On Nursing, Squeaky Wheels and Disruptive Innovation

An Oration in Honour of the late Donna Diers, PhD RN FAAN
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Good evening friends, colleagues, and visitors from far and wide. Welcome to the 13th Annual Conference of the Australian College of Nurse Practitioners! Tonight, I've been given the honour of presenting the Donna Diers Oration, in memory of a past colleague and nursing scholar, whose cheeky grin, tenacity and passion for nursing helped guide and nurture the origins of the nurse practitioner role in Australia.

But first, I'd like to acknowledge that we are meeting on the lands of the Turrbal people. I wish to celebrate and acknowledge them as the traditional caretakers of the land upon which we meet tonight. It has always been under their custodianship, and always will be. I would like to pay my respects to their elders, both past and present, and the elders from other communities who may be here today.

When preparing for this oration, I must admit I was bit intimidated. If you'd known Donna, you knew she was one of the most humble and personable people you'd ever met. But she was also a force to be reckoned with, in her vision for nursing, as evidenced through her *writing* and *action*. If ever you need a primer (or perhaps even a little reminder) of your passion for nursing, I invite you to read her book, *Speaking of Nursing: Narratives of Practice, Research, Policy and the Profession.* Like many of us she came from humble beginnings and, whether by accident or design, she ended up leading nursing locally, then regionally, nationally and finally internationally. She, like many of us, realised and achieved her potential, and then continually redefined herself throughout her career. We were blessed to have her for as long as we did. I'll do my best tonight to honour her memory by giving my own narrative, in the hopes that you can learn from my triumphs, and not repeat my failures.

I actually never wanted to be a nurse. In fact, like Donna, who wanted to be a journalist, a series of events led me to a place I never imagined I'd be. My dad of course wanted me to be a veterinarian, just like him. What I've learned from him is an appreciation for science and numbers, and that animals are just like people…they just can't speak. However, as my Grandma Helms once pointed out "Christopher, you've got too much diarrhoea of the mouth to take care of patients that can't talk back." And just like that, my veterinary career reached a premature end. My mom, a paediatric oncology nurse and paramedic, 'hazed' me with many nursing parables throughout my early adolescence and adulthood. This hazing mostly took the form of illustrative books on sexually transmitted infections, along with helpful advice on what would happen to me if I got "footloose and fancy free" with the wrong girl. Luckily, my husband ended up being the right girl for me, and for the record, I'm also happy to report that my hazing resulted in a relatively clean record. What I've learned from my mother is that there is honour in service, and that the echelon of nursing is not notoriety or

position, but having this natural ability to 'be' with your patient, and by sharing that space, being able to assist them in re-establishing dignity lost through illness or disability. Despite those solid foundations of veterinary medicine and nursing, the comforts of science, facts and numbers led me down the immutable path of medicine.

The path that led me here tonight has been a very long, and protracted one. It took me five years of full time undergraduate studies dabbling in pre-medicine, and living in impoverished and developing countries to realise that for me, medicine was lacking. I was a terribly slow learner. Medicine didn't explain how to teach a sex worker into tricking their customers into using condoms. Medicine didn't explain how to comfort an intellectually disabled toddler left to stare at the ceiling in a forgotten crib, who'd been abandoned by parents that didn't have the capacity to care for their child because 'a bad spirit got into him'. And thus I turned to nursing. And that is why *I* am here tonight.

But why are you here? More importantly, what *keeps* you here? Is it because of the notoriety? I think not. All one needs to do is watch the news, read the newspaper, a blog, or attend a multi-profession meeting to realise that nurse practitioners, and nursing in general, have largely abstained from, or have been excluded from, leading discussions. It is, in fact, the squeaky wheel that gets the attention and the oil. And what a squeaky, whingy wheel it is! But do you really want to be in the position of that wheel? Maybe getting the oil is superfluous to the fact that the wheel *doesn't actually run the show*. The patient peddling the bicycle does. It's the patient that keeps us here. And bureaucrats, patients and policy makers realised, long ago, that *one wheel does not a bicycle make.* Healthcare has a steady stream of oil going to one profession right now. But that's a sure sign of an ailing health system…so we need to start working together to our *maximum capabilities*, to rescue something that is beautiful and unique in this world.

