Discussion paper

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Achieving change through clinical leadership: The rewarding journey of advocating for perioperative nurses and nurse surgical assistants in Australia

Abstract

This paper explores the transformative impact of clinical leadership within the perioperative setting of the Australian healthcare system. It details the grassroots advocacy led by perioperative clinicians, particularly nurse practitioners, who invested significant personal time and effort to address inequities in patient access to surgical care. Their work resulted in a landmark policy change under the Medical Benefits Schedule. This advancement not only improves financial equity for patients but also strengthens the professional standing and sustainability of perioperative nurse practitioners. The journey was complex and time-intensive, and came with personal financial costs to those involved, yet it exemplifies the power of clinician-led reform.

Introduction

This paper emphasises the significant influence of clinical leadership within the perioperative setting of the Australian healthcare system. The progress made was largely driven by clinicians who dedicated substantial personal time and emotional energy to the very protracted process. Their contributions have led to meaningful improvements in patient access to surgical care, greater financial equity for patients previously exposed to out-of-pocket costs, and the strengthening of nursing leadership in clinical roles. Through effective clinical advocacy, a change in government policy was achieved, creating a new pathway under the Medical Benefits Schedule (MBS) that allows rebates for patients when a nurse practitioner (NP) serves as a surgical assistant, enabling perioperative nurses to advance their roles in direct clinical care. This process demonstrates that clinical leaders are ideally positioned to improve systems and processes, and highlights that organisations must be mindful of avoiding complex systems which serve to stifle rather than foster clinical leadership. A culture of open and honest communication in organisations encourages innovation to support clinican-led governance[1].

Background

Clinical leadership

Clinical leadership advocates for patients and promotes a culture of patient safety, delivers high-quality, cost-effective and feasible care while promoting retention of experienced clinicians and providing a clinically focused pathway for the profession[2,3]. Traditionally, leadership roles in health care have been reserved for academics, bureaucrats, administrators and multidisciplinary health service managers. However, clinical leadership could be the solution to problems faced by health service providers both locally and globally[4]. Too often nurses must apply workarounds in the clinical area to adapt restrictive risk management strategies or simply inappropriate or non-feasible processes instigated remotely by non-clinical leaders. Acknowledgment of clinical leadership, not only in the hospital setting but by government bodies and policymakers, would also provide the opportunity for nurses to contribute to appropriate, cost-effective and safe healthcare policy[1].

Clinical leadership empowers frontline healthcare professionals to actively contribute to solutions and innovations

in patient care. While not a novel idea, it echoes a time when roles like the medical superintendent and matron were deeply embedded in clinical practice, granting them firsthand insight into the healthcare system and the foresight to identify emerging challenges. Today, many hospital administrators and academics are distanced from daily clinical realities. To ensure meaningful progress, it is essential that those directly involved in patient care have a respected and influential role in shaping the future of health care.

However, the baton of clinical leadership must be taken, it cannot be given. Clinicians need to take initiative and actively seek a place at the leadership and decision-making table, whether at the local, state or federal level. They must consistently and professionally assert their right to be involved until their presence in these roles becomes the norm.

In the perioperative setting, clinical work is typically viewed as a collective effort with little focus on individual leadership, especially among nurses. Opportunities for perioperative clinicians to engage in leadership activities are rarely, if ever, built into their roles, meaning participation often comes at the cost of personal time. For many perioperative nurses, this sacrifice can feel disheartening, especially when they are given limited opportunities to contribute to or influence innovation in healthcare practice.

Nurse surgical assistants in Australia

Bernadette Brennan, a nursing pioneer, proposed in 2001 that the advanced practice of the perioperative nurse in Australia – incorporating the role of surgical assistant – could provide a cost-effective and proficient service in the healthcare sector[5]. This notion was supported by two papers from 2016. The first was a survey of perioperative staff and surgeons which demonstrated that nurse surgical assistants had a high impact as a resource, and a high to moderately high impact on promoting leadership in the perioperative setting[6]. The second paper was a practice audit of nurse surgical assistants and highlighted a decrease in in-theatre preparation time when nurses perform this role[7].

In 2018, a publication reporting on task transfer demonstrated support from members of the Royal Australasian College of Surgeons for the role of nurses as surgical assistants in the private sector[8]. Two additional papers from 2020 explored how the NP is a legitimate and lawful provider of surgical assistance according to the opinions of other service providers, recommendations of peak professional bodies and the law; and that there is no difference in patient outcomes whether a nurse or medical practitioner performed the role of surgical assistant[9,10].

