Australian Medicare Local Alliance

National Primary Health Care Conference 2012

Address

by

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"After Hours Patient Care in Australia: Lessons from the Coal Face"

Adelaide Convention Centre
7th-10th November

Introduction

Doctors, Distinguished Guests, Delegates, Ladies and Gentlemen,

I've chosen as the title for today's presentation: "After-Hours Patient Care in Australia: Lessons from the Coalface".

I thought about the title very carefully and picked it deliberately, because for a country whose prosperity is built on coalmining, we don't actually know very much about it, about how it is done, about its history and dangers and about the language associated with the mining industry.

For instance, you may be surprised to learn that the term "Coalface", which we might imagine to be a very modern term is actually very old – it originated in the 17th century about the same time as the first development of long wall coal mining, in Shropshire in England.

Four centuries later, longwall mining is still the most common method of underground coal mining in Australia and contributes enormously to the prosperity of this nation.

Importantly, longwall mining is a method which is tried and tested over time. It is extraordinarily efficient and while the basic idea hasn't changed, new technology and innovation have made it vastly safer and much more productive.

Longwall mining happens in the dark – out of sight and often out of mind, little understood, and yet critically important not just to the people involved, but to the prosperity of all Australians.

We think that's a pretty good metaphor for After Hours Medical Deputising Services.

After Hours Medical Deputising is also based on a method which is tried and tested over time – the Doctors' house call.

The members of the National Association of Medical Deputising Services provide an extraordinarily efficient way of delivering acute medical care, to keep the patient in their home and each year around 650,000 Australians get a house call from an after-hours Locum.

We, at NAMDS also use cutting edge technology - to keep our after-hours doctors safe, to ensure the highest quality of medical care is provided to the patient and to guarantee best practice communication with the most important person in that patient's health care environment – their daytime, regular GP.

And yes, just like longwall mining, our work occurs in the dark – in our case late at night, in the early hours of the morning – and out of sight, on weekends and public holidays.

The importance of our work, not only to the patients involved, but to the functioning of the Australian health care system is not well understood, either by those working in the Canberra bureaucracy nor by the general public.

Which is why I have drawn on the 40 years of experience and expertise of the accredited members of NAMDS – the National After Hours Medical Deputising Services –which I am privileged to lead, to help you to understand what we do, and why we are so critical to the smooth functioning of the primary health care system.

I would like to give you several examples of who we care for, and how we do it.

1: Patients with disabilities

My first example is a real life situation concerning a particularly challenging – but relatively routine – callout by a NAMDS accredited Medical Deputising Service in an Australian Capital city.

Last month, as spring brought with it a particularly nasty strain of gastroenteritis, a young mother with two small children moved house in Sydney.

During their first week in the house, her husband had to fly interstate, and her four-year-old son Nathan came down with a severe case of gastroenteritis.

She anxiously watched as Nathan steadily worsened through Saturday afternoon and evening, unable to keep down water, vomiting uncontrollably and clutching his stomach, apparently in severe pain.

I say “apparently” because Nathan suffers from severe-autism, and cannot speak.

He is unable to cope with loud or unexpected noises. When placed in noisy environments he becomes extremely distressed and aggressive – biting, kicking and screaming.

The havoc Nathan would have caused in a busy North Shore Emergency Department setting was unimaginable to his mother – not to mention how she would deal with her six-month-old baby whilst trying to calm a vomiting, distressed and aggressive Nathan.

The medical clinic in their new suburb subscribed to a Medical Deputising Service to care for their After-Hours patients. Nathan’s mother called the NAMDS service and explained – in tears – the situation.

Experienced call centre staff worked with her to understand both the acute medical need and the nature of Nathan’s disorder.

An experienced doctor was dispatched and arrived at her home with his mobile phone safely turned to silent mode, examined Nathan with his Mum’s assistance and support, and was thankfully able to exclude diagnoses requiring a hospital stay.

The deputising doctor was able to provide treatment for Nathan at home thus allowing him to recover without being hospitalised.

