

Older age *per se* has been well studied in the cardiology literature on management of myocardial infarction. However, in the literature on adherence to guidelines, few studies have attempted to fully identify the non-cardiac-related characteristics of those receiving guideline-discordant care. Krumholz et al reported that altered mental state is one factor, and that, of a large “real-world” cohort aged 65 or more, only 8% were considered ideal candidates for thrombolytic therapy.<sup>4</sup>

Quality healthcare involves multiple dimensions, including both personal and process factors. Practice guidelines are valuable tools to reduce practice variation, but we need to continue to evaluate whether they can be applied as broadly as may be advocated.

Surely, evidence-based guidelines can only be confidently applied to situations for which an evidence base exists. It will be important to test the application of guidelines in many settings, with attention to potential confounders, and, in particular, to outcome measures.

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**IN REPLY:** We thank Pearson for her kind comments and agree the design of our study<sup>1</sup> prevented identification of all patient factors that may, quite reasonably, impact on clinicians' decisions to administer specific treatments to older patients with acute myocardial infarction (AMI). These factors may also have precluded such patients from enrolment in clinical trials, the results of which underpin recommendations within clinical practice guidelines.

On the other hand, we know advancing age is an independent predictor of increased mortality after AMI, with several possible causes: age-related reductions in protective mechanisms (such as myocardial preconditioning),<sup>2</sup> presence of cardiac and non-cardiac comorbidities unaffected by treatments for AMI,<sup>3</sup> and — the focus of our study

— underuse of effective therapies in the absence of discernible contraindications.<sup>4,5</sup> While cognitive impairment, renal dysfunction and poor functional status may dissuade patients and/or clinicians from pursuing “aggressive” management, we have no evidence that these factors, singly or in combination, necessarily attenuate the benefits of specific interventions for AMI in patients at high baseline risk of cardiac death.<sup>6</sup> We also adjusted mortality comparisons between concordant- and discordant-care groups for multiple measures of illness severity at presentation which predict a poor prognosis.

Nevertheless, we support calls for more randomised trials of treatments for AMI and other conditions in older patients with liberal, “real-world” inclusion criteria in determining absolute risks and benefits of intervention in the presence of multiple comorbidities and impaired function.

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4. Ellerbeck EF, Jenks SF, Radford MJ, et al. Quality of care for Medicare patients with acute myocardial infarction: A four state pilot study from the Co-operative Cardiovascular Projects. *JAMA* 1995; 273: 1509-1514.
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### A Quality Use of Medicines program for continuity of care in therapeutics from hospital to community

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**TO THE EDITOR:** Several studies have documented the high incidence of adverse events arising during hospital admission. The potential for discontinuity of care and poor communication is significant when patients are admitted to and discharged from hospitals, hence the Australian Pharmaceutical Advisory Council (APAC) has established guidelines to ensure continuity in the quality use of medicines.<sup>1</sup> A study reported in 2001 by Mant et al found very low compliance with a minimum dataset based on the APAC guidelines.<sup>2</sup> These

authors subsequently held workshops to identify problems, develop action plans and refine these strategies. However, the follow-up report, published recently in the *Journal*, reported little change in adherence to the minimum dataset.<sup>3</sup>

Why are providers failing to follow the APAC guidelines? Certainly, one cannot assume that the formulation and dissemination of guidelines will necessarily lead to their implementation.<sup>4</sup> To be effective, users must be aware of guidelines and convinced that they will add value to the way in which they work. Guidelines need to be credible and should make sense in the “real world”. Given the attitudinal barriers of some groups to the uptake of guidelines, multiple strategies are required to ensure their effective implementation. Among these is the involvement of key stakeholders in guideline development.

Who are the key stakeholders for ensuring continuity of care regarding therapeutics between hospital and the community? While Mant and colleagues report workshops involving general practitioners and hospital staff, their reports do not identify which hospital staff were involved.<sup>2,3</sup> Were clerical, pharmacy and junior medical staff included? These staff could make a critical difference in adherence to the minimum dataset. Furthermore, are these staff even aware of the APAC guidelines?

The APAC guidelines use the definition of discharge planning established by the Council on the Ageing (Victoria). This describes *people*, hospitals and community-based services working together — but the guidelines and associated minimum dataset place little importance on the patient. Patients' knowledge of their medications is discounted. Despite being mentioned in principles 4 and 6 of the APAC guidelines, patient knowledge of medication changes and satisfaction with the communication regarding medications is not considered in the minimum dataset.<sup>1</sup>

Strategies involving consumers should be explored as a mechanism for improving information exchange between hospitals and GPs. Similarly, an enhanced role for pharmacists warrants further consideration.<sup>5</sup> Certainly, further critique of the APAC guidelines and exploration of reasons for their poor uptake is important to ensure optimal patient outcomes.

