Noncompliance – not always the patient's fault

Dear Editor

The article 'Long term persistence with statin therapy – experience in Australia 2006–2010'[1] (*AFP* May 2011) truly inspired me. As a hospital physician and periodically serving general practice, I feel an obligation to my patients for their physical, mental and social health. In fact, I think mental and social robustness contributes significantly to their physical integrity. During practice, I greet a variety of patients, mostly elderly ones, and their families. We discuss the medication regimen and I always reiterate this to the patient's caregivers.

With our aging population, we are facing an increasingly 'isolated' population, with poor hearing ability and less physically able which can make fetching a prescription a difficult task. Some patients also have some emotional distress from frustration ('why have I become so fragile?'). In such cases, a caregiver plays an important role in the daily care of these patients, acting as a surrogate for them when it comes to filling prescriptions, communication about the necessity of medication compliance, and even ameliorating mental anguish. Then, is it possible that the poor persistence of drugs, such as the phenomenon elucidated in Simons et al's article, may stem partly from factors revolving around caregivers rather than patients? I often educate my patients' family members about the importance of drug compliance. Hired caregivers may require an even higher degree of repeated communication so that they realise the risk accompanying poor medication persistence. In light of this, I think 'caregiver apathy', or other issues prohibiting caregivers from implementing their role, may contribute somewhat to poor persistence in addition to 'patient apathy'.

Dr Chia-Ter Chao
Department of Internal Medicine, National Taiwan University Hospital, College of Medicine, National Taiwan University, Taipei, Taiwan

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Primary palliative care

Dear Editor

I enjoyed reading the article 'Primary palliative care – facing twin challenges'[1] (*AFP* July 2011).

Having a strong interest in palliative care, I can relate to Geoffrey Mitchell's twin challenges.

I would have liked Professor Mitchell to have expanded on his second challenge, that of 'innovative ways of enticing GPs to provide adequate palliative care'.

Encouraging GPs to obtain postgraduate qualifications in palliative care would be one way of enticing interested practitioners. However, I have found that the Faculty of Palliative Medicine at the RACP is very rigid and unyielding in its provision of postgraduate courses. Rather than considering external courses, they want GPs to go back to a tertiary palliative care unit. This is not always feasible for GPs established in their practices, particularly in rural areas.

It would be nice if this could change, because I feel, like Professor Mitchell, that it is important to 'provide as good as care at the end of life as... in the rest of life's journey'.

Dr David Healey
Taree, NSW

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The pre-employment medical

Dear Editor

Fenner helpfully describes various aspects of the conduct of pre-employment medical examinations (*AFP* July 2011).[1] We would like to make some comments based on the evidence one of us gave to the inquiry into the Waterfall train crash regarding the medical examinations of the driver and guard,[2] as well as being the principal medical consultant to the National Transport Commission in the development of the National Medical Standards for Private and Commercial Drivers and for Rail Workers.[3,4]

Pre-employment examinations are intended to assess fitness for a job from various aspects: a) can the person meet the inherent requirements of the job, particularly if the job is safety critical work such as a bus or petrol tanker driver; b) could the person be a hazard to him/herself or others in the course of their work; and c) could reasonable accommodation be made by the employer for a person with a disability. Pre-employment examinations should be conducted so as to assist an employer meet various legal obligations including: a) the duty of care to the employee and others; b) avoidance of unfair disability discrimination; and c) compliance with privacy legislation. The pre-employment medical assessment cannot be used as a predictor of future workers' compensation claims, rather it is a medical assessment of capacity to do a specific job at the time of the assessment.

Fenner rightly emphasises the importance of the doctor conducting a worksite visit to permit him/herself to become familiar with the inherent requirements of the job. This point was made in the findings of the Waterfall inquiry as well as the need for the employer to facilitate work site visits. However, the suggestion that the pre-employment examination be seen as an opportunity for a general men's health check is more questionable even if well intended. It is necessary to assess cardiac risk factors in safety critical jobs such as bus or petrol tanker drivers. However this assessment does not apply to ordinary jobs such as a process worker. Unnecessary assessments may place the doctor in an awkward position regarding recording of abnormalities which have been found but are not relevant to the inherent requirements of the job. In addition there is an ethical question of who pays for the extra pathology and other investigations. Obviously if a serious condition, such as a melanoma is found coincidentally it must be managed as per normal practice.

What information should be reported to the employer is problematic. Privacy legislation is based on the 'need to know' principle. The medical report needs to respond to legitimate questions by the employer regarding fitness for the job but should not infringe the applicant's privacy in providing information about medical conditions. It is questionable if the prospective employee has freely given informed consent to disclosure of medical information, if it is stated or implied, that if they

do not sign the consent form they will not get the job. Moreover it is questionable if the employer really needs to know diagnostic information rather than the functional implications for doing the job. For example, if the person has a back injury the employer needs to know they cannot lift more than, say 10 kg rather than the person has 'low back pain' or 'lumbar spondylosis without radiculopathy'. Records with personal medical data should be held by the GP or only conveyed to a medical or nursing colleague at the company who will hold the records securely. This is a difficult area and it is suggested further advice be sought from one's professional indemnity insurer.

Dr Bruce Hocking and Dr Andrea James
Specialists in Occupational Medicine
Melbourne, Vic

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3. Assessing Fitness to Drive. Austroads and National Transport Commision, 2003. Available at www.austroads.com.au/aftd/index.ht [Accessed 15 July 2011].
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Reply

Dear Editor

Thank you to Bruce Hocking and Andrea James for their comments. While I agree with many of their comments, the article was aimed at GPs performing medicals on their own patients. The information that the GPs gather is used as a general men's health check for their, and their patient's benefit and is not intended to be conveyed on to the employer. I understand the need for total 'secrecy' on patient medical facts for medicals sent to future and current employers, even other doctors, without patient permission. I am sorry if this did not come across in the article. I am not teaching specialists how to do medicals, I am advising fellow GPs how to get the most from this opportunity.

It is also correct that, due to space restrictions, there was not enough words left in the article to convey the various 'double talk' that has to be sent to employers, as per the example of the low back pain. Again, the article was directed at GPs for their own records and nowhere else – this is why I referred to the person having the medical as 'the patient' and not the (potential) employee – or worse still as 'the client'!

I hope this clarifies your concerns and thank you for your input.

Associate Professor Peter Fenner
Mackay, Qld

Borderline personality disorder

Dear Editor

I was delighted to read the article on borderline personality disorder (BPD) by Professor Lubman et al[1] (*AFP* June 2011). I feel that BPD is an increasingly frequent yet underdiagnosed condition that should be at the forefront of mental health initiatives. As 1–2% of the population are affected by this condition[1] (and in recent practice with homeless youth, I would say that 75% of such youth are affected), it is our profession's poor awareness, lack of understanding, stigmatisation and poor treatment of sufferers that urgently needs to be addressed. I would go so far as to say the doctors are, in general, going against their Hippocratic oath and frequently 'doing harm', albeit inadvertently, to this group of patients.

Even basic knowledge needs dissipating to doctors – that this is a common condition; it is not the patients fault; they are not being 'manipulative' or 'attention seeking' on purpose but out of necessity; they successfully commit suicide in up to 10% of cases;[2,3] there are frequently comorbidities (eg. substance use, depression); and that the condition is treatable.

Perhaps *AFP* could publish a whole issue on this condition.

Dr Ingeborg Shea
Perth, WA

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Nutrition care in general practice

Dear Editor

Lauren Ball asks the question whether 'we' are waiting for patients to ask for nutritional advice[1] (*AFP* July 2011). This article goes on to point out how GPs aren't doing their job properly and recommends even more study as to why that might be occurring. For those who have studied for a medical degree, done their time in the trenches of the hospital environment as well as their general practice training, the reasons nutrition doesn't pop up at every consultation becomes abundantly clear. Is it just me or is anyone else sick of 'research' in general practice that states the obvious while criticising the failings of practising GPs?

Dr Chris Topovsek
Noosaville, Qld

Reference

1. Ball L. Nutrition care in general practice: are we waiting for patients to ask? Aust Fam Physician 2011;40:463.

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