Because the patient was under the age of 16, the visit was bulk billed as are 95% of all Doctors house calls by NAMDS member services.

I should point out that if Nathan had required hospitalization, the deputising doctor would have been able to help coordinate his visit to hospital, ensuring Ambulance staff were aware of his disorder and how to manage it to minimize his distress.

Nathan’s daytime GP is intimately involved with Nathan’s care and with helping his parents to access appropriate early intervention services.

The day after this episode she promptly received a computerised patient report from the deputising doctor and now has a record of Nathan’s treatment, which will help her to keep a complete picture of this high-need patient.

Nathan's case is relatively routine for our Medical Deputising Services. We do not receive any additional funding for treating patients with disabilities, and neither do we ask for it: like daytime GPs we take our patients as we find them, and our doctors have the expertise common to all General Practitioners in diagnosing and treating patients with a range of disabilities.

One of our concerns, as we are moving through the Medicare Locals process, is that more attention needs to be paid to the needs of house-bound patients with disabilities. The "typical patient" that is often referred to in the literature is an able bodied adult or child with a single medical complaint, able to speak and advocate for themselves, who is also able to navigate telephone advice, for instance, or to explain their symptoms to a doctor in an extended after-hours clinic who has no access to the patients' medical history.

Such patients definitely represent a proportion of our patients – but only a proportion. We regularly treat house-bound patients with complex care needs, patients with physical disabilities and those with intellectual impairment, patients with co-morbidities and patients on multiple medications.

For these patients, our databases and long standing collaborative relationships with daytime GPs mean that when they get ill during the after-hours period, we are able to provide not just appropriate treatment but treatment coordinated by the regular GP.

Medical Deputising Services look after a large number of children in the after-hours period. Partly that's a consequence of modern family working arrangements – children are often picked up from daycare at 5:30pm, have dinner at home and may only start to display symptoms at that point.

With their medical practice closed, the Medical Deputising Service is one of the only alternatives to going to the Emergency Department at the local Public Hospital.

Just like Nathan's mum, thousands of other mothers and fathers who call our services on behalf of their sick child very often have other young children in the house and don't want to uproot the entire family to take the unwell child to the ED.

Often, parents do not have transportation so their only way to get to hospital late at night is via an ambulance.

It is a very distressing issue for single parents with multiple children or for those without private transport. In all these circumstances, the alternative to a Doctors' house call by an accredited medical deputizing doctor is more difficult to access, and involves greater delay – and for the healthcare system, involves avoidable cost.

Example 2: ELDERLY PATIENTS: Esme

As you all know, the after-hours period in which medical deputising services operate is from 6pm to 8am, Monday to Friday, and from noon Saturday to 8am Monday, and all day Public Holidays.

The after-hours period comprises 70% of any given week. Within that period there are peaks and troughs. But one of the peak times for calls to attend elderly patients is Sundays.

That's because families typically visit their elderly relatives on Sundays, and one of the most common stories is that the son or daughter go to visit Mum and find, to their dismay, she has developed a hacking cough, or Dad has a nasty-looking wound on his leg, which requires prompt medical attention.

Esme's story is typical – and again, this is a real life example which is replicated everywhere throughout the country.

It also illustrates what might be termed social barriers to accessing different forms of after-hours care, including Doctors' house calls.

Frail, but managing to continue living at home thanks to a community aged care package, Esme is visited by her son and daughter every Sunday. On arriving they find Esme has a hacking cough and is running a fever.

They called their GPs medical deputizing service, and a doctor was dispatched to the home who diagnosed Esme's condition within 2 hours of the call being logged. Esme's daughter was able to drive out and fill the script for her mother, allowing treatment to commence immediately.

Esme is unable to drive, so had her children not visited her that weekend, she would likely have stayed home rather than get on a bus, too sick to attend her GP or emergency department.

While her condition was able to be appropriately managed at home if caught early enough, like many infections caught by frail and elderly people, delay would have resulted in a fairly swift deterioration and consequent hospitalization with all the cost consequences and dislocation that entails.

