Parliamentary Inquiry into Ambulance Ramping

Dr C J Edwards
[redacted]

26 Sep. 23

Dear Sir / Madam

RE: "Transfer of Care Delays"

I am a retired surgeon who actually worked in the Royal Hobart Hospital Accident and Emergency – "Casualty" as it was called then - some 56 years ago. I have always thought it is somewhat of an anathema to have ambulance ramping the way it is occurring today but I am aware that things change, and a "would not happen in my day" opinion would probably not be helpful. I will briefly mention how it was just for the record:

"In my day" we worked with a fraction of the staff, were often under considerable stress and commonly worked many extra unpaid hours to help the next shift clear the backlog. Ambulances arrived, gave whoever was closest a history of the patient they were delivering and left. Was this ideal? No. But we certainly learned a lot and got the job done. I am aware health care has markedly changed since that time, and mostly for the good. There are a myriad of technical advances, particularly in imaging, but what has gone along with that are more bureaucratic requirements and, dare I say it, some reduction of basic clinical examination techniques and the reliance on expensive imaging. Will this change? Almost certainly not. "Do I want my children to go back to working in coal mines?" I hear you say!

That said, I am stimulated to write as I had the unfortunate experience to be taken to A&E by ambulance a couple of weeks ago after being knocked off my mountain bike by a car who failed to give way.

I cannot fault the care I received from the rapid ambulance and police response, through 'ramping', formal A&E and onto EMU. (The fact that one of my mates had written "retired surgeon" on my COVID mask may have helped.) The experience lasted about 7 hours and I was discharged with a diagnosis of two broken ribs, good advice and analgesia. In "my day" without the state-of-the-art imaging I may have had to be admitted for observation, or even undergo a peritoneal tap to exclude a liver laceration. The expensive CT scan even provided useful information on other medical issues!

I had thought that 'ramping' was lying in the ambulance waiting to get through the doors – that may be the case at times – but found that there is, in fact a dedicated 'ramping' room within the hospital where the paramedics remain responsible for the patients care until A&E staff are available.

The care I received, again was excellent but it tied up two paramedics and one ambulance where a trained nurse would have been sufficient.

I do understand that some of the following may be at play:

- Staff shortages.
- Trying to achieve accepted standards criteria such as acceptable time spent in A&E.
- Responsibility / blame shifting.
- Perhaps even bureaucratic / political demarcation – numbers shifting.
- Maybe a lack of 'all on the same team' from the top down.

How do you fix this? I do not know but there are glaringly obvious issues at play.

Firstly, people need to understand that despite all the imperfections we have a state-of-the-art health system. The problems we have are not unique to Tasmania. They are a symptom of the many advances in medical technology available - now expected at little or no cost; an aging population; and a lack of taking some responsibility for one's own health.

Consider 'employing' underutilised Paramedics on an add hock basis in the 'ramping room' rather than tie up two, along with their ambulance for each ramped patient.

Address the GP 'crisis' with incentives to make this field of medicine attractive to doctors.

Provide incentives for non-critically ill patients to seek help outside the A&E system. Maybe a bit of 'carrot AND some stick'.

To state the 'bleeding obvious' - preventative health measures.

Our health care is very first world, but people must understand that as the technology continues to advance in benefit and expense, the population ages – partly due to these advances – and we continually fail to take responsibility for our own actions, there will not be enough money to fund the present system. The cake is only so big.

A degree of financial rationalism is required by knowledgeable, strong managers within the hospital. From my past experience – hopefully this has changed – everyone wants the 'Rolls Royce' of equipment and consumables for their unit or department. As with our private lives some practical compromises need to be made. It is all very well for a 'best care' bureaucrat to come up with the ideal, but we cannot all afford a Rolls Royce, and often have to make do with a Toyota.

The same applies to negotiating deals with drug companies and prostheses manufactures. I am getting a little off subject now!

I believe the current Federal – State mix of funding is not ideal. It tends to encourage a degree of cost shifting and ultimately inefficiency and overall added cost.

Some acceptance of some of the above by all sides of politics and working together to optimise an imperfect and ever-changing model would be far superior to the constant 'blame game' practiced at present when no side actually has the 'Holy Grail" solution. The

constant bickering is counterproductive and makes the people see the system as worse than it actually is.

Not a solution but a few things to think about. I am sure I am not the only one to raise some of these points.

Kind regards

Yours sincerely

Chris Edwards