Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: South Metropolitan Health Service – Mr P Forden, Dr J Cooper
Date: 10 February 2022, Time: 1305 - 1327

KENNEDY, DR: Good afternoon. Thank you for your interest in the Inquiry and for your appearance at today's session.

The purpose of the hearing is to assist me in gathering evidence for the Inquiry into aeromedical services in Western Australia. I'll begin by introducing myself, my name is Marcus Kennedy, and I have been appointed by the Chief Health Officer, to undertake the Inquiry. And beside me is Jonathan Clayson, who is the Inquiry Project Director.

You will need to be aware that the use of mobile phones and other recording devices is not permitted in this room, so if you could please make sure that your phones are on silent or switched off, that would be appreciated.

This hearing is a formal process convened under part 15 of the Public Health Act 2016, and while you are not being asked to give evidence under oath or affirmation, it is important that you understand that you must answer all questions and that there are penalties under the Act for knowingly providing a response or information that's false or misleading. It's a public hearing and a transcript of your evidence will be made for the public record. If you wish to make confidential statements during today's proceedings, you should request that that part of your evidence be taken in private.

You should have previously been provided the Inquiry's terms of reference, the Inquiry's current state considerations paper, a focused list of relevant considerations and information on giving evidence today.

So, before we begin, did you have any questions in regard to the process this afternoon?

So, for the transcript, could I ask that each of you state your name and the capacity in which you are here today?

FORDEN, MR: My name is Mr Paul Forden, and I'm the Chief Executive of South Metropolitan Health Service.

KENNEDY, DR: Thank you.

COOPER, DR: Dr James Cooper, Emergency Specialist at Fiona Stanley Hospital.

KENNEDY, DR: Thank you.

You'll now be invited to address the focused considerations list that's been provided to you, and you can speak to those for up to 15 or 20 minutes, and after you address, I may ask specific questions either related to those, or more generally.

So over to you, the time is yours to address whichever of the considerations you wish to, in whatever form you wish, and then we'll come back to questions afterwards.

COOPER, DR: Okay.

KENNEDY, DR: Thank you.

COOPER, DR: I think I'll go first; I think is more about the interaction with the aeromedical services with the - - -

KENNEDY, DR: Sure.

COOPER, DR: - - - hospitals, and I've probably got more of a day to day handle on that than Paul, as the Chief Executive.

I think, firstly, the considerations document that's come out has had a good considered body of work to it and the points to go through are really just to agree with, predominantly. And there's a - there's one or two points that aren't on the considerations that I might make mention to with regards to - - -

KENNEDY, DR: Yes, please do.

COOPER, DR: - - - education and training and standards, but if you want me to go through these dot by dot, or just - - -

KENNEDY, DR: I'm happy to go through them in whichever way you like. The dot by dot approach can get a little bit tedious - - -

COOPER, DR: Yes.

KENNEDY, DR: - - - however, if you've got a themed view in mind or - - -

COOPER, DR: No, look, I predominantly agree with most of the - - -

KENNEDY, DR: Okay.

COOPER, DR: - - - considerations that have been made on the paper that was sent through that was relevant for today. The thing that isn't on there, which, I think, mentioned to you is the training and the skill set of the people providing the aeromedical service.

The RFDS is a highly respected organisation in this State, but also, almost put on a pedestal and beyond being talked ill of, so whilst I highly respect it and have worked for it for 20 years ago, I do think there have significant areas where it could improve.

We, as tertiary hospitals, I think, have an obligation to provide tertiary level education to services that are not tertiary. We've tried to assist RFDS in doing this with remedial practitioners, who have needed upskilling, but we've not been able to engage them in an ongoing process where they could rotate their clinicians through either our tertiary hospital or other tertiary hospitals. This might be a problem, as per their contract, and their availability to be released from what is a predominantly service-driven model.

I think you need clinicians with certain skills to be able to do those jobs - to do that job, but by doing that job, you become deskilled. So, unless you are able to have part of your time in a more high acuity, high volume for maintenance of those standards, you, inevitably, will remove those skills that you have.

