

TRANSCRIPT

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

Inquiry into end-of-life choices

Melbourne — 18 November 2015

Members

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Witness

Mr Ian Patrick, general manager clinical and community services, Ambulance Victoria.

The CHAIR — I declare open the Legislative Council’s legal and social issues committee public hearing in relation to the inquiry into end-of-life choices. I welcome Mr Ian Patrick, the general manager of clinical and community services at Ambulance Victoria. Thank you very much, Mr Patrick, for joining us. Before I invite you to make some opening remarks, I just caution that all evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. Therefore you are protected against any action for what you say here today, but any comments made outside the hearing are not afforded such privilege. Today’s evidence is being recorded. You will be provided with a proof version of the transcript within the next week, and transcripts will ultimately be made public and posted on the committee’s website.

We have allowed 45 minutes for our session today. Before inviting you to say a few words, we have heard a great deal of evidence from healthcare providers and others around Victoria about the challenging circumstances your members find themselves in. We look forward to what you have to say. I invite you to make some opening comments and we will have questions thereafter.

Mr PATRICK — Thank you for the welcome and the opportunity to come here today to contribute. Firstly, I will make the point that Ambulance Victoria, as part of its annual plan, has got an item that is looking at having a much more patient-centred approach to care planning, which means how do we get involved with the community and with places like nursing homes and care facilities, and families who are looking after their relatives at home. How do we get involved as an ambulance service to try to be better able to assist them with this issue? The answer to that I do not know, but it is certainly a piece of work that we are looking forward to working with. As you said, this is an issue for our staff, where they do not know what the current status is, and it is an issue for our workload from the point of view of the availability of ambulances and what is the best thing to do.

Also the issue about patient-centred care is that regularly paramedics know that it is not the best answer to take a patient who is at the end of their life with a condition that there is no plan for to a busy emergency department at 3 o’clock on a cold winter’s night. It is disorientating, it is unpleasant and it actually does not add anything to their experience. I do not believe it adds much to their continuing good health. It certainly does not help their psychological wellbeing. So I think it is something that is a big issue; it is something that having a planned approach from a system perspective is the answer. I am very encouraged to see this sort of activity going on. Thank you for that.

I extracted some data in the brief time that I have had to think about this. This is data on calls to cardiac arrests in care facilities over the last five years. I have not broken down exactly what those care facilities were, but that is certainly some work that we will do. In that period there were 2237, so that is a lot. Is that the right thing to be doing, I don’t think it is, from an ambulance perspective, that is approximately 2237 hours of ambulance resource that is being used in that time, because each case takes about an hour.

Ms PATTEN — That was over a year?

Mr PATRICK — No, that is over a five-year period. I extracted out 2010–11 to the end of 2014–15. The mean age of those patients was 80.6 years old and 53 per cent of them were women. Bystander CPR was only started in less than 50 per cent of cases, so what was the intention? I cannot tell you how many of these people had a care plan, but I am making an assumption that many did not otherwise this would not have happened. I do not think it would have happened in many of these cases. The fact that they had not started CPR makes you immediately think that someone is just not prepared to make a decision. Again, that is my opinion, but I have seen it a lot where people just want someone else to come, so I think there are issues. We know that almost 200 of them had terminal illnesses, so that is nearly 10 per cent. There is a whole heap of things in there where good care planning and end-of-life discussions could actually change a whole lot of circumstances in the system.

I should probably say that in 44 per cent of those cases paramedics initiated some sort of resuscitation. There are two parts to that: one is because they will often start it, even though they think it is probably not in the best interest of everybody, to collect more information rather than say, ‘Could you tell me about this?’. They are seeing what the problem is, so that is the action. That is what our guideline says — go into it, you start resuscitation and within 20 minutes you can make your mind up whether you think this is worthwhile or not.

