

Debating health workforce innovation

The profession should speak with one voice in the debate about task transfer

In mid December last year, a group of senior doctors, nurses, allied health professionals, hospital administrators and consumers in New South Wales publicly announced that they had had enough. So great was their frustration with the failure of the government to creatively confront the continuing workforce crisis in NSW public hospitals that they had banded together as the Hospital Reform Group to initiate open debate in the community and to find solutions. The media dubbed them the “health rebels”.¹

Listed in the group’s manifesto is the statement:

We see an urgent need for major workforce reform. The health workforce and workplace practices must be modernised. The traditional divide between professional disciplines and responsibilities is not necessarily appropriate for the future.²

In short, the group believes that public hospitals need to be dragged into the 21st century and their workplaces need to capitalise on current professional capabilities and not be bogged down by 19th century professional boundaries.³

The Hospital Reform Group workforce challenge follows closely on the back of similar calls from:

- the Australian Government Productivity Commission, which, in its draft report *Australia’s health workforce* (released in September 2005), called for an independent assessment of the opportunities to extend the role of some health workers so as to make best use of their skills while maintaining safety and quality.⁴
- the Health Workforce Innovation Conference organised by the University of Queensland and Queensland Health and held in Brisbane in November 2005.

A report of the conference is published in this issue of the *Journal* (page 105).⁵ Speakers from the United Kingdom and the United States described how their respective countries have responded to health workforce crises by introducing task transfer roles. These roles are played by nurse practitioners, physician assistants and a new professional species in the UK — the medical care practitioner. To the cynic, this is a watered-down version of a general practitioner. The UK speakers also outlined a new model for health care education — an education escalator, based on competence rather than time spent in training. Health care workers can “jump on” the escalator at different levels, depending on previous attainment of knowledge, skill and work experience, acquire further expertise, and then “jump off” the escalator at a higher level. The system’s apparent value is its capacity to encourage flexibility and multitasking.

Australia is traditionally an importer of educational and health care ideas. There is no doubt that debate about the education escalator concept, along with the push for medical task transfer to other health care professionals, will escalate. This will be especially so if the Council of Australian Governments (COAG) endorses the major recommendations of the Productivity Commission’s report.

These developments should come as no surprise, as the drivers for changes have been with us for some time. These include:

- the prevailing shortage of doctors, exacerbated by the federal government’s cap on medical graduates in the 1990s, early retire-

ment of doctors, shortened working hours, the feminisation of the workforce, and generational attitudes to work;⁶

- the continual increasing demands for medical services, driven by the increasing burdens of ageing and chronic diseases, along with new technology and the medicalisation of daily living;
- the ascendancy of multidisciplinary and multiskilled teams, which already blur some professional boundaries;⁷ and
- ever-narrowing subspecialisation, in which many medical tasks are reduced to discrete and limited knowledge and skill bytes which, it is argued, do not require a broad clinical perspective and have the potential to be undertaken by other health workers at lower costs.^{8,9}

But there are deeper undercurrents. Sir Graeme Catto, President of the UK General Medical Council, recently observed that:

... the exclusivity of medical knowledge and skill is being broken down.

Interprofessional learning is now commonplace in medical education and seems likely to increase. Professional boundaries are being blurred as more and more of the things that were once the sole domain of doctors are being undertaken by other healthcare professionals. None of us works alone any longer, but in multidisciplinary teams in which we depend upon the expertise of others. This is not a diminution of medicine, but a strengthening of healthcare. We must also acknowledge that, more than ever before, knowledge is available to patients and the public.¹⁰

So how should the profession respond to the inevitable debate on task transfer? Most of the doctors who attended the plenary sessions of the Brisbane conference were surprisingly silent. Others were singularly dismissive of any encroachment by other health care professionals into the traditional domains of doctors. And the limited evidence for, and the value-laden opinions surrounding, task transfer came to the fore in the conference’s breakout sessions. It was the epitome of tribalism!

In this context, it is worth noting that:

The most common temptation facing any long-established profession is to cling on too long to practices, privileges and traditional craft skills that have simply become outmoded. This can happen for many reasons including changes in demand or technology. It is an uncomfortable experience for a professional when technical mastery is commoditised and overtaken by some creative innovation. But the wise professional should not feel threatened by the impact of, for example, paralegals or paramedics, or simply computers. It is the task of the true professional to remain intellectually curious and to continue acquiring new skills. That said, knowing when to let go and to delegate responsibilities hitherto reserved to the profession is a task not just for the individual practitioner to face alone, but for the profession as a whole to confront.¹¹

And therein lies a problem. To be effective, the profession needs to speak with one voice and not in the babble of its many tribes. The latter will only be seen by the public as negative, defensive and self-serving. The profession needs to unite and develop a position that is evidence-based and has at its centre quality and safety for

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patients. In this debate, it is patients and the public who need to be convinced.