KENNEDY, DR: I think that's a very valid point, and I think when you are considering your service, which provides medical and broader healthcare across the entire spectrum, from primary care to tertiary critical care, that's a very broad bandwidth to have to cover and to expect clinicians to maintain currency in. So, I think your point is very valid. It goes to the question of the clinical governance of the aeromedical system and what that should look like in the future.

Did you have any statements or feelings or thoughts in that space?

COOPER, DR: No, I think you're right, and that's what it comes down to, ultimately. If we have concerns with regards to patients who are delivered with regards that clinical care, it can be a - it's not a well-trodden path or easy to know where to go to, we're relying on relationships within services, as opposed to clear lines of process.

KENNEDY, DR: Relationships as opposed to systems?

COOPER, DR: Yes.

KENNEDY, DR: Yes. I'm taking this as being a general comment about aeromedical services, rather than, specifically, RFDS - although, you did mention that, is - - -

COOPER, DR: No, look - - -

KENNEDY, DR: Did you want to - - -

COOPER, DR: - - - I think you could - and not just necessarily aeromedical services, you could say the same for inter-hospital transport, whether it be - - -

KENNEDY, DR: Yes.

COOPER, DR: - - - road-based or rotary or fixed wing.

KENNEDY, DR: Yes.

COOPER, DR: So rotary wing services seem to have a - seem to be much more governed. We do have, you know, an interdisciplinary document from the College of Anaesthetics, Intensive Care and Emergency Medicine about the minimum transport requirements for the critically ill, which is actually referenced on the RFDS website and all the other colleges' websites. And you know, the tenet of that is that care should not drop during the course of transfer.

And as the prevalence of specialists outside of Perth has increased, then that's not necessarily maintained now, you can go from specialist-driven care at both ends, but not necessarily in between.

KENNEDY, DR: Did you have other points?

COOPER, DR: No.

KENNEDY, DR: Okay. Allow me to ask a couple of questions, then?

In terms of, particularly, the - at a system level, one of the considerations that's raised in here relates to the lack of an overarching integrated structure to provide assistance to decision-making, distribution, outreach support et cetera - coordination, by any other word, and in a collaborative sort of environment, did you - do you agree with that as a concept, and does your health service feel comfortable with that concept, and also, the potential for that service to, at times, need to take an arbitrating role, in terms of destination et cetera?

COOPER, DR: Yes, I think it's necessary. I'm aware that the APTC service has recently started. Having said that, there's still clearly some governance in that, which need resolving, as they seem to be caught in the middle. Whilst they are well-meaning - and it's a good start without having the governance behind them, they're going to be hamstrung. You know, they - whilst they can see where all the assets are, whether they can direct those assets who are currently under the direction of other services, it's clearly problematic, currently.

FORDEN, MR: I think it's fair to say that, at the point in time of the transfer, somebody's going to have to make a decision where the patient has to go. I do think it needs to move away from just relationships, to learn from these events, where they're not necessarily the most appropriate journey. And that's probably something we haven't got in place, which is where you have a more formalised feedback and clinical review process.

After the event, well, you can say, "Well, actually, this patient was transferred to Fiona Stanley, in hindsight, the appropriate journey would've been", so we can continue to learn, because at the moment, it's a phone call to say, "Well, why did you send them here?" et cetera, which not the way to embed learning.

So, I think that would be an enhancement, and I'd suggest to add to that.

KENNEDY, DR: So, would you see that as the function of this coordinating body, to be a facilitator in those conversations? It's the place you go to, say, how - "Why did that happen that way"? or - - -

FORDEN, MR: Yes.

KENNEDY, DR: - - - "How do we look in - - -

FORDEN, MR: Well, there needs to be a structure set up and multi-agency commissions who can review cases of concern or learning to make decisions so they can pass it back through their organisations and continually improve.

