

## LETTERS

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## Automated SMS notification to facilitate the retrieval of donated corneas

Peter M Herriot

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**TO THE EDITOR:** Readers may be interested to learn of an SMS notification system introduced in South Australia to facilitate the retrieval of cornea donations.

The South Australian Department of Health has recently completed the 5-year implementation of its "careconnect.sa" clinical information system (formerly known as the OACIS program), a system which supports clinical activities across the eight major Adelaide metropolitan public hospitals.<sup>1</sup>

A relatively simple and inexpensive enhancement to the system has been the use of short message service (SMS) text messaging to notify the Eye Bank of South Australia of a potential corneal donor.

Following the recording of an inpatient death in the hospital patient administration system, an SMS death notification comprising the relevant medical record number, hospital location and time of death is automatically generated by the OACIS gateway and sent to selected recipients, including the Eye Bank of South Australia. Staff can then check the potential donor's clinical details online via OACIS to obtain accurate information on the person's suitability as a donor and also to cross check the National Organ Donor Registry to determine whether the person is registered as a donor.

Before SMS notification, Eye Bank staff made many calls daily to the major public hospitals to obtain information on recent deaths. Medical or nursing staff would then sift through the medical record to determine whether the patient might be a potential donor and to obtain next-of-kin details. SMS notification has resulted in less disruption to hospital staff, as well as considerable time savings. The whole process of retrieval is now easier and timelier.

The actual number of corneal retrievals has increased since the introduction of the new SMS notification system. There has also been a substantial reduction in the number of corneal transplants postponed because no cornea was available. Donations are now retrieved earlier and more efficiently. The development of the system

also corresponds with a shift to South Australia becoming a net exporter of corneal tissue.

The SMS notification system demonstrates how relatively simple information and communications technology can be applied to make a substantial impact on clinical practice and outcomes.

1 Firor P, Herriot P. Australia's largest clinical information system – South Australia five years in. In: Grain H, Wise M, Chu S, editors. Proceedings of HIC 2005: Thirteenth National Health Informatics Conference. Melbourne: Health Informatics Society of Australia, 2005. □

## Baby boomer doctors and nurses: demographic change and transitions to retirement

Peter C Arnold

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**TO THE EDITOR:** Schofield and Beard,<sup>1</sup> discussing demographic shifts among doctors, raise the spectre of "workforce shortages within the next 5 years".

For decades, Australian health authorities have used various proxy indicators, ranging from Medicare utilisation to World Health Organization and other comparative data, to deny the existence of shortages of doctors. Based on those faulty premises, government policies have aggravated these shortages.

The *Oxford English Dictionary* defines a "shortage" as "a deficiency". For many years, there have been deficiencies in services provided by Australia's doctors, including, among others:

- General practitioners available for house calls and visits to nursing homes; working past 6:00 pm on weeknights or on Saturday mornings; available at nights and on weekends; offering prompt appointments; and being available in locum tenens.
- Specialist initial consultations within a week or two, especially dermatologists, oncologists, neurologists, and, more recently, neurosurgeons and obstetricians.

And all this in our cities and large towns.

The shortages of all medical personnel in rural and remote areas has long been obvious. Our current reliance on overseas-trained doctors is undeniable proof of the existence of those shortages.

For more than three decades, the general practice "positions available" advertisements in the medical newspapers have far outnumbered advertisements from doctors seeking GP positions.<sup>2</sup>

None of the proxy indicators of workforce adequacy, so beloved of politicians and bureaucrats, can rival the plain truth that the supply of doctors, probably in every field of medicine and in every region of Australia, is plainly insufficient to meet reasonable demand, and has been so for at least 30 years.

1 Schofield DJ, Beard JR. Baby boomer doctors and nurses: demographic change and transitions to retirement *Med J Aust* 2005; 183: 80-83.

