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A simple intervention to improve hospital antibiotic prescribing

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TO THE EDITOR: It was refreshing to see the report by South et al, describing a simple, inexpensive intervention which resulted in a positive effect on the appropriate prescribing of antibiotics and a cost saving for the organisation.¹

In the current climate, it has been much more fashionable to suggest computerised prescribing as the cure-all for medication and prescribing errors. As demonstrated by Newby et al,² computerised prescribing has inherent problems, including an increase in repeat ordering of antibiotics.

The Australian Council for Safety and Quality in Healthcare suggests

computerised prescribing as one of several strategies to reduce medication critical incidents.³ However, the costs of establishing such a system in smaller hospitals and community health centres can prove prohibitive. This can lead to an attitude of "too expensive" so do nothing.

Other strategies and interventions can be introduced at minimal cost to the organisation and yet prove effective in reducing both inappropriate prescribing and the number of critical incidents or errors. The provision of easily accessible standardised protocols and guidelines, the review of medication charts and their ease of use, changing the times of daily medication administration to maximise access to clinicians, and empowering patients to be more aware and responsible for their medications are just a few.

In summary, other strategies need to be developed and their success or failure reported. There should also be awareness that familiarity with procedures can lead to errors and reinforcement is required for all interventions. Computerised prescribing should not be viewed as the solution to all medication adverse events, but one of several strategies that

healthcare organisations can use in their battle with medication errors.

1. South M, Royle J, Starr M. A simple intervention to improve hospital antibiotic prescribing. *Med J Aust* 2003; 178: 207-209.
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TO THE EDITOR: Australia has a high rate of antibiotic use. Increasing antibiotic resistance, spiralling pharmaceutical cost, need for evidence-based practice, public awareness, and widespread variation in prescribing practice, which may lead to quality and safety issues, are reported as the drivers for improving antibiotic use and prescribing.

South et al are to be commended for the introduction of a laminated card for doctors as a simple intervention to improve prescribing practices.¹ Despite the passive nature of the intervention,

www.medicalpioneers.com

READERS INTERESTED IN MEDICAL HISTORY may like to know about the Australian Medical Pioneers Index (AMPI), which is the first major Australian medical history website, and the first published encyclopaedia of Australian medical biography.

AMPI aims to provide basic personal and professional information on every doctor resident in Australia, or professionally connected with Australia, up to the year 1875. This includes medical officers on immigrant and convict ships, doctors who practised in Australia, and doctors who pursued other occupations here. Over 3000 pioneer doctors are listed.

In addition to biographical data, the website provides interesting material on the medical profession in colonial times, including a picture gallery containing rare images of pioneer medical life (Box). There is also a section on sources of information about early doctors.

The original compiler of AMPI was Dr David Richards (1937-1998) of Nottingham, England, whose card file was computerised at the Geelong Hospital Library. The website was developed in conjunction with the State Library of Victoria as a community service. Anyone with additional data about a particular doctor is encouraged to contribute to the project.

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Colonial medical transport. Dr S R Robinson adopted this modern mode of transport when most of his colleagues still kept horses and buggies. (Geelong Heritage Centre — reproduced with permission.)

they found significant improvement in the appropriateness of prescribing.

The authors acknowledge that they are not claiming that their intervention "is the cause or only cause" for change in practice. Areas like antibiotic prescribing and physician behaviour are highly complex and require a series of systematic approaches. Doctors are only one of the multiple stakeholders involved in this process. The level of experience, training background, and awareness of the public health and clinical implications of such interventions vary widely among doctors.

Improvement of South et al's methodology from a passive mailout to gathering systematic baseline information about the medical staff involved, clarifying the purpose of the initiative and finding the proportions of uptake among junior and senior staff would have made the intervention more robust. One of the fundamentals of any change process is to instil a sense of urgency and develop a coalition to drive and lead it.

Development and evaluation of quality initiatives need more than just passive information provision. It has been suggested that any such quality and safety initiative should have set priorities, and these priorities should be developed using a systematic evaluation process with explicit criteria.² Various systemic strategies that involved systematic methodology and evaluation processes, such as antibiotic decision support systems (both computer and manual) and drug utilisation reviews, reported sustainable changes in prescribing practices.³

The intervention by South et al is a welcome initiative, but it is important to realise that simplifying a complex problem like drug prescribing may lead to setting up wrong priorities for action and trivialise the problem and solution. Such initiatives will suffer the fate of the many quality programs that we hear about in hospital corridors but which fail to make a sustainable change.

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Debriefing: care and sympathy are not enough

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TO THE EDITOR: I read with interest McFarlane's article on post-traumatic stress disorder and debriefing,¹ which reminded me of a long-term patient.

Over a decade ago, I discovered that this patient was a Vietnam veteran, and expressed concern that he had not told me previously. His reply came thus (although, of course, I no longer remember the exact words): "How would you know what it feels like to be, by sheer chance, the only man left alive in a group of soldiers?" I acknowledged that he was correct, that I had no idea.

With that poignant remark in mind, I planned his care. He is doing OK.

Can we really address an abstraction that we cannot conceptualise, or predict the resulting obstacles in a person's journey through life? This is equally valid at the beginning of the journey or anywhere along its course. Perhaps the notion of debriefing at an appropriate time is not the problem; perhaps it is the formula we use.

1. McFarlane AC. Debriefing: care and sympathy are not enough. *Med J Aust* 2003; 178: 533-534. □

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