KENNEDY, DR: Yes. And at times, as you've suggested, be the point of decision-making, when there may be options that need to be resolved, I think, you know, the system, as you're referring to it at the moment, is pretty new in its journey and I don't think has yet quite got the structure or the clinical governance framework or the corporate governance framework around it to allow it to fully adopt that position of authority, but - is that what you're saying, essentially, that there needs to be some authorising capability at that point of coordination?

COOPER, DR: Look, I think the tasking of assets, whether they - whatever that asset be, needs to be done by an agency that's separate from the current agencies, because the - they don't know what the other hand is doing, and there may be other ways to do it that are more efficient, depending on where the assets are at the time. It's a movable face, it's a resource-limited arena, and only the person who's got oversight over all the resources can decided, at the moment in time, which is the best thing to do.

KENNEDY, DR: Yes.

COOPER, DR: I think it goes a long way to addressing the inefficiencies on the floor of referral and by freeing up the referring clinician to get on with treating the patient. I think it's a very quick fix, and it's providing that, but I don't think it's doing the rest.

KENNEDY, DR: So I think that - I mean, there's several things in what you've just spoken about, and I think the referring clinician question is very well-understood, and one that's been provided through the consultation process - you know, the value of having a one stop shop, where you can go and explain your situation and then it all happens and you go back to look after the patient.

The other concept that you raised was the movement of the tasking process away from the existing into another space. And another way to consider that could be bringing all of that knowledge into one space - - -

COOPER, DR: Yes.

KENNEDY, DR: - - - so that rather than creating another agency - in fact, if that became a - you know, a high-visibility collaboration, if you like, between, you know, all of the players - the St John's, the - you know, the rescue helicopter, the - you know, the medical coordination, the road - - -

COOPER, DR: Yes.

KENNEDY, DR: - - - coordination, if that existed in a space where that colocation and collaboration, fundamentally, drove the best result, it would make the same sense.

COOPER, DR: Yes, I agree.

KENNEDY, DR: Having said that, in that space, someone, sometimes, needs to make a decision.

COOPER, DR: Ultimately, there's only one umpire.

KENNEDY, DR: Yes, well, usually, those things will resolve themselves - - -

COOPER, DR: Yes. I mean, you know - - -

KENNEDY, DR: - - - through what's the sensible thing to do, but there will be a time, yes, when someone in that room needs to make the call.

COOPER, DR: Yes.

KENNEDY, DR: And you build a system for that, so - yes, I understand.

Were there any other issues in particular that you wanted to talk to, or - - -

COOPER, DR: No.

KENNEDY, DR: The other questions that we did have related to - well, one in particular, which has come up in several settings, has related to back transfer or repatriation at an aeromedical level, would it - do you have a view on that, in terms of - I mean, the current conversation is that this is an area for potential improvement, that the lack of coordination of it results in excess consumption of bed days and people sitting in queues, who are then not getting back to where they should and need to be, is that something that's reflected in your experience as well?

COOPER, DR: I might let you speak - - -

KENNEDY, DR: It's probably not - - -

COOPER, DR: - - - to that, because - - -

KENNEDY, DR: - - - from the Emergency Department.

FORDEN, MR: No, probably the other side of the hospital from where Jim works. So - yes, this does occur, not only in terms of patients from the aeromedical, but it happens across the metro as well.

I think there is an opportunity that's arisen, which is the construction of the medi-hotel on the Murdoch site. The medi-hotel would potentially be somewhere where, whilst coordinating decisions are taking - because it's not always a case where you can just call an aeroplane or a doctor et cetera, there could be some use of that facility for looking after these patients, which frees up the very precious acute bed stock. But clearly, you'd have to be at a point in where the patient's discharged to a different facility, because the governance would be under another organisation.

COOPER, DR: Yes, my - we - I was a bit - - -

FORDEN, MR: But its location is near Jandakot et cetera, so it's not a bad location.

Sorry, Jim.

COOPER, DR: Yes, we - ours is a minority, it's generally the patient who's come down for a rule out of a life-threatening diagnosis and (indistinct) 1.21.48 sometimes they come out quickly, depending on the condition. And then, once that's been ruled out, we can sometimes be left with patients for a night or two in our obs ward, pending transfer back.

