Submission

No 9

INQUIRY INTO REVIEW OF THE EXERCISE OF THE FUNCTIONS OF THE MOTOR ACCIDENTS AUTHORITY AND THE MOTOR ACCIDENTS COUNCIL - SEVENTH REVIEW

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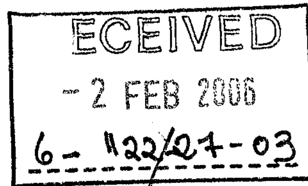
Theme:

Summary:

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Patron: H.R.H. The Prince of Wales



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27 January 2006

The Honourable Christine Robertson MLC
Chair, Standing Committee on Law and Justice
Legislative Council, Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Ms Robertson

Re: Seventh Review of the exercise of the functions of the MAA and MAC – invitation to participate

Thank you for inviting the Royal Australasian College of Surgeons (the College) to submit to this Review. Wide consultation has taken place with the College Trauma Committee, Fellows and associated organisations, including the Australian Orthopaedic Association.

Please find attached our submission. I appreciate your flexibility in allowing an extension to the due date for submission to 27 January 2006.

We would be happy to appear before the Standing Committee on Law and Justice should further clarification be required.

Yours sincerely

Russell W Stitz FRACS
President, Royal Australasian College of Surgeons

cc- Mr Michael Phillips, Principal Council Officer (Legislative Council)
Mr Ian Dickinson FRACS, Chair Professional Development and Standards Board
Professor Danny Cass FRACS, Chair Trauma Committee
Mr Arthur Richardson FRACS, Chair New South Wales State Committee
Dr David Hillis, Chief Executive Officer
Dr Pam Montgomery, Director Fellowship and Standards
Dr Greg Wilson, Manager Fellowship Services

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Seventh review of the Motor Accident Authority (MAA) of New South Wales

Submission from the Royal Australasian College of Surgeons
January 2006

Thank you for inviting the Royal Australasian College of Surgeons to contribute a submission to the seventh review of the MAA. The College values the work the MAA has undertaken, and finds many of its aims in harmony with those of the MAA. Much good work has been done in the past and we will seek new partnerships to further reduce the road toll and provide better care for our trauma patients. The College and the MAA are both innovators searching for better ways of doing things. There are ways that the College can help the MAA reduce the incidence of road trauma, and ways the MAA can help the College to train trauma surgeons and to devise ways to provide optimal care.

Role of the College

The College's prime responsibilities are the education and continuing professional development of surgeons for the benefit of the care of surgical patients in Australia and New Zealand. In addition, the College has a long history of activity in promoting health in the Australasian community. There is no stronger area of this commitment by the College than in Trauma. The College has been a leader in partnerships for the introduction of seatbelts, the introduction of drink driving legislation, lobbying for gun control legislation, and many other important issues.

Injury prevention

Like the MAA, the College strongly believes that prevention is better than cure, and continues to commit resources of the College, particularly through the College's Road Trauma Committee, to investigating ways we can promote injury prevention. There is some encouragement from the fact that efforts at prevention mean injuries occur less frequently and are less severe.

Injury management

Unfortunately, despite efforts of the College, the MAA and others towards prevention, injuries still occur. Therefore, the College remains committed to training surgeons to care for these injuries and is proud of its tradition in the areas of general surgery, neurosurgery, orthopaedics, plastic surgery and paediatric surgery as the prime specialties that treat injured patients. With increasing specialisation we can train surgeons to offer many of these patients more sophisticated care, for example in the area of spinal injury. However, this specialisation raises the potential for gaps in the treatment of trauma patients, and the College strives through its training programs to continue to develop generalist trauma surgeons who can be present in a major teaching hospital as a first line of senior care for road trauma victims.

Recommendations

1. **Clinical care**

   There is very good individual clinical care given by Fellows of the College, but the care is often individualistic and fragmented. This is because there is often little in the way of support from institutions in the form of coordinated trauma services, including gaps in non-surgical clinical support services and in cohesive and reportable follow-up.

   The position of the Royal Australasian College of Surgeons is that, in collaboration with the College's Trauma Committee, hospitals providing trauma services should look at ways we can improve trauma care in the following areas:

   - Ensure senior medically qualified personnel are present at the reception of a trauma patient. Currently through our Trauma Committee we recommend that a senior surgeon be available within 15 minutes of being notified of a serious injury. It would be ideal if surgeons were in-house.

   - To ensure such a quick call-in or to facilitate the presence of in-house surgeons there needs to be a sufficient volume of work in that institution to allow for such a structure to be practical. If a surgeon works in an institution where there is an expectation of two to three major traumas per on-call shift day, then they would make themselves readily available for the care of those patients.

Alternatively, if the surgeon worked at a smaller hospital, where the chance was remote that there would be more than, say, one serious injury per month for that practice, then it would be difficult for the surgeon to forego practice at another institution just to allow for the possibility of that patient being admitted. Due to the very unpredictable nature of injuries this often means that the surgeon is otherwise occupied when the injured patient arrives. The following recommendations are designed to ensure that this high level of senior clinical expertise can be made readily available to trauma patients.