It is the same as if someone says, ‘There’s a care plan that said they don’t want to be resuscitated. We can’t find it’. If the paramedics believe that is a reasonable thing to take into consideration — for instance, it is an elderly

person who is in a nursing home in a dementia ward, who is bed bound and who has got lots of comorbidities — they may say, ‘This isn’t in the best interest’, and stop resuscitation, and they are quite entitled to do that. In some of these cases people’s hearts do start, so of the 44 per cent of those patients 19 per cent ended up getting to hospital with some sort of rhythm, but less than 4 per cent actually survive. There is a whole heap of issues in that. I thought just to give you some context, but that is in those care facilities. It might be useful.

We have in place a number of documents, including policies, procedure, work instructions, clinical practice guidelines regarding end of life, and I have provided you with some of the work instruction and the clinical practice guideline.

The CHAIR — Thank you for that.

Mr PATRICK — The work instruction is about urgent inter-hospital transfer and paramedic skills. It talks about whether the crews should always check to see if there is a care plan in place. We have got some things that say, ‘If you’re taking this really sick person, can you ask if there is a care plan in place?’. A lot of the work instructions follow that in terms of inter-hospital transfers, whether it is from our non-emergency people or our emergency people.

The non-emergency patient transport sector has advance care planning documents that they are expected to recognise. Our operational bulletin, which has changed to a work instruction ‘Withholding or ceasing resuscitation’ is the one you have, says a patient should be transported to the nearest appropriate ED 20 minutes post collapse if they decide they are not going to withhold resuscitation.

There are some issues around people ringing us saying they want to log a patient who has an advance directive with us. That is a very difficult thing to do, because the CAD system recognises places not people, because people can have the same name et cetera. If you log the housing commission flats in Smith Street, you get the housing commission flats in Smith Street so it is hardly helpful. We think a better approach is that the responsibility should be with the facilities to provide these plans, and there should be more and more people encouraged to have their care plans available at home with their end-of-life wishes in a place where the family knows. We think that it is worth us having an education process to say, ‘If you ring for an ambulance and you have one, can you just tell us so we will tell the paramedics to ask for it when they get there to see it’, for whatever it says that they should do.

We do have some for individuals with different medical conditions, but it is very difficult to manage from our end because we do not know how current they are. It is a very hard process to make sure that you have got the right ones in the right place for the right people, because people move they do not ring up — all the things that we know happen. So we think it should be facilities and families and medical professionals, and the system as a whole should have a way to flag it.

I will give an example of my in-laws. My in-laws are both in their 80s and both very frail. I spoke to them just before I went overseas to work about their wishes when they die. I said, ‘Has your doctor talked to you about this’, and they said, ‘No, never’. They have both got complex medical problems. They did not want to talk about it, but they now have them. That is one anecdote, but from my experience I do not think it is uncommon that people have never had the discussion.

I do not know what the barriers to that are from a medical point of view. I do not know whether people do not like to ask. I do not know what it is, but I think that is something we have to change — the whole culture. This is a discussion that every family needs to have so that we can be better informed. If every family has that, that would help us enormously when they ring for an ambulance to say, ‘We don’t know what to do, but there is a care plan here’ or ‘Their end-of-life wishes are very clear here’. The ambulance service is happy to come along and assist if we know.

I have had experience working in Tasmania, in a small town there, where I, at the request of the GP who was not available in the town, went to a family’s house who were at that point of someone’s life. They had made a decision, but they did not have any support, so we went there and supported them for an hour and a half. There are options, I think, where ambulance services can play a role, especially in the smaller communities where we are not that busy and where other health professionals may not be available. I think it is a canvas that we can paint. I think they are the real issues for us, I believe.

The CHAIR — Thanks very much, Mr Patrick. We appreciate that. Perhaps to expand on what I said briefly in the introduction, we have heard a lot of evidence from healthcare providers and various organisations talking about the ambulance being called in the middle of the night because the GP is unavailable, as we briefly discussed outside, or the situation where there is an advance care plan but no-one can find it. They are various issues that all impact on Ambulance Victoria.

