

REMOVAL OF RESTRICTIONS ON PATHOLOGY REQUEST FORMS

DISCUSSION PAPER

Australian Association of Pathology Practices Response

The Australian Association of Pathology Practices represents pathology practices providing pathology services to over half the patients referred to private pathology. This accounts for almost 40% of all patients having pathology tests performed in Australia in both the public and private sectors.

We have reviewed the proposed changes to the Health Insurance Act and considered its impact on the patient and their referring doctor. We strongly support the principle of patient choice and are happy to promote actions that achieve that outcome. All medical practitioners, including pathologists have a responsibility to ensure patients are safe as they move through the complicated processes involved in healthcare.

In responding to this discussion paper, we must also raise serious concerns about the consultation process. Proper consultation should have occurred before the final decision to change the legislation was made. We are deeply disappointed and concerned that the government has introduced the legislative change into parliament without consultation and an understanding of the risks of this change for the patient. There has been consultation about the details of implementation but not about the original decision to change the legislation. We would question the government's commitment to patient safety if it is not prepared to allow time to seek advice and analyse the consequences of such a significant policy change.

We will address the proposed change in two parts.

Part 1: Is the proposed legislation in the best interests of the patients?

In our considered view, this legislation gives patients freedom of choice to select a pathology provider which we support however an adverse outcome is that it seriously puts at great risk patient safety and compromises the patient care. Patient choice is a desirable goal but, in practice, unreasonably assumes the patient has the knowledge and expertise to understand the complex process of pathology testing and the key elements that are necessary in order that a provider is able to ensure a quality outcome for the patient.

Diagnosis of disease is a complex process requiring professional medical expertise to understand its important elements. Patients simply don't have this expertise and it is manifestly unreasonable to require them to assume such knowledge in order to make a competent choice of pathology provider. Price is not the only nor is it the most important determinant of the best pathology provider for a patient.

The relationship between a referring doctor and the pathology practice to whom they routinely refer is an important factor in ensuring that the patient not only gets the test done but that it arrives without delay at the laboratory and that test results are communicated to the referring doctor in a timely, efficient and familiar manner.

There are well developed protocols established between a provider and their referring doctors that are reliable and predictable for each individual doctor and that ensure the specimen arrives at the laboratory within the strict tolerance specifications relating to each test and the result in turn reaches the referring doctor in a standardised format that the doctor is familiar with and who has internal checking and audit systems in place to ensure the result is read.

An important part of the service is the consistency of report format, cumulative reporting showing changes in results over time, reference ranges and interpretative comments tailored to the referring doctor requirements. Referring doctors become very familiar with the format and so misinterpretations due to pressure of work or distraction are greatly reduced.

This regularity of information exchange between pathologist and referring doctor, allows checks and balances to be built into this process so that samples or results do not go astray because of lack of familiarity with the logistics, delivery systems and IT systems that link well established referral relationships.

It is the unanimous view of all pathologists represented by the AAPP that the proposed change to the legislation as set out in the discussion paper removes a major safety element of the pathology testing procedure that underpins the quality and safety of pathology testing in Australia.

When a patient changes the advice of the referring doctor and makes a judgement about the suitability of a pathology practice, then they must assume responsibility for the consequences that flow from the choice. If a sample is not received by the pathology practice of the patients choice because there is not a usual pick up by the selected provider at the patient location or the result is not delivered to the referring doctor because the pathology practice's IT system does not link to the patients doctor by the normal channels, the patient's care may be placed at significant risk because of a lost test or not communicated result.

A "lost" result may have serious health consequences such as delayed diagnosis of cancer, delayed diagnosis of an increased risk of bleeding in a patient on warfarin.

Importantly these situations will create a medical indemnity/negligence dilemma if the patient should later wish to seek redress for any adverse outcomes which may result from the unexpected change in pathology provider.

Case Study 1

A patient attended a cardiologist who referred him to the local private hospital for a cardiac procedure. The doctor ordered a number of tests which he would need during the procedure. The patient was referred to the doctor's normal pathology provider who always has the test results available within 2 days and these test results can be readily accessed by the patient's doctor over the internet.

The patient chose to go to a different pathology provider without reference to the cardiologist. The patient arrived at the hospital for the procedure and was anaesthetised while the doctor looked for the test results. They could not be found, the cardiologist called his normal provider and asked them to find the results. They searched across many thousands of results and samples to see if the specimen had been missed placed.

Eventually the patient was allowed to wake from the anaesthesia, the tests were repeated and the procedure rescheduled for another day.

The result was an unnecessary anaesthetic, a delay in treatment that may have injured the patient, and a waste of time, and resources, and patient and doctor anger and frustration.

Case Study 2

An elderly man wanted his PSA tested regularly and with the support of his local doctor was having them done twice a year. At the last occasion he chose to go to a different pathology provider without discussion with his GP. This resulted in a PSA of a higher number than the GP expected for a normal result. The surgery was busy and when his GP saw this, he didn't realise the new lab used a different method with a different normal range. He became concerned and referred the patient to a urologist for further management and discussed his suspicion of prostate cancer with the patient. The urologist undertook a prostatic biopsy which was normal.

Thus the patient had unnecessary and uncomfortable tests and unnecessary anxiety.

This example highlights the increased risks when a patient goes to a pathology provider who is not the regular provider to the referring doctor.

Case study 3

A patient presented to her GP in August last year with symptoms of a significant flu like illness. The GP suspected swine flu and ordered the necessary tests. The patient chose to go to a pathology provider who was not the normal pathology provider that the GP referred to.

