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An unusual neonatal zoonosis

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To the Editor: *Pasteurella multocida* is an oral commensal of domestic pets known to be an opportunistic human pathogen after traumatic animal contact. The most common infections in humans are skin and pulmonary infections. This report outlines a case of *P. multocida* meningitis, which has not previously been reported in Australia.

A 19-day-old girl presented with a 12-hour history of fever and poor feeding. Her temperature was 39.5°C, and she was irritable, with no localising signs or skin lesions. A full septic screen was performed. Cerebrospinal fluid (CSF) showed a neutrophilic pleocytosis and gram-negative coccobacilli. She was treated with intravenous cefotaxime and gentamicin. Within 24 hours both CSF and blood cultures showed growth of gram-negative bacilli. The initial Gram stain, growth on chocolate agar and positive oxidase and catalase tests were suggestive of a *Haemophilus* species. However, further biochemical tests revealed the organism to be *P. multocida.* The infant made an excellent clinical recovery, with normal neurological and growth assessments at 6 and 12 months.

The family owned two cats but reported no contact between their baby and the pets. A single tonsillar swab performed on each cat by a veterinarian 10 days after the baby's presentation failed to isolate *Pasteurella* species. The family elected to keep the pets.

Pasteurella meningitis occurs at extremes of age, in the immunocompromised (associated with liver cirrhosis, renal disease and haematological malignancies) and after traumatic head injury.[1] Infants aged under 1 year account for almost half the cases of *P. multocida* meningitis.

On review of the literature, we found 37 reported cases of *P. multocida* infection in infants (Box).[1-5] In more than three-quarters of these cases, there was known contact with household animals — in more than half of these contact was non-traumatic (licking or presumed handling of the pet). Molecular studies in one of the cases with no history of traumatic contact confirmed that *P. multocida* isolates from pet and infected child were indistinguishable.[2]

This infection is unusual, and, given the popularity of household pets, the risk appears low. However, this case highlights the relative immunocompromise of newborn infants, and is a reminder of the importance of hand hygiene and preventing contact between newborn infants and pets.

1 Weber DJ, Wolfson JS, Swartz MN, Hooper DC. *Pasteurella multocida* infections. Report of 34 cases and review of the literature. *Medicine (Baltimore)* 1984; 63: 133-154.

2 Boerlin P, Siegrist HH, Burnens AP, et al. Molecular identification and epidemiological tracing of *Pasteurella multocida* meningitis in a baby. *J Clin Microbiol* 2000; 38: 1235-1237.

3 Thompson CM Jr, Levkoff AH. *Pasteurella multocida* meningitis in infancy. *Am J Dis Child* 1986; 140: 1216.

4 Voss A, van Zwam YH, Meis JF, et al. Sepsis puerperalis caused by a genotypically proven cat-derived *Pasteurella multocida* strain. *Eur J Obstet Gynecol Reprod Biol* 1998; 76: 71-73.

5 Wade T, Booy R, Teare EL, Kroll S. *Pasteurella multocida* meningitis in infancy (a lick may be as bad as a bite). *Eur J Pediatr* 1999; 158: 875-878. ❑

Details of 38 case reports of invasive *Pasteurella multocida* infection in infants (including current case)[1-5]

Mean age (range)	2.6 months (1 day–11 months)
Type of infection	
Meningitis	30 (79%)
Puerperal sepsis, chorioamnionitis	7 (18%)
Bacteraemia (postnatal)	1 (3%)
Nature of animal contact	
Traumatic (scratch, bite)	9 (24%)
Non-traumatic	22 (58%)
Unknown	7 (18%)
Type of animal ($n = 31$)	
Cat	16 (52%)
Dog	11 (35%)
Both	4 (13%)

Reliability of parental reports of head lice in their children

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To the Editor: For parents to treat head lice (pediculosis) effectively in their children, it is necessary for them first to recognise it is present. We conducted a school-based screening program involving 1838 children from 16 randomly selected primary schools in Victoria between May and October 2001 (participation rate, 55.2%).[1] As part of this program, we compared a written report from parents on their child's pediculosis status against results of our examination (7–10 days later).

We examined the scalp and hair of each child for lice ("crawlers") or viable louse eggs ("active infestation") and dead or hatched louse eggs ("inactive infestation") using white hair conditioner, which makes lice and eggs easier to see with the naked eye, and a fine-toothed head lice comb. This is a validated, accurate and sensitive diagnostic technique.[2] Parents were unaware of the proposed screening date, and the study team was unaware of the parents' reports.