In the home setting Esme can show the deputising doctor the medications she is taking, and the doctor can take these into account when prescribing medication.

Absolutely critically, the deputizing doctor will send a thorough patient report to her daytime GP the next working day, so when Esme presents at her GP practice the GP has the full picture of what has occurred – and what medication has been added to the patient's medical file.

The proportion of elderly patients – those aged 70 plus – attended by accredited NAMDS members varies by State, but for all services, those aged older than 70 comprise the biggest proportion of users of our services.

For many, if not most, the only realistic alternative to the after- hours Doctors' house call is evacuation via ambulance to hospital, with all the attendant stress and all the attendant cost to the public purse.

Other regular examples are patients of aged care facilities and nursing homes.

If a resident becomes unwell after hours, the nursing staff can either call an ambulance for the patient to be taken to hospital for treatment or they can arrange for a medical deputising doctor to visit the patient in the comfort of the aged care facility.

Without a Medical Deputising Service, residents requiring medical care after hours would be uprooted and unnecessarily transported via ambulance to the nearest public hospital.

This can be distressing for aged and infirm patients and their families and it is often avoidable, especially in instances where the patient's medical condition could easily have been managed by a GP at the aged care facility.

Example 3: PALLIATIVE CARE

The third example I've chosen is a palliative care patient, to demonstrate to you a little known aspect of the operation of medical deputizing services, and that is our close relationships with our daytime GPs.

Many of you will be aware of the detailed, computerised patient reports we send to our daytime GPs about the visits to patients after hours.

This is the most tangible example of the communication with our daytime GPs, but it is by far from being the only communication.

GPs will often contact us 24/7 about the needs of particular patients – particularly those undergoing palliative care at home.

A GP who is going on holiday, for instance, will let us know of the situation of particular patients and we record these details in special patient files. The GP may direct us as to how he or she wants us to address, for example, a failure of a medication protocol to adequately control a patient's pain.

Or he may leave that up to the deputizing doctor. In other words, the care our deputizing doctors provide is entirely regulated and integrated by the patient's regular GP.

For palliative care patients, this close collaboration can avoid the unnecessary distress – and the system expense – of an after-hours trip to the emergency department.

Example 4: LIFE EXTINCT CERTIFICATES

Which brings me to the next example of the kind of situations our after-hours doctors confront regularly and which has never, to my knowledge, been mentioned in the after-hours literature.

That's not a big surprise, because it is a very difficult issue to speak about, and that is death – in this case, where death occurs expectedly at home as the result of a terminal illness or due to natural causes.

It will come as no surprise that many Australians who are suffering from terminal illnesses would rather die at home. According to the Centre for Palliative Care, around 25 per cent of Australians choose to die at home.

Where a death is anticipated, the patient's daytime GPs normally contacts the medical deputising service advising of the patient's situation and alerting the service to the likelihood that the patients death is expected to occur in the forthcoming days or weeks.

Where that death occurs during the after-hours period, our deputising GPs attend the home and issue what is known as a "Life Extinct" certificate.

Every State and Territory has slightly different legislation relating to deaths that occur at home, but generally speaking, nationwide, only medical practitioners, registered nurses, paramedics and police officers can sign-off on a “Life Extinct” form, although in practice, nurses are extremely reluctant to sign them off.

In all States and Territories, Funeral Directors will not remove a body from the home without a Life Extinct certificate in case the death was not natural or expected, but instead may involve unexplained reasons which may need police investigation.

Our doctors typically attend the home where the death has occurred, deal sensitively and respectfully with the bereaved, and issue the life extinct certificate form to the funeral director, allowing the patients’ body to be removed to safe storage. This is particularly important in Australia in summer for obvious reasons.

The Death Certificate is then completed by the patient’s GP when next their rooms are open.

If there is no doctor able or willing to issue a Life Extinct Certificate, then the legislation is very clear: the police must be called. Where the police are involved, the body must be removed to the Morgue where an autopsy is often performed.

