GP LINK Lunches | Dr Alex Mackey

Dr Kenneth McCroary, Chair of Sydney South West GP Link, hosts a series of meetings with clinical/ political/regional individuals or organisations to discuss issues and solutions for GPs working in South Western Sydney.

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Ken McCroary - Welcome everybody to a further edition of GP Link Lunches. Whilst recently co-presenting a South West Sydney PHN webinar COVID-19 information session on what we learnt and where to from here, I caught up with Dr Alex Mackey the Director of Emergency Medicine at Liverpool Hospital.

Alex was very keen to continue his efforts to build relationships with between local emergency departments and general practices and practitioners wisely noting that we work so closely together but have little interaction outside of referrals and discharge summaries. I thought it would be a good opportunity to discuss further Alex's thoughts and his understanding of general practice in South Western Sydney, but also get some feedback from him and his experience throughout the COVID-19 pandemic having worked in what is most likely the emergency department seeing more COVID-positive patients in NSW.

Dr Alex Mackey is the Director of the Liverpool Hospital Emergency Department and a Conjoint Lecturer at the University of NSW. He is an Emergency Physician with a strong interest in education, clinical medicine, mentoring and promoting a positive workplace culture. After graduating from UNSW in 2007 he trained at Royal Prince Alfred Hospital in Sydney before completing a fellowship year in simulation and medical education and the Sydney clinical skills and simulation centre. He joined the team at Liverpool emergency department in 2017 excited by the diverse population and pathology that South Western Sydney presents.

Thanks so much Alex for spending some time talking with Sydney South West GP Link today as probably the only other true generalist medical practitioners in an ever-increasing sub-specialised world. I am keen the hear your thoughts and experiences throughout the COVID pandemic but also being a worker here at the coalface of South Western Sydney your take on the special needs and special solutions required to manage this region's diverse population.

Ken McCroary - Alex I am thinking about your experience of COVID in Liverpool and the pandemic in general, can you bring us up to date with what it has been like?

Alex Mackey - Thanks Ken so I guess it has been a bit of a rollercoaster is one way of putting it. It has all sort of been a wave of emotions, a wave of clinical changes, a wave of sort of varying different processes and patient sort of challenges along the way.

We are at the stage now where things are ironing out a bit but we are working out what the new normal is. I guess putting that all in context, at the start it was all very much anxiety attached to it, the population was very anxious, medical staff where very anxious, colleagues where dying from COVID overseas and we didn't really know how to manage it and trying to just try different processes and changes to our models of care was a real challenge. It impacted a lot of our staff. There was a lot of panic and it was hard to manage that as well, but as you know in that first wave it didn't really hit us that hard and it gave us a chance to practice and fine-tune how we were going to manage this.

That was all relatively straight forward because not only did COVID not hit but actually general presentations dropped significantly as well so we had time where we weren't actually working hard we were just trying work out how to prepare for COVID so that was a godsend in a way. Then with future waves that wasn't the case you know, we had Omicron and Delta that both hit us hard, Delta mainly with the acuity - at some stages we were intubating you know 11 to 15 people a day with COVID all with SATS of 40% when the ambulance picked them up on room air, all pre-arrest at some stage on their journey in our hospitals.

(It was) really challenging managing that from a medical point of view, and not only just the sick people but as you can imagine, the huge amount of anxiety that comes with COVID. You know with people coming in with concerns they were going to contract COVID, with concerns they were going to die, how do we manage the side effects of the vaccination, is someone going to have chest pains after a vaccine. Everyone was terrified they were going to get sick after the vaccination and then just people with their common coughs and colds really significantly more concerned than they should be about contracting COVID. So that kind of really hit us then towards the end with Omicron, it was just we lost control a bit I think. It just became so widespread that our ability to really separate COVID from non-COVID patients was lost because we were seeing sometimes up to 100 COVID patients a day and on the same day seeing 200 patients without COVID. We were the busiest we have ever been and we had a lot of challenges adding to that and we had our own staffing issues. At one stage we had 17 empty nurse shortages in the department and we had 7 or 8 doctors with COVID.

