

Great debate: how clinicians make their views heard in health reform

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PUBLIC HEALTH SYSTEMS in Australia and internationally are faced with the need to implement significant reforms. These reforms are driven by the need to balance the delivery of best practice clinical care with rapidly spiralling cost pressures. With much of the agenda for reform driven by managerial, administrative and even political priorities, clinicians have often felt sidelined from the reform process. Indeed, there is some evidence that clinicians have had decreased enthusiasm for their work in recent years, coinciding with a greater role of non-medical managers and more restrictions on resources.¹ There is a wealth of experience and intelligence within the clinical workforce that can contribute to finding solutions to the many complex issues facing the health system.² This experience and intelligence is expressed in advice on the clinician's specific areas of expertise and often within their own environment.

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This may work against the clinician having an effective impact on the reform agenda at the macro level. In that context, the establishment of a Clinical Senate in Western Australia to inform the health reform process by debating major issues that impact across the system is innovative. The Clinical Senate requires that Senators adopt a broad view, set aside their particular clinical allegiances and debate the issues in the best interests of the community. The Clinical Senate is a forum that allows clinicians to influence statewide-level processes through formally recognised channels. This article examines the rationale, processes and operation of the Clinical Senate in WA as a mechanism for effective clinician input into health reform.

The health reform challenge

The Western Australian Government appointed the Health Reform Committee in March 2003. This Committee was required to report to the Minister for Health, the Treasurer and Cabinet's Expenditure Review Committee. The Committee was charged with developing a vision for the state's health system while also ensuring that the growth in the health budget was sustainable.³ At the time, the state's health system was dealing with the implications of the Douglas Inquiry into patient safety at WA's main maternity hospital⁴ along with considerable public and political comment on hospital waiting lists. The resulting report, published in 2004, found that incremental reform would not deliver the necessary changes and that a "fundamental reprioritisation of the public health system is needed, and should be carried out over the next decade, in a systematic and integrated way."³ The report's final recommendation was that the principal advisory

group for clinical reform should be the Clinical Senate.

The mandate

The Clinical Senate was established in 2002 to provide a mechanism for advice to the Director General of Health and the State Health Executive Forum by clinicians. It operates outside the formal Department of Health structure to provide independent clinician advice.⁵ The Senate is made up of 73 clinical members, including doctors, nurses, allied health professionals and aboriginal health workers working across the Western Australian health system, either as public and/or private practitioners.⁶ The Senate meets four times a year to debate topics that have been selected by the Clinical Senate Executive Committee through a formal Filter Process.⁶ Examples of topics that have been debated include; principles for a statewide clinical service plan, Indigenous cultural respect, consumer engagement, and workforce redesign. A comprehensive report is prepared from each debate and the recommendations presented to the Director General and the Department Executive.

Operation of the Clinical Senate

Senators are recruited from a broad cross section of the health sector through a large number of nominating bodies in an expression of interest process and appointed for a 3-year term. At each refresh of nominations the senate executive reviews the contingent to ensure a strong balance of input from all sectors, disciplines and geographic regions. To ensure an apolitical process it is made clear to both nominating bodies and nominees that they do not represent any particular group.⁶ Health is acknowledged to be a highly political environment; however, a non-representational model reduces the potential for advocacy by organised health interests.

The deliberations of the Senate are expected to be above the consideration of the background discipline of the Senators.⁶ Senators are reminded at the start of each session that they are there to provide their clinical intelligence in the best

interests of the whole health system, articulating the expectation that profession or clinical specialty-specific agenda must be set aside. Vigorous, structured debate is encouraged and consensus is reached using the Deliberative Decision Making Model.⁷

The Deliberative Decision Making Model describes a process that is also used for citizens juries, constitutional conventions, citizens forums and other debates where a diverse group of people are brought together for the common good. It has been adapted for use by the Clinical Senate. Its essential features are:

- Selection of people who are from a broad cross-section of the population. In the Senate, it is a broad cross section of clinical practice from across the state;
- Commitment to making decisions in the best interests of the whole community. For the Clinical Senate, this means Senators are to make recommendations in the best interests of the health of all Western Australians;
- Provision and consideration of unbiased information and evidence on the given subject. Senators are given brief presentations from experts and provided with papers on the subject. The presenters inform the debate but do not direct it. Information from community members is gathered from a consultation process or by including community members in the debate;
- Time to deliberate. The Clinical Senate has facilitated open debate over a full day in which the topic is freely discussed in a managed but reasonable period of time;
- Decisions to be made. The Clinical Senate recommendations are formulated by the Senators through a workshopping process after the main debate and ratified by the full Senate at the end of the session;
- A guarantee the work of the deliberative process will be heard and acted upon. An Executive Sponsor, who is a senior manager, works with the Senate Executive to prepare each debate and to take responsibility for enacting the resulting recommendations. The Clinical Senate's recommendations are presented to the

Director General of Health and through him to the Minister for Health.

The advantage of the Clinical Senate pathway over other clinical advocacy groups is that there is a formalised route for the advice to be delivered to policy makers and administrators. It also seeks external input from experts outside the health sector, including non-government organisations and other non-health agencies. There is a process for the Executive to seek advice from the Clinical Senate on issues that they nominate as requiring clinical advice. On some occasions, the Minister has sponsored the debate and the recommendations have passed to him through the Director General. The report is presented to the State Health Executive Forum, with the aim that the recommendations reach all aspects of the WA health system.

The importance of a formal structure for clinical input to the reform process

Australian health systems have been criticised for being inward looking and that much of the reform debates occur among insiders.⁸ Yet for more effective change-management, clinicians need to be an active and involved part of the reform process.²⁻⁹ Reform requires not only concepts but the capacity to implement the changes.¹⁰ This can be particularly challenging when dealing with entrenched cultures, as may be found in clinical fields, leading to a dismissal of the evidence when it conflicts with their underlying beliefs.¹¹ The WA Clinical Senate model overcomes some of these barriers through its multidisciplinary approach and its acceptance of community and other expert opinions within its debating forum. It also requires Senators to debate for the best outcome of the health system as a whole, not within their areas of clinical interest.

A similar experience to this approach is described in a commentary on the implementation of recommendations of the Report of the Greater Metropolitan Services Implementation Group¹² in New South Wales, where a multi-

disciplinary group of clinicians was charged with leading the changes, overseeing changes in a discipline not directly related to their specialty. Braithwaite and Goulston report that an independent evaluation suggested that many clinicians moved beyond their traditional responsibilities as a direct result of their participation and there was increased motivation towards system reform.⁵ Furthermore, Braithwaite and Goulston argue

... it is important to take clinicians beyond their individualised, patient-centred responsibilities, give them considerable authority to engineer systems change, and ask them to shape the reform measures to which they would otherwise be subjected.¹²

Case study: drugs and alcohol

In March 2007, the Clinical Senate met to debate drugs and alcohol as a major issue with system-wide impacts. The subject was chosen because of its many tensions. It is among the most challenging of comorbid mental health issues and impacts on all other clinical services, all ages, and all socioeconomic and cultural groups. The Executive Sponsor of the debate was Mr Terry Murphy, Executive Director of the WA Drug and Alcohol Office. It was considered by the Executive Sponsor that there was a tendency for all other clinical services to refer drug and alcohol issues elsewhere or to see them as the sole province of drug and alcohol-specific services. Experts were drawn from drug and alcohol service providers, police, Mission Australia and mental health services.

Over a full day, the task for Senators was to discuss and debate the nature of the drug and alcohol problems in Western Australia. They were challenged to consider the impact on their clinical practice and to examine and identify who is responsible and who should help.¹³

After a morning of presentations and debate, a series of key messages emerged that:

- Alcohol is the biggest substance abuse problem and alcohol advertising and community atti-

tudes to alcohol consumption must be addressed;

- Consideration is needed for other comorbidities such as domestic violence and child welfare in addition to drugs, alcohol and mental health;
- Resources are required with an increased focus on early intervention, and better use and education of the workforce, particularly emergency department staff and general practitioners;
- Collaboration is required across the broader health community to break down silos.

The Senate then divided for two workshops. One considered “Opportunities for intervention across all clinical services”, while the second examined “What collaboration had to offer in drug and alcohol issues.”