The role of nurses as surgical assistants has been formally established in countries like the United States since the early 1960s. In Australia, although the role has existed informally for a similar length of time, it wasn't until 1990 that an Australian nursing organisation began formally exploring it. This investigation was prompted by a shortage of doctors available to serve as surgical assistants, particularly in rural areas[5,11,12].

Nurses now perform the role as their only form of clinical practice, predominately as sole traders i.e. not employees of a hospital or healthcare facility. Their scope of practice can encompass pre-operative assessment, intra-operative care including technical surgical skills, and post-operative education and follow-up[13]. However, despite the formation of a professional body – the Australian Association of Nurse Surgical Assistants (AANSA) – and active lobbying of the Australian Government Department of Health and Ageing (DoHA) by AANSA, the Australian College of Nurse Practitioners (ACNP), the Australian College of Nurses and individual clinicians, progress to formalise a mechanism by which patients can access a rebate through the MBS has been protracted. This lack of rebate creates challenges in remuneration and results in out-of-pocket costs for patients. Such a disparity is inequitable, particularly given that NP surgical assistants are skilled, legitimate and capable clinicians[9,10]. Their exclusion from MBS patient rebates undermines the value they bring, despite their legitimate role in the surgical team and their contribution to improving patient access and equity in care[9,10,12,14,15].

The process of gaining MBS access

The process was prolonged and is outlined in Figure 1. The journey began in 2011 with patients receiving services through the Department of Veterans' Affairs (DVA), as these patients could not pay an out-of-pocket expense. While this submission was unsuccessful, the DVA advised that the appropriate pathway for changing access to the MBS was through the Medical Services Advisory Committee (MSAC). The initial application to MSAC in 2013 was from AANSA on behalf of all registered nurses (RNs) with a postgraduate surgical assisting qualification. This application, while not formally rejected by MSAC, did not proceed through the system.

Two key insights emerged early in the process. First, while the government had a well-defined process for adding new procedures for medical practitioners to the MBS, there was no established pathway for extending existing procedures to include additional clinician groups. The second key insight was that the Nursing and Midwifery Board of Australia (NMBA), that regulates advanced practice nursing (APN), limits its regulation of APN to the NP and does not include other RNs with specialty master's degrees.

In 2019, a second MSAC application was submitted by an individual clinician, this time focusing on the NP. However, this application was paused during the Australian Government's review of the MBS, which concluded in June 2020. During the review, AANSA advocated for MBS access for RNs, while the ACNP and individual NPs submitted several proposals aiming to secure MBS access for NPs.

Although the MBS review did not approve any changes to MBS access for nurses, the united advocacy of peak nursing organisations and persistent efforts by individual clinicians contributed to the establishment of the Medical Benefits Schedule Review Advisory Committee (MRAC) in 2021. Once again, AANSA, ACNP and individual clinicians submitted proposals advocating for nurse surgical assistants.

Access to MBS surgical assisting item numbers has now been granted for NP surgical assistants, an achievement

shaped by several key contributing factors. Firstly, NPs are the only APN practitioners formally endorsed by the NMBA. Extending endorsement to other specialty nursing roles is complex, primarily due to rigorous course approval standards set by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and the endorsement process governed by the Australian Health Practitioner Regulation Agency (AHPRA). Second, NP endorsement grants access to MBS provider numbers in the private sector and permits limited use of MBS item numbers. Finally, the scope of practice for NPs is determined by individual clinicians[16,17]. As a result, all NPs with an MBS provider number will be eligible to access MBS surgical assisting item numbers from 1 November 2025. This mirrors the access provided to medical practitioners and will be subject to the same governance through the credentialing processes of healthcare facilities.

Discussion

In the early stages of our efforts, we were admittedly naïve. We did not fully understand how the system operated, nor did we realise there was no established pathway within the MBS or Medicare to achieve what we were aiming for. At the same time, it seemed the government had not fully appreciated that no process existed to enable such change for nurses within the MBS. We believed that providing a safe, competent service would be sufficient to support our case. In reality, it took nearly 14 years to establish a formal pathway.

