Red tape emergency

The burden of bureaucracy in medical practice has long been a problem and technology is not yet making it any easier

Red tape and bureaucracy have long been a considered a menace to medicine. The profession says the problem is as acute as ever.

There is the driver’s licence form that asks for the patient’s name to be entered three separate times. There is the form that arrives in the mail but still requires the clinician to enter their postal address. There are DVAs, DSPs and ACATs. And then there is the PBS Authority system and the estimated 2 million unnecessary phone calls from doctors it entails every year.

In the United States, some doctors now pay medical scribes to tail them during consultations, keeping the medical notes and completing necessary forms in order to allow the clinician to focus on face-to-face health care. It’s not yet happening in Australia, but the time and cost of endless box-ticking and form-filling has engendered serious concern for the impact this is having on patient care.

In one recent instance, it all became too much for a rural general practitioner with a bulk-billed client list heavy with those suffering drug and alcohol addictions and the morass of associated morbidities. She took down her shingle and closed her practice.

Emeritus Professor of Public Health and Community Medicine at the University of New South Wales, Dr Ian Webster, says there were complications involved, but it was an example of the current burden of bureaucracy in general practice.

“Most doctors, even the experienced doctors, get fed up with it. They feel constantly under threat by the regulations and being under surveillance”, Dr Webster says.

“Of course, there are people who do the wrong thing, but the vast majority of people are doing the right thing.

“The consequence is that they get irritated. They get cross and they don’t want to deal with these things. They disengage.”

In the example he cites, the required paperwork associated with the doctor’s many complex patients itself also became a serious deterrent to other doctors taking on their care.

“Oh of course, then all of these complicated people have to find other doctors and they don’t want to see them — thanks very much!”

General practice

Dr Webster’s anecdote is an acute example of the consequences of GPs bearing the brunt of the health system’s red tape requirements.

A 2013 Australian Medical Association (AMA) survey on red tape found that many GPs now devote 9 or more hours each week to administrative processes.

According to separate results recently released from the long-term Bettering the Evaluation and Care of Health (BEACH) survey, on average, GPs spend 2.5 hours each week on non-billable patient care, adding up to $15 000 lost income per year.

As far back as 2003, and again in 2006, the Australian Productivity Commission recommended that the bureaucratic processes and requirements be amended to increase system efficiency. Progress has been

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Practice perfect protocols

General practitioner Dr Harry Hemley declares he is in a good mood when we speak, partly due to the fact the bureaucracy of practice falls dramatically over the summer period.

“I can actually see patients and have a peaceful existence”, he says.

The phone at his Melbourne practice goes quiet over summer when compared with the rest of the year, as the calls from the various levels of government temporarily stop.

“All the bureaucrats have gone on holidays. It just makes life so much easier.”

The former president of the Victorian AMA has been campaigning against red tape for years. He says that it’s not just his time and his GP colleagues’ time that is wasted on filling out forms and answering calls — the entire practice is involved.

“Our phones run hot, with people ringing up all the time from various government departments, patient carers, caring organisations and so forth.”

To help cope with the demand, over time the practice has devised a set of protocols on who can answer particular calls and fill out particular forms. Patient confidentiality requirements have played a big role in determining who can do what. As a result, Dr Hemley says that the practice’s GPs now rarely have to speak to a bureaucrat on the phone themselves.

The introduction of smart bureaucrats by the Victorian Government has also gone some way to reducing the time required to meet red tape requirements. And despite current frustrations, Dr Hemley says he is optimistic that ultimately the personally controlled electronic health record will dramatically reduce the amount form-filling and box-ticking required.

“But I’m not holding my breath.”

Too much authority

Despite recent changes to try to improve the efficiency of the system, the PBS Authority system — entailing roughly 500000 doctor phone calls each month — remains one of the most frustrating bureaucratic bugbears for the profession.

A call for its removal led the AMA’s Commission of Audit submission.

“We quantified in our submission that there are 2 million phone calls a year that don’t need to be made”, Dr Hambleton says.

“It’s an enormous waste of time when GPs can increase their productivity by directly seeing patients, not waiting on the phone for someone to approve something that’s routinely approved.”

The problem is not confined to general practice. It affects anyone who interacts with the PBS, from palliative care clinicians to anaesthetists, oncologists and intensive care specialists.

However, early indications suggest that the current federal government may address this problem. While cautioning that a positive outcome should not be assumed, Dr Hambleton says he’s encouraged by the fact that there is now a minister who is seriously looking at the problem.

“We’ve got some sensible suggestions coming out of the AMA therapeutics committee about which particular drugs pose low risk, we’ve got evidence from the drug utilisation committee that there’s not an explosion of misuse of drugs when they move from Authority to General Benefit, and all of those ducks are lining up in the right direction”, he says.

Technology — problem or solution

In theory, many of the inefficiencies that riddle the system could be solved by technology. Already, software templates are making form completion much less onerous for many practices.

