The doctor-patient

Dear Editor

Jane Smith[1] strongly endorsed William Osler's aphorism, 'A physician who treats himself has a fool for a patient' in her article 'A is for aphorism' (*AFP* August 2012). I strongly agree, but difficulties can be encountered when a doctor seeks treatment from another doctor.

I have been working in the United Kingdom since mid-2009 but prior to that, in the 1980s, I had been prominent in the Australian Medical Association and to a lesser degree in The Royal Australian College of General Practitioners. In the 1990s and through to the time I left Australia, I was very well known for my work in the area of medical defence. When I sought medical care, most of the people I saw knew me or knew of me.

If it was a GP, there was often one of two extreme responses:

> 'You might be Paul Nisselle but to me you're just another patient and I expect you to act like one and do as you're told'.
>
> 'Yes, Paul, what would you like?' – pen hovering halfway between the prescription pad and the referral pad.

Both these responses are inappropriate and disappointing.

I am delighted though to report that for more than 10 years before I left Australia I was looked after by a GP who managed me entirely appropriately as a reasonably intelligent patient with knowledge of medicine. She did not allow me to dictate my care but was always careful to ask what I thought was going on and what I thought I needed. She always explained to me what she thought and what she recommended and why. I felt very confident in not just her technical abilities and knowledge of medicine, but also how she managed me. (We had only one area of disagreement. We worked out that I was approximately double her weight, but she kept telling me I was obese and I kept telling her she was anorectic.)

But you can also overestimate just how much your doctor-patients do know. For example, I was diagnosed with angle closure glaucoma just before I left Australia. On arrival in London, I went to see the glaucoma specialist my Australian ophthalmologist had recommended. He performed a very careful assessment and then started to give me his findings and recommendations. After only 15 seconds or so, I interrupted him and said, 'Look, I haven't been in clinical practice for 20 years and I have never worked as an ophthalmologist. Would you mind talking to me in plain English?' He roared with laughter and then gave me the 'plain English' (but not dumbed down) version rather than the ophthalmic-speak version! It takes careful assessment to find out what level of language is appropriate. Your doctor-patient may be too embarrassed to admit that he or she does not understand what you are saying.

Finally, if you are a VIP (Very Important Practitioner), confidentiality flies out the window. In 2002, I had coronary angiography after angina had been diagnosed. Even though I felt perfectly well, as the angiogram revealed what are apparently called 'widow maker' lesions – severe disease in the left main coronary artery involving the origin of both the left anterior descending and circumflex vessels – I was kept in after the angiogram and scheduled for cardiac surgery 2 days later. The angiogram I think was performed during an afternoon. That same evening, while still in hospital, I received a number of calls from medical friends who wanted to wish me well for my surgery!

Dr Paul Nisselle AM
London, UK

Reference

1. Smith J. A is for aphorism: if a 'a physician who treats himself has a fool for a patient' – are we all fools? Aust Fam Physician 2012:41:622.

Oral glucose tolerance testing

Dear Editor

The recent article by Dr Phillips[1] (*AFP* June 2012) was a useful summary of oral glucose tolerance testing. However, I would like to clarify some points regarding testing for diabetes during pregnancy.

It was reported that the Australasian Diabetes in Pregnancy Society (ADIPS) recommend a 50 or 75 g glucose challenge test at 26–28 weeks in all pregnant women, followed by an oral glucose tolerance test if the result is abnormal.[1] While this information, from 2008 *Medical Journal of Australia* guidelines, is still available on the ADIPS website, it has been replaced by new guidelines. The latest ADIPS recommendations,[2] which align with international recommendations (including the International Association of Diabetes and Pregnancy Study Groups and American Diabetes Association), are for all women to undergo screening for diabetes at 24–28 weeks (an expanded timeframe) with a 75 g glucose tolerance test (GTT). In addition, the ADIPS recommend that all women are screened early in pregnancy with a GTT, fasting blood glucose level (BGL) or random BGL depending on their individual risk of diabetes and the availability of testing. HbA1c is not currently recommended because it has not been validated in pregnancy and does not attract a Medicare rebate. Glucose challenge testing has been shown to lack sensitivity and specificity and is no longer recommended.

New ADIPS recommendations for diagnosis of gestational diabetes based on a 75 g fasting GTT include fasting venous BGL 5.1–6.9 or 2 hour BGL 8.5–11 mmol/L. Overt diabetes, encompassing pre-existing or newly diagnosed type 1 or type 2 diabetes during pregnancy, should be diagnosed when the fasting BGL is ≥7.0 or 2 hour BGL ≥11.1 mmol/L.

Table 1 listed a fasting BGL of ≥6.0 as no evidence of diabetes, this should have been ≤6.0 mmol/L.

Dr Laura Edwards
GP/public health registrar, NT

References

1. Phillips P. Oral glucose tolerance testing. Aust Fam Physician 2012;41:391–3.

2. Australasian Diabetes in Pregnancy Society. Consensus guidelines for the testing and diagnosis of gestational diabetes mellitus in Australia. Available at www.adips.org/images/stories/documents/adips_gdm_draft.pdf.

Reply

Dear Editor

I thank Dr Edwards for referring me to the ADIPS Consensus Guidelines for the Testing and Diagnosis of Gestational Diabetes in Australia which are posted on the internet.[1] The diagnostic criteria are those I alluded to as one of the future directions in diabetes diagnosis.

Dr Edwards is quite right about my error in Table 1 for which I apologise to readers.

Dr Patrick Phillips
Consultant endocrinologist
Queen Elizabeth Specialist Centre
Adelaide, SA

Reference

1. Australasian Diabetes in Pregnancy Society. Consensus guidelines for the testing and diagnosis of gestational diabetes mellitus in Australia. Available at www.adips.org/images/stories/documents/adips_gdm_draft.pdf [Accessed 3 September 2012].

Health Professionals Prescribing Pathway project

Dear Editor

Thank you for the article, 'Gatekeeper, shopkeeper, scientist, coach?' by Dr Kees Nydam[1] (*AFP* July 2012) regarding the Health Professionals Prescribing Pathway project.

HealthWorkforce Australia (HWA) welcomes the input and feedback from all stakeholders into this project. This article provided some interesting insights into the future roles and relationships between health professionals, including in the context of prescribing.

I would like to clarify that the Health Professionals Prescribing Pathway project will not be 'proposing to further extend the list of practitioners who are eligible to prescribe to include physiotherapists, pharmacists and psychologists'. The objective of the project is to develop a nationally consistent approach to prescribing by health professionals other than medical practitioners that supports safe prescribing practice and quality use of medicines.

The project is considering how important issues such as safe and effective models of prescribing, prescribing education and training, processes for accreditation, registration and endorsement of practitioners to prescribe can be applied consistently within the confines of a health professional's recognised scope of practice. It should be noted that the eligibility to prescribe is determined by a health professional's registration board and the authorisation provided by the legislation in force within each state and territory.

HealthWorkforce Australia has received significant feedback from stakeholders, including the medical workforce, in the first round of consultation. Key themes included the need to maintain important safety steps in prescribing, such as the separation of prescribing from dispensing of medicines, for consistent standards of prescribing education to be applied, and for health professionals to work collaboratively to ensure patient care is not fragmented.

HealthWorkforce Australia expects to undertake a further round of consultation on a draft prescribing pathway early in 2013. Feedback can be provided at any stage by emailing: hppp@hwa.gov.au.

Mark Cormack
CEO, HealthWorkforce Australia

Reference

1. Nydam K. Gatekeeper, shopkeeper, scientist, coach? Aust Fam Physician 2012;41:457.

Reply

Dear Editor

I think that Mr Cormack's comments are terrific and contribute to this important discussion. I would only reiterate that my article was based on my assignment tendered for a subject completed as part of a Masters in Health Management (UNSW). The aim of this assignment was to comment on a contemporaneous news media report. The news media report in question was from the *Australian* and is included in the references.

