognised hospitals' own staff or by agreed arrangements. In relation to out-patient visits, clause 9.4 of the Medicare Agreement provides that any eligible person, other than a compensable patient, will be entitled to receive, without charge, out-patient, casualty and emergency services provided by a registered hospital. As a general statement, eligible persons are Australian citizens.[21]

As the authors go on to acknowledge, there is currently no specific prohibition under the Medicare Agreement for the admission of eligible patients as public patients under the care of a nurse practitioner. The reason for this is that the current Medicare Agreement focuses on the particular treatment provided and the category of patient admitted, leaving considerable flexibility to the hospital to make its own arrangements as to the provision of its services. Accordingly, whilst a public patient is presently capable of being cared for by a nurse practitioner, there is no capacity to charge that patient for any fees in that

21. Chiraella & Kelly, *supra* note 8, at 23.

regard.[22] Consequently, this model for reimbursement is perhaps the most restrictive on private practice rights for nurse practitioners as it would prevent any payment of fees incurred for the services of a nurse practitioner even under a contractual relationship with the patient.

5) Fee-for-service Reimbursement Under Medicare

Under the Health Insurance Act 1973 (Cth),[23] designated providers are entitled to reimbursement rights on a fee-for-service basis under the Medicare Benefits Schedule for those selected services. A nurse practitioner is not currently a provider under the legislative scheme; the result is that,

> on a private room basis, all patients would be required to meet the fee charged by the nurse practitioner. Under clause 8.2 of the Medicare Agreement, a private patient may elect to be treated in a recognised hospital as an in-patient by a medical practitioner of his or her own choice. The current Agreement specifically states that a private patient may only be treated by a medical practitioner. This excludes the possibility, at this stage, for a nurse practitioner to treat a private patient in a recognised hospital.[24]

Under the existing arrangements, to be eligible for a benefit, all nursing care must be initiated by a medical practitioner. There is, therefore, in effect, a noted duplication of service. As acknowledged in the Discussion Paper, because "some medical services may be more cheaply delivered by a nurse practitioner,"[25] there are considerable arguments in favour of extending the current fee-for-service reimbursement available under the medical benefits scheme. The Discussion Paper does, however, acknowledge the existence of arguments against fee-for-service reimbursement for nurse practitioners. In particular, concern has been expressed about the problem of excessive supply of services, a concern currently identified in the context of general medical practitioners. The Discussion Paper also acknowledges a problem with the current reimbursement arrangements for general medical practitioners. Because of the various schedules and designated services upon which reimbursement is

22. Clause 9.1 of the Medicare Agreement states that any eligible person electing to be a public patient is entitled to receive care and treatment as such without charge. Medicare Agreement Act 1992, 1992 AUSTL. ACTS 226.
23. 1974 AUSTL. ACTS 42.
24. Chiraella & Kelly, *supra* note 8, at 23.
25. NURSE PRACTITIONERS, *supra* note 4, at 12.

based, it has been argued that medical practitioners are discouraged from spending extended time consulting with their patients. One of the major benefits claimed by the establishment and recognition of nurse practitioners is the potential for increased time spent with patients and consequently higher patient satisfaction. The concern, therefore, is that financial imperatives resulting from the current reimbursement arrangements may result in similar financial imperatives being placed on nurse practitioners and a concomitant reduction in the length of time spent consulting with patients.[26]

There are additional legal implications surrounding the formal recognition of nurse practitioners. Under current legislative provisions in all states and territories, registered nurses are not authorised persons for the purpose of prescribing drugs, although there are some exceptions for both emergencies and remote area nursing.[27] In practice, however, additional variations often exist, with some institutions now permitting registered nurses to initiate the administration of Schedule 2 drugs. Although Schedule 2 drugs do not require a prescription by a medical practitioner, many health care institutions do require a medical practitioner to initiate such medications by way of a written prescription. This is clearly another area requiring further clarification and legislative amendments if the practice of a nurse practitioner is to be recognised.