This is an enormously distressing outcome, to say the least, where the death was expected but where the process for managing the death, issuing the certificates and the removal of the body to safe storage failed. State authorities with whom we have discussed this issue are extremely concerned about any breakdown in the GP/after-hours provider relationship which could potentially overwhelm the coronial and autopsy systems.

Any breakdown in the Australian 24/7 patient care support system could also lead to terminally ill patients electing to enter hospital in their dying days to avoid the stress and trauma on their relatives of having to have police attend the home following their deaths, and a probable autopsy.

To my knowledge this issue hasn’t yet been ventilated publicly, but I think it is fair to assume that such an emotive issue would likely attract a significant level of attention once it becomes more widely known.

It is at this point that any severing of the nexus between GPs and Medical Deputising Services bears its most bitter fruit. Right now, our after-hours Doctors are willing to sign off on Life Extinct certificates because we have been in contact with daytime GPs, we have confirmed their willingness to sign the death certificate and we know in advance about a patient’s clinical predicament.

If accredited Medical Deputizing Services are commissioned directly by Medicare Locals, and lose that close clinical link with GPs, then our doctors will not be able to complete Verifications of Death Certificates.

This will mean that the patients regular GP would have to either attend the patient themselves or the patient will be taken to the morgue for a compulsory autopsy after police involvement.

We at NAMDS fear that without having confirmation from the patient’s regular doctor that they are willing to sign the death certificate, that after- hours Doctors will be forced to refer the patients’ death to the police. This could easily overwhelm the state coronial systems.

Such an outcome would be a disaster for all concerned and must be avoided at all costs.

The International Experience

In all of the examples I have cited in this speech, there is a unifying theme – that GPs must retain the principal 24/7 role in the patient's care, irrespective of whether the patient requires urgent medical attention in the after-hours period or not.

Where this nexus between the GP and patients has been severed by government action, the result has been an increase in cost and an increase in adverse patient outcomes.

Until 2004, GPs in the United Kingdom were required to cover the After Hours period themselves. In 2004, the UK Health Department allowed GPs to "opt out" and hand responsibility to "Primary Care Trusts" for after-hours service provision. 90% of UK GPs chose to abandon after-hours patient care responsibilities.

To comprehend the scope of this policy disaster, I recommend you read a report by the Nuffield Trust, an independent health charity, who found that the number of Accident and Emergency admissions leapt 12 per cent following the 2004 changes, largely because patients with minor complaints chose to go to the Emergency Department.

The authors identified fragmentation of the system – with some Trusts employing nurses rather than doctors to cover the after-hours period, while in other Trust areas patients were forced to use a phone service as the first point of call –with the result that patients did not know what to expect during the after-hours period and were either confused or felt they were receiving a poorer standard of medical care than would be received face-to-face at the emergency department.

Perversely, the Public Hospital Emergency Department became the easiest, less risky option for after-hours patient care.

Worryingly, the UK Primary Care Trust model (now disbanded) is a close copy of the Medical Local Model .We must make sure we don't repeat the mistakes made in the UK.

CONCLUSION

In outlining the examples I have spoken about today, I hope I have been able to show you how accredited Medical Deputising Services operate at the Coalface of patient care in Australia.

NAMDS see ourselves as guarantors of the quality of the after-hours system.

It is a requirement of membership of NAMDS that the service be accredited to the current Royal Australian College of General Practitioners Standards for General Practice.

Additionally, NAMDS members must be accredited to the NAMDS/Commonwealth definition of an MDS.

This requires the MDS to meet an additional 15 criteria before membership of NAMDS will be granted.

If we go back to the analogy of the Coalface, longwall coalmining is regarded as a safe mining method because of rigorous quality control enforced by the mine operators, closely checked by regulators and understood by a highly skilled and work-safe workforce.

Changes to the definition of after-hours in the **3rd and 4th Editions of the Standards** for General Practices– and the failure to adopt the higher, more rigorous NAMDS standard - which I note has now been adopted by the Commonwealth - has the potential to create unsafe work standards in medical deputizing.