I note your comments that we need to have an education campaign and people need to think about having an end-of-life care plan. You were talking about members of the family knowing where that plan is et cetera and it being accessible. I suppose my question is: is that the best we can hope for, given all the issues with IT?

Mr PATRICK — I am always cautious when I say there is a technology fix to something because people focus on the technology and not on what the problem is. I actually believe this is an issue that is surrounded with a bit of an emotional no-go zone. I think people do not talk about it, or do not talk about it sufficiently to find an answer, and I do not know whether technology will actually make any difference to that. I am sure there is technology to help.

The other thing I will say is that from a paramedic's point of view there is protection for paramedics if they reasonably believe that that was the patient's best wishes, because a whole roomful of the family is going, 'He's got a care plan. We can't find it. This is what it said', and it is resounding, and he looks at the clinical picture and it fits, it is okay for that paramedic to support their wishes. I think that is — —

The CHAIR — Important.

Mr PATRICK — That is important. Just because they cannot find it, it will not stop us enacting that patient's and family's wishes if the paramedic can reasonably expect that it is right.

The CHAIR — Yes, sure.

Mr PATRICK — We would also support him if he thought, 'Ah, I'm not sure', and he tried to resuscitate the patient. So we would support that as well. But there is that ability for him to make that decision.

The CHAIR — I will just ask one other question. You talked about the ambulance being called to a nursing home or a care facility and the patient going off to emergency at a big hospital and the challenges that in itself poses. How do we reduce that from occurring?

Mr PATRICK — I actually think this is broader than just end-of-life issues. I think this is about proper care planning and availability of the resources. We take patients to hospital in the middle of the night to get a catheter changed. We have arrangements with locums now that we will get the doctor to come or we will get a continence nurse, in some places, to come. We are trying to set up referral pathways to connect these people so they do not have to be taken out of the nursing home.

As I see it, there are a couple. One is the level of care that is provided, especially in the dark, wee hours when no-one wants to be at work. What level of care is there and what are their capabilities? There is the availability of doctors out of hours. I understand they work very hard, and no-one wants to be working at night-time, trust me. It is not the great thing that some people think it is. It is all right when you are 20; it is not as good you get on. I get that. There have been all sorts of things put in. If you look around the country, South Australia and Queensland led the way, where they have used nurse practitioners and extended care paramedics, and, to be honest, what they have turned into are catheter and PEG tube changers in the middle of the night for nursing homes. That is what they are doing. That tells me it is not an ambulance service problem; it is a system problem. That is why this is such an important conversation to be having, to say, 'How do we make the system work?'. So I think your point about — and this is a long way to say that, isn't it?

The CHAIR — No.

Mr PATRICK — The point about the technologies may well be part of how we manage it, but the actual issue is how does the system identify that we need to get better at this and what are the steps we take to do that? Firstly, people have got to start having the conversation. Secondly, there may be funding issues for GPs, who are very, very busy, to spend that extra time to write a care plan. That is a complex piece of work, I would expect, in many, many cases, where you have to get it right and the conversation is long. You have to explain it

to the family. I can see that those sorts of things could be barriers. So I think technology on its own is not the answer.

The CHAIR — With the indulgence of the other two members, can I just ask one other question. We have heard from the law institute this morning about their wish for advance care plans to be legislated.

Mr PATRICK — Mandated.

The CHAIR — Mandated. Does Ambulance Victoria have a view on that, whether it should be mandatory to follow the wishes articulated in — —

Mr PATRICK — Again, we do not have a policy on that, but I would see that Ambulance Victoria would support a position like that because we would at least know there is one, or there should be one, and it would actually give us a different conversation to have rather than the conversation about, ‘You should go and get one’. It would be, ‘You have one. Where is it?’. I think there is a lot involved. Mandating it would be one thing, but getting the conversation happening is still the other one.

The CHAIR — I was talking about whether the advance care plan would be legally binding.