We compared parental report about pediculosis against results of our screening for 1179 children who could be matched with completed questionnaires. Overall, 149 children (12.6%) had active pediculosis, but parents reported head lice in only 36 children (3.0%) (Box 1 and Box 2). These comprised 24 of the 149 children with confirmed pediculosis (16%), and another 12 children who did not have pediculosis

Correspondents

We prefer to receive letters by email (medjaust@ampco.com.au). Letters must be no longer than 400 words and must include a word count. All letters are subject to editing. Proofs will not normally be supplied. There should be no more than 4 authors per letter. An "Article Submission Form" (www.mja.com.au/public/information/instruc.html) must be completed and attached to every letter.

There should be no more than 5 references. The reference list should not include anything that has not been published or accepted for publication. Reference details must be complete, including: names and initials for up to 4 authors, or 3 authors et al if there are more than 4 (see mja.com.au/public/information/uniform.html#refs for how to cite references other than journal articles).

1 Screening results compared with parental report

Pediculosis by parent report	Pediculosis on examination		
	Yes	No	Total
Yes	24	12	36
No	99	969	1068
Unsure	26	49	75
Total	**149**	**1030**	**1179**

2 Sensitivity and specificity of parental report versus screening

Pediculosis prevalence	
By parental report	3.0% (36/1179)
By screening	12.6% (149/1179)
Sensitivity	16.1% (24/149)
Specificity*	98.8% (1018/1030)
Positive predictive value	66.6% (24/36)
Negative predictive value*	89.0% (1018/1143)

* Specificity and negative predictive value were calculated after grouping "unsure" and "no" responses.

when examined. The positive predictive value (PPV) of parental report was 66.6%, indicating that parental reporting was not a reliable indicator of pediculosis. An implication of the low PPV is that some children may have been unnecessarily treated with insecticide for an infestation they did not have.

On the other hand, a substantial proportion of children with head lice had not been identified by their parents and could contribute to ongoing transmission within schools. While it was possible they were infected subsequent to completion of the questionnaire, this seemed unlikely, as 72% were found to have multiple louse eggs, indicating a longer duration of infestation than the 7–10 days since the questionnaire was completed.

Our study clearly demonstrates that parental reporting of head lice in their children is unreliable. We suggest several possible reasons: parents did not see the head lice, did not recognise them, or used a diagnostic technique with a lower sensitivity than the method we chose, such as examining dry hair. It is also possible that parents were inhibited from reporting pediculosis by the possible repercussions, such as exclusion of the child from school. Indeed, children whose parents failed to answer the question about pediculosis had a higher prevalence of head lice than those whose parents answered. Nevertheless, parents' management of pediculosis is likely to improve if a sensitive detection method is used. To improve the sensitivity of parental diagnosis and control of head lice we recommend that parents be instructed to screen their children weekly using hair conditioner and combing.

1 Counahan M, Andrews R, Büttner P, et al. Head lice prevalence in primary schools in Victoria, Australia. *J Paediatr Child Health* 2004; 40: 616-619.
2 Mottram P. Research report on the effectiveness of hair conditioner as a non-chemical agent to control head lice. Brisbane: Queensland Health, 2000. ❑

Major burns: incidence, treatment and outcomes in Aboriginal and non-Aboriginal people in Western Australia

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To the Editor: People with major burn injuries (50% total body surface area or more) now have an improved likelihood of survival with the implementation of aggressive treatment regimens, including supportive therapy, nutrition, and advances in the control of sepsis. Technological developments and treatments, particularly expedient wound closure, early surgical debridement, covering of large burn wounds, early skin repair,[1] use of cultured epithelial autograft[2] and ventilation,[3] have also contributed to improved outcomes for people with these injuries.

In Australia, there are inequities in access to health services which may particularly affect Aboriginal people.[4] We therefore undertook a retrospective, observational study to compare the incidence of major burn injuries, clinical and demographic characteristics of patients with burns, as well as treatment and outcomes between Aboriginal and non-Aboriginal children and adults in Western Australia between 1992 and 2002. Potential cases were identified using data linkage from the Western Australian Department of Health. Raw data came from clinical records.

Of the 84 people identified with major burn injuries, nine were Aboriginal (11%) and 75 were non-Aboriginal (89%). The incidence of major burn injury among Aboriginal people is greater than expected, as data from 2001 show that 3.5% of the WA population are Aboriginal.

