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## Lady Windermere syndrome

### Dear Editor

While I enjoyed Dr Maguire's article on bronchiectasis (*AFP* November 2012),<sup>1</sup> it does perpetuate one error. Progressive nodular bronchiectasis in elderly women is often referred to as 'Lady Windermere syndrome'. However, Lady Windermere in Oscar Wilde's play<sup>2</sup> is certainly not elderly, self conscious nor overly polite, but in fact quite a rebellious young woman who has her 21st birthday in the middle of the first act. Unfortunately, the American authors<sup>3</sup> who suggested the name must never have seen the play.

Professor Graham Simpson  
Cairns, Qld

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## Disclosure of child abuse

### Dear Editor

Congratulations to Lee and colleagues (*AFP* November 2012) for their article,<sup>1</sup> which the authors believe is the first study of disclosure of child abuse to GPs and the thoughts of women survivors of child abuse on being asked about histories such as these.

During the 30 plus years that I have been in practice it has certainly become a little easier to directly ask patients about sexual abuse (as well as of physical abuse, drug and alcohol use), due, I imagine, mainly to the increased publicity that these issues have received over recent years.

However, doctors remain reticent in many cases. This may be due to concerns that the patient may find such questions objectionable. Lee et al's study should put that concern to rest.

The concern that remains is the 'can-of-worms' that may be opened. In some cases, patients may presumably benefit from just being able to share their histories of abuse, but for many, substantial follow up would be needed. Even with the Better Access initiative, suitable referral pathways often seem difficult to locate.

Did the authors assess reasons that patients may have had for not disclosing histories of abuse?

Dr Nicholas Silberstein  
Barcelona, Spain

### Reference

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### Reply

#### Dear Editor

Thank you Dr Silberstein for your interest in the article and your comments.

It is very encouraging to hear that the practices of some practitioners have changed throughout the years, with some directly asking patients about abuse histories.

Unfortunately, the concern of opening 'Pandora's box' is not a new one and has been cited by many practitioners in previous studies as barriers to asking patients. Asking patients is the first step to identification of survivors and providing early intervention.

A crucial opportunity to challenge this insidious social and health problem is missed by not asking and perpetuates the idea that it is an issue that cannot be spoken about, further silencing survivors. Although the referral pathways are not ideal, it provides the follow up that survivors may welcome and may mitigate the long term consequences of child abuse. Just as the article's premise that survivors do not get offended when asked about abuse histories and most felt hopeful and relieved.

Unfortunately, we did not assess patients' reasons for not disclosing child abuse histories. This is definitely an area that warrants future research. Previous studies (which focused only on child sexual abuse) have cited factors such as

guilt, shame, negative repercussions of abuse disclosures such as 'social death' and not being validated when abuse was first disclosed as factors hindering survivors from disclosing abuse.

Adeline Lee  
Melbourne, Vic

## Quality care plans

### Dear Editor

General practitioner management plans and team care arrangements ('care plans') help practices to provide care for patients with chronic or terminal medical conditions. There is wealth of details about claiming rules and plenty of templates for organising care plans, but there is a paucity of information on what defines a 'quality' care plan.

Over 3 months of practice visits with GPs and practice nurses, a high need for support and training for preparing good care plans was determined. Based on this, a workshop was put together by Inner West Sydney Medicare Local in consultation with GPs and PNs. A consensus was reached that a quality care plan is one that is meaningful, efficient and productive to both health professionals and their patients. It is meaningful as it encourages patient self-management; efficiency is about articulation of medical management and patient self-management, and that treatment goal and actions are mutually agreed between patients and health professionals. Enhancement of a planned care approach and better outcomes (both patient and business) define the productive component of a quality care plan.

Two sessions were conducted in mid-2012, with 43 GPs and PNs attending. The workshop focused on promoting patient centredness of care plans and differentiating between goals, targets and outcomes. The 'Chronic Care Model'<sup>1</sup> was demonstrated and the role of a care plan within that model was identified. A simple, user friendly checklist tool was developed to ensure that the care plan met the basic Medicare Benefits Schedule requirements and

contained the 'quality' elements. Evaluation (pre- and post-workshop) data demonstrates that the workshop achieved promoting patient centredness of care plans. Although the degree of importance that GPs and PNs placed on care plans did not change, their level of confidence in performing care plans did change. The checklist was well received, especially by those new to general practice.