Juxtapose the observation that healthcare discussions are currently being led by the squeaky wheel upon the fact the Australian nursing profession, for the 23rd year in a row, has topped the Roy Morgan *Image of Professions Survey* as the nation's most highly regarded and trusted profession. Despite us not always being at the table, despite us not having the loudest voice, our patients still look to and trust us. They highly regard us. Therefore, it's critical we centre arguments about policy decisions upon their impact they have on the care delivered to our clients and communities. So why are we abstaining from leading those discussions? Why aren't we, with a united voice, steering discussions and challenging the rhetoric using *informed* and *strategic* foresight? I suspect the reason has something to do with the fact that successful disruptive innovators don't *lead* discussions…at least, they don't lead them in the beginning. They're meant to work from the grassroots up.

If you're unfamiliar with the term 'disruptive innovation', in 1995 an academic at Harvard Business School named Clayton Christensen first described it as "a theory whereby an innovation creates a new market and value network, and eventually disrupts an existing market and value network, displacing established market leading firms, products and, eventually *alliances*." When translating the theory of disruptive innovation to healthcare, one sees the medical profession currently leading the market. They're the profession patients generally think of when they get sick. Medical practitioners are *the norm*. They are the innovation that *sustains* current mainstream practice. And because of their esteemed

position in society, they tend to be at the head of the table. And because they've cornered the market, the medical profession can afford to pick and choose. Importantly, because of their esteemed position, *they* determine the benchmark of what good care looks like, and how it should be funded.

A role that is disruptive of the sustaining, mainstream innovation is one that identifies who is underserved by the medical profession, who has been disenfranchised from mainstream healthcare, or who has simply been placed in the 'too hard basket.' I think everyone here knows who I'm talking about: rural and remote, the Indigenous, refugees, the aged, sex workers and the homeless. Enter the nurse practitioner. The nurse practitioner role was designed to target those underserved and often ignored communities. But targeting such communities alone is not what makes you a disruptive innovator. Disruptive innovators not only gain a foothold in a marginalised population, they usually start out with a product that still requires refining. (And I'll come back to that later.) But it's only when the disruptor constantly *refines* and *improves* its products and services, when the mainstream health consumer takes notice. At that point *mainstream consumers* decide *they* want that type of health care. Eventually, a successful disruptive innovator gains *so* much market foothold, that it *re-defines the norm of what good care looks like*.

Now don't think for one second my intention here is to describe the eventual destruction of the medical profession. Not only is that careless, but it's not helpful. Again, we need to work together because *everyone* knows there's more than enough work to go around. In fact, looking to directly compete with a mainstream market holder will result in triggering lots of interesting behaviours and strategies, which are designed to keep the disruptor in its place. We've all seen how misinformation, discrediting, exclusion, regulation and policy have been used to keep us from caring for our clients and communities. Mainstream innovators have even been known to *acquire* and *own* disruptors, to control things like scope of practice under the guise of patient safety. When you think about it, that's pretty diabolical, as disruptive innovation through nursing is intimately linked to your individual scope of practice, and the scope of practice of the profession. Why use such strategies? Because there's this erroneous perception that livelihoods are at stake, as opposed to the health of our communities. In addition, disruptors often impinge upon social status and, ultimately, disruptors *break down protected silos of knowledge*.

So as we've heard from others, we need to keep calm, and carry on collaborating with our colleagues, whilst always keeping the patient at the centre of our arguments. The argument isn't "*I'm* not reimbursed enough for my services, and *I* need more access to the MBS otherwise *I* can't afford to practise". From a mental health perspective, it's certainly OK to *start* here, but it certainly shouldn't be the message you're *ending* with when you're in a public forum, otherwise your message is lost and you sound like the squeaky wheel. Lord knows I've made that same mistake…many times. Instead, the message to our decision makers should be: "*Our healthcare team* cares for refugees and the aged who can't afford complex case management health services. Are there opportunities to subsidise enhanced case management health services offered by a *nurse practitioner* that not only reduce morbidity and mortality, but improve the patient experience when they intersect with the health system?" And *that,* my friends, is the correct argument. *That*, was the type of argument that set the foundations for the nurse practitioner role in Australia. And more

recently, *that* was the argument that set in motion the NP role within the Australian Government's Health Care Homes initiative.

Now if you haven't heard about Health Care Homes, then you need to inform yourself, as it offers a narrow window of opportunity for disruptive innovators. It's heralded as one of the biggest reforms to Medicare since Bob Hawke re-introduced Medibank as universal healthcare in 1984. It's as huge as the 2010 MBS/PBS reforms, which allows subsidies for patients who are seen and treated by an eligible nurse practitioner. Health Care Homes will support enrolled patients and their carers to be *active* partners in their care, and achieve the ambitious quadruple aims of: enhancing patient experience, improving population health, reducing health system costs, and improving healthcare provider work life balance, by allowing *each* of us to work to our fullest abilities so we can share the burden of care. Patients will be able to choose a general practitioner *or* a nurse practitioner to lead the management of their chronic health conditions. Therefore, there will be greater reliance on NPs to work in primary healthcare, to use their advanced skills and expertise in the management of clients with complex, long-term health conditions to their *maximum abilities*. This sounds like the *perfect* space for a disruptive innovator, and because we know this is coming, we can prepare for an *appropriate and strategic* response to this future demand.