Following the release of the Discussion Paper, a broad consultation process began, commencing with individual interviews with each member of the Working Party and the key stakeholders. In addition, a number of workshops and Working Party meetings followed. These meetings were largely an attempt to formulate appropriate "operating norms" with which the Working Party was to comply. The sorts of things identified are indicative of the highly political, emotive, and sensitive nature of the review of nurse practitioners. Specifically, the Working Party was asked to comply with the following operating norms: "professional respect, no 'us and them,' no anecdotes, provide supportive evidence for assertions, big picture view v. turf battles, no ambit claims, confidentiality, [and] inform the group when you can't attend."[28]

26. *Id.* at 12-13.

27. *See* SUZIE LAUFER (LINDEN), LAW FOR THE NURSING PROFESSION AND ALLIED HEALTH CARE PROFESSIONALS ch. 7 (CCH Austl. Ltd. 1992).

28. Mary Chiraella, *Review of Nurses in New South Wales*, 2 AUSTL. HEALTH L. BULL. 47 (1993).

On 30 June 1993, the New South Wales Minister for Health released the Stage 2 Working Party Report on Nurse Practitioners. The two major issues identified in the Executive Summary were "[t]he need for improved inter-professional collaboration in the evaluation of existing models of health care service delivery and in the assessment of alternative models; and the need to assess objectively both community and professional reactions to, and benefits and disadvantages arising from, such alternative models."[29]

Acknowledging the lack of effective Australian data on the issue, the recommendation of the Working Party was the establishment of a series of pilot projects (Stage 3). These recommended pilot projects were largely to assist in assessing the community and professional reactions to the role of nurse practitioners. Specifically, the series of recommended pilot projects were to be designed so as to "examine the role in terms of feasibility, safety, effectiveness, quality and cost under the auspices of a multidisciplinary evaluation committee . . . ."[30] Each pilot is to be designed in such a way as to evaluate the role of the nurse practitioner on the following dimensions: competencies, accountability, professional indemnity insurance, diagnostic radiology, diagnostic pathology, prescription of medications, and referral procedures.

The Stage 2 Report recommended the implementation of a minimum of three pilot projects within the following models: (i) Nurse Practitioner, remote area; (ii) Nurse Practitioner, general practice; and (iii) Nurse Practitioner, area/district health service.

The series of pilot projects described in the report are recommended to be established within six months, and each project is to be completed within an 18-month time frame. Furthermore, the Working Party recommended that the pilot projects be specifically funded from various sources, including state and commonwealth research/enhancement funding as well as the National Health and Medical Research Council (Cth). The introduction of these projects is to be accompanied by a "communication strategy which informs the community involved of the general purpose of the pilot."[31] Interestingly, the issues concerning accreditation and professional indemnity insurance, although identified as requiring further consideration, were rec-

29. NEW SOUTH WALES HEALTH DEP'T, *supra* note 9, at 0/3.
30. *Id.* at Executive Summary and Recommendations.
31. *Id.* at 29, Recommendation 8.

ommended to be addressed only once the pilot project has been completed and evaluated.

With respect to each of the proposed pilot projects, specific operational frameworks have been outlined and, in particular, definitions and parameters of practice have been clearly defined. Because of the problems with respect to necessary legislative amendment, both in terms of referrals and nurse-initiated prescriptions, the definitions and operational guidelines for the pilot project specifically define the parameters of practice.

The actual selection of eligible project proposals will be based upon written expressions of interest sought by the New South Wales Health Department, each being required to address the specific essential and desirable criteria published in an initial advertisement by the Health Department.[32] The projects will be supervised by a Steering Committee comprised of representatives of the stakeholder organisations in the Stage 2 Working Party. It is the Steering Committee that will be responsible for making recommendations to the Chief Nursing Office of the New South Wales Health Department regarding the particular pilot project sites considered appropriate to be part of Stage 3. As noted by Chiraella, the Stage 2 Report identifies in some detail the levels of responsibility between the various project teams and the Steering Committee. For each particular pilot recommended, "additional parameters are specified with respect to such matters as employment, practice context, source of referral, medical support, customer contact, funding and legal issues."[33]