Recommendation 1 – major centres for trauma
That the MAA indicates some form of financial support to encourage the concentration of trauma work into fewer institutions that would be much more dedicated to the care of trauma patients

- Our proposal would be to have an extra fund available for hospitals that see more than one major trauma case per day. Associated with this would be some sort of recompense to surgeons whose individual volume of trauma and level of expertise and training were such that they could offer a higher level of care. For this to be achieved the surgeon would have to forego other practice and this would need to be recognised in funding for that individual surgeon. One suggestion for this is that surgeons who have personally treated more than 100 serious trauma cases per year, attended educational trauma meetings and published research material relevant to trauma would be suitably rewarded for giving up other aspects of their outside private practice to care for public trauma patients.

- The MAA needs to understand that the provision of surgical trauma services in hospitals is fragile with gaps in care opening up. If we are to avoid the mistakes made in the USA we need to ensure that the in-hospital trauma services are not taken for granted. It is interesting that when one looks at the MAA website there is little discussion of the provision of in-hospital definitive care. Yet the decision-making by a senior surgeon and the technical expertise is, in most cases, the most important variable in the future outcome of the patient. Transport to hospital is important as is rehabilitation; but the definitive repair of the injuries is the pivotal event. In the USA due to a number of factors the acute trauma service has collapsed in many areas, sometime in what seems to be "in the blink of an eye". When Teams are dismantled and surgeons walk away from acute trauma care there are not only problems of patient care but high costs associated with providing funding for rosters. Figures of $3000 (USA) per night per specialty area have been verbally reported.

  Therefore, we must work together not only to try to further improve care but also to ensure that the services already provided are not neglected. Provision of after hours acute trauma services is a difficult job and many young surgeons are questioning their commitment to this area of practice. They do so because of a feeling of contribution to the community, but it would not take much for them to feel unwanted and hence not seek public hospital reappointment. One of the main contributions to job satisfaction is to work in a trauma service with adequate equipment, ready access to theatres and a patient focused emphasis on optimal care.

  In the USA the provision of extra funds is call P4P (Pay for Performance). It can represent a 10% or more extra reimbursement to institutions and individuals who can document a better outcome.

2. Long term follow up
Currently long term follow-up does not occur in trauma management. In contrast, it is accepted that we do not know the end result of cancer treatment unless there is a two and a five year follow-up. Therefore there needs to be support to set up:

- trauma outpatients services
- systematic documentation and reports to allow optimal follow-up for individual patients
- coalescence of information to provide data on the outcome of certain injuries.

This would enable the surgeon to understand the long term clinical outcomes of individual surgical treatments and also liaise closely with physiotherapists and other rehabilitation specialists, so that they are very aware of both the surgical procedure that was initially undertaken and the long term outcome.

Recommendation 2 – trauma outpatient clinics
That the MAA supports the development of trauma outpatient clinics of a multidisciplinary nature that are centred on major trauma centres.

- In this way stable practices with well defined outcomes could be established, which in turn would encourage teams in the future to provide ever improving care.
- The ultimate goal of trauma care is to ensure that patients return to normal activity and return to gainful employment. There should be support and encouragement to trauma centres to maximise these outcomes. There should be rewards to institutions successful in improving their trauma outcomes, such as better than average return to activity and employment.

Recommendation 3 – rewards for superior outcomes
That the MAA looks for ways to reward institutions that have outstanding long term results for trauma care.

3. Prevention

There is a need to reinstitute prevention back into the clinical coalface. Clinicians actually treating and managing trauma and collecting the primary information for the benefit of their patients can coalesce that data to allow meaningful conclusions to be made about injury prevention. In addition the clinicians that treat injuries should have a public profile, a depth of understanding of individual cases and stories, and a broader understanding of trauma services and trauma outcomes, to allow much more potent messages to be given to the public about injury prevention and safety.

The current mechanism whereby data is gleaned from various databases and then cleaned, matched, coalesced and published in scientific journals allows for a small splash of disconnected information to be given to the public, and then the research team moves on to another topic. If we are to further improve our injury prevention and lowering of the road toll there is a need for a much more constant, sophisticated prevention campaign centred around our trauma hospitals and trauma clinicians. It will only be by constant meaningful weaving of a risk behaviour benefit knowledge base to the public that they will start to respond with improvements in behaviour and will be more accepting of legislative change.

The current situation is often cost inefficient and is providing the public with a multiple peppering of disconnected pieces of information which is tending to have less and less impact for the effort spent, rather than building up into a pattern of better behaviour on the roads.

Recommendation 4 - new partnership between the MAA and the College

That a new partnership be founded between the MAA and the Royal Australasian College of Surgeons in the review of injury prevention measures, to assess and reward trauma treatment centres with enhanced outcomes.

