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HONING HOSPITAL PRESCRIBING

Prescribing errors made by interns may reflect a hospital culture that views medication charting as a routine chore and does not offer junior doctors enough supervision, rather than a simple lack of knowledge. Coombes et al (*page 89*) came to these conclusions when they interviewed interns from a teaching hospital in Queensland who had made a range of errors, including charting incorrect doses, omitting prescribed therapies and overlooking prior adverse drug reactions.

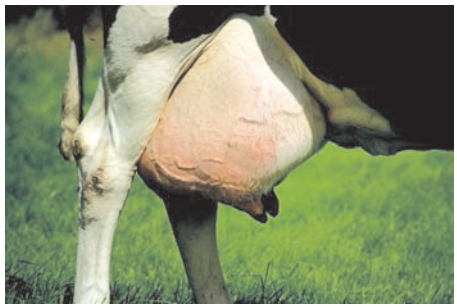
Poorly organised or confusing medication charts were another factor that has also been raised before. A national inpatient medication chart (NIMC), aimed at standardising hospital medication orders, has been developed and introduced to varying degrees over the past few years. On *page 95*, Millar et al present their audit of implementation of the NIMC in 14 hospitals across Australia, together with a comparison of the NIMC's design with that of the chart previously used at Royal Perth Hospital. Overall average compliance with the requirements of the NIMC's chart fields was less than 60%, and the study reveals some important deficiencies in the new chart, bringing into question its superiority to the previous model.

ACCORDING TO THE OXFORD ...

You may have noticed some contributions from the *Oxford Health Alliance* in our recent special December issue. The Alliance seeks to involve as many stakeholders as possible in discussions about chronic disease and public health — hence the brief perspective on the health-promoting role of government, and the note from corporate food giant, PepsiCo, outlining its efforts to improve its health profile. In the next article in the series (*page 104*), Magnusson and Colagiuri consider how the law might be used to keep us healthy.

MILK ALLERGY GUIDELINES

About 2% of children aged less than 2 years have cows milk protein allergy. Three types of formula (soy, extensively hydrolysed and amino acid) are appropriate for use in these infants, depending on the specific allergy syndrome they are experiencing. On *page 109*, Kemp et al provide an Australian consensus panel opinion, outlining when to use which formula.



MIDWIFE-LED MATERNITY CARE A WINNER

Rural obstetric units run entirely by midwives under the supervision of a tertiary referral centre are a viable model of maternity care, say Scherman et al after describing the first year of operation of the midwife-led maternity unit at Mareeba, 64 km south-west of Cairns (*page 85*). Among those presenting for pregnancy care, 170 women initially categorised as low risk received antenatal care at Mareeba, with 24-hour cover by 12 midwives, and regular case-conferencing with an obstetrician in Cairns to identify women whose care should be transferred to the larger centre. Mareeba GPs were also on hand to perform elective and emergency caesareans. There were 158 deliveries at Mareeba, with six women requiring intrapartum transfer, and two requiring postpartum transfer to Cairns Base Hospital. Neonatal resuscitation rates were low compared with state averages. According to Pesce (*page 70*), about 130 rural maternity units have closed in Australia since 1995. The experience at Mareeba illustrates the need for a flexible approach to allow optimal use of local workforce and resources, and models that include expeditious transfer when it is desired or required.

MOVING FORWARD WITH CHLAMYDIA SCREENING

Australia needs an innovative chlamydia control program that engages with primary care, includes education and health promotion, and is tested and refined via randomised controlled trials. According to Hocking et al (*page 106*), chlamydia screening programs overseas have had little long-term impact on prevalence, despite high screening rates, and we need to make a concerted effort to do better. The authors will be heartened by the results of a randomised controlled trial from the Australian Capital Territory, reported by Bowden et al (*page 76*), which found that asking GPs to screen for chlamydia when performing a Pap smear significantly increased screening rates.

FLIGHT RELIEF WITH COMPRESSION TIGHTS

Wearing graduated-compression tights during a long air flight can reduce ankle oedema and travel-related symptoms, such as perceived swelling, leg pain, reduced energy and concentration, and sleep disturbance. So say Hagan and Lambert (*page 81*), who were commissioned by Skins Compression Garments to perform an open-label randomised crossover trial assessing the ability of the company's full-length graduated-compression tights to alleviate flight-related symptoms. Among 23 pilots and 44 passengers, self-measured increases in ankle circumference and self-reported associated symptoms were reduced when the tights were worn during flights, compared with when they were not worn. The effect of the product on deep vein thrombosis incidence is not known.

Dr Ruth Armstrong, MJA

ANOTHER TIME ... ANOTHER PLACE

It became popular in recent years to divide medicine into cognitive and noncognitive disciplines — a throwback to the schism between medicine and surgery in the Dark Ages, when use of the hands was demeaned and the status of surgery, and indeed of all medicine, declined significantly. But the labeling of surgery as a noncognitive discipline is fallacious and totally unsupported by its history and achievements.

Michael E DeBakey, 1991