The majority of legal issues identified in the initial Discussion Paper, relating specifically to accreditation and accountability, do not arise in the context of the pilot projects, as each project envisages the nurse practitioner working as an employee and, more importantly, in close collaboration with a medical practitioner.[34] Of interest are the conditions for participation in a pilot project. All nurses working as nurse practitioners in pilot projects will be required to work as employees or have independent and adequate professional indemnity insurance. This requirement, no doubt, addresses the concerns expressed in the initial Discussion Paper. In addition, to ensure adequate supervision, there are requirements for close liaison with the Stage 3

32. *See* Annexure A.
33. Chiraella, *supra* note 28, at 52.
34. *Id.*

Nurse Practitioner Project Manager and regular progress reports (three monthly). Furthermore, there are specific confidentiality provisions regarding the release of results of the projects and copyright provisions ensuring that copyright remains with the New South Wales Health Department. Additional publicity and media management protocols are specified, limiting contact with the media to designated approved spokespersons.

The current situation regarding Stage 3 of the Nurse Practitioner Project is as follows. The Expressions of Interest were published early in 1994. Thereafter, some 400 resource kits were forwarded to those individuals inquiring about the project. By the closing dates of the Expressions of Interest (March 1994), some 58 proposals for pilot sites in the predefined practice areas were received. After analysis by the Steering Committee, successful pilot sites were identified. Thereafter, in a press release by the Minister for Health on 21 May 1994, it was noted that detailed protocols relating to each of the pilot projects were to be finalised over the next six to eight weeks. The development of these detailed protocols would occur at a local level with each project team, overseen by the Steering Committee. The next 18 months will see the implementation of these pilot projects and, pending their review and evaluation, further decisions will be made. The Minister did, however, indicate in his press release that these were to be considered as pilot projects and, more importantly, "no changes in legislation, policy, industrial or registration arrangements have occurred, nor will they be likely to occur until each of the pilot studies have been rigorously evaluated and there is significant evidence to warrant such action."[35] A final report on Stage 3 is to be submitted to the Minister for Health, the current estimated date being December 1995.

As might be expected, support for formal recognition of nurse practitioners is not forthcoming from all levels of health care professionals. In particular, the medical profession has been quite vocal in the media, expressing concern that nurse practitioners are seeking to "take over the roles of [general practitioners] as deliverers of health services in the community."[36] However, as noted by Chiraella and Kelly, such criticism may

35. Press Briefing Notes, Minister for Health (New South Wales), The Hon. Mr. Ron Phillips (May 21, 1994).

36. Peter Arnold, *Nursing Paper Not Answered*, NSW DOCTOR, Aug. 1992, at 4.

well be inappropriate as the evidence indicates that the concept of a nurse practitioner involves, in the main, the provision of specialist nursing care, rather than general practice in competition with general medical practitioners.[37] In this respect, it is appropriate to take account of the conclusions reached by the United States Department of Health when considering the scope of nurse practitioners in the United States. Without a collaborative approach by both the nursing and medical professions, formal assessment, development, and recognition of the role of nurse practitioners will be difficult to achieve.[38] Regardless, the results of Stage 3 of the Nurse Practitioner Project will be looked at with considerable interest, not only by members of the medical profession, but also by other state governments and their respective health departments.

CONCLUSION

The issue of nurse practitioners raises medico-legal and ethical implications, having considerable impact upon all health care professionals. Contemporary nursing culture in Australia reflects nurses' desires to acquire more knowledge about legal and regulatory processes. This change in focus is equally reflected in nursing education programs, with undergraduate nursing courses comprising more discrete units on law and ethics. Indeed, the role of the nurse as an important member of the health care team is changing. In many ways, it is often only through the input of a nurse as part of the health care team that important ethical principles are consciously raised, discussed, and addressed.