Mr Vijayarathi Ramanathan

Ms Lisa Maude

Inner West Sydney Medicare Local, NSW

### Reference

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## Non-adherence to prophylactic medication

### Dear Editor

Australia has one of the most diverse populations in the world, with 27% of people being born outside of the country and 21% speaking a language other than English at home.<sup>1</sup> It is a real shame that ethnicity and language concordance were not included in the data on the patients or their doctors in the study by Craig and Wright (*AFP* October 2012).<sup>2</sup> A negative attitude towards the doctor is likely to be much higher if there are communication problems due to lack of language concordance, and it is common for there to be less comfort in seeing a doctor from a different ethnic group from your own. There is no mention of any effort to enable recruitment of patients who were not English competent, so I presume this was not done.

Health outcomes for minority populations are worse than for the mainstream who were studied here, one likely mechanism of which would be lower adherence to medications. Research that excludes those most affected by the problem being researched is in effect exacerbating those health inequalities.

Dr Ben Gray

University of Otago, Wellington, NZ

### References

1. Australian Bureau of Statistics. Available at [www.abs.gov.au/ausstats](http://www.abs.gov.au/ausstats).
2. Craig H, Wright B. Nonadherence to prophylactic medication – negative attitudes toward doctors a strong predictor. *Aust Fam Physician* 2012;41:815–8.

## Reply

### Dear Editor

Thank you for your comments regarding our article. We do think the points you raised are valid and worthy of empirical investigation. Our aim however (like many researchers), was first to study a specific sample to test our hypotheses and later to see if the findings could be generalised to other populations, for example, those for whom English is a second language. We chose to investigate factors related to adherence with those that could easily comprehend the questionnaires, as to do otherwise would confound the results attained.

We agree that this is an area worthy of research, and we would hope to pursue this line with separate, tailored investigations for the population you suggest.

Heather Craig and Dr Brad Wright  
Melbourne, Vic

## Rise in new HIV infections

### Dear Editor

Following the reported 8% rise in new HIV infections<sup>1</sup> in Australia and the media attention this received, I expected a flood of patients arriving on my doorstep requesting HIV tests. This has not occurred and I am reminded that people have many health and life issues to be concerned about.

As doctors we can't just rely on patients to request sexual health tests. Primary care practitioners are in a unique position to raise the issue of testing opportunistically, when patients are visiting the clinic for other reasons.

The Australasian Society for HIV Medicine can support GPs with information and resources around testing and delivering a positive result.

With 15–30% of people infected with HIV in Australia going undiagnosed, rising rates of chlamydia in people aged less than 25 years and a spike in gonorrhoea documented in the Kirby Institute's 2012 Annual Surveillance Report, we need to take a more proactive approach to offering testing to sexually active patients when they present.

Dr Cathy Pell

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Sydney, NSW

## Reference

1. The Kirby Institute. HIV, viral hepatitis and sexually transmissible infections in Australia annual surveillance report. Sydney, NSW: The Kirby Institute, the University of New South Wales, 2012.

## On botany and gardening

### Dear Editor

In Dr Stone's discussion of the classificatory frameworks that guide and constrain us (*AFP* October 2012), she mentions that the 'botany' style is especially limiting where complex chronic illness exists alongside psychosocial trouble.<sup>1</sup> This is of enormous importance. People with multiple comorbid chronic conditions are the greatest consumers of healthcare resources,<sup>2</sup> and the most poorly studied and vulnerable members of our society. They make up about 37% of GP consultations, and as the population ages this will increase.<sup>3</sup> The health system is siloed into disease specific specialties;<sup>4</sup> clinical practice guidelines focus on one disease at a time, and many doctors take a 'treat the presenting complaint/one-problem-per-visit' approach. In multimorbidity this is ineffective, inefficient and unsafe.<sup>5</sup> Stone points us towards something better.

I have found it useful not simply to add psychosocial formulation and psychiatric diagnosis to medical diagnosis, but to integrate the three. I try to identify the entire set of problems (and strengths) a person has and how these interact (with each other and with the social system). I seek the structure of a person's whole suffering, and look for the keystone problem – a problem upon which all the others hang, and where intervention therefore gives the highest yield. This is not time consuming or difficult: sick individuals belong to sick populations, and complex patients usually fall into the pattern of some syndemic.