Ms PATTEN — On you?

Mr PATRICK — Okay.

The CHAIR — Because we have heard conflicting evidence from various witnesses about — —

Mr PATRICK — I think there are two issues there. If the evidence is sufficient to meet the requirements of the advance directive, that it was related to ‘If I have a stroke, I don’t want to be resuscitated’, but there is nothing about ‘If I have a cardiac arrest, I don’t want to be resuscitated’, then I would expect that some people may well go, ‘I’m going to resuscitate him because it doesn’t say ‘cardiac arrest’’. That is not a very good example, but — —

The CHAIR — No, I suppose this is the challenge that others have put to us.

Mr PATRICK — I think we would consider that it would be binding but related to the specifics of the individual case.

The CHAIR — Specifics, yes. Thank you.

Ms SPRINGLE — You talked before about ambulance officers effectively becoming carers or medical staff in the middle of the night to change catheters and all of that sort of stuff, and that being a repercussion of under-resourcing within aged care and a whole host of other sections of our healthcare system. How do you perceive that impacts on ambulance resources?

Mr PATRICK — I think I gave the example. Our average, a case takes about an hour, whether you transport the person, or by the time you get them to the time you go back, clean up and all that sort of stuff. In fact if you leave someone behind or have these conversations, sometimes that can be longer because the paramedics become part of the conversation and do not go until they are happy that people have heard them and that they have made the right decision. It takes about an hour.

I think the issue from a resource point of view is much broader. I think the first comment would be it is not about under-resourcing particularly; it is appropriate resourcing. I do not know whether they are under-resourced in those places. In fact I guess many of them are, but if they had someone who could put a catheter in 24 hours a day or change one or they could consult with the GP 24 hours a day, who says, ‘Yes, go ahead and do that’, then that would be appropriate.

The other thing is that that patient now goes into an emergency department, where we have ambulances — 10 ambulances, maybe — sitting outside there waiting to clear. Now we are taking another person in there who cannot sit in the waiting room, cannot be unsupervised and has to be attended to. A blocked catheter can become a major problem. So it is a complete system-wide bottleneck, and if you have 50 of these a day, it is a lot.

I think the system should be designing our primary health care to do the best we can for patients and their families as close to home as possible and with the least disruption, especially for these people who are easily disorientated and distressed.

Ms PATTEN — Thanks for collecting that data for us. That was really interesting. Just one quick question on that data. What is the percentage of those cardiac arrest calls to aged facilities of the whole number of cardiac arrest callouts for that kind of cohort?

Mr PATRICK — I do not have that number, but we could get that for you.

Ms PATTEN — I would just be interested in what are home calls versus aged-care calls.

Mr PATRICK — There are two parts to this. One of the issues here is that at the end of someone's life their heart stops, and we get called to many cardiac arrests in the home that are expected. People do that because they do not know what to do, and that is part of what we do. So I think the percentage is not as relevant as the fact that if these people have wishes we need to know about them so that we can treat them in the way that they wanted to be treated. The number of elderly people who have cardiac arrests is high; it is a big percentage. The number of successful resuscitations in the elderly is much lower than in the young, because for a lot of them it is the event. I have not answered your question.

Ms PATTEN — That is fine, Ian. I suppose in my mind I was starting to think that if they have an advance care plan in an aged-care facility they should be able to manage that, and with the aged-care facility ringing the ambulance they should be able to have it at hand to be able to tell you that there was a plan there.

Mr PATRICK — Yes. They say, 'Aged-care facility. We have an advance care plan. We can't make the decision not to resuscitate them, but this is here'. So the paramedic goes there, he looks at the plan and says, 'Oh, yes. Under these circumstances they're not for resuscitation'. We are happy with that.

Ms PATTEN — That seems to be something that would be easier to implement than in the broader community where it would be much harder.

Mr PATRICK — Yes, it is much harder in the broader community, because people do not carry it around with them. We have to deal with that all the time.