However, the personally controlled electronic health record (PCEHR) continues to cause more problems than it solves.

“Signing up for the PCEHR as a GP is like doing a triple somersault with a twist”, Dr Hambleton says.

“If you don’t land properly, you have to start again.”

Senior BEACH researcher and deputy director of the Family Medicine Research Centre at the University of Sydney’s School of Public Health, Dr Joan Henderson, says that the system needs to recognise the time involved in asking GPs to become processors.

“If you want them to tick every box in the desktop software about what they did for the patient and what was the result of each test, to find out what the care processes are and what the outcomes are, you have to consider the time that’s involved in that”, she says.

Both Dr Henderson and Dr Webster believe that an increased involvement of GPs and other doctors in the development of regulation and data collection systems would be a valuable step towards reducing red tape to its bare essentials — a move towards collecting only the information that will produce a meaningful outcome.

BEACH began monitoring non-billable time 2 years ago in response to requests from the AMA and the Royal Australian College of GPs.

Dr Henderson laughs at the irony that monitoring the non-billable time of GPs has required her and her fellow researchers to ask them to fill out still more forms and says that the GPs are being incredibly generous in taking part in BEACH.

The 2013–14 results will be available later this year and Dr Henderson says non-billable time is unlikely to be any less than in previous years given the growing demands for monitoring in general practice.

BEACH’s previous results have shown that non-billable time also increases with the age of the patient, so it looks likely that red tape will continue to loom large in medicine for a long time to come.

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Playing for keeps

Neurosurgeons see tough things, including young people killed and maimed by one punch. If you’re choosing it as a specialty, be prepared to do the hard yards, says Professor Andrew Kaye — one of the world’s best.

As in neurosurgery, you can’t just play at being a Hawthorn fan. Professor Kaye’s medical career is as storied as his beloved Hawks’ premiership-winning record.

He graduated from the University of Melbourne in 1973, spent two years in Oxford as a neurological registrar and a year in London doing research at the Institute of Neurology.

He came home to a post at the Royal Melbourne Hospital and, in 1992, was appointed Professor of Neurosurgery at the University of Melbourne, the first position of its kind in Australia. In 1997, he was appointed the James Stewart Professor of Surgery and chairman of the Department of Surgery.

He is the founding editor-in-chief of the Journal of Clinical Neuroscience. In 2003, the American Association of Neurological Surgeons honoured him with the Ronald Rittner Award for contributions to the treatment of brain tumours and, in 2006, the Bucy Award for his contribution to neurosurgery education. In 2004, he presented the Sir John Eccles Lecture at the Australian Neuroscience Society.

In 2010, he was awarded the Commonwealth of Australia Centenary Medal in 2003 and Order of Australia in 2004.

There is still so much to discover about the human brain, he says. “We’ve hardly started. If this were school, we’ve just graduated from kindergarten.”

As head of surgery — all surgery — Professor Kaye spends a lot of time talking with medical students about their future specialties, and he is even-handed, publicly at least, about where they should direct their passion.

“You only saw your father once a week in those days, and that was when he took you to the game.”

“Of course”, he says, joking, “We all know if you’re not a neurosurgeon you’re a lesser form of life.”

Professor Kaye’s best advice to students is to “spread their net wide”. “Do as much as you can, try everything, go wherever you can, and then make a decision.”

“Spend a year doing research early in your postgraduate life. It teaches doctors so much about how to make evaluations.”

When he’s not saving lives and barracking for the Hawks, Professor Kaye is a football coach. It has led to his two passions coming together in unexpected ways.

“I was coaching the Kew Juniors”, he says. “James Macready-Bryan was one of my players.”

When James was assaulted in 2006, leaving him permanently and totally disabled with an acquired brain injury (ABI), it was Professor Kaye whom his parents called for help.

When they set up the JMB Foundation, which aims to provide appropriate accommodation, rehabilitation and financial support for young people with ABI, they asked him to be patron.

It’s a role he is pleased to fill. “ABI is every parent’s worst nightmare”, he says. “They watch their children die, every day.”

“There are no facilities — young people who are maimed by ABI are being housed in aged care homes, which is inappropriate.”

The issue of coward-punch assaults is at the forefront of public consciousness at the moment, but Professor Kaye isn’t convinced the current focus on alcohol is the right way to go.

“We can’t just blame this on alcohol”, he says. “It plays an important part, yes, but most people who get drunk don’t get aggressive in this way.”

“I think there is a societal issue here and focusing just on alcohol is missing the point.”

Neurosurgery is, he says, “a tough life”.

“We see bad nightmares sometimes. It is an unforgiving kind of surgery in terms of the sort of work we do. The hours are really difficult and families have to embrace and accept it.”

“That’s why you can’t just play at it. It’s all or nothing.”

Cate Swannell