2 Arnold PC. The ageing GP. *Quadrant* 1976; April: 8-9. □

## Constipation and toileting issues in children

Graham D Hocking

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**TO THE EDITOR:** Catto-Smith gives a very good account of the medical management of constipation and soiling in children,<sup>1</sup> but fails to mention psychological, interpersonal and social factors in the main part of his article. He does mention "behavioural abnormalities" towards the end, in the section "When to refer".

I think it is generally accepted among paediatricians and child psychiatrists that the problem of constipation and soiling, or encopresis, often has multiple determinants and varied psychological effects on the child and the family. Certainly, the older the child is, the more likely these effects will be present.<sup>2</sup>

If this condition is to be managed in general practice over a period of "6–12 months", general practitioners need to be aware of these factors so they can be addressed.

Twelve months is a long time in the life of a 5 year old, and in that time pathological patterns can become well established and hard to shift. Most children over 5 years with soiling have developed secondary psychological problems as a result of the soiling.<sup>3</sup> At this stage, assessment by a child psychiatrist will often reveal that the child has developed a pathological fantasy world around what they believe is happening inside them.

The physical management of constipation and soiling is an essential part of the management no matter what the aetiology, but addressing the psychological interpersonal and social factors is equally important. If these factors are obvious to the GP and are not responding to intervention, the family should be referred to a child

psychiatrist. With children over 5 years, the secondary effects have almost always become significant, and I believe that all these families should be referred for assessment.

Catto-Smith quotes a 30%–50% relapse rate,<sup>1</sup> and “there is evidence that they do not improve on reaching puberty”. This is not my experience with families that have the benefit of a multidisciplinary approach to the disorder.

- 1 Catto-Smith AG. Constipation and toileting issues in children. *Med J Aust* 2005; 182: 242-246.
- 2 Fisher SM. Encopresis. In: Noshpitz JD, editor. Basic handbook of child psychiatry. Vol II. Disturbances in development. New York: Basic Books, 1979: 556-568.
- 3 Connell HM. The practical management of encopresis. *Aust Paediat J* 1972; 8: 273-278. □

### Anthony G Catto-Smith

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**IN REPLY:** Hocking emphasises secondary behavioural and emotional effects that occur in some children with longstanding faecal soiling. Fortunately, there is good evidence that these tend to resolve with effective multimodal treatment of the constipation.<sup>1</sup> The relatively high long-term relapse rate of soiling among children who have been treated in tertiary centres has only recently been recognised,<sup>2</sup> but the psychological features of this relapsing group are not well defined. My review was directed toward general practitioners and was as much as possible evidence-based.

I am unaware of any good quality evidence to support Hocking's assertion of the benefits of automatic referral to a child psychiatrist of all children over the age of 5 years with ongoing faecal soiling. Given the beliefs of both myself and Hocking, that constipation and soiling are likely to have multiple determinants and varying psychological effects, it would seem to be appropriate to triage “problem” patients through a general paediatrician, with referral for psychological assistance if deemed appropriate. This is best summed up in my article in the section that Hocking mentions, “When to refer”.<sup>3</sup>

- 1 Nolan T, Debelle G, Oberklaid F, Coffey C. Randomised trial of laxatives in treatment of childhood encopresis. *Lancet* 1991; 338: 523-527.
- 2 van Ginkel R, Reitsma J, Buller H. Childhood constipation: longitudinal follow-up beyond puberty. *Gastroenterology* 2003; 125: 357-363.
- 3 Catto-Smith AG. Constipation and toileting issues in children. *Med J Aust* 2005; 182: 242-246. □

### Correction

Re: “**The *Messiha* and *Schiavo* cases: third-party ethical interventions in futile care disputes**”, by Thomas A Faunce and Cameron Stewart, in the 5 September issue of the Journal (*MJA* 2005; 183: 261-263). Two words were omitted from the title. The title should read “**The *Messiha* and *Schiavo* cases: third-party ethical and legal interventions in futile care disputes**”. □

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