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SUBMISSION

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AMA submission to the targeted consultation on the review of the colonoscopy clinical care standard

Introduction

The Australian Medical Association (AMA) is generally supportive of the revisions to the Australian Commission on Safety and Quality in Health Care (the Commission's) draft colonoscopy clinical care standard. Broadly, the quality statements and supporting information for patients, clinicians and healthcare services are appropriate, but in areas does not provide specific clinical guidance.

Role of the General Practitioner

The AMA wants to see greater focus and autonomy for General Practitioners (GPs) in this space. For patients who have a low surgical/anaesthetic risk and return a positive faecal occult blood test (FOBT), GPs nationally should be supported to directly book colonoscopy for their patients.

The Direct Access Colonoscopy initiative in New South Wales demonstrates direct access can work and should be made available for all Australians as part of standard care. The resultant clinical governance from these models must be made explicit. In these models, the AMA call for information to be clear for the patient, referrer and the colonoscopist and health service. The information must also be clear who is responsible for organising the preparation and consent.

Sometimes it is impracticable to conduct a colonoscopy, or the patient refuses. For example, those unable to complete bowel preparation are typically individuals living with a disability and the elderly. There must be clarity in this instance, and the standards must guide clinicians on what is the place of CT colonoscopy and sigmoidoscopy, or use of both, in these circumstances.

Linkages to the National Bowel Cancer Screening Program

The standard must explicitly link the National Bowel Cancer Screening Program to primary care. The national bowel screening register needs to link in with all common GP software to enable

transparency in results for treating practitioners. With the age of screening now brought forward, the AMA call for the kits to be mailed directly to people rather than to the GPs, it must reach everyone.

In addition, when a patient returns a positive FOBT in the National Bowel Cancer Screening Program, the standards must guide the clinician/GP as to when the patient should be booked in for a colonoscopy based on the level of risk of bowel cancer. For example, whether the colonoscopy should be conducted 30 or 60 days post positive result. This information needs to be reported to the public to ensure transparency in wait times and how hospitals perform against performance indicators.

Artificial intelligence (AI)

The documents provided exhibit a notable lack of focus on the impact and potential applications of AI during colonoscopy procedures. The AMA notes the evolving nature of AI and recommends the consultation considers deeper considerations for AI-assisted colonoscopies, or more thoroughly covers AI within the quality statements.

AI holds immense promise for advancing patient care and benefiting the medical community, provided it is used safely and effectively. Given AI is already being integrated into various aspects of procedures, it is imperative future medical imaging standards and governance procedures incorporate a dedicated focus on AI. AI has demonstrated its ability to enhance diagnostic accuracy and patient outcomes, its advanced capabilities enabling the detection of subtle tissue changes that may be missed by the human eye. Nevertheless, the integration of AI also introduces potential risks to patient safety, which must be addressed within the standards.

The use of AI in healthcare must also protect the privacy of patient health information. It must continue to uphold the rights of patients to know what information is held about them, their right to access their medical records, and their right to have control over its use and disclosure, with limited exceptions. This will uphold the notion of data integrity and security of data.

The new guidelines should specifically advise on how to safely integrate AI into clinical care or acknowledge another resource to do this, noting the rapid evolution in this field and the time required to refine AI processes in medical imaging.

AI must adhere to the following principles:

- Safeguard patient protection
- Support enhanced patient outcomes
- Ensure final clinical decisions are made by qualified clinicians
- Facilitate informed consent from patients for all treatments and diagnostic procedures
- Protect both patient and practitioner data
- Clearly define responsibility and accountability for any diagnostic or treatment errors.

Incorporating these elements into the standards will ensure AI contributes positively to patient care while mitigating potential risks and maintaining high standards of safety and efficacy. The AMA has contributed extensively to submissions on the adoption of AI in healthcare and has released a position statement — *AI in healthcare —* which we are pleased to see referenced in the draft guideline. The AMA urges the consultation to consider this area of evolving healthcare as a priority.

Cultural safety and equity considerations

The standards do not include considerations for people living with disability or those from culturally or linguistically diverse backgrounds. This cohort of individuals has different needs to the rest of the population. For example, the issue of language barrier for patients who cannot understand English. Patients typically receive an SMS appointment in English, which they can't read, despite the GP explicitly writing that the patient does not speak English, the GP provides another contact, or the language they speak in the referral. The patient then misses their appointment, and their diagnosis is subsequently delayed.

There is a strong focus on Aboriginal and Torres Strait Islander peoples as a separate population group. Consideration must be given to those living with a disability and from culturally diverse backgrounds. Practical solutions should be discussed in the standards, so they are more inclusive of all patients, promoting equity in healthcare access and outcomes. In line with cultural safety, the commission should consider publishing the standard, or aspects of the standard in languages other than English to ensure it is consumer focused.

The AMA recommends cultural safety, equity considerations, and principles of communication be discussed at the beginning of the document along with a section written for the consumer using consumer-focused language. Outlining these principles at the beginning of the document ensures the nine standards are focused and specific.

Equity of access for regional, rural and remote Australians is also important and should be included. There are issues with wait times to access colonoscopy procedures being longer than their metropolitan counterparts. For example, improving equity of access for regional and remote populations by supporting ongoing development of the GP-endoscopist workforce through rural generalist training and expanding outreach models. The AMA is supportive of this proposal, noting the challenges of rural specialist medical training. The AMA is aware of GESA's Regional, Remote and Indigenous Outreach program in Alice Springs which provides a positive example of efforts to address this issue.

Additional resources recommended to support implementation of the quality statements

The AMA encourages the commission to refer to our position statement on Doctors' Role in Stewardship of Healthcare Resources 2023. Healthcare resources must be managed appropriately. Doctors have an ethical and professional responsibility to serve as stewards of healthcare resources. This involves caring for the resources available to improve health, avoiding wasteful expenditure, and enhancing the safety and quality of the care to protect patients from harm, while considering the resources required to provide care. Decisions affecting healthcare taken without clinical involvement may lead to inappropriate resource allocation.

The position statement suggests clinical practice guidelines should be used to assist doctors in determining the most appropriate tests, treatments, and procedures for individual patients based on the best available evidence.

Other comment

The AMA recommend separating the non-clinical information, for example cultural safety, to preserve the clinical standards and ensure they are concise and usable for clinicians and services. The non-clinical information and guidance can be noted in an 'other' section.

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