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- 2 Hospital Reform Group manifesto. Available at: <http://www.newmatilda.com/policytoolkit/policydetail.asp?PolicyID=254> (accessed Dec 2005).
- 3 Black N. Rise and demise of the hospital: a reappraisal of nursing. *BMJ* 2005; 331: 1394-1396.
- 4 Australian Government Productivity Commission. Australia's health workforce. Position paper. Canberra: Productivity Commission, 2005. Avail-

able at: <http://www.pc.gov.au/study/healthworkforce/positionpaper/index.html> (accessed Dec 2005).

- 5 Brooks PM, Ellis N. Health Workforce Innovation Conference. *Med J Aust* 2006; 184: 105-106.
- 6 Gavel P, Evans J, Young J. Who are the doctors of tomorrow? Some Australian perspectives and thoughts. International Medical Workforce Collaborative. 9th Conference. Melbourne, 15–19 November 2005. Available at: <http://www.health.nsw.gov.au/amwac/amwac/9conf.html> (accessed Dec 2005).
- 7 Lawrence D. From chaos to care. The promise of team-based medicine. Cambridge, Mass: Perseus Books, 2003.
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- 9 Peyton R. The industrialisation of surgery. *Ann R Coll Surg Engl* (Suppl) 2005; 87: 300-301.
- 10 Catto G. In: Royal College of Physicians. Doctors in society: medical professionalism in a changing world. London: RCP, 2005: 39-44.
- 11 Coombes P. In: Royal College of Physicians. Doctors in society: medical professionalism in a changing world. London: RCP, 2005: 32-38. □

Acute pain management: the evidence grows

An Australian document now has an important role in acute pain management worldwide

More than 50% of patients continue to have severe pain after surgery and trauma.¹ This situation not only results in unnecessary suffering, but occurs despite evidence that inadequate treatment of acute pain increases the risk of postoperative complications and may lead to persistent (chronic) pain. Indeed, operations and injuries are considered to contribute to at least 25% of the burden of chronic pain.¹

These points were highlighted at a forum cosponsored by the International Association for the Study of Pain (IASP), the European Federation of IASP Chapters, and the World Health Organization on 11 October 2004. This forum launched the Global Day Against Pain in support of the declaration that in acute, chronic non-cancer and cancer pain, “the relief of pain should be a human right”, and that improvements in the management of pain, including acute pain, require “global education of health professionals, patients and their families”.¹

In Australia, there has been long-standing awareness of the need to improve the management of acute pain. This was supported by the publication of the first edition of *Acute pain management: scientific evidence* by the National Health and Medical Research Council (NHMRC) in 1999.² At that time, the NHMRC and the Agency for Health Care Policy and Research in the United States were the only organisations worldwide to have produced evidence-based documents on the treatment of acute pain. More recently, this awareness has been highlighted by a number of high-level activities including the Pain Management Project of the National Institute of Clinical Studies,³ the development of the *Operational principles for acute pain management* by the Victorian Quality Council⁴ and the release of a *Statement on patients' rights to pain management* by the Australian and New Zealand College of Anaesthetists (ANZCA) and the Faculty of Pain Medicine (FPM), a multicollegiate Faculty under ANZCA.⁵

International awareness of the need to improve the management of pain also continues to grow. The IASP held another Global Day Against Pain on 17 October 2005, which focused on pain in children.⁶ The Global Day Against Pain is to become an

annual event. The IASP is also forming a special interest group on acute pain, which will further promote better management.⁷

Over recent years there has been an enormous increase in the amount of evidence available on the management of acute pain. Therefore, ANZCA and the FPM convened a working party to oversee a revision of the 1999 NHMRC acute pain document. To summarise the substantial amount of new evidence in a concise and easily readable form to help health care professionals and consumers, a large panel of contributors was appointed to draft sections of the document, and a multidisciplinary consultative committee (including medical, nursing, allied health and complementary medicine providers as well as consumers) was chosen to review drafts of the document and contribute more broadly as required. Evidence was annotated according to the levels recommended by the NHMRC.⁸ In addition, many practical recommendations for the treatment of aspects of acute pain were included by the working party as “clinical practice points” because of their clinical relevance, even though they are not purely evidence-based.

The revised document⁹ was approved by the NHMRC in June 2005 and launched at the World Pain Congress in Sydney in August 2005. It has already received widespread recognition with formal endorsement by the IASP and the Australian Pain Society. As it forms the basis for the section on acute and postoperative pain in the third edition of the IASP's *Core curriculum for professional education in pain*, its use worldwide is ensured.¹⁰ It has also been endorsed by the Royal College of Anaesthetists in Britain and recommended by the American Academy of Pain Medicine to its members.

Much of the evidence relating to acute pain management comes from the hospital setting, but many of the principles can be extrapolated to other acute pain settings, such as managing pain from renal colic or migraine or the use of opioids and non-steroidal anti-inflammatory drugs (NSAIDs). Examples of updated key messages and clinical practice points for the use of opioids, paracetamol, NSAIDs and cyclo-oxygenase-2 (COX-2) inhibitors are listed in the Box.