Ms PATTEN — Yes, or they might be at home alone.

Mr PATRICK — There are two parts to this for me. One is the end-of-life stuff and the other is the total care planning issue that these people get looked after in the setting that is best for them, as opposed to going ahead and doing a CT scan that they do not need.

Ms PATTEN — I totally get that. I have another question, which is kind of shifting the direction. I was really interested in what you said about that Tasmanian town where you actually acted as a palliative care provider for that family, in going out there when the doctor could not make it. That really struck me. Is there a possibility to look at the ambulance service having a greater role in palliative care rather than emergency care?

Mr PATRICK — I think there are two parts. I think there is a role in terms of primary health care, and I think this is primary health care. We have paramedics in places who have to be there because of the distance and things, but they can take a role. As long as it is well defined and medically oversighted and all those things they could play a bigger role in the care of their community. How many of those, I do not know. It is unlikely to work in the city unless you put special people on to do it. You might as well put on the right people to do that work. I am not talking about substitution, but as to the opportunity to use the best person available at the time, there are plenty of opportunities to use paramedics in these places.

Ms PATTEN — Yes, in those regional areas. That is an interesting thought.

Mr MELHEM — Just to follow on from Ms Patten's question earlier about do not resuscitate, is there enough legal protection for paramedics when they adhere to someone's clear directive not to resuscitate that patient, particularly the elderly? Do you believe the current laws give them enough protection?

Mr PATRICK — Yes. We did a bit of work around this when we put that clinical practice guideline in. Even if they have not seen it, if they reasonably believe that the wishes have been conveyed and clearly enunciated — if the family members are all there saying, ‘Yes. We’ve seen it. We can’t find it today, but this is what it says’ — if the paramedic thinks that clinical situation fits that picture, it is okay for him and he cannot be prosecuted if he makes a decision not to resuscitate.

Mr MELHEM — So basically you agree that the current laws are adequate to cover that situation?

Mr PATRICK — We believe so. That is why that clinical practice guide is reflected the way it is.

The CHAIR — What about the situation where there is not an advance care plan but your ambulance members turn up to a house or a scene and they get instructions from family members that there was a clear wish from the person not to be resuscitated, and the ambulance members then do not do that; do you have legal clarity with regard to that? I ask that question because we have just heard so many anecdotes from others, not from Ambulance Victoria, about the situation where grandma was resuscitated and she did not want to be and, then in that situation you described, she was taken into emergency et cetera. The reason for that, as was proffered by others, is that the default position, in a risk-averse way, is to resuscitate unless there is absolute clarity or it is crystal clear. By that I assume other witnesses have been talking about advance care plans.

Mr PATRICK — I think the answer to that is to my knowledge it has never been tested, but those decisions are made regularly. It is based around the special notes in this ‘Withholding and ceasing resuscitation’. Even if you cannot see the documents, if you take on face value the advice you have been given and it makes sense, then you are entitled to withhold resuscitation. It is the same thing. If you have a very elderly person who has had a series of strokes and is at home and in discussion it becomes very clear, the paramedics may start, but then they may stop. Most likely they would start until that became very clear and they were very confident, and they do that all the time, but it has never been tested.

Ms SPRINGLE — We heard some testimony in Warrnambool from the director of Centre for Rural Emergency Medicine, and he was talking a little bit about the transferral of patients in rural settings and the complications around them and their end-of-life choices. He said:

Unfortunately there are a few peculiarities about urgent care centres that make end-of-life decision-making more difficult and result in patients being unnecessarily transported to larger centres. Moving unstable patients often requires them to be placed in an induced coma with a tube down their throat and on a ventilator to make the journey safely. Then they die in a large impersonal hospital away from their family and friends, and their last words are usually to the retrieval team reminding them, ‘Don’t forget I’ve got false teeth’, rather than to their family reminding them not to forget them.

I think what we are looking for is perhaps for you to maybe unpack that a little bit from your perspective and what can be done.

