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Dear Dr Cusack

RE: CLINICAL PRIORITISATION CRITERIA – GERIATRICS, GYNAECOLOGY, NEUROSURGERY, OPHTHALMOLOGY (ADULT AND PAEDIATRIC), UROLOGY

On behalf of AMA(SA) President Dr John Williams and AMA(SA) Council, thank you for the opportunity to comment on the draft Clinical Prioritisation Criteria (CPC) to guide referrals to specific public hospital specialist outpatient services.

As we have noted in previous responses to proposed CPC policies, AMA(SA) members welcome measures to improve communication between public sector hospital outpatient services and general practice, which can only support continuity of care for patients and ultimately their health and wellbeing outcomes. We commend the department's approach to engaging with a range of clinicians to formulate these protocols and to develop the links and resources to support referrals.

Our members note that the triage and referral criteria to specialist outpatient services are reasonable for each condition and that it is helpful to have these explicitly stated on a website.
However, we suggest referrals are often complicated; it is important to avoid overly procedural or 'tick-a-box-type' applications of protocols that may lead to patients being denied treatment. Outpatient departments must be adequately funded to meet demand. Some outpatient services have long waiting lists, which makes it difficult for clinicians to follow up with some patients after in-hospital treatment and procedures.

An overly complex set of criteria may also become a barrier to optimal care. General practitioners (GPs) among our membership asked for feedback on the criteria advise that it is not possible to use the protocols as presented in the submitted documents within the timeframes of a consult and so would be unlikely to use them. They suggest that presenting the necessary steps in a Healthpathways format would be more user-friendly. A flow-diagram or an interactive e-document with stem/cascade or decision tree would be more efficient ways to access the information.

In addition, GPs note that the requirement for care plans to be sent with a referral to geriatric services is onerous unless Healthlink is the referral option. The Myagedcare referral via Healthlink allows a clinician to quickly pick a document within 'Best Practice' and add it as an attachment rather than printing, faxing or emailing it as a separate document. It has also been suggested that the online referral template should enable the referrer to add or arrange relevant information necessary for that patient. A larger space for a paragraph is

needed for a clear reason for referral as this may not fit neatly into a category; GPs should be able to cross-reference more than one clinic. It may be more efficient for Clinic A to refer directly to Clinic B rather than returning the referral to the GP.

As we have previously noted, GPs have raised concerns about the protocols replacing personal communication with specialists, especially if the diagnosis is complex. While the protocols provide a useful filter, it is important to ensure there is appropriate support for GPs to manage patients who do not neatly fit the outpatient criteria. Many issues can be resolved in a matter of minutes if GPs have rapid access to high-level advice from a consultant or senior registrar. GPs also note it is also important to be able to talk and discuss with experienced colleagues rather than merely referring to emergency departments. Patients often feel that this is simply GPs 'passing the buck because they do not know what else to do' as opposed to having no other option.

Doctors have also raised concerns about the protocols leading to a diagnostic bias through attempting to fit the patient into a specific clinic. We propose that GPs be able to refer for opinion and review rather than directing into pre-set channels.

We also consider it important that protocols do not lead to further barriers to care for geriatric patients. Considerable time is wasted debating whether Geriatrics or Older Persons Mental Health (OPMH) should see a patient, especially if OPHM insists all 'significant physical factors' have been addressed before a patient can be seen. In this context, the proposed exclusion of mental health patients from geriatric services is unworkable. Clinicians also recommend that the SA Virtual Care Service (SAVCS) and other hospital avoidance services should be the preferred avenue for urgent care for older patients instead of them being sent to emergency departments by default.

In relation to the gynaecology protocols, there are concerns around the category 3 timeframe of removal of an IUD where strings are not visible. GPs require a clear link to outpatient hysteroscopy services as they cannot manage this without access to specialist input. Similarly, in relation to fertility, there needs to be clear advice around next steps following baseline investigations.

We would be pleased to expand on any issue raised and warmly thank you for the opportunity to contribute.

Yours sincerely

Assoc Professor Peter Subramaniam

Vice President
Australian Medical Association (SA)