It was a real challenge and moving forward to where we are now, I think it is where we have got a big workload at the moment, the trajectory of healthcare is slowly going up and up and up and we have been so busy focusing on COVID we haven't actually recognised what the workload would be two years ago with the working hours now so we are trying to stay on top of the current workload while still trying to incorporate COVID into our normal daily duties.

So to summarise, a real challenge, a real rollercoaster, but I am lucky I am surrounded by a brilliant team. My department is exceptional in the way they have held together and problem solved and thought on their feet and looked after each other. We have got a whole bunch of wellbeing programs and various other things we do and it is a full credit to the department how well we have worked through this.

Ken McCroary - Yes, it must have been pretty stressful at times with all the changes but everyone working together is such a great thing to hear. What do you think was the biggest challenge as a group and also as a doctor yourself during the last two years essentially?

Alex Mackey - I would say it's not COVID itself as a disease but it is COVID as the phenomenon, so managing COVID from an emergency point of view is not that hard. They have either got a minor illness and they can be quickly assessed as a flu or viral-like illness and sent home or they have got a severe illness that requires oxygen and admission. Staying on top of all the disease modifying agents is actually not that hard because there are not many that have really shown to work that well.

And then the final group of the patients are those that just have chronic illnesses exacerbated by COVID or they haven't been able to access primary care as much so they come in with disease progression more than what it would have been, so that has been a challenge but not COVID itself.

Also the logistics of things, for instance if you had COVID you might be able to drive to hospital but if you imagine at the start during lockdown someone who has COVID comes to the hospital, how do they get home? People were saying 'call your loved ones to come and pick you up' but there was a curfew, we were in lockdown, there was no one that could come and pick them up so they would end up staying in ED for transport home but how does our transport service all of a sudden multiply its activity 10 times.

So the challenges and social issues someone with COVID comes with, they can't go home to their elderly or immuno-compromised parents they don't want to give it to their sister with cystic fibrosis or they have COVID but they are a fulltime carer for the autistic child, how do they then come in? They need to be admitted and they have got twins to be looked after and there is no father on the scene - like just all of these logistical issues about how to look after people irrespective of how sick they are where it was actually much more of a challenge than COVID itself.

We had a family ward where people with COVID could bring their kids with COVID and if only one of them needed treatment they could all be in the same room under shared care with paediatricians and adults, and setting up extra COVID friendly clinics, we had an area in a discharge lounge where people with something like an eye condition where someone needs to be seen by an optometrist except they incidentally have COVID, where do you bring them? The ED is bursting at the seams. To use our clean eye room for a COVID patient has its own challenges so we were able to set up a makeshift eye clinic in the discharge lounge so people with eye conditions could be seen there. It is trying to keep the clean areas COVID-free and the COVID areas stop people without COVID entering those areas - on a district and organisational level a lot of work goes into that, a lot of logistics and a lot of problem solving, and a lot of that was hindered by staff shortages as well.

We could have improved things greatly if we had staff but we can't open extra wards because we have no staff we can't open that little COVID ward next to ED because there are no nurses to staff it, so none of this is really COVID related it is the effects of COVID the whole phenomenon, not the actual disease itself.

Ken McCroary - It is good to see the whole policy management of patients is really big in your thoughts but yes that whole additional dynamics in terms of family and living and all of that social stuff seems to get a bit neglected doesn't it but it is such a big issue with trying to get things running smoothly in the hospital and trying to get people back home as well we have had that sort of problem a lot out here as well in primary care.

Alex Mackey - It was a massive issue. Getting people home was one of our biggest problems. At one stage I think early in Delta getting people home was just impossible so there would be people just sitting in our department overnight waiting for transport home because no one could pick them up.

I remember there was one guy we admitted that was like I want my laptop and he was calling his girlfriend to bring in his laptop and we were like 'no, no you can't, your girlfriend is now a close contact she is likely to have COVID she cant come in'.

Ken McCroary - Yes, the challenges or moving forward. So, GP Link we are a local organisation in south west Sydney representing the general practices in the region you have worked here for a while so you have got a really good understanding of the various groups we have I am just wondering if you are aware of any particular issues and challenges facing GP's working in south western Sydney?

Alex Mackey - I don't have a good understanding to be honest. I can sort of tell from some of the referrals that come in I think there probably is a lack of access to specialist care. I think attracting specialist in South West Sydney who can bulk bill and meet the socio-economic needs of this population I think is a challenge which puts a challenge on the GP's and then subsequently ending up with people coming into the ED more that they probably would in more affluent socio economic areas. So I think that is the big challenge for the local GP's but I would be interested to see your views on that. But we do see people coming to hospital for an iron infusion and coming to hospital for an ENT appointment because they can't get an outpatient one or people coming into hospital to see a dermatologist because the local dermatologist is booked out for 12 months we see a bit of that you kind of feel for the local GP's because they have probably very much tried to get their patients cared for but the lack of clinics and other services in the area are a challenge and I know there is a long wait to get a patient an iron infusion and I know an ENT appointment at an outpatient clinic is a long wait I am really hopeful there is talks of a new private hospital being built in Liverpool and the details around that are on the website and I am really hopeful that will help bridge that gap and bring out some specialists to the area it will help create some outpatient specialist clinics to help to ease the burden on the hospital system. So I am sort of keeping optimistic time view that maybe there is a good outcome in the end for that problem. But I am not too sure of what other problems there are. It would be good to know what problems the GP's have in the area it would be good for us to actually get some feedback about what the problems you guys have so we can appreciate where the gaps are in the patients care and help try and cater to that.

Ken McCroary - That leads on to our next thing we normally talk about how you support general practices in the region. I was wondering about how moving forward emergency medicine and the GP's can improve the cooperation in working together and do you have any thoughts and ideas about that?

Alex Mackey - I think probably having some kind of overlap with some of the higher end discussions that occur and I know that one of our physicians is on the clinical council or the equivalent for GP's in the area or primary health networks and things like that are helpful I think it would be useful for ED to have some kind of representation at those meetings as well just to understand or at least put a collaborative body in the seat that can help recognise and work towards solutions I think it is very hard to come up with immediate solutions without knowing the problems first. We sort of put one of our consultants forward sort of being a primary health liaison person and I know she explored that initially a few years back and reached a few dead ends so didn't continue to pursue it but I know previously we did have education sessions and a few other meetings with GP's and primary health care providers that I think was seen very favourably probably did do a lot of good things for patients in the community but like a lot of these things they all require time and everyone is getting more and more overworked trying to find these innovative solutions is becoming more and more challenging but I would be open to ideas and suggestions to how we can help.

Ken McCroary - Yes, I think we will have to explore that liaison officer program a bit closer at another time because that sound very promising.

Alex Mackey - One of our specialist has a plan to become a fellow of the GP college so she sort of always expressed an interest in pursuing that and she sort of mentioned that she has already started some meetings with our outpatient clinics and hospital in the home clinics so she has already done a bit of work on that so I guess she is just looking for that in into the GP network so I am more than happy to try and support that.

Ken McCroary - Thank you, when we were discussing previously to I think you have mentioned at one point the language barriers as we have a really diverse population as you are well aware and has language been an issue to with treating people through the department.

Alex Mackey - Yes, definitely and there is no great solution as interpreters would not come on site IT is always an issue if you are relying on peoples phones or our sort of wired cordless phones or relying on internet coverage or WIFI reception and all those kind of things that always prove a challenge. I think and also visitors were not allowed in sometimes so our primary ways of communicating with people who do not speak English are to have interpreter services via phone or we have people reaching out to there family and doing 3 way chats on their phone or we rely on the visitors to help translate and it all just kind of fell apart a bit because interpreter services were overwhelmed or were sick with covid and we couldn't get them and there was no visitors so the tolerance for not finding out every detail sort of increased so you became more tolerant of just accepting that you didn't have all of the information and from an emergency point of view you can clearly determine without knowing everything you can gather information by calling people or by speaking to patients or acting or brief words or using translator apps and things like that you got enough information to know that you were covering the basic needs of the patient but all the complex issues their detailed medication lists their social history issues the finer details of their symptom's that would often have to wait until the following day when patients are more sorted the department was more under control we had teams that could spend a bit of time with the patient but in the ED that often became impossible so we just had to do the best we could which often meant that we were not getting all of the information that we usually would rely on we were becoming a bit more tolerant of working and treating the obvious without knowing every single detail if that makes sense.

Ken McCroary - Yes, it just adds to the challenge doesn't it.

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