Such a partnership is not guaranteed to work, but the College is optimistic. We would be happy to enter into discussions with the MAA, but would set targets for various health areas around major trauma centres. If deaths, serious injuries and claims were reduced in those areas, then a reward (payment) for prevention performance could be made to the major trauma centre. The new reorganisation of health areas into eight health areas in NSW with the metropolitan ones being over one million patients. This has produced a large enough volume for meaningful results to be combined and interpreted.

A trial of such an arrangement has taken place in the Hunter region, where extra funding was to be provided to the trauma service if the number of claims dropped in a particular month. Such arrangements encourage the Area Health service to mobilise their considerable resources to drive prevention campaigns. The system could be called R4P (rewards for prevention).

4. Patient financial classification

One of the significant disadvantaqes of the treatment of patients admitted to NSW hospitals after road trauma relates to the uncertainty of their financial classification. Patients may either be classified as third party (under the MAA/CTP insurance scheme) or Medicare. This

determination depends on factors relating to the accident which may not come to light for several days, or even months if an investigation is required. Consequently, many surgeons in NSW do not take a leading role in managing road trauma patients as, for example, they do in cases covered by workers compensation. The agreement between the surgeons and Workcover, and the knowledge that all injured workers are covered by this insurance is such that the consultant surgeons at trauma centres will usually take the lead role in managing these patients. This extends beyond the performance of the surgery, to the provision of aftercare. Such ideal care would only occur for road trauma patients if the arrangements were such that satisfactory remuneration was provided reliably for the treating surgeons.

This may require the introduction of a no-fault system such as that used in Victoria, where all road trauma patients are equally covered. Obviously, adoption of a no-fault system carries with it many other changes. The MAA may have already considered this possibility carefully, but the guaranteed remuneration of specialist care for all road trauma patients also carries with it many advantages to both the patients and the MAA.

Recommendation 5 – A no-fault system

That NSW moves towards a no-fault system whereby all road trauma patients are equally covered financially and therefore clinically.

Further background and discussion

The particular concern of the Royal Australasian College of Surgeons is the training of the next generation of trauma surgeons. Due to the success of injury prevention, including safer cars, safer roads, better legislation, public education, etc., there has been a reduction in the road toll.

The outcomes of trauma surgery have also improved because the experience of surgeons has also increased. For example, surgeons are now much more comfortable to not operate on many trauma patients, and this greatly decreases the morbidity and cost of trauma management. In many ways this confidence to not operate has only come about from the concentration of work into centres so that surgeons could discern a pattern. In particular if surgeons repeatedly operated and consistently found no active bleeding under certain circumstances, this knowledge could then be put into the clinical practice of being more comfortable not to operate. Unfortunately, the alternative in small hospitals where the surgeons only operate on trauma once or twice a year results in those surgeons being more anxious. They tend to operate a lot earlier and if they do not find bleeding in that particular case they do not usually have enough volume of cases to consolidate their experience into a coherent pattern that allows them to change their clinical practice. Therefore one of the benefits of facilitating concentration of trauma work into major centres and the subsequent building up of experience would be more prevalence of non-operative approaches to trauma. This approach has been initiated in the area of paediatric splenic injuries, which has now led to a similar management in paediatric liver injuries and in adult splenic and liver injuries.

However, a consequence of this is that the skills of actually operating on life threatening haemorrhage is now much diminished, and there is now a need for even further concentration of work into major trauma teaching centres to allow the College to train the next generation of trauma surgeons. We need the MAA's help in concentrating this work and this could be done by giving financial signals that encourage state governments and area health services to concentrate their trauma services into individual, major centres.

Such consolidation is being done in Victoria, where there are two adult and one paediatric trauma centres for the whole state. An analysis of transfer times and errors in treatment of patients has indicated a much reduced error rate. NSW is achieving good results at this point in time, but only because of the good will of a large number of clinicians who are dedicated to the management of trauma and are willing to live close to and serve large public hospitals in the provision of trauma care. However, this situation is unsustainable and we are finding it increasingly difficulty to attract trauma surgeons, such that recently a number of appointments within Australasia have been "Area of Need" appointments – that is, we have had to import surgeons from overseas. Although these surgeons are contributing greatly to our care of trauma patients and are much appreciated, we have to develop a system that is sustainable in the long term in which we are able to train our own surgeons.

Summary

It is the opinion of the Royal Australasian College of Surgeons that

- optimal patient care;
- best practice training of future trauma surgeons;
- use and continuation of skills in use of mortem techniques (such as interventional radiology);
- cost structures (keeping costs minimal);
- providing a focus for research;
- facilitating outcome analysis, and
- providing a credible voice in injury prevention

can be met by further concentration of our resources into major trauma teaching centres.

The College wishes to emphasise the importance of the experienced trauma surgeon either operating or being at the coalface in cases of serious trauma injury to ensure:

- better and quicker performance;
- better outcomes;
- shorter hospitalisation;
- better and shorter rehabilitation, and
- therefore, better long term outcomes.

This means that experienced trauma consultants are present and appropriately rewarded.

We hope to work with the MAA in advancing these aims.

27 January 2006