The sessions produced recommendations including:

- Introduce brief intervention regarding alcohol and drug use and incorporate it into routine assessments and procedures;
- Develop a central referral system for health providers to access drug and alcohol services;
- Provide a robust directory of alcohol and drug services accessible to all health providers;
- Provide comprehensive workforce development for the health workforce;
- Extend the specialist services of the Chemical Dependency Unit at King Edward Memorial Hospital; and
- Formalise a drug and alcohol health network for information sharing, understanding of roles and collaboration.

The recommendations were subsequently endorsed by the State Health Executive Forum, which also supported the development of a drug and alcohol health network.

The Executive Director, Drug and Alcohol Office reports that progress has been made:

- WA Country Health Service policies and procedures for brief intervention in general health settings have been developed and are proceeding through the approvals process following pilot projects;

- Some other regional hospitals are formally admitting patients for detoxification, others are doing so informally;
- Medical officers have been registered as pharmacotherapy providers in the Midwest and Kimberley; and
- Regional public health units have made drug and alcohol issues a priority, linking with public health campaigns on smoking, alcohol and drugs, including region-specific alcohol campaigns and prevention forums.

The report can be accessed at www.clinicalsenate.health.wa.gov.au

Discussion

The Clinical Senate is not a unique concept, but the model utilised in WA has become established as a useful tool for health reform. Its strengths lie in its independence from the departmental organisational structure, allowing for a strong informed clinical voice that is heard at the highest decision-making levels. Clinical Senate debates that have had an immediate policy impact include:

- May 2007 debate on emergency departments that resulted in the development of the concept of Integrated Primary Health Centres in WA. This debate highlighted the need for a cultural change in hospital practice allowing emergency department needs to be better prioritised. The findings of this debate have informed a Ministerial review of emergency department services;
- August 07 debate on educating future health professionals that has facilitated greater acceptance of the value of interprofessional learning (IPL) in both the health and academic sectors. As evidence of this, an interagency partnership between Health and Education is ensuring that IPL is written into the Health Workforce Curriculum Framework.

An additional strength is the positive influence that the multidisciplinary debating forum has had on organisational culture. During the life of the Senate the culture of the organisation has evolved and matured, particularly with regard to transprofessional behaviour. When the Senate began, participants were unaccustomed to being

part of such a broad range of clinicians in a decision-making forum. Over time, the sharing of perspectives has led to an increasing ability for Senators to show respect for their colleagues from other disciplines and to leave aside their own agenda when making decisions for the betterment of the system as a whole.

This positive behaviour is in contrast to the professional and interorganisational rivalries typically demonstrated in the past and has a direct impact on the clinical culture in WA. The Senate, in modelling this behaviour, has set the benchmark for other transprofessional groups such as the Health Networks and has therefore positively influenced organisational culture¹⁴ across the health sector.

The Clinical Senate differs from the Health Networks in WA as, although involving all health disciplines as well as consumers, they are based largely on disease-specific groupings. These groupings tend to reinforce traditional clinical hierarchies making it more challenging to share wider perspectives. The Senate also offers a forum for clinicians to bring their expertise to consideration of issues beyond their usual domain.

A weakness of this model of Clinical Senate is that it has no mandate to enforce its recommendations. This is countered to some extent by formal receipt of the recommendations by the Director General and health executive. The Senate now also requests progress reports from debate Executive Sponsors on key recommendations to provide a level of accountability.

The Executive has learned that much of the success of the debate flows from and through the sponsors. When they can be encouraged to embrace the process, the Senate gets good information that leads to a strong debate and an excellent set of recommendations, which the sponsor is then keen to endorse and advocate.

The Clinical Senate has been viewed as the “quiet achiever” of health reform, thus there has been a need to raise the profile of the Senate within the health sector. Communication is a key issue as there has been some difficulty in broadcasting the recommendations and content of meetings to the whole sector. A critical means of facilitating the

maturation of the Senate culture has been the use of feedback. As a learning organisation¹⁵ the Senate has continually sought and embraced feedback from its members and other stakeholders through end of session surveys, in order to develop its policies and processes.

Beyond the boundaries of the senate quarterly debates, clinical senators become embedded change agents for health reform as they take the new perspectives and professional behaviours back to their workplace, where they are in a position as senior clinicians to exert an ongoing positive influence.

In conclusion, the Clinical Senate has established a leadership role in health reform in WA by bringing the “clinical mind” from its frequently narrow focus to one that exerts a strongly positive clinical influence on the big picture aspects of improving health services for all West Australians.

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