KENNEDY, DR: Okay. All right. Do you have a sense of the appropriateness of current transfers that come into your service - in terms of appropriateness, but is there an issue where you know, people are presenting to your organisation through the aeromedical service, who perhaps could be managed elsewhere, or for whom there may be better or alternate plans?

Where do you see that responsibility sitting and/or why is it not working at the moment, if that is an issue?

COOPER, DR: Yes, there are patients who are transferred, who could be managed by alternate pathways, unfortunately, I think part of it comes down to how individuals' practice. Be - I haven't worked for the telehealth service previously, and having worked for aeromedical services, the - people practice differently.

I think young specialists' practice in a different manner to more elderly specialists, and I think that what we're missing a lot of the time - and especially with the country people, who are vastly more pragmatic, is conversations. And there's still a paternalistic practice of medicine.

KENNEDY, DR: Yes.

COOPER, DR: - - - in the majority of time. And by missing out on that interaction and giving people opportunities to make their own decision about, "Do you want to go now and have this

done?" Or, "Would you consider this alternate pathway to potentially get to the same end (indistinct) 1.23.46 falling into a different timeframe?" That's ubiquitous throughout medicine. It's not just a function of the aeromedical service, it happens everywhere.

Could things be done differently? Yes. How can you fix that? I'm unsure, unless you have - handpick certain people in certain roles.

KENNEDY, DR: How involved is your health service in the decision to receive a patient and how do you try and inject appropriateness into that discussion? How does that process work?

COOPER, DR: Yes, again, it's individually driven by the clinician who takes the phone call, but it's - it can be difficult, it can be time consuming. The same as the clinician making the referral, is the receiving doctor competing demands for your time. You know, when you're the floor seeing people, then it's - a lot of the time, it's just easier, given the information that you have, for safety - safe. And things have improved with the telehealth service with regards to people having eyes on the patient and making a more informed decision.

Yes, you know, in retrospect, they're going to get a few - is it - I don't think it's enough to be a problem.

KENNEDY, DR: Okay.

COOPER, DR: So, you're going to get a few individual cases that are acute, but whether that may be a function of how you feel on the day, rather than - - -

KENNEDY, DR: Okay.

COOPER, DR: - - - it was that inappropriate, and if - and ultimately, if the patient doesn't have the resources to - not necessarily for their clinical needs, but possibly, for their diagnostics, they don't have the skills or the equipment to be able to do that, then they're in the wrong place.

So, if all it means is, they're getting a more senior review, that's not necessarily a bad thing.

KENNEDY, DR: No, it's certainly risk averse. Do you have a sense in the - in terms of the aeromedical system, for unmet need, at the moment, either in terms of you know, extent or standard of care or capacity or response timeliness et cetera?

COOPER, DR: I don't have a feel for the unmet need with regards to response times, because we have no say over the tasking and times of them, and I don't think we should. With regards to the standard, we certainly see a (indistinct) 1.26.38 standard. The majority of the time, the standard that is delivered is high. There are some cases where things could be done better, and I spoke to that before.

KENNEDY, DR: Okay. Thank you.

Is there anything else that you wanted to raise today?

FORDEN, MR: No, thank you.

KENNEDY, DR: Okay.

Well, thank you for coming in for a relatively short session.

A transcript of this will be sent to you so that you can correct any minor factual errors before it is placed on the public record. You will need to return that transcript to us within 10 working days of the date of the covering letter or email, otherwise, we will deem it to be correct.

While you can't amend your evidence, if you would like to explain particular points in any more detail or elaborate on them or present further information, you can do that by attaching further submissions to the Inquiry to the return transcript, if there's a need to do that.

So once again, thank you very much, Mr Forden and Dr Cooper, for your attendance. Thank you for coming in.

FORDEN, MR: Thank you, pleasure.

COOPER, DR: No worries, thank you.