Aboriginal people with major burn injuries were younger than non-Aboriginal people with those injuries (mean, 21 v 35 years). Eight of the nine Aboriginal people (89%) had flame-only burns, compared with 33 of 75 non-Aboriginal people (44%). No statistically significant difference was seen between the groups in the percentage of total body surface area affected, provision of treatment (including number of operative procedures, applications of cultured epithelial autografts, units of blood products used, nasogastric feeds, and antibiotic doses) or length of hospital stay.

We found that, although a greater percentage of Aboriginal people sustained major burn injuries, after this group entered the hospital system they experienced comparable levels of service and outcomes to non-Aboriginal people. Further research into burn care is warranted, from culturally and environmentally appropriate prevention through to critical appraisal of outcomes.

1 Wood FM. Quality assurance in burns patient care: the James Laing Memorial Prize Essay 1994. *Burns* 1995; 21: 563-568.
2 Carsin H, Ainaud P, Le Bever H, et al. Cultured epithelial autografts in extensive burn coverage of severely traumatized patients: a five-year single-center experience with 30 patients. *Burns* 2000; 26: 379-387.
3 Papini RP, Wood FM. Current concepts in the management of burns with inhalation injury. *Care Crit Ill* 1999; 15: 61-66.
4 Henry BR, Houton S, Mooney G. Institutional racism in Australian health care: a plea for decency. *Med J Aust* 2004; 180: 517-519. ❑

Paget's disease of bone

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To the Editor: I read with interest the recent review of Paget's disease by Walsh.[1] I would recommend that calcium and phosphate levels should be included in the initial biochemical assessment, as both tests are cheap and readily available. As Paget's disease predominantly afflicts the older population, coexisting vitamin D deficiency is likely. Low (but within the normal range) calcium and phosphate levels may support this diagnosis. Conversely, hypercalcaemia, a rare event in Paget's disease except in prolonged immobilisation,[2] may indicate primary hyperparathyroidism, which is significantly associated with Paget's disease,[3] or, less commonly, metastatic bone disease. Both these conditions have prognoses and management distinctly different from those of Paget's disease.

Serum total alkaline phosphatase levels may not be elevated in 15% of active Paget's disease.[4] While bone-specific alkaline phosphatase level is more useful in these situations, this test is not readily available in some laboratories and, even among those in which it is available, some only provide qualitative results, making it less useful for monitoring Paget's disease and the response to therapy. A suitable alternative test is urinary deoxypyridinoline/creatinine ratio, which can be done either on a random urine sample or a 24-hour urine collection.

In addition, the serum total alkaline phosphatase level can be spuriously low in malnourishment, and specifically in zinc deficiency,[5] a frequent occurrence in elderly people. I describe here a case highlighting such a problem.

A 72-year-old socially isolated widower of 8 years presented with progressively worsening pain in his right hip in the preceding 3 months. He had poor appetite and had lost 6 kg in weight, but had no symptoms of malignancy. Clinical examination showed a thin man (body mass index, 20 kg/m^2), who was otherwise normal with no features of zinc deficiency. A plain x-ray of the pelvis showed bilateral osteosclerosis. His total alkaline phosphatase level was 28 U/L (reference range, 35–110 U/L). Other investigations for metabolic bone disease gave normal results, including one for vitamin D level. Among other nutritional parameters, his zinc level was 5.2 μmol/L (reference range, 10.0–18.0 μmol/L).

A computed tomography scan of the thorax and abdomen showed no evidence of malignancy, and a bone scan was consistent with Paget's disease. A zinc supplement was prescribed and his diet optimised.

At 6-week review, the serum zinc level had improved to 12.5 μmol/L, but the serum total alkaline phosphatase level was 250 U/L. This confirmed that the patient's acquired hypophosphatasia was secondary to zinc deficiency, with zinc being a critical cofactor for alkaline phosphatase activity.[4]

In light of the "correct" total alkaline phosphatase level, the patient was given intravenous pamidronate, with resulting marked resolution of his symptoms, including a 5-kg weight gain and normalisation of total alkaline phosphatase level.

Although this case is unusual, it nevertheless highlights the need to consider occult and coexisting nutritional morbidities in an elderly population.