Are we up for the challenge? Although this approach to healthcare might seem 'novel and innovative' to other health professions, this is *exactly* the type of care that nurse practitioners currently provide, and is wholly congruent with the philosophy and science that is nursing. Nurse practitioners will be increasingly viewed as significant leaders and co-collaborators in the management of a patient's long-term health condition, whose contributions are *equally* as important as those made by general practitioners. This is *not* to say we're aiming to be substitute doctors…it simply means the philosophy of our care, and the skills, knowledge and expertise we bring to the clinical care and case management of our clients will be viewed *as equally valid as* a philosophy of care informed by medicine. Finally, we'll be playing a game of our own choosing, instead of playing the hand that's been dealt to us over the past 100 years.

About right now a few of you are sitting in the audience thinking "*But Chris, I don't know anything about chronic disease management or primary healthcare."* Respectfully, I disagree. Throughout your entire nursing career, you've cared for persons with long-term health conditions, and I'm betting you a fiver you've even thought about the impact of prevention and early intervention on long-term morbidity and mortality. That *is*, essentially, the crux of primary healthcare. The truth of the matter is that, no matter what your specialty, you've intersected with other specialties and have cared for those associated conditions throughout your career. Whether by osmosis, practise or rote memory, those formative nursing years leading to endorsement are *yours*. Just because you've achieved endorsement in a particular specialty area *does not negate the depth of those experiences*. That depth of experience is, in fact, what brings so much potential to the Australian nurse practitioner role. It's simply the primary health care *context of practice* of which, most likely, you're unfamiliar. Therefore, believe it or not, most of you are likely *generalists with specialty expertise*. And those with specialty expertise, who can apply it in a generalist setting, are perfectly suited for primary healthcare, especially when working alongside general practitioners and other health providers.

So. You're ready to remove those training wheels, and take your place as a disruptor. First, you'll want to expand your scope of practice. As we've seen from our New Zealand colleagues, it's *normal* and *expected* to continually expand your scope once endorsed. However, in Australia we have a multitude of reasons why we've been reluctant to expand our scopes once endorsed: fear of reprisal from the nursing regulator, fear of being judged by colleagues as 'being a cowboy', and the *CONSTANT, SQUEAKY WHEEL*. Would somebody please *oil* that damned thing! Earlier, I mentioned that *owning* and *controlling* an individual's scope of practice under the guise of patient safety is one means of keeping the disruptor in its place. Who do you think coined the phrase that "nurse practitioners care for minor illnesses and injuries, leaving the more complex conditions to the doctor." I assure you, it wasn't myself or the nurse practitioners I work with, although I've even caught *myself* parroting such drivel for the sake of keeping it simple and not wishing to unnecessarily ruffle the peacock's feathers. It's time we have the courage of our convictions, and take ownership of our individual scopes of practice...lest someone control the most powerful tool we have, which is the key to us becoming successful and effective disruptors.

You may be a student sitting in the audience, wondering how you're going to expand your scope to meet the expectations of the nurse practitioner role. You might even be a seasoned nurse practitioner, wishing to bin the training wheels and expand your scope. Both of you are likely wondering "*How?*" Well, I'm pleased to report that an answer is coming, and it's coming *soon*. It may not be *the* answer to nurse practitioners becoming effective disruptors, but it's *part of that answer*, and it's a bloody good one. Under the auspices of Professor Anne Gardner and the CLLEVER2 research team, I wanted to take this opportunity to tell you we've now a validated, robust framework that supports the clinical development and ongoing education of nurse practitioners. This framework has been contextualised to Australia and has been established and validated using experienced Australian nurse practitioners. If you were part of this immense body of work, I want to personally thank each and every one of you for contributing to our future. There's still a great deal of translational work to be done, but this work is *ours*, and promises to help lead us to advancing, refining and improving the nurse practitioner role. We are well on our way to becoming effective disruptive innovators.

We are living the zeitgeist, my friends and colleagues. Reach for it. Embrace it. Grab it, and don't let it go. Seize the opportunity and don't let it pass you by.

Thank you.