Kiwi A&Ms lead world in urgent care

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A panel of A&M doctors agreed Kiwis are leaders in recognising the scope: Adam Janson (Australia), Ainsley Goodman (Ireland), Lee Resnick (US) and David Gollogly (New Zealand)

Accident and medical doctors held their inaugural conference in Auckland this month. The Emergence of Urgent Care was attended by 120 delegates and included speakers from Australia, the US and Ireland. ***Jodi Yeats*** *reports*

Other countries would like to follow New Zealand's lead and gain formal recognition for urgent care, a panel discussion at AMPA's recent inaugural conference revealed.

White Cross founder David Gollogly described the experience of getting branch recognition here in the hope it could assist other panellists in their quest for accreditation in the US, Australia and Ireland.

Urgent care clinics started appearing in New Zealand from the late 1980s, thanks to a combination of poorly resourced GP after hours, and accident compensation legislation ensuring the Government pays for accident treatment. Dr Gollogly observes in those days ACC did cover actual costs of treatment, although the value of cover has eroded over time.

In 1995, the Medical Practitioners Act set out pathways for vocational registration. AMPA doctors developed a structured training programme and gained probationary acceptance in 2000, followed by formal recognition shortly afterwards. Since then AMPA has established an office and developed a clinical standard.

Such a pathway was the envy of Australian Society of Emergency Medicine honorary treasurer Adam Janson. He works in emergency departments and gave his own view of urgent care, which has not developed in the same way across the Tasman.

Public hospitals don't recognise referrals or take phone calls from Swiftcare so, where possible, the clinics refer or transfer patients to private hospitals

The closest thing would be specialising in rural and remote medicine, Dr Janson says. He is developing a business model for an acute care clinic, and says it is likely patients would have to pay a premium.

In the US, around 10,000 urgent care clinics provide quick cost-effective care for the 80 per cent of injuries that aren't life threatening, president and chair of academics for the Urgent Care Association of America Lee Resnick says.

The clinics have developed to fill a niche common the world over, capacity created by overflowing emergency departments and a lack of the necessary skills to cope in general practice, Dr Resnick says.

In the US it could easily be a 20-year process to gain official recognition of the specialty, he says, so the association acts as if it is recognised and has developed standards for care and a fellowship training programme, as well as launching the *Journal of Urgent Care Medicine*.

New Zealander Ainsley Goodman, gaining experience at a Swiftcare clinic in Dublin, spoke about the recent emergence of A&M clinics in Ireland, where relations with hospitals and GPs are strained.

Swiftcare is in the process of setting up six clinics in central Dublin, with assistance from AMPA chief executive Brenda Evitt, in order to help people stay out of public hospitals where they pay for appointments and face waits of eight to 10 hours, Dr Goodman says.

Public hospitals don't recognise referrals or take phone calls from Swiftcare so, where possible, the clinics refer or transfer patients to private hospitals. Also, the public hospital system repeats all tests done by Swiftcare doctors.

GPs aren't much better as they see A&M clinics as a threat, Dr Goodman says. While the clinics encourage people to see their doctor for a follow-up, people often don't want to as they have to pay the GP a full fee, rather than a usually discounted follow-up fee.

Urgent care is not recognised as a specialty, but doctors can do a diploma course and are given a generous allowance (€5000) for CME.

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Gadgets aid actual patients

Attendees at AMPA's first conference watched a patient have two moles removed by dermascope. While the procedure did seem quick and painless, observers had to take a step back to avoid the acrid smoke. GP and cosmetic doctor Garsing Wong explained he had to install an Expelair in his cosmetic practice.

The Ellman dermascope uses radio frequency and vibrates at four million times a second. It costs around $20,000, so is more expensive, but also more reliable than a bivalve, Dr Wong says. It can be used to remove superficial skin lesions, ingrown toenails, scar revisions, wart removal and snoring procedures, without causing pain or scarring afterwards, he says.

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Garsing Wong demonstrating a shave biopsy on Lisa Zhou

It is important to take a biopsy from the centre and edge of the mole and have it tested for melanoma before removing the mole, Dr Wong emphasised. The dermascope should not be used on cancerous moles.

It is suitable for GP use, but doctors need special training and should contact dermatologist Amanda Oakley at Waikato University, or Dr Wong could arrange a training session.

During Auckland Hospital radiologist Quentin Reeves' ultrasound demonstration, Biolab radiologist Cay Thompson was disturbed to discover a rotator cuff injury she thought had improved was yielding wonderful images of tendon pathology (as it is now known because there are not many inflammatory cells in tendons).

Dr Reeves believes there should be more referrals for ultrasound before embarking on physiotherapy, because it allows doctors to see what is actually going on. Too often patients are referred for numerous physiotherapy treatments, which prove ineffective because no accurate diagnosis has been made.

Ultrasound is also useful for guided steroid injections, which are far more effective if they accurately target the damaged area, as well as less painful.

Ultrasound is suitable for ligament and tendons around joints, but not for deep imaging where bones might obscure the view. JY