1 Walsh PJ. Paget's disease of bone. *Med J Aust* 2004; 181: 262-265.
2 Lyles KW, Siris ES, Singer FR, Meunier PJ. A clinical approach to diagnosis and management of Paget's disease of bone. *J Bone Miner Res* 2001; 16: 1379-1387.
3 Gutteridge DH, Gruber HE, Kermode DG, Worth GK. Thirty cases of concurrent Paget's disease and primary hyperparathyroidism: sex, distribution, histomorphometry, and prediction of the skeletal response to parathyroidectomy. *Calcif Tissue Int* 1999; 65: 427-435.
4 Davie M, Davies M, Francis R, et al. Paget's disease of bone: a review of 889 patients. *Bone* 1999; 24 (5 Suppl): 11S-12S.
5 Milne DB. Trace elements. Chapter 30. In: Burtis CA, Ashwood ER, editors. Tietz textbook of clinical chemistry, 3rd ed. Philadelphia, Pa: WB Saunders, 1999: 1029-1055. ❏

Time for hard decisions on patient-centred professionalism

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TO THE EDITOR: Two recent articles in the Journal highlight the need to re-evaluate the collection of performance data in Australian healthcare, as well as the uses and analysis of these data.[1,2] Individual report cards are an extremely good and ethically mandated means of monitoring performance, especially when the information is given to patients as part of an informed-consent process.[2] However, it is possible to provide more valuable analyses than simple crude complication or mortality rates.

Cusum (cumulative summation) analysis was developed for industrial quality assurance to monitor production processes and detect subtle deviations from a preset, defined level of achievement. It can be applied to clinical practice to identify statistically significant improvements (or decrements) in performance, using agreed definitions of "acceptable" and "unacceptable" performance levels.[3,4] It can be risk-adjusted if necessary. Cusum analyses are routinely undertaken by the Geelong Hospital Department of Anaesthesia for monitoring performance of College-accredited trainee anaesthetists, and have been suggested by surgeons as a method for monitoring performance of a series of procedures.[5]

Although cusum analysis may seem highly threatening to many senior professionals, the support it provides and the cultural change it achieves in trainee anaesthetists have already been well documented in a unique Australian initiative.[4]

Modern regulatory theory describes three levels of regulation: the individual (micro), organisational (meso), and state or national (macro) levels. The personal professional monitoring program based on personal digital assistants (PDAs) and cusum analysis that was introduced for accredited trainee anaesthetists by Geelong Hospital operates at all these levels. It encourages reflection on individual performance by accredited trainees in a supported environment; organisational review by the supervisor of training within a clinical governance framework; and College supervision, collation and endorsement as part of a national training program.

The fact that the reporting structures inherent in this PDA-based model conform to these highest standards of regulatory theory and clinical governance confirms that the required professional change recommended by Irvine[1] can be easily achieved through mechanisms already operating in Australian hospitals. The model also achieves cultural change in the trainees and the highest incident reporting rate in modern healthcare (96.7%–100% voluntary reporting of critical incidents occurring in their practice).[6]

These two factors should mandate the wider introduction of the PDA-based program in Australian hospitals if the profession and the industry are to be taken seriously on this issue.

1 Irvine DH. Time for hard decisions on patient-centred professionalism. *Med J Aust* 2004; 181: 271-274.
2 Neil DA, Clarke S, Oakley JG. Public reporting of individual surgeon performance information: United Kingdom developments and Australian issues. *Med J Aust* 2004; 181: 266-268.
3 Bolsin SN, Colson M. Making the case for personal professional monitoring in health care. *Int J Qual Health Care* 2003; 15: 1-2.
4 Bent PD, Bolsin SN, Creati BJ, et al. Professional monitoring and critical incident reporting using personal digital assistants. *Med J Aust* 2002; 177: 496-499.
5 De Leval MR, Francois K, Bull C, et al. Analysis of a cluster of surgical failures. Application to a series of neonatal arterial switch operations. *J Thorac Cardiovasc Surg* 1994; 107: 914-923.
6 Bolsin S, Patrick A, Creati B, et al. Electronic incident reporting and professional monitoring transforms culture. *BMJ* 2004; 329: 51-52. ❏

Reducing drug-related harm: Australia leads the way

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To the Editor: Threatened with a surge of Athenian, one-eyed jingoism regarding Australian drug policy that the recent conference report by Ritter et al[1] might have elicited, we offer a warning.

Australia has achieved much to be proud of with its harm-reduction policies in recent decades. As Ritter et al attest, Australian researchers and practitioners are "leading the way" in generating political and community support for greater harm-reduction efforts. However, the implementation of real harm-reduction measures can hardly be described as "Olympian" under the current administration. