Clinic groups sideline doctors: AMA

The AMA has hit back at the government’s latest plans for Lead Clinician Groups, saying they still sideline doctors in favour of bureaucrats in the way health services are run.

AMA president Andrew Pesce says the government’s new position statement on its plans for the groups shows little improvement from the discussion paper it released in January which was “an insult” to clinicians.

He claims it still ignores the promise made by former Prime Minister Kevin Rudd that the panel would allow clinicians more input.

Health Minister Nicola Roxon has described how the LCGs at a local level will provide advice on the implementation of Local Hospital Networks and Medicare Locals.

While at a national level, the groups will advise the Health Department on the development and implementation of clinical standards and guidelines.

But AMA President Andrew Pesce told 6minutes: “There is very little movement from the original document.

“It just shows how determined state departments are in not accepting that clinicians should have more of an input into the management of their local hospitals.

“We will continue to lobby and say if the government does not do this properly it will all be for nothing.”

According to the position paper, the local LCGs will include at least two clinician nominees from the equivalent Medicare Local Board, will be chaired by a practicing clinician and at least 75% of their membership will be practising clinicians.

What do you think? comment@6minutes.com.au

Action needed on asthma plans

Michael Woodhead

Only 37% of adults and 47% of children with asthma have a written asthma action plan from their GP, despite recommendations that all people with asthma be given an action plan.

The findings from a 2008 survey of 225 adults and 75 children in Melbourne with GP-diagnosed asthma show that new efforts are needed to promote the use of asthma plans, say specialists.

Their study in the Primary Care Respiratory Journal shows that usage of asthma plans by children increased slightly from 29% in 2001, possibly due to interventions such as the Asthma 3+ Plan and practice incentive payments.

The increase may also be due by requirements from schools and kindergartens that asthmatic children have a written action plan as a condition of attendance, the study authors say.

Asthma plans were used more by people with poorly controlled asthma, and those with frequent ED and GP visits for asthma.

Patients with asthma perceived that provision of an asthma plan was a sign of a “good GP”, and this finding might be used to motivate GPs to provide plans for all their patients, the authors say.

In an editorial, Dr Helen Reddel of the Woolcock Institute of Medical Research in Sydney says lack of certainty among doctors about what treatment changes to recommend may be a barrier to provision of action plans.

What do you think? comment@6minutes.com.au

Pre-operative will drags doctors into dispute

Michael Woodhead

Doctors who recorded a new will for a frail old lady just before she went into the operating theatre have found themselves caught up in a family legal dispute over who will inherit her “substantial assets”.

The 81-year-old lady with a broken hip decided she wanted to revise her will after being told about the risk of complications from surgery was about to have at Nambour Hospital in Queensland. In what a judge in the Queensland Supreme Court described as “an unusual move” she dictated a revised will to two anaesthetists and a nurse, who recorded that she wanted to split her inheritance equally between her children rather than favouring her youngest son.

Although she made a good recovery from surgery, the son contested the new will after she died, saying his mother had been delirious and not in a fit state to make revisions while in hospital.

However, the judge accepted testimony from the doctors that their patient had been in a lucid and capable state of mind before she went in for surgery, and he accepted their dictation of the will as a valid and legal document. He even agreed to accept a photocopied will from the hospital records department after the original was lost during her hospital discharge.

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Medicine in the media

'GRANNY DUMPING' IN EMERGENCY DEPARTMENTS is a significant but unrecognised cause of strain on hospitals, say emergency specialists. Sydney Morning Herald

PREMATURE INFANTS MAY HAVE DIED NEEDLESSLY at Westmead Hospital's neonatal intensive care unit in Sydney because of poor clinical care but the former head of the unit will not face a disciplinary review, a report notes. Sydney Morning Herald

POOR GP RECORD KEEPING THAT LEAD TO A MISSED HIV TEST RESULT and transmission of the infection has resulted in Primary Health Care paying costs of $300,000. Sydney Morning Herald

A PREGNANT WOMAN HAD TO BE FLOWN INTERSTATE to give birth because one of Sydney’s largest maternity units did not have enough specialist neonatal cots for her triplets. The Australian

OBSTETRICIANS HAVE REJECTED ACCUSATIONS from an academic sociologist that they are arrogant and promote interventions in childbirth. Sydney Morning Herald

THOUSANDS OF RESIDENTS IN SOUTH AUSTRALIA have been drinking water that is regularly contaminated with trihalomethane at levels above safe guidelines. The Advertiser

A GP WHO TALKED ABOUT GOD TO HIS PATIENTS has been disciplined by UK medical authorities. Daily Telegraph

HEALTH MINISTER NICOLA ROXON SAYS PEOPLE in regional areas don’t earn enough to feel the effects of Labour’s changes to private health cover. Sydney Morning Herald