1. Australian Pharmaceutical Advisory Council. National guidelines to achieve the continuum of quality use of medicines between hospital and community. Canberra: Commonwealth of Australia, 1998.
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**TO THE EDITOR:** It is refreshing to see quality initiatives like that of Mant et al,<sup>1</sup> which examine issues of continuity across different territories. Use of a simple audit tool (minimum dataset) and methodology has worked well to illuminate what misleadingly appears to be a simple problem (ie, the two-way exchange of information between the hospital and general practitioner in relation to medication). Unfortunately, like many problems that appear straightforward and easily fixable, the reality is that this issue is far more complex to address. A lack of clinical governance has been made apparent in both the public hospitals and the Divisions of General Practice that participated. Clinical governance demands that organisations be accountable for standards and performance in relation to clinical care,<sup>2</sup> and this is integral to addressing problems both internally and across the continuum of care.

Mant et al demonstrated that many hospitals had policies and strategies to accomplish the exchange of medication information,<sup>1</sup> indicating that these procedures were thought to be achievable with current resources. Before this study, knowledge among staff of implementation was scant and confused, and there was no system of review to reveal existing problems. When problems were exposed and changes made, staff were not upskilled to incorporate the change into their practice (eg, junior doctors not completing the new discharge referral form). Similarly, the Divisions of General Practice did not resolve issues surrounding the production and distribution of business cards that they had agreed to undertake.

This study has determined a means to measure performance and has intervened to analyse problems and yield some improvements. However, if the organisations involved do not commit to develop clinical governance, the path towards continued improvement will be extremely slow (if at all) and the findings of this project made irrelevant.

- Mant A, Kehoe L, Cockayne N, et al. A Quality Use of Medicines program for continuity of care in therapeutics from hospital to community. *Med J Aust* 2002; 177: 32-34.
- George M, Davey P. The responsibility of health boards for clinical governance. *The Quarterly* (Journal of the Royal Australasian College of Medical Administrators) 1999; 33(2): 20. □

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**TO THE EDITOR:** Mant et al<sup>1</sup> explore an important aspect of the quality use of medicines in their study on the continuity of medicines from hospital to community. Their study on compliance with an agreed minimum dataset for patient medication information exchange between hospitals and general practitioners provides a useful perspective of an approach to systems change. I wish to point out a number of limitations that may have affected their results and make some suggestions to improve the quality use of medicines.

GPs were audited on whether they provided medication information to hospitals. Many GPs work part-time. There is the possibility that the medical practice was contacted by a hospital employee, who obtained the information from a doctor other than the patient's usual GP.

The audit covered discharge summaries received by the GP by fax. Although faxing discharge summaries is convenient, there are potential problems with this method. There are the possibilities of dialling a wrong number, and faxed discharge summaries (particularly handwritten ones) may be difficult to read, which could also result in medication errors. In addition, a discharge summary may have been posted to the practice instead of faxed, which would under-report the true percentage of GPs who received the information.

It is not uncommon for patients to have multiple GPs.<sup>2</sup> However, it is my experience that only one GP is documented in the patient's medical file. This issue could have influenced the results of the GP audit and would be a further factor complicating the continuity of medicines from hospital to the community.

The authors mention the introduction of GP liaison officers to facilitate the notification of GPs about patient admissions and the rationale for medication changes. They do not report any other measures that they plan to introduce to improve their results. Given that systems problems have multifaceted answers, further expansion on what other steps could be taken would have been a useful addition to their article. I suggest that it would have been appropriate to include a broader range of key stakeholders in the workshops, such as community pharmacists and patients. In addition, a computerised hospital prescribing system could be integrated with an on-line evidence-based clinical guide to prescribing to assist in optimal medication selection. This could also be used to generate a discharge

medication list that was automatically sent to the patients' GPs. Such an approach would reduce errors and improve outcomes.<sup>3,4</sup>

- Mant A, Kehoe I, Cockayne NL, et al. A Quality Use of Medicines program for continuity of care in therapeutics from hospital to community. *Med J Aust* 2002; 177: 32-34.
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- Monane M, Matthias DM, Nagle BA, Kelly MA. Improving prescribing patterns for the elderly through an online drug utilization review intervention: a system linking the physician, pharmacist, and computer. *JAMA* 1998; 280: 1249-1252. □

