Ensuring the effectiveness of the primary care health workforce

Dear Editor

As a huge believer in maximising the effectiveness of the primary care health workforce, I have applauded initiatives such as allowing Medicare rebates for psychologists and other allied health providers through care planning and team care arrangements. After all, surely patients get the best care from those who are best trained for the role, and we should all be working to the fullest extent of our training. Which is why I was appalled when a member of staff for whom I had recommended an antihistamine eye drop for her allergic conjunctivitis returned from the pharmacy with a bottle of chloramphenicol. The pharmacist had read my note and told her that chloramphenicol would work better than the antihistamine I had recommended, despite the absence of any signs of bacterial infection and the presence of classic 'cobblestoning' of the inflamed conjunctivae.

By all means let's distribute tasks appropriately throughout the primary care team. But let's also make sure that each member is properly trained and competent in the task.

Professor Steve Trumble
Melbourne Medical School
The University of Melbourne, Vic

Data extraction and feedback

Dear Editor

As a quality improvement coordinator, I understand the lack of significant change in clinical outcome indicators highlighted in the study by Schattner et al[1] (*AFP* August 2011). However, I am concerned by the conclusion that the study 'failed to detect important clinical changes'.

In relation to the data analysis, the results were aggregated across all practices, despite the fact that 'practices could choose what issues they wanted to work on'. Data was not presented against only those indicators practices were working on.

In addition, the results would have been different if the timeframe of the study (12 months) was aligned with the definition of a 'recent' patient (presentation in 30 months) to apply strategies across the entire patient population.

The 'modest' improvements to the recording of data also impact on clinical care. Safety improvements from recording allergies linked to prescribing software are difficult to measure. Recording allergies and smoking status to achieve The Royal Australian College of General Practitioners standards, and thus accreditation, can fund staff who will further impact on patient care.

Data collection problems for some indicators were mentioned. Our practice took several years to make data collection both efficient and accurate.

This article highlighted GP incentives with little emphasis on other effective strategies. It would have helped if there was more information about the conclusions it has drawn; I also have concerns about the attitudes it will encourage. I feel data should be presented with a realistic perspective on results, targets and timeframes to encourage quality improvement.

Ms Jacqueline D'Arcy
Desert Springs, NT

Reference

1. Schattner P, Saunders M, Stanger L, Speak M, Russo K. Data extraction and feedback – does this lead to change in patient care? Aust Fam Physician 2011;40:623–8.

Address letters to

The Editor, Australian Family Physician
1 Palmerston Crescent, South Melbourne
Vic 3205 Australia
FAX 03 8699 0400 EMAIL afp@racgp.org.au