Dr Kees Nydam
Bundaberg, Qld

Gatekeeper, shopkeeper, scientist, coach?

Dear Editor

It is not often I am annoyed by what I read in *AFP*, but for the first time in I don't know how long I am putting finger to keyboard to comment on the article by Dr Kees Nydam[1] (*AFP* July 2012). I understand the thrust of his article is that he is keen on allied health professionals being able to prescribe.

I personally do not have a problem with this provided the list of drugs that can be prescribed is accurately documented with firm guidelines so that allied health professionals do not overstep their prescribing expertise (for example, physiotherapists do not prescribe NSAIDs to someone in chronic renal failure or do not prescribe an antihypertensive).

I take issue with a number of comments that Dr Nydam makes. First, he says that patients rarely seek advice on preventive healthcare. I am not sure how much time Dr Nydam has spent in general practice but patients are more than happy, and in fact I think, expect information on preventive medicine during most consultations.

He also states that GPs are sole traders and they should ride the wave of innovation to remain relevant. What on earth does this mean? In our group practice we are 'sole traders' in that we work one-on-one with patients but hardly 'sole traders' in the sense that we work in a medical centre with 15 doctors in the practice and we are regularly in consultation with each other. I would be surprised if the alcohol, tobacco and drug service has 16 doctors in its employ.

With regards to 'ride the wave of innovation', I find this a meaningless statement. What does he mean by innovation?

I find most GP are more than happy to embrace IT in their practice (for example). I personally would be ecstatic if I could receive specialist reports by email, if I could be guaranteed that privacy was secure. If Dr Nydam means innovation is allowing pharmacists and other allied health professionals to prescribe then I do not see this as innovation, as it does not necessarily improve patient care. It just gives patients convenience of access to drugs.

Dr Nydam also states that an overarching collaborative practice framework between medical and nonmedical prescribers is now espoused by many early adopters of change – would this include people who are keen to reduce expenditure on prescriptions? – actually, this statement is also so vague as to be meaningless. Who are these early adopters of change?

Last, Dr Nydam says we (ie. GPs) should embrace the coaching mantle and coach in a wider sense in multidisciplinary teams as meta-clinicians. What gobbledegook! I spend most of my day coaching and encouraging patients in what they should be doing to optimise their health.

Dr Andrew J Benson
Victor Harbour, SA

Reference

1. Nydam K. Gatekeeper, shopkeeper, scientist, coach? Aust Fam Physician 2012;41:457.

Reply

Dear Editor

I thank Dr Benson for his letter. In response, firm guidelines and quality assurance audits are understood to be a given – even doctors need them and they are already in place for many categories of drugs. (Note: regrettably small numbers of doctors continue to prescribe NSAIDs to renal failure patients.)

My suggestion that patients rarely seek advice on preventive health was not just my editorial comment. Reference(s) are given of studies that show that patients rarely seek advice on preventive health. This is especially so for those in lower educational and socioeconomic circumstances, ie. those who need it most.

By sole traders I was not referring to geographic location. I was referring to real collaborative practice with nonmedical health practitioners such as what happens in most modern hospitals. I don't need 16 doctors in my service because I leverage the skills of my team. I maintain that this is a much more effective use of my skill set. That way I can spend more time with those patients that need me, rather than spread myself so thinly as to be noneffective.

Also, I meant innovation to be broader than just IT, ie. to include looking at work practice and work process.

'Early adopters' are, for example, hospital practices; a stroke unit could not operate without a raft of allied health practitioners. Yes, it is shamelessly resource (mainly personnel and but also financial) efficiencies.

As meta-clinicians I meant we should be coaching our nonmedical colleagues and paramedical staff as well as our patients.

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