I believe that 'gardening' is not a craft that lacks objective standards of quality, or requires us to relinquish 'the restitution narrative', as Stone suggests. Good gardening (biopsychosocial formulation) accurately identifies the epidemiological context, derives from that the dynamics of the problem list (finds the inter-disease/social pathology synergies and rate-limiting factors to

improvement), and identifies the highest value intervention. We must bear in mind that patient goals may differ from ours, and that the time horizon to benefit of some treatments may be longer than remaining expected life span. Still, we fix what we can.

But it would be naïve to think that suggestions such as Stone's, or mine, go out into a healthcare system inherently eager for improvement. Patients with a long problem list and psychosocial complexity are not popular. In hospitals especially there is a culture of hostility towards them; Stone's mention of 'doctor centred classificatory systems' that brand some as 'heartsink patients' takes a great deal of venom and profanity out of the picture. Institutional counter transference – often tinged with racism, in hospitals with a significant Indigenous clientele – is an obstacle that must be named and challenged if change is to come.

Dr Nicolas Jefferson-Lenskyj  
Tully, Qld

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1. Stone L. On botany and gardening – diagnosis and uncertainty in the GP consultation. *Aust Fam Physician* 2012;41:795–8.
2. Tinetti ME, Studenski SA. Comparative research and patients with multiple chronic conditions. *N Engl J Med* 2011;364:2478–81.
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## The doctor-patient

### Dear Editor

Paul Nisselle's letter about the 'doctor-patient' (*AFP* October 2012) resonated very much with my own experiences of being a doctor-patient.

I had a laparoscopic cholecystectomy performed in 2004. I met my anaesthetist a few minutes before being wheeled into the operating theatre. He asked me what my job was, so I told him. I then informed him of my sensitivity to analgesic side effects. He responded by asking me what type of analgesic I'd like and in what

dose. I had to tell him that was for him to decide!

I also noticed that the patient in the bed next to me, who was also having a laparoscopic cholecystectomy that day, received a reassuring, detailed explanation of what was involved from her nurse, whereas I received no explanation from my nurse. Was this because my nurse knew I was a doctor and should therefore know what to expect? Possibly. Although I did have a different nurse to the patient I was sharing a room with.

Some years later, I had to see a superspecialist who, like Dr Nisselle's ophthalmologist, had to be asked to modify his highly specialised explanation to one that I could understand.

As a result of these experiences, I have asked my GP to write Mrs rather than Dr on future referrals. I wonder if other colleagues have had similar experiences, and if so, whether they too have chosen not to reveal that they are a doctor.

Dr Bambi Ward  
Melbourne, Vic

## Recruitment in general practice

### Dear Editor

General practice is an ideal platform for public health researchers as it provides access to a large proportion of the population and enables researchers to target a range of health conditions. While research in this setting is both valuable and essential, difficulties with practice and practitioner recruitment may hinder the development of evidence in this setting. We read Jones et al's reporting of barriers and enablers to research participation with interest (*AFP* June 2012).<sup>1</sup> This article provides valuable insight to guide researchers in the future design of recruitment procedures in this setting, particularly with the changing demographics of the workforce.

In our experience with recruitment in this setting, we conducted a cross-sectional study, where we sought practice consent to approach patients in the practice waiting room.<sup>2</sup> Despite the known challenges faced in recruitment of practices in this setting, we found little evidence on how to maximise practice consent rate. We employed a number of strategies in line with those recommended by the RACGP.<sup>3</sup>

These included: clinician involvement in study design; financial reimbursements provided to practices; minimising recruitment burden on GPs; minimising complexity of study design; initial telephone contact by lead investigator in the area; and professional development incentives. Our study achieved a 25% practice consent and 75% physician consent rate. Clearly, the recruitment of general practices as research participants is a resource-intensive and challenging process. Researchers using this setting need to take into account these unique barriers while estimating recruitment costs and designing recruitment protocols. While national initiatives exist in the form of the Primary Health Care Research, Evaluation and Development program, further systemic changes to reduce time demands placed on practitioners needs to be implemented in order to increase practice engagement with research.

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Dr Mariko L Carey  
Professor Rob Sanson-Fisher  
Professor Catherine D'Este  
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2. Yoong SL, Carey ML, Sanson-Fisher RW, et al. Touch screen computer health assessment in Australian general practice patients: a cross-sectional study protocol. *BMJ Open* 2012;2:4.
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## Letters to the Editor

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