PEOPLE WHO EAT JUNK FOOD ARE MORE PRONE TO DEPRESSION and anxiety, according to research at Deakin University in Victoria. Herald Sun

A PLAN TO MAKE SMOKERS APPLY FOR A LICENCE to light up has been rejected by the health minister. The Australian

A RE-THINK IS NEEDED ON CARE OF THE TERMINALLY ILL, say palliative care specialists after a study found high rates of hospital admissions in the last three months of life. Sydney Morning Herald

PLANS TO GIVE A LUCRATIVE HOSPITAL CLEANING CONTRACT in WA to a private company are being opposed after a union found a report showing Serco did not meet basic hygiene targets in Scottish hospitals. The Australian

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Your say

GPs reluctant to initiate insulin (link)

I regularly initiate insulin therapy for my Type 2 diabetic patients. It probably helps that my partner (also a general practitioner) is a type 1 diabetic.

One older patient told her daughter after a recent consultation “I’m on insulin now.” Reply: “Don’t be silly, how could you give insulin?” Response: “I’ve already given myself the first dose.”

She was started on a low dose for a week (first dose given by herself in the practice) and her diabetic control is now brilliant.

One trick is to point out that insulin is much less painful than finger prick blood glucose testing. It is worth having a selection of insulins in the practice fridge so that patients can give the first dose.

And yes, I have three superb practice nurses that can support patients with injection techniques (it probably also helps that one of the nurses herself has Type 2 diabetes and is on insulin).

Maggie Mackay

As a pharmacist I see tens of thousands of dollars of Lantus, etc going to waste by non-compliant diabetics.

Whether it’s by lack of diabetes training or whatever, the way diabetes is being managed now is quite poor.

Is this the kind of thing doctors want pharmacists to be doing? Where do you stand on this?

Guy, MPS AACP

“Tracy” states “As a practice nurse I do not feel I have the expertise and knowledge to instruct Type 2 diabetics how to administer insulin.”

We’re always being told how nurses today are more highly trained than ever, and yet she is unable to do this comparatively simple and commonly required nursing task?

Whatever are they teaching them in the four years of a nursing course these days?

Peter G

There is far more to commencing insulin than simply dialing up a dose on a pen.

You need to know which devices are best for those with arthritic hands, and which devices are best for those with low vision.

How many times can patients reuse needles (which they do) before they deteriorate and affect the absorption of insulin?

Correct rotation of sites? What to do on sick days? Or perhaps you deny your patients this knowledge.

Oh, and I am hospital trained but I am professional enough to work within my scope of practice, which is not that of a diabetic educator.

TracyS

Use of the title ‘Dr’ (link)

The term physician should be the one used by people holding an MBBS, or medical degree.

The term doctor should be limited to those who have completed a doctorate degree, such as Ph D. Unfortunately, the medical profession has always stolen titles and other things (like pharmaceuticals use from pharmacists) from other professions - and now believe they are the only ones entitled to use or do certain things.

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Precautions: Patients with: aortic stenosis; heart failure; risk of hypotension; liver dysfunction; perform periodic LFTs; high alcohol intake; fusidic acid therapy; history of renal impairment or risk factors for renal failure secondary to rhabdomyolysis; history of haemorrhagic stroke or lacunar infarct; medicines that may increase the activity/levels of steroid hormones. Rare worsening of angina; no protection against beta-blocker withdrawal; peripheral oedema; myalgia, myopathy (monitor CK); interstitial lung disease; significant decreases in ubiquinone levels; variable effects on lipoprotein(a). Children. Interactions: cyclosporin, fibric acid derivatives, erythromycin, niacin, azole antifungals; cytochrome P450 3A4 inducers or inhibitors, including protease inhibitors; OATP1B1 transporter inhibitors; diltiazem; grapefruit juice; digoxin; oral contraceptives. See full PI. Adverse Effects: Most common – headache, oedema, fatigue, dizziness, nausea, abdominal pain, somnolence, flushing, palpitations, asthma, dyspepsia, flatulence, constipation, diarrhoea, myalgia, arthralgia. Serious but rare – paraesthesia, arrhythmia, allergic reaction, dyspnoea, cholestasis. See full PI.

Dosage and Administration: Once daily. Individualise treatment and titrate dose. Titrate to 5mg amlodipine before use in small, fragile or elderly patients. See Precautions. Based on TGA approved PI of 18 December 2008 and amended 11 August 2010. PBS Dispensed Price: CADUET: $51.17 (5/10mgx30); $67.32 (5/20mg x30); $88.37 (5/40mgx30); $119.57 (5/80mgx30); $57.71 (10/10mgx30); $74.33 (10/20mgx30); $95.39 (10/40mgx30); $126.58 (10/80mgx30).

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