Mackay, Mark Andrew Maio; Millard, Peter H.  
**Trends in the use of hospital beds by older people in Australia: 1993-2002**  
Medical Journal of Australia, 2005; 182(5):252-252

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A MEETING TOO MANY

“Sorry, [he or she] is in a meeting” commonly frustrates attempts to talk to people in academia, hospitals or bureaucracy. It appears these organisations are afflicted with the modern epidemic of ever-increasing growth of committees, conferences, retreats and workshops and institutional meetings.

The purpose of a meeting is simple: to deliberate, debate and decide. Anything else is superfluous. But, inevitably, this purpose is hijacked. Some see meetings as an opportunity to communicate, obfuscate or obstruct. Others use meetings to create the illusion of participatory decision-making, when decisions have already been made elsewhere. Power seekers dominate, and ineffective chairpersons tend to tolerate their behaviour — all the while the meeting time ticks on.

What to do?

Abraham Bergman, a US physician, recommends all-out war — a 31-day moratorium on all meetings involving more than three people, conference rooms to be locked and the chairs thrown out! After this period of enforced “cold turkey”, there should be a careful and structured return of meetings, provided their stated purpose is decision-making.

Further suggestions range from a reduction in meeting time from the maximum 50 to 15 minutes, to meetings held without chairs, or even convened in corridors. Chairpersons should ensure full participation, quashing repetitive rambling, and should close the meeting on time. Ineffective chairpersons should seek remedial therapy for their failings. Finally, participants in meetings should continually ask themselves whether this is optimal use of their time.

Perhaps we would be better served by reflecting on a comment by renowned US columnist Dave Barry — “If you had to identify, in one word, the reason why the human race has not achieved, and never will achieve, its full potential, that word would be ‘meetings’.”

Martin B Van Der Weyden
Severe childhood pneumonitis caused by the Queensland strain of community-acquired methicillin-resistant Staphylococcus aureus

Bradley T Martin,* Pamela Palanshiran,† Iain B Gosbell,‡ Thelma Barbagiannakos,§ Emma J Best,¶ Richard L Henry**

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TO THE EDITOR: We report a case of severe pneumonia in a previously healthy 3-year-old girl of European background. Non-multiresistant methicillin-resistant Staphylococcus aureus (MRSA) was isolated from her sputum, and she was treated with intravenous vancomycin, followed by oral rifampicin and fusidic acid.

After antibiotic therapy ceased, symptoms recrudesced, and computed tomography of the chest showed bronchiectasis. Sputum grew MRSA (now also resistant to rifampicin, fusidic acid and erythromycin), again grew MRSA (now also resistant to rifampicin, fusidic acid and erythromycin).

The patient's only risk factor was contact with her mother, who had an MRSA buttock abscess incised several months earlier. Phage typing and pulsed-field gel electrophoresis revealed that the mother's and daughter's isolates were identical (Box). They were non-multiresistant, and oral antibiotic options include clindamycin, trimethoprim–sulfamethoxazole or rifampicin and fusidic acid. Intravenous vancomycin is commonly used in severe infections, but recent evidence suggests that linezolid, an oxazolidinone antibiotic with efficacy against multiply resistant bacteria, including MRSA, penicillin-resistant Streptococcus pneumoniae and vancomycin-resistant enterococci, may be more effective. Issues of cost, toxicity, local availability, potential development of resistance and sensitivity of isolates in vitro need to be considered before determining appropriate treatment.

In conclusion, clinicians should be aware of the growing problem of CA-MRSA and the potentially devastating consequences of infection with this organism, even in otherwise healthy children.

Acknowledgements: We thank Dr Michael Free- lander and Dr Andrew Numa for their assistance in the management of this case; SEALS Microbiology for provision of isolates; Alison Vickery and Yvonne Kwok (SWAPS Staphylococcal Reference Facility) for performing phage typing and polymerase chain reaction for Panton-Valentine leukocidin. Dr Bradley Martin and Dr Emma Best are supported by the Sydney Children's Hospital Foundation.

