

After-hours medical deputising services for older people

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Older people need GPs who know them well

Medical deputising services are invaluable, responding to large numbers of after-hours calls, particularly for older people at home and in residential aged care (RAC). Without these services, emergency departments and ambulance services would be much busier than they are now. The article in this issue of the *MJA* by Joe and colleagues¹ reviews 357 112 bookings logged by one such service, the Melbourne Medical Deputising Service (MMDS), over a 5-year period (2008–2012).

The proportion of general practitioners using deputising services increased from 38% in 2005–06 to 48% in 2014–15.² The data presented by Joe et al show a concomitant increase in the number of home and nursing home visits by the MMDS for those over 70 years of age, with the booking rate rising over the 5-year period from 33 to 40 per 1000 people over 70 years of age for home visits, and from 121 to 168 per 1000 people for RAC visits.

The reasons for this increase are undoubtedly complex, and require further examination. They include the increase in the size of the population of older people, and government initiatives that encourage GPs to provide after-hours services, either directly or through deputising services. The annual collection of data on 100 000 GP consultations in Australia known as BEACH has revealed a GP workforce that is “more feminised, older ... and worked fewer hours per week”.³ Other factors might include the dangers of after-hours visiting, stretched GP workforces, and a trend among GPs toward a better work–life balance.

Deputising services differ from ordinary general practice. There is no requirement for their doctors to have a college fellowship, and only about half of the doctors in the MMDS do so.⁴ There is little continuity of care. Older people have high rates of dementia and may not be able to fully communicate their history. It takes time to trawl through medical notes in RAC facilities. This potentially reduces the quality of service compared with attendance by the patient’s own GP, who knows them and their medical history well. On the other hand, the deputising service keeps track of their locum service doctors, and should know whether something has gone amiss.

The article by Joe et al notes that over 80% of calls were from or on behalf of patients in RAC. These patients represent less than 5% of the older population, and they present with levels of complexity and disability that have qualified them for entry to RAC on the basis of the ACAT (Aged Care Assessment Team) criteria. The authors of the study ask why there are so few community call-outs, but it might also be interesting to consider why there are so many RAC call-outs.



Only 48% of the BEACH GP sample in 2014–15 had visited an RAC facility in the previous month.⁵ Barriers to GP visits include the poor level of GP remuneration, increased time seeing the patients,⁵ difficulty in finding staff (or indeed the patient), and staff with training below the levels of registered or enrolled nurse who are unable to hand over the patient history in a manner that makes medical sense.⁶ Handover comments such as “Mrs Smith is a bit behavioural today” are very difficult to interpret clinically.

Nurses with the ability to attend to complex needs are currently few in number in RAC, particularly at night. Nurses with lower levels of training may follow protocols that require at least a phone call to a medical practitioner if certain parameters are exceeded (eg, blood pressure). This call is even more likely in some areas, where hospitals require a medical practitioner review before receiving an ambulance patient from RAC.

RAC providers argue that changes in the Aged Care Funding Instrument, which funds RAC, will result in a decrease of 11% in income, with over 50% of survey respondents stating they would be likely to reduce the number of nursing staff.⁷ The New South Wales Nurses and Midwives’ Association has called for an approach that also takes the patient’s needs into account:⁸

We should be looking to establish a needs-based system to determine staffing ratios, consistent with those found in public hospitals to ensure our health care system is equitable, and does not discriminate on the basis of age.

When a patient’s usual GP is unavailable, the deputising service may be called, resulting in the large number of visits found by Joe and her colleagues. The service doctors are not equipped to care for these complex elderly patients in an optimal manner; they do not necessarily have a postgraduate qualification, they

do not know the patient, and they are not supported by staff who are well trained and familiar with the medical conditions of each patient. We need to examine the reasons for calls to medical deputising services, and whether they are associated with excess morbidity and mortality. It is a problem that might be partly ameliorated by systems such as Hospital in the Home.⁹ Urgent change is needed if we believe that our elders should receive at least the same quality of medical care as the rest of our community.

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