All Australian Medicare Locals are encouraged not to lessen after-hours standards and to adopt the Commonwealth MDS Definition in the tendering processes for service providers.

I know any mention of changes to definitions or loosening of standards has the potential to cause eyes to glaze over – so I'd encourage you, when pondering this question to do a simple Google UK news search.

The search will starkly demonstrate, the loosening of standards around medical deputizing in the United Kingdom combined with the removal from GPs of responsibility for after-hours care resulted in highly public, lurid cases of avoidable patient deaths splashed on the front pages of the tabloids at regular intervals for years. It is this UK outcome which must not be allowed to occur in Australia.

The 24/7 primary health care system in which we are major stakeholders has grown up to reinforce and strengthen the responsibility, authority and accountability of the GP as the primary care provider and gatekeeper of the Australian primary health care system.

From a funding perspective, it has been dependent on the after-hours Practice Incentive Payment being paid to GP practices.

With the changes proposed to after-hours funding so closely modeled on the UK system, there is a high risk that if tenders are let that allow standards to slip, Australian doctors will follow the example of their UK counterparts and opt-out of providing 24/7 patient care services.

In our view, the risk of unintended consequences of this policy change is very high.

We think there is a good argument not to introduce untested new service models until Medicare Locals can be sure that incentives have been aligned so as to ensure that they do not result in a reduction of after-hours care accessibility for patients or allow GPs to be alienated from 24/7 patient care responsibility in Australia.

With so many complex variables around after-hours care, the lessons from the Coalface are that any changes must be considered in light of the complexities of the varied groups of patients we care for, the impact on the doctor/patient relationship, and the potential unintended consequences of any changes to the system, including to arrangements around expected deaths in the family home.

With timelines so short, and the potential adverse consequences of any change so profound, NAMDS is proposing two practical models of care. One we have titled the "Flow Through" payment model, the other the "GP Link Payment" model. We believe that either model will preserve all the good aspects of the Australian General Practice managed primary health care system and avoid the risks associated with GP abandonment of 24/7 care responsibility that occurred in the UK when practice payments for after-hours were abolished in 2004.

Both the models proposed by NAMDS can be found in delegates conference packs or at our booth. The benefits of both NAMDS models are threefold :

- Medicare Locals become the fund-holder and fund distributor to General Practices for after-hours primary medical care (instead of it being funded by the Practice Incentives Program managed by DoHA);

- The General Practice (and any contracted support they choose) remains responsible to provide 24/7 care to patients, directly or via an accredited MDS.

- The Medicare Local sets the standards for the GP Practices allowing them to access funding and carries out an audit function to ensure compliance and genuine access to care for patients.

I said at the beginning of my remarks today that I had chosen the title “Lessons from the Coalface” very deliberately.

I likened After Hours Medical Deputising to longwall coalmining – tried and tested, efficient, and operating out of sight and often out of mind.

There is a fourth similarity, and that is to note that when a longwall mine collapses the results are catastrophic. Lives are lost. It is no hyperbole to say – based on the UK experience – that if the system of after-hours care currently operating well in this country collapses as a result of hasty or ill-thought-out changes, people will die. It’s not hyperbole – it occurred in the UK, and people died unnecessarily. It must be avoided here.

Lastly, could I say that “Coalface” has two definitions in the Oxford Dictionary. The first refers to the “Exposed working surface of a coal mine”; the second to “Any place where work is performed “in PRACTICE rather than Theory”

It is the strong view of NAMDS members that Medicare Locals should not damage well-functioning after-hours medical services due to hurried implementation of new ideas or untested theories of service provision, no matter how well intentioned.

With so much at stake, we think it is sensible to grandfather existing arrangements for a period of time so that equity considerations, including the circumstances of patients with disabilities and complex health needs and palliative care patients, can be properly encompassed in any new system.

I urge all Medicare Locals not to disturb the good work accredited NAMDS members have done for 40 years at the Coalface of After Hours Medical Care, and to work together with NAMDS to improve 24/7 primary health care service availability for all Australians.