The results were not clear cut, and the GP was not sure what they meant. She rang her normal provider but they had not performed the test so could not comment on the method used by the laboratory performing the test.

The GP rang the lab that did the test but no microbiologist was available to assist. The GP referred the patient to a specialist infectious diseases physician who made the diagnosis that the test results were not indicative of swine flu.

The patient was reassured but had incurred gap payments for the physician visit as well as further tests and had to lose an extra two days from work to get the final diagnosis.

Case Study 4:

A patient who had noticed changes in their bowel motions went to his GP who ordered a number of tests including occult blood testing.

He decided not to go to the pathology lab the GP suggested but went to one close to home instead. This pathology provider did not know the GP nor did they have a computer link to the practice.

The results were posted but never reached the referring GP. The patient phoned for results and was advised they had not arrived yet so postponed making another appointment until the results arrived.

Time passed and the patient forgot to make an appointment until three months later.

The tests were repeated and this time arrived and the patient underwent colonoscopy. A bowel cancer was detected but unfortunately had already spread.

The GP had a system with her regular provider that meant specimens were tracked to make sure the result was sent electronically to the referring doctor. Had this happened the first time, the cancer would have been detected three months earlier.

Thus the AAPP believes that the existing legislation is the best means of protecting the patients' interests, minimising risk and ensuring a safe outcome

Thus we urge the government to reconsider the implications of this change in legislation and undertake a full risk assessment before the legislation completes its passage through the Parliament.

Conclusion

The legislation should be withdrawn or delayed a full risk assessment of the impact of this change on patient safety is undertaken.

Part 2: One question that arises in this discussion is - "This policy is already in place for diagnostic imaging, why is it a problem for pathology?"

In diagnostic imaging, the number of tests per encounter that a patient has is much less than for pathology.

The examination is performed with the patient present and the films are given to the patient at the time.

Imaging is only occasionally used to monitor chronic disease conditions or medication treatment. When monitoring does occur, the patient is given the films so the next radiologist can compare results over time.

In pathology, the number of tests is much greater and therefore the risk of errors is higher.

The patient does not carry the results, they are sent electronically to the GP records.

Monitoring of chronic conditions, diabetes, warfarin therapy, drug monitoring, and cancer markers is much more common.

Part 3: Response to the Discussion Paper questions should the legislation proceed?

ISSUE: What are the most effective strategies for ensuring that patients are informed in choosing their pathology provider, and understand the importance of keeping their requesting practitioner informed of their choices?

The most effective strategy is to have a statement on the request form advising patients that they can change but requiring the patient to discuss any change in selection of pathology provider with the referring doctor prior to making the change.

ISSUE: What factors currently influence patient choice of provider? What impact will increased choice (through more collection centres) or greater variability in billing practices between providers have on patient preferences?

Patients are currently guided by their referring doctor. It is reasonable to assume issues such as location, price, convenience, and familiarity will all impact on a patient's choice. To what extent

is unknown and information from the QUP committee project being run by the Consumer Health Forum on consumer satisfaction will more scientifically inform this question.

However the more important point which has not been raised in this discussion paper is what are the key elements in ensuring a test is performed to the highest standards needed to ensure the patient gets the right result and it is acted upon by the referring doctor?

The major question should be how to give the patient choice without impacting patient safety?

If the patient exercises choice without informing the referring doctor, errors will occur. Should the patient notify the referring doctor before or after the test is collected? In our view for the sake of safety, the patient needs to consult with the referring doctor before they choose a pathology provider.

Referring doctors should be encouraged to give the patient the opportunity to raise concerns before they leave the consultation. However in reality this is not simple as there are so many issues to be discussed in a short time frame and the doctor and patient will be more focussed on the diagnosis and treatment rather than a discussion about which provider to choose.

Thus the statement, on the form advising the patient to discuss the choice of provider with the doctor needs to make it clear to the patient that they need to discuss the matter with the referring doctor if they want to choose a different provider.

ISSUE: Are there collection scenarios where the patient's intention regarding a preferred provider is not clear? How should those be managed?

There are scenarios where the patient does not able to handle or sight the request form and hence won't see the statement on the form. For example, where the patient is unconscious or anaesthetised, or is confused or demented.

In these situations it is important to leave the decision with the referring doctor. It becomes impractical to try and find relatives if they are not present and in our health system, there is a long standing practice of trusting a patient's personal doctor to guide the patient through the health system.

ISSUE: How can effective professional relationships between requesters and providers of pathology be maintained where patients choose providers other than those preferred by requesters?

Again the relationship can be maintained if the patient discusses the choice of provider with the referring doctor. Where a patient chooses a provider with no links to the referring doctor, there is significant risk of error and increased likelihood of repeat testing.

Once again the solution reverts to the wording on the form raising patient awareness of the importance of contacting the referring doctor before making a change.

Wording on the form

We would suggest a modification to the proposed wording:

“The services listed on this form need not be performed by the provider to whom it is addressed to be eligible for Medicare Benefits. If you choose a different provider for reasons of safety and your care it is important that you discuss this with your own doctor before doing so.”

ISSUE: What is the most effective way to notify patients of their right to choose their pathology provider and make them aware of their responsibilities? How can this be done with minimal impact on those who produce pathology request forms?

The most effective way is to encourage requesting doctors to explain this to patients as they are generating the request forms.

This will stimulate the necessary discussion to allow informed patient choice.

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