One of the most challenging aspects of the process was the pace of bureaucracy. As clinicians, we are accustomed to acting swiftly – urgent and emergent situations require immediate attention and timely decisions. In contrast, working within a government framework meant navigating complex systems with rigid submission formats, multiple layers of review and various committees that met infrequently – often monthly or quarterly. Each committee dealt with numerous submissions, which meant ours could be delayed across several cycles before even being considered. The process lacked transparency, offering little to no feedback once a submission was lodged. At one point, we were even advised to

2011–2013

Submission made to the Repatriation Commission is unsuccessful. Department of Veterans' Affairs (DVA) confirms Medical Services Advisory Committee (MSAC) is the correct process as they follow the Medical Benefits Schedule (MBS).

April 2013

Application is made to MSAC by newly formed Australian Association of Nurse Surgical Assistants (AANSA).

August 2014

The Department of Health and Ageing (DoHA) informs AANSA that MSAC is not the correct pathway.

June 2014 – 2021

PhD undertaken by individual clinician to demonstrate patient safety of the nurse practitioner as surgical assistant role with Australian data. Multiple papers published.

March 2017

Nursing and Midwifery Board of Australia (NMBA) state no interest in regulating advanced practice nurses who are not nurse practitioners (NPs).

March 2018

Meeting with MBS, Medicare and MSAC confirms that MSAC is the correct pathway.

January 2019

Application made by individual clinician to MSAC for NP access to MBS for surgical assisting.

April 2019

Received notification that MSAC application is on hold due to MBS review. Lodged a submission with and participated actively in the MBS review.

June 2020

MBS review concludes with no changes to MBS access for nurses. A request is made for the second MSAC application to be re-activated.

November 2020

Received notification that MSAC is not the correct pathway.

July–August 2021

Received notification that a new committee, Medical Benefits Schedule Review Advisory Committee (MRAC), is to be formed. Lodged an application to MRAC for NP access to MBS.

September 2021

Attempted, unsuccessfully, to gain support from Australian Competition and Consumer Commission (ACCC) or Commonwealth Ombudsman.

May 2022

Made a presentation to the Surgical Assistant Working Group of MRAC during the public consultation period.

April 2023

Met with MRAC co-chairs to discuss protracted process.

July–August 2023

Participated in Surgical Assistant Implementation Liaison Group meetings.

March 2025

It is announced that NPs will have access to an MBS patient rebate for surgical assisting from 1 November 2025.

Figure 1: Key events in the process of gaining MBS access

withdraw a submission to avoid it being marked as unsuccessful without any clear explanation as to why.

An added layer of complexity came from the simultaneous lobbying efforts by nurses with varying qualification levels for access to MBS. Although the initial push came from RNs who had completed postgraduate studies in surgical assisting, it quickly became clear that gaining MBS access was not a single issue, but a collection of interconnected challenges. One major hurdle was the lack of recognition of specialty nursing master's degrees, such as the nurse surgical assistant degree, as APN by nursing regulators. Despite years of delivery by two universities, no steps had been taken to gain recognition as an APN qualification for nurse surgical assistants. This could be attributed to the absence of a clear regulatory pathway through bodies such as ANMAC, AHPRA and NMBA. Early efforts to integrate the surgical assisting course into an NP program may have offered a practical solution but were not pursued.

Related to this is the broader regulatory challenge of granting MBS access to RNs. While this paper focuses specifically on nurse surgical assistants, many RNs are working in specialised roles, often with master's level qualifications. Allowing these clinicians MBS access with or without AHPRA endorsement would require significant systemic change, including a large-scale restructure of regulatory processes and substantial investment in both initial implementation and ongoing governance.

Conclusion

This was a demanding and prolonged process for everyone involved. It required countless hours of personal time dedicated to writing submissions, engaging in various forms of advocacy, exploring potential pathways, recruiting stakeholders and maintaining ongoing communication with government departments. Significant time otherwise spent in private practice was redirected toward attending government meetings, presenting at committee hearings, networking, conducting research and publishing work. As a result, the financial cost to individuals in terms of both lost income and out-of-pocket expenses was substantial.

Nevertheless, the reward lies in recognising the impact this achievement will have on Australian perioperative nurses and the improved, more equitable access to surgical care now available to our patients. Having influenced nursing at a national level has exceeded all our expectations. Many of us, when beginning our nursing careers, could never have imagined contributing to such meaningful change. Knowing that the role we are so passionate about will now be both professionally recognised and financially sustainable for future generations of NP surgical assistants has made the journey worthwhile.