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**IN REPLY:** We were pleased at the number of letters received exploring issues raised by our recent article.<sup>1</sup>

Jefford and colleagues question whether staff are aware of the Australian Pharmaceutical Advisory Council guidelines.<sup>2</sup> We expect to answer this question during the consultancy that the NSW Therapeutic Assessment Group is conducting for the Commonwealth Department of Health and Ageing. In this consultancy, we are evaluating the implementation and effectiveness of these guidelines. After its completion in October this year, we will have an implementation map of activities being undertaken relevant to the guidelines in Australia. Recommendations formalised at a national workshop will be made to the Department of Health and Ageing regarding future implementation, including alternative models and workable solutions.

All three letters raise questions about the key stakeholders for continuity of care. We invited a range of clinical and administrative staff, including senior and junior medical staff, nurse clinicians, clinical pharmacists and general practitioners from the relevant Divisions. However, participation of junior medical staff was limited. As Jefford et al comment, consumers and community pharmacists warrant further consideration in strategies for improving information exchange between hospitals and GPs. We also agree that patients' knowledge of their medications is often deficient: with limited resources, we were only able to address this through the GPs who interviewed their patients following discharge.

Wilson rightly observes that continued improvement is dependent on organisations' developing clinical governance — accountability is a key driver for change. Change in practice is usually incremental, however, as we found in our study. Sustained change requires ongoing effort and support.

New comments on practical problems with faxing discharge summaries. In our study, GPs identified faxing as preferable because of problems experienced with summaries posted or delivered by patients. New also refers to the problem of patients having multiple GPs. It is up to the patient to advise the hospital appropriately, and this is a matter for consumer education. His suggestion of computerised hospital prescribing is an ideal we all hope will come to fruition sooner rather than later. In the meantime, we believe we have demonstrated the quality improvement process and its limitations and the value of GP audit in prompting that process.

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## Competing interests and careers

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**TO THE EDITOR:** Thanks for the interesting opinion pieces by Reid<sup>1</sup> and Paterson.<sup>2</sup> Would I be correct in assuming that they are the Reid and Paterson who were formerly health bureaucrats in New South Wales and Victoria, respectively?

May I suggest that your readers, especially those interstate and overseas, would have been better informed on the import of these articles if you had made some editorial mention of this fact? In this era of "career-hopping" between industry, government and academia, your readers, if they are to intelligently interpret an opinion piece, need to know more than merely the present position held by the author.

You rightly ask about the "competing interests" of contributors of research articles. Perhaps the writers of opinion pieces should declare their background?

1. Reid MA. Reform of the Australian Health Care Agreements: progress or political play? *Med J Aust* 2002; 177: 310-312.
2. Patterson JP. Australian Health Care Agreements 2003-2008: a new dawn? *Med J Aust* 2002; 177: 313-315. □

### Martin B Van Der Weyden

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**IN REPLY:** As always, I appreciate Arnold's input, and he is right yet again: M Reid was Director-General, New South Wales Health, 1995-2001, and J Paterson was Secretary, Health and Community Services, Victoria, 1992-1996. This information was conveyed in the author's details for Paterson, but inexplicably not for Reid.

The Journal asks its contributors to declare "competing interests"; that is, disclosure of "any situation in which an individual ... might be influenced ... by financial or personal factors that involve self-interest".<sup>1</sup> Most journals, including the *MJA*, choose to focus on competing financial interests, but an ongoing quandary is where to draw the line in the sand of competing interests — should they be religiosity, sexuality, consultancy within the political or health bureaucracy, or positions on committees or advisory boards, and so on?

Arnold wishes to move to a higher plane through disclosure of relevant areas of contributors' life stories, presumably to alert readers to the potential for bias. But might not the publication of a contributor's relevant career prejudice the response of the reader?

Kenneth Rothman, editor of the journal *Epidemiology*, has argued that objectivity in communication "depends on each contribution receiving its due regard, whatever the motivations for bringing it. It depends on judging a work on its merits, rather than on the inferred state of mind of the author".<sup>1</sup> The contributions by Reid and Paterson were published under the Journal's *For Debate* banner. I was hoping for a debate on the messages rather than the messengers.

1. Rothman KJ. Conflict of interest. The new McCarthyism in science. *JAMA* 1993; 269: 2782-2784. □

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