37. Chiraella & Kelly, *supra* note 8, at 14.

38. U.S. DEP'T OF HEALTH, EXTENDING THE SCOPE OF NURSING PRACTICE (1971).

ANNEXURE A

EXPRESSION OF INTEREST
NURSE PRACTITIONER PROJECT - STAGE 3

The NSW Health Department invites expressions of interest for the conduct of pilot projects as part of Stage 3 of the Nurse Practitioner Project (NPP).

This Project has evolved over a period of several years and the progress and outcome up until mid-1993 is described in the document *Nurse Practitioner Review Stage 2, Vol I & II*, available from the Nursing Branch of the NSW Health Department.

For the purposes of this Project nurse practitioners (NPs) have been defined as *registered nurses educated for advanced practice, the characteristics of which would be determined by the context in which they practice.*

The objective of the pilot projects is to examine the clinic judgments and services provided by NPs in terms of customer satisfaction, feasibility, safety, effectiveness, quality and cost in a rigorously monitored setting where the parameters of practice have been clearly defined. The final report will go to the Minister for Health in December 1995.

PRACTICE CONTEXTS

Each pilot project will be implemented within one or more of the following practice contexts:

- **Remote Area** - employment within a remote area or attachment to a rural employment base but providing services to a remote population;
- **General Practice** - employment by, or under contract to a general medical practitioner (GP) within a GP practice; and,
- **Area/District Health Service** - employment by an Area/District Health Service. The specific services that will be considered are: sexual health, mental health, outreach services to homeless persons, hospital-based emergency departments, hospital-based maternity services.

SELECTION CRITERIA

ESSENTIAL:

Each pilot proposal will demonstrate the following criteria:

- management and evaluation from a local multi-disciplinary **Project Team**, comprising broad representation from key stakeholder working collaboratively with the NPP Manager

and the Steering Committee (further information given in *Resource Kit*);
- detail the application of the **essential indicators** identified for this project relating to: ACCESS, BEST PRACTICE, APPROPRIATENESS, COST & OUTCOMES (further information given in *Resource Kit*);
- outline the proposed methodology for the development, implementation and evaluation of context-specific **competencies** and **protocols**;
- include **mechanisms** to ensure that all customer contact by a NP is reviewed by a supporting medical practitioner involved in the pilot project; and,
- provide a broad statement of expenditure for the project.

DESIRABLE:

Preference will be given to proposals that:
- provide a detailed budget statement;
- identify local or other sources of funding;
- demonstrate a high level of **inter-professional collaboration** in the planning, implementation and evaluation of the pilot project;
- outline services provided by NP which ensure **continuity of care** and are **complementary** to existing services;
- incorporate appropriate **consultation** with other service providers;
- include a mechanism whereby a **comparison** of the costs and quality (including appropriateness and outcomes) of services provided by nurse practitioners and other service providers can be made, based on concurrent observations of care;
- have application to other NSW (and Australian) localities;
- include assessment of **community attitudes** to the role of the NP and of the **impact** of NP on other health care services; and,
- outlines a process for integration with the Area/District Health Service.

FURTHER INFORMATION:

Amanda Adrian, Project Manager for the Nurse Practitioner Review in the Nursing Branch at the NSW Health Department, telephone (02) 391 9528.

There is a *Resource Kit* available from the Nursing Branch that contains the Application Form and gives further essential infor-

mation about the Project, the pilots and the process of application.

An Information Session will be held in the Conference Centre at Concord Hospital at 1.30pm on Thursday 3 February 1994 to give potential applicants and interested parties an opportunity to discuss the process of application, as well as to clarify other issues pertaining to the overall Project and the individual pilot sites.

APPLICATIONS:

Should be forwarded to:

The Chief Nursing Officer
Nursing Branch
NSW Health Department
Locked Mail Bag 961
NORTH SYDNEY NSW 2059

CLOSING DATE: 5pm Friday 4 March 1994

Notice of the NSW Health Department, 73 Miller Street, North Sydney, NSW 2060; Locked Mail Bag 961, North Sydney, NSW 2059; Telephone (02) 391 900, Facsimile (02) 391 9101.