Impact of a formal removal policy for central venous catheters on duration of catheterisation

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TO THE EDITOR: Bloodstream infections are frequent in healthcare settings and cause significant mortality and morbidity. Most of these infections are caused by intravascular catheters, particularly central venous catheters (CVCs). Over 250,000 catheter-related bloodstream infections occur annually in the United States, and over 3000 in Australia. Many CVCs are retained when no longer essential. For example, a recent one-day audit in a US teaching hospital found that 15% of CVCs (11/74) were “unjustified”, most of these had been inserted in the intensive care unit but retained unnecessarily after discharge from the unit.

The risk of bloodstream infection is much higher with CVCs than with peripheral venous catheters (+0.2 vs 0.2 per 1000 line-days). Such simple facts are often overlooked or inadequately emphasised in preventive programs, and CVCs may be retained for convenience.

Our intensive care unit maintained an informal clinical practice of routinely removing CVCs when patients were discharged from the unit. However, an audit found that many CVCs were retained, often inappropriately, thus exposing patients to needless increased risk. A formal intervention policy aimed at improving CVC removal was implemented. This included a month of staff education, culminating in a formal study of all patients with CVCs in the period March to August 2003. Patients were grouped according to whether the CVC was removed per policy before or at discharge from the intensive care unit; or whether it was retained per policy at discharge from the intensive care unit; or whether it was retained unnecessarily, and CVC in-situ times were significantly prolonged. The risk of sepsis with CVCs may be substantially lowered by policy-driven removal of CVCs, without compromising patient care.


**Inhalation-device polypharmacy in asthma**

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**To the Editor:** The delivery of asthma drugs via inhalation offers the best balance between efficacy and safety. However, poor inhalation technique limits the efficacy of this approach. In recent years, there has been a progressive increase in the types of inhalation devices used in asthma management. We questioned whether this would lead to “inhaler-device polypharmacy”, a

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**Comparison of patient characteristics and CVC outcomes when removal policy was followed versus when it was breached**

<table>
<thead>
<tr>
<th>Policy followed</th>
<th>Policy breached</th>
<th>P (policy followed vs breached)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVC removed</td>
<td>CVC retained*</td>
<td>Total</td>
</tr>
<tr>
<td>Number of patients</td>
<td>176</td>
<td>71</td>
</tr>
<tr>
<td>Age (years) (SD)</td>
<td>60.2 (17.9)</td>
<td>64.9 (15.7)</td>
</tr>
<tr>
<td>ICU length of stay (days) (SD)</td>
<td>4.7 (8.2)</td>
<td>3.3 (5.2)</td>
</tr>
<tr>
<td>APACHE II score (SD)</td>
<td>14.7 (6.9)</td>
<td>14.8 (7.0)</td>
</tr>
<tr>
<td>Ventilation time (h) (SD)</td>
<td>51 (89)</td>
<td>46 (123)</td>
</tr>
</tbody>
</table>

**CVC outcomes**

<table>
<thead>
<tr>
<th>Patient characteristics</th>
<th>Policy followed</th>
<th>Policy breached</th>
<th>P (policy followed vs breached)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of CVCs (% of all CVCs)</td>
<td>202 (66%)</td>
<td>77 (25%)</td>
<td>279 (91%)</td>
</tr>
<tr>
<td>In-situ time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours (SD)</td>
<td>97 (115)</td>
<td>202 (186)</td>
<td>124 (148)</td>
</tr>
<tr>
<td>Days</td>
<td>4.0</td>
<td>8.4</td>
<td>5.1</td>
</tr>
<tr>
<td>Tips cultured (% of CVCs)</td>
<td>136 (67%)</td>
<td>51 (66%)</td>
<td>187 (67%)</td>
</tr>
<tr>
<td>Tips infected (% of CVCs)</td>
<td>20 (9%)</td>
<td>11 (14%)</td>
<td>31 (11%)</td>
</tr>
</tbody>
</table>

**Catheter-related bloodstream infections**

| Total no.                                      | 2 (1%)          | 0               | 2 (1%)                          | 1 (4%) |
| Per 1000 CVC days                              | 2.5             | 0               | 1.4                             | 6.0 |
| CVC reinsertions (% of CVCs)                   | 15 (7%)         | 4 (5%)          | 19 (7%)                         | 0 |
| Mean no. of ports idle (per day)               | na              | 1.5             | na                              | 1.6 |

**Peripheral catheters**

| Total no.                                      | 260             | 36              | 296                             | 50 |
| Mean no. per patient                          | 1.5             | 0.5             | 1.2                             | 0.5 |
| Mean in-situ time (h)                          | 63              | 66              | 64                              | 81 |

CVC = central venous catheter. nt = not tested. na = not applicable.