Mr PATRICK — I am not sure what he means by the ‘complexities of urgent care centres’, so I do not know that, but certainly the story he is telling is an awful way for someone to end their life — to have all this stuff done to them just to go and die somewhere else. I do not know whether that is to do with the level of care that is in these urgent care centres to make those decisions. Someone from an emergency medicine background would make that easily, I would think, whereas someone else may not. It may be to do with who is in those centres. I think that is the bit we need to unpack about what he means by that, because the rest of it makes perfect sense and I could not agree more.

Not only that, those retrievals can take 6 hours by the time we get out, get there, put the tube down, get the ventilator right and then wait for another ambulance to come to load the retrieval team up to then come down or to get an aeroplane. It is just not right, in my opinion. It is not the right way for people to end their life or to finish their last days, so I agree with him. I am just not sure about the unpacking bit.

Ms PATTEN — Just following on from that, I think one of his issues was making the decision not to transport, and that is where it became — —

Mr PATRICK — Yes, that is what it sounds like to me. Someone says, ‘We can’t deal with this here; let’s go’, as opposed to one of the other options which is not to go, ‘Don’t worry; everyone will be all right’. I think this comes back to your point about, ‘Am I going to get into trouble if we don’t do everything possible to make

some miraculous save here?', which is completely against the person's wishes anyway. I would have thought that if the advance directive is very clear that should not be an issue about the decision.

Ms PATTEN — Going back to the palliative care idea, that the ambulance service becomes more involved in that palliative care side, in some circumstances I know families have been calling doctors because of uncontrollable pain and things like that. Are you legally equipped to provide that kind of pain relief to somebody like that?

Mr PATRICK — I actually looked after my mother for the last week of her life in her home, but I had a very clear care plan that was agreed to by a palliative care team. A palliative care nurse came morning and night. I was with her for the rest of the time, and I gave her her drugs as prescribed. They came with a prescription within the limits. It said, 'She goes on this subcut infusion. If she gets restless she has breakthrough medication. For secretions she has this at that dose'. I could ring the doctor anytime I liked. That was her big wish: she wanted to die at home. It was either die at home or go and have renal dialysis. She was 86 years old, and she said, 'I'm not doing that'. It was actually a great honour for me to be able to do that, but because of the expertise of those palliative care people, the way forward is very easy to follow. The drugs that you use are the same drugs that paramedics use for acute care.

Ms PATTEN — Was that in an urban setting?

Mr PATRICK — It was in Gippsland.

Ms PATTEN — Gippsland, right. Because one of the things that has been raised in regional areas is that just getting a palliative care nurse out to someone's home twice a day is logistically — —

Mr PATRICK — That is one of the issues that came up with mum. They could get a palliative care nurse there in the morning and at night, but for the rest of the day that was the problem they were having and they were not sure what to do. Then it became pretty obvious to me the best way to do it.

Mr MELHEM — Just following on from that, other witnesses have raised the issue that doctors are sometimes reluctant over the phone to advise a nurse looking after someone to increase the dose. We have heard that from a number of witnesses. Has that been an experience you have been through, because your experience is obviously different?

Mr PATRICK — It is. That is true. In these instances the doses usually have a range, so the palliative care doctor prescribes a range. There will be a standard, say, between 5 and 30 milligrams given subcutaneously over a 4-hour period, and then for breakthrough pain if they get restless, you can give increments of 5 to 10 milligrams. If that does not work, you would expect that they would then come out to see what is going on and work out what else they are going to do. The plan they provided to me was very easy to follow and worked a treat.

The CHAIR — Is there anything else you would like to add before we conclude?

Mr PATRICK — No, thank you. I would just like to thank you on behalf of Ambulance Victoria for the opportunity to come and put our position.

The CHAIR — We appreciate hearing your position. As I have said several times now, many others have referred to it so it is good to hear it directly from you. Thank you very much.

Mr PATRICK — Thank you.

Witness withdrew.