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References

1. McSherry R, Pearce P. What are the effective ways to translate clinical leadership into health care quality improvement? [Internet] J Healthc Leadersh. 2016[cited 2025 Jun 6];8:11–7. DOI: 10.2147/JHL.S46170
2. Mrayyan MT, Algunmeeyn A, Abunab HY, Kutah OA, Alfayoumi I, Khait AA. Attributes, skills and actions of clinical leadership in nursing as reported by hospital nurses: A cross-sectional study. BMJ Lead. 2023[cited 2025 Jun 6];7(3):203. DOI: 10.1136/leader-2022-000672
3. Mianda S, Voce AS. Conceptualizations of clinical leadership: A review of the literature. J Healthc Leadersh. 2017[cited 2025 Jun 6];9:79-87. DOI: 10.2147/JHL.S143639
4. Gauld R. Clinical leadership: What is it and how do we facilitate it? J Prim Health Care. 2017[cited 2025 Jun 6];9(1):5-8. DOI: 10.1071/HC16041
5. Brennan B. The registered nurse as a first surgical assistant: The 'downunder' experience. Semin Periop Nurs. 2001;10(2):108–14.
6. Smith C, Hains T, Mannion N. An opportunity taken: Sunshine Coast University Private Hospital's perioperative nurse surgical assistant experience [Internet]. J Periop Nurs. 2016[cited 2025 Jun 6];29(3):23–8. DOI: 10.26550/2209-1092.1005
7. Hains T, Turner C, Strand H. Practice audit of the role of the non-medical surgical assistant in Australia, an online survey [Internet]. Int J Nurs Pract. 2016[cited 2025 Jun 6];22(6):546–55. DOI: 10.1111/ijn.12462
8. Hains T, Turner C, Strand H. Task transfer: A survey of Australian surgeons on the role of the non-medical surgical assistant [Internet] J Periop Nurs. 2018[cited 2025 Jun 6];31(1):11– 7. DOI: 10.26550/2209-1092.1020
9. Hains T, Rowell D, Strand H. Effectiveness of the non-medical surgical assistant measured by patient outcome assessment [Internet]. Int J Nurs Pract. 2020[cited 2025 Jun 6];27(1):e12822. DOI: 10.1111/ijn.12822
10. Hains T, Rowell D, Strand H. The legitimacy of the nurse practitioner as a non-medical surgical assistant: Historical evidence from Australia [Internet]. Collegian. 2020[cited 2025 Jun 6];27(6):654–660. Available from: www.collegianjournal.com/article/S1322-7696(20)30085-8/abstract
11. Hains T, Strand H, Turner C. A selected international appraisal of the role of the non-medical surgical assistant [Internet]. J Periop Nurs Aust. 2017[cited 2025 Jun 6];30(2):37–42. DOI: 10.26550/2209-1092.1015
12. Hains T, Navaratnam A, O'Brien A, Walsh K, Neilsen J, Firth S. Can the role of the nurse as surgical assistant add value in the Australian public health care sector? J Periop Nurs. 2021[cited 2025 Jun 6];34(1):9–14. DOI: 10.26550/2209-1092.1108
13. Australian College of Perioperative Nurses (ACORN). Standards for perioperative nursing in Australia. Adelaide: ACORN; 2018.
14. Hains T, Rowell D, Strand H. The non-medical surgical assistant and inequity in the Australian healthcare system. Aust J Adv Nurs. 2020[cited 2025 Jun 6];37(4). DOI: 10.37464/2020.374.278
15. Hains T, Turner C, Gao Y, Strand H. Valuing the role of the non-medical surgical assistant. ANZ J Surg. 2017[cited 2025 Jun 6];87(4):222–3. DOI: 10.1111/ans.13900
16. Nursing and Midwifery Board of Australia (NMBA). Endorsement as a nurse practitioner [Internet]. Melbourne: NMBA; 2016 [cited 2025 Jun 6]. Available from: www.nursingmidwiferyboard.gov.au/Registration-Standards/Endorsement-as-a-nurse-practitioner.aspx
17. Nursing and Midwifery Board of Australia (NMBA). Nurse practitioner standards for practice [Internet]. Melbourne: NMBA; 2021 [cited 2025 Jun 6]. Available from: www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/nurse-practitioner-standards-of-practice.aspx