*Reasons for appropriate CVC retention were drug administration (32%), poor peripheral access (34%), transfer to another high dependency unit (25%) and total parenteral nutrition (9%).
When all methodologically acceptable randomised controlled trials were considered, the Cochrane review did find the prevalence of smoking at end-of pregnancy was 6% lower in intervention than control groups. However, this does not equate to a 6% reduction in the population prevalence of smoking among pregnant women, as Ford and Dobson assume. A mean between-group difference reported in a meta-analysis is not equivalent to a difference of exactly the same magnitude in a population prevalence of a risk factor unless 100% of the population exhibit that risk factor. Clearly, as Ford and Dobson have reported, this is not the case with smoking in pregnancy, where they correctly note that about 20% of pregnant women report current smoking at their first antenatal visit. Therefore, smoking-cessation interventions would not reduce the prevalence of smoking by 6% from 20% to 14%. The expected reduction can be calculated as follows: expected reduction in prevalence of smoking in pregnant women = current smoking prevalence in pregnant women (20%) - between-group difference in smoking prevalence (0.06) = 1.2%.

This calculation rests on two assumptions: namely, that all pregnant women in Australia currently receive usual smoking-cessation care equivalent to that of control group conditions in the Cochrane review and that, in the short term, antenatal care can be transformed to the point where all future pregnant women receive smoking-cessation care equivalent to that received by those in intervention groups in the Cochrane review. Therefore, it is obvious that the expected smoking prevalence of 18.8% (20% minus 1.2%) is considerably higher than the 14% calculated by Ford and Dobson. Unfortunately, this means the rates of reduced infant deaths, hospital separations and costs to the healthcare system estimated by Ford and Dobson have also been overstated.

In summary, the gains to be expected by clinical interventions with pregnant smokers are modest. Furthermore, past evaluations of media campaigns directed specifically at pregnant women have not shown significant positive effects. This reinforces the importance of tobacco-control strategies which target the whole population in addition to those which target pregnant women.

3 Lumley J, Oliver SS, Chamberlain C, Oakley L. Interventions for promoting smoking cessation during

<table>
<thead>
<tr>
<th>Number of asthma patients using single or multiple inhalation devices and proportion of those patients with inadequate technique, over two time periods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Period 1</strong> (n = 278)</td>
</tr>
<tr>
<td>One device</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>75 (27%)</td>
</tr>
</tbody>
</table>

*R 1 Jan 2000–1 Jan 2002; †2 Jan 2002–1 Jan 2004.*
Trends in the use of hospital beds by older people in Australia: 1993–2002

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To the Editor: Gray, Yeo and Duckett used the wrong basis of measure for their analysis of bed trends.¹ Bed use per thousand of the population masks the trends in total bed-days or separations and does not address the issue of supply. These issues have important ramifications for policy decision-making.

Using the same sources of data,²,³ we compared bed-related statistics and population changes for the periods 1993–94 and 2001–02. What should be of most interest to planners is that the number of multi-day bed-days only declined marginally (from 14,434 to 14,231; −1.4%), despite the significant increase (from 1698 to 3343; +96.8%) in same-day activity.

Although multi-day separations and bed-days did decline (separations, −4.2%; bed-days, −14.9%) for those aged 65–74 years, for those aged 75 years or over bed-days and separations increased significantly (separations, +41.6%; bed-days, +27.7%). Furthermore, same-day activity increased significantly for those aged 65 or more years.

Furthermore, the authors failed to highlight the implications of changes in the relative age mix of activity. For those aged 75 years or more, the increase in proportion of separations (+5.8 percentage points) and bed-days (+1.8 percentage points) was greater than the increase in this proportion of the population (+1.1 percentage points). For the 65–74-years age group, the proportion of same-day hospital activity increased (+1.3 percentage points), unlike the reduction in that proportion of the population (−0.2 percentage points).

Moreover, the question of whether an ageing population has resulted in the need for more beds can not be answered without considering the supply of beds. From our experience, the growth in same-day activity has been achieved, at least in part, by substituting same-day beds for inpatient beds. The need for increased same-day beds has been considerable. Statistics relating to same-day beds do not appear to be reported for Australia as a whole. However, the increasing implied bed occupancy (including same-day) shown in the Box supports this conclusion.

We surmise that the reduction in supply of multi-day beds combined with a marginally altered demand for multi-day beds has led to increasing numbers of bed crises. Given that relative growth in same-day activity can be attributed to people aged 65 years or over, and that the number of multi-day bed-days for those aged 75 years or more has increased, it appears that the ageing of the population, combined with the manner in which the substitution of beds has occurred, has contributed to increasing bed crises.

Competing interests. None identified. The views of Mark Mackay are personal and in no way represent those of his employer.

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IN REPLY: Mackay and Millard have raised
some important issues in relation to our
analysis. Our article was developed to
courage wider reflection and their
response is thus welcomed.

The primary criticism levelled by
Mackay and Millard was that we under-
played the importance of supply of beds in
our interpretation of the trends. We agree
that bed supply is an important driver of
utilisation patterns. We acknowledged
this, in part, in the discussion as a possible
explanation for rising separation and
declining bed-utilisation rates in the older
patient population. We are also sympa-
thetic to the hypothesis that there may be a
process of substitution of same-day separa-
tions for multi-day separations.

However, data relating to bed availabil-
ity are not readily available, and thus could
not be included in our study. Our article
was designed to highlight different trends
between age groups, which have not previ-
ously been reported. Now that these trends
have been identified, further research and
analysis is required to fully explain them,
with a view to supporting an intelligent
strategy to prepare for future population
ageing.

Whistleblowing in the
Australian public hospital
system

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TO THE EDITOR: Three recent articles in
the MJA about complaints by patients
attending hospital,1 attitudes of hospital staff
toward incident reporting2 and
whistleblowing3 show that complaints are
common, that cultural change is needed to
allow staff to understand that a complaint
from a patient or staff member should be
viewed as an opportunity for change, and
that quality assurance sometimes relies on
whistleblowers but does not always appreci-
ate their efforts.

Faunce and Bolsin report on three
whistleblower incidents,3 but fail to men-
tion one at the Royal Children’s Hospital,
Melbourne, in which I was involved.
Attempts to highlight deficiencies in deliv-
er of paediatric surgical care and concerns
about the response to adverse events were
managed with threatening tactics (of dis-
missal) by the division of surgery. This was
followed by a hospital board investigation
that, in my opinion, had neither the skill
mix nor the terms of reference to adequately
investigate the quality of care or the bully-
ing. The subsequent investigation by the
Department of Human Services involved
narrowly focused terms of reference and
failed to consider outcomes in some circum-
stances, thereby facilitating the “shooting of
the messenger”.

Current legislation does not effectively
allow for dealing with threatening behaviour
in the workplace, particularly when the
refusal to look at complaints and adverse
events in a productive manner goes well beyond the confines of the hospital involved. The Community Advisory Committee parliamentary enquiry was held in camera, with evidence being kept from the public. Worksafe legislation on bullying does not deal well with the complex situations that arise in the healthcare industry.

The Colleges and other professional bodies, such as the AMA and the Medical Boards, need to take a proactive rather than a reactive role if further whistleblower incidents are to be avoided.

I concur with the statement of Faunce and Bolsin that: “Even after substantiation of their allegations, the whistleblowers ... received little respect and support from their institutions or professions”. From personal experience, I am very aware of the lack of support that stems from an ethos wary of public criticism, and the reactive bullying to which the whistleblower is often subjected.

Until the culture of healthcare focuses on quality and caring, whistleblower sagas will continue to occur.


The direct thrombin inhibitor melagatran/ximelagatran

Luke R Bereznicki,* Shane L Jackson,† Gregory M Peterson‡

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TO THE EDITOR: If a new drug such as ximelagatran is to be considered as a replacement for warfarin in preventing the thromboembolic complications associated with atrial fibrillation (AF), drug cost becomes an important issue. Brighton's recent article in the Journal,1 while comprehensive, does not discuss the cost-effectiveness of ximelagatran treatment. Ximelagatran was approved in several European countries for the prevention of venous thromboembolism associated with orthopaedic surgery. The cost of the drug for this indication (24 mg given twice daily) is 4.5 euros (AUS 7.7) per day.2 This represents the best available estimate of the cost of using ximelagatran for AF, although the dose is higher in AF (36 mg twice daily), and there are limitations in applying the drug cost in one country to another country.

Routine monitoring of the antithrombotic effect of ximelagatran (ie, international normalised ratio [INR] testing) was not conducted in clinical trials. While this is potentially advantageous, frequent testing of alanine aminotransferase (ALT) levels is recommended at baseline and monthly for the first 6 months of therapy, every second month for the remainder of the first year, and every third month thereafter, for safety reasons.3 This is because some patients taking ximelagatran will develop elevated ALT levels (about 6.1% of patients to greater than threefold normal, and 3.4% to greater than fivefold normal) when ximelagatran therapy is commenced.3

The costs of INR and ALT tests are very similar (about $25 and $22, respectively).

** Table: Estimated costs of treating 1000 patients with atrial fibrillation (AF) with ximelagatran or warfarin for the first year of therapy.

<table>
<thead>
<tr>
<th></th>
<th>Ximelagatran*</th>
<th>Warfarin†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cost</td>
<td>$2 803 821.00</td>
<td>$106 800.00</td>
</tr>
<tr>
<td>Cost per patient</td>
<td>$2 803.82</td>
<td>$106.80</td>
</tr>
<tr>
<td>Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test (frequency/year)</td>
<td>ALT (10)‡</td>
<td>INR (20)§</td>
</tr>
<tr>
<td>Total cost</td>
<td>$217 000.00</td>
<td>$507 000.00</td>
</tr>
<tr>
<td>Cost per patient</td>
<td>$217.00</td>
<td>$507.00</td>
</tr>
<tr>
<td>Major bleeding¶</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual incidence*</td>
<td>1.6%</td>
<td>2.2%</td>
</tr>
<tr>
<td>No. of expected events</td>
<td>16</td>
<td>22</td>
</tr>
<tr>
<td>Total cost</td>
<td>$38 730.00</td>
<td>$53 253.00</td>
</tr>
<tr>
<td>Ischaemic stroke††</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual incidence‡‡</td>
<td>1.6%</td>
<td>1.6%</td>
</tr>
<tr>
<td>No. of expected events</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Total cost</td>
<td>$101 936.00</td>
<td>$101 936.00</td>
</tr>
<tr>
<td>Overall cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$3 161 487.00</td>
<td>$768 989.00</td>
</tr>
<tr>
<td>Per patient</td>
<td>$3 161.49</td>
<td>$768.99</td>
</tr>
<tr>
<td>Cost difference compared with warfarin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$2 392 498.00</td>
<td></td>
</tr>
<tr>
<td>Per patient</td>
<td>$2 392.50</td>
<td></td>
</tr>
</tbody>
</table>

ALT = Alanine aminotransferase. INR = International normalised ratio.

* Cost of giving ximelagatran (24 mg twice-daily) to prevent venous thromboembolism post-surgery (German data; the dose for prevention of thromboembolism in AF is 36 mg twice-daily).‡
‡ Cost of warfarin taken from the Australian Pharmaceutical Benefits Scheme, December 2004.
‡‡ Monitoring cost derived from the cost of conducting ALT testing (Medicare Benefits Schedule, December 2004) according to the manufacturer's directions (tests at baseline, monthly for the first 6 months, 2-monthly for remainder of the first year).
§ Cost derived from Medicare Benefits Schedule (December 2004) based on a frequency of 20 tests per annum.
¶ Cost derived from Medicare Benefits Schedule. In January 2005, the cost was $507.00.
* No significant difference between warfarin and ximelagatran in either SPORTIF III5 or V;6 statistically significant when data from both trials were combined at P<0.05.
†† No significant difference between warfarin and ximelagatran in SPORTIF III5 and V;6 no significant difference when data from both trials were combined at P<0.05.
Although INR monitoring may be more frequent with warfarin than ALT testing with ximelagatran, the cost difference associated with therapeutic monitoring would remain far less than the likely cost of ximelagatran. We estimate the cost associated with treating 1000 patients with AF with ximelagatran instead of warfarin for 1 year, taking into account drug costs, monitoring costs and the slight difference in major bleeding rates, to be about $2.4 million (Box).

A United States Food and Drug Administration advisory committee has recently raised concerns about the safety of ximelagatan (after episodes of severe liver damage), and has recommended that it not be granted any indication for use without further safety data. In particular, ALT monitoring may be more frequent with warfarin than INR monitoring, but it is a starting point. The services offered are confidential, and can be anonymous if desired. In Western Australia, the contact number is (08) 6223 2047.

The attached table of contact phone numbers does not cover every state and territory, but it is a starting point. The services offered are confidential, and can be anonymous if desired. In Western Australia, the contact number is (08) 6223 2047. Further information is available on the Doctors’ Health Advisory Service website <www.doctorshealth.org.au>.

LettErs

Australasian Association of Doctors’ Health Advisory Services

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To the Editor: Thank you for your in-depth look at some of the concerns in doctors’ health in the October 2004 issue of the MJA.

I believe it would have been useful to include in the issue some practical information for doctors wanting to seek help, either for themselves or for a colleague.

The attached table of contact phone numbers does not cover every state and territory, but it is a starting point. The services offered are confidential, and can be anonymous if desired. In Western Australia, the contact number is (08) 6223 2047.

Further information is available on the Doctors’ Health Advisory Service website <www.doctorshealth.org.au>.

Prescription shoppers line

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To the Editor: Over the past two years, the Journal has pointed out the health hazards and the lack of logic in the Health Insurance Commission’s closure of its previously cost-effective and successful “Doctor Shopping Hotline”. But it has taken the death of a 25-year-old “prescription shopper” in Cairns, his crusading mother, a scathing report by the Queensland Coroner and public exposure of these problems by Mark Bannerman on ABC TV (<The 7.30 Report>, 22 Dec 2004) for discernible action to occur.

On that program, the Federal Minister of Health and Ageing promised that a “Prescription Shopper Line” would be up and running by the end of January 2005, and indeed it was activated on 31 January.

This leaves two outstanding issues. The first is for the Health Insurance Commission to engage in an open exercise of mutual education by clearly reviewing its process of thinking in closing the previously successful Doctor Shopping Hotline and its lack of urgency in reinstating its proposed better and broader successor.

The second, and more important, issue is in understanding the underlying factors and thought processes of those doctors who have prescription shoppers describe as an “easy touch.”

5 Inquest into the cause and circumstances surrounding the death of George Shoobridge. 28102004 D9 T4/GRB m/T CAIR03/298 (Preivetera, Coroner).
Free Auslan interpreter service for healthcare practitioners

31 January, 2005, saw the commencement of a new initiative through the Commonwealth Department of Family and Community Services. The new service — the National Auslan Interpreter Booking and Payment Service (NABS; <www.nabs.org.au>) — is available to private medical and healthcare practitioners and Auslan users free of charge.

Until now the cost of having an Auslan (Australian Sign Language) interpreter at private medical or healthcare appointments has been borne by either the patient, or by state deaf societies. This has been recognised as an access and equity issue for the Australian deaf community and other users of Auslan. As a result, the Australian Government has allocated $18.4 million over the next 3.5 years to provide this essential service.

Wesley Mission Brisbane has been selected as the organisation to establish and operate the service, which operates from a national call centre located at the corporate office of Wesley Mission on the north side of Brisbane.

The national call centre will operate between 8 am and 8 pm local time in all Australian states and territories.

An interpreter to attend appointments with users of Auslan can be booked by:

- Phone (voice): 1800 24 69 45
- Phone (telephone typewriter [TTY]): 1800 24 69 48
- Fax: 1800 24 69 14
- Email: bookings@nabs.org.au
- SMS: 0427 671 261
- Post: National Auslan Interpreter Booking and Payment Service, 930 Gympie Road, Chermside, QLD 4032

NABS provides free interpreting services for private medical appointments with:

- general practitioners and specialists
- Aboriginal health workers
- audiologists
- dietitians
- mental health workers
- occupational therapists
- physiotherapists
- podiatrists and chiropodists
- chiropractors
- osteopaths
- psychologists
- speech pathologists
- dentists
- optometrists