AUSTRALIAN MEDICAL ASSOCIATION
(VICTORIA) LIMITED.
ABN 43 064 447 678
293 Royal Parade
PO Box 21
Parkville, Victoria 3052
t 03 9280 8722
f 03 9280 8786
w www.amavic.com.au
Country Freecall 1800 810 451

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Ms Sandy Bell
Manager, Acute Inpatients Program
Department of Health
50 Lonsdale Street
MELBOURNE VIC 3000

By email: sandy.bell@health.vic.gov.au.

Dear Ms Bell,

RE: Proposed recommended clinical urgency categories

Thank you for the opportunity to provide feedback on the proposed recommended guide on the assignment of clinical urgency categories. Please see our comments below.

- **Consistent categorisation**

  AMA Victoria supports consistent and transparent categorisation of patients for elective surgery across all public health services. This can promote equitable treatment of patients and facilitate priority being given to those with greatest clinical need.

  The proposed guide states that a key priority for elective surgery management is to treat the right patient at the right time. This is true however all patients who have been assessed by a medical practitioner as requiring surgery should have their operation as soon as possible.

  It is worth acknowledging here that the need for a system of allocating patients to elective surgery categories arises directly from the inadequate resourcing of public hospitals to meet the demands being placed on them. The Government must enhance the capacity of the public hospital system to treat patients within clinically appropriate timeframes.

- **Recommended guide on the assignment of clinical urgency categories**

  We support the categorisation of surgical procedures listed in Appendix 1.

- **Clinical urgency category definitions**

  Definitions for elective surgery categories are a reasonable tool for promoting equitable prioritisation of patients for surgery; but it is important that the definitions reflect the fact that medical practitioners make decisions about what elective surgery category a patient should be placed in based on an assessment of the patient as a whole.

  Category definitions should therefore take into account all the factors relevant to a patient's requirement for elective surgery and should not be limited to the type, or volume, of procedures a patient requires.

A particular clinical condition is only one aspect to be considered. Co-morbidities and other patient factors such as chronic diseases, disabilities, and, where appropriate, non-clinical factors, such as social/economic issues are factors that determine the clinical urgency of the surgery.

To this end we support the removal of references in the current definitions to pain, dysfunction and disability with a view to focusing on the clinical condition of each individual patient. We feel that factors such as pain, disability and dysfunction are sufficiently taken into account by the words 'clinical condition'. We accept this definition to mean an evaluation of a patient's condition as a whole.

We would suggest however that some reference is made to the social context of a patient's condition. In assessing patients for surgery, surgeons are guided by information provided by referring general practitioners regarding patient circumstances. This information can include if a patient is homeless and has a knee complaint which is limiting their capacity to walk, or if a patient is unable to work because of their condition.

The ability of patients to support themselves during the time they are waiting for surgery should also be a factor in categorisation; similarly, an elderly patient living alone will require surgery sooner to maintain independence. A set of criteria for the social circumstances which should be considered when categorising patients may be useful.

We also support the change to the Category 3 definition which refers to a 365 day time period as opposed to 'some time in the future'. This enhances the clarity of the definition and sensibly sets a specific time by which a patient should be treated.

Our concern however is that the clarity of the definition is undermined by stating that admission within 365 days is 'acceptable'. It is open to inference that admission beyond this time is unacceptable but this is not clear. We would suggest replacing 'acceptable' with 'desirable', as in Category 2.

We support the statement that the allocation of urgency categories to patients is a matter of clinical judgment for the clinician. The primary consideration for surgeons in categorising elective surgery patients will always be clinical urgency. Therefore it is important that medical practitioners are able to make their decisions autonomously with the support of the guidelines – it is vital that the guidelines are not inflexibly enforced.

- **Data reporting**

  Consistent categorisation of patients for elective surgery is important to enhance consistency in the data collected. However the most accurate measure of the length of time public patients wait for surgery is from when they are referred by their GPs to specialists for assessment and, until this data is published, the reported waiting times will not accurately reflect the ability of Victoria's health system to meet demand. We once again call on the Government to release this data.

- **Consultation with clinicians**

  It is essential that in formulating a policy of this sort there is appropriate consultation with various craft groups. We acknowledge that the guide was reviewed by the Ministerial Advisory Committee for Surgical Services and would emphasise that clinicians must have direct, ongoing input into the development of the policy and its continuing review.

To discuss any of the matters raised in this letter, please contact Elizabeth Muhlebach, Policy Officer, on (03) 9280 8754 or elizabethm@amavic.com.au.

Yours sincerely,

Bryce Prosser
Director, Policy and Public Affairs