

I am a health professional working in a public Allergy service and one of my roles is to triage referrals of which we refer approximately 120 per month with a waiting time of more than 2 years depending on triage. I wanted to convey the lack of knowledge by a significant proportion of referring doctors that I see daily in my job.

I can provide many examples of this but the most common are: a poor understanding of the difference between lactose intolerance and cow's milk allergy, poor recognition of symptoms of anaphylaxis and when an EpiPen is indicated and basic management of eczema and allergic rhinitis. Even more concerning, is the ordering of tests in a patient that presents with a rash and then unnecessary removal of foods based on these tests which they are unable to interpret and are often of no clinical significance. Also, there are many allergic conditions that could and should be managed in the community yet are being referred to sub-specialty hospital services that should be focusing on the more complex allergies. The tsunami of inappropriate referrals delays access to those who truly need it. It is hard to know whether this is due to lack of knowledge or a lack of time to manage the patient. An common example of this is a patient with hay-fever that has not been commenced on any treatment including something as simple as an antihistamine. Our service declines these as our model is that patients with hay fever should only see a specialist if they fail conventional treatment and need immunotherapy. A single episode of rash is also another common referral reason to a specialist but these are often self-limiting and not allergic in nature.

Our patients wait anywhere from a few weeks to several years depending on urgency. A patient recently seen by our service had waited 6 years with severe hay-fever and had missed lots of school. There was no management strategies tried in the community. There are hundreds of patients in this situation some of whom are probably avoiding foods unnecessarily but we simply can't see them in a timely manner. Our service is working at capacity and is severely under-resourced. Bureaucratic processes are stifling expansion of services – any changes to models of care require business plans, approval by multiple people at different levels and numerous meetings with no real outcomes. Any changes in our service have come about purely from our staff as there are no extra resources or money. We have an extremely well trained doctor who is working in London as could not get a job in her home state. We have other doctors who can only work privately as there are no jobs in the public system so lack of qualified people is not the problem. The focus is on the dollar not the patient and until this paradigm is changed then progress will not occur.

Lastly, appropriate management can be lacking in our ED's. Examples I have encountered include patients receiving a variety of medications to treat symptoms of anaphylaxis but not adrenaline, or using adrenaline where it isn't indicated i.e. for just rash. A recent concerning example of a referral received from an ED is a 16 month old boy who developed facial swelling, cough, wheeze and extreme drowsiness (likely hypotension) after peanut ingestion who was not given an EpiPen on discharge. According to the parent they were not sure that this was an allergic reaction and not sure what the trigger was therefore should wait for allergy assessment before prescribing an EpiPen. Fortunately the mother recognised that this was a severe reaction to peanut. This patient will be seen urgently but this lack of appropriate management meant that I had to inform the GP and parent that he needed an EpiPen which in turn takes up more resources when it takes a phone call and a 10 minute discussion to get this right in the first instance.

Clearly an injection of resources would assist this problem but there are some other solutions that I would like to suggest: a more robust referral system to health systems – a referrer submits a referral electronically that can be declined or accepted at point of entry and could also direct referrers to basic advice. i.e. we decline any patient with a rash unless it has persisted beyond 6 weeks so if the referral did not meet this criteria it would be declined at point of entry with an information sheet on how to manage rash. The current system means I have to write back to the GP's – with 20% of our referrals declined again this takes up unnecessary resources. It also provides immediate feedback to the referrer and provides education.

Also, Allergic disease should form a bigger part of medical training given its prevalence. We can no longer say food allergy or anaphylaxis is an uncommon condition. There are also many resources available but not well publicised. Referrers don't ring for advice. It's a tick and flick system for most. There are also misconceptions on who does what – 'an Allergist can only prescribe an EpiPen', an Allergist has to fill out the Action Plan, a child with egg allergy cannot have the influenza vaccine – these misconceptions lead to delays in patient treatment and can cause significant harm.

There is a large number of very passionate and committed health professionals working in this area that are frustrated by their inability to provide the care that we know will prevent re-attendance in ED's and that can be life changing to a patient. We need to take a good look at existing services and set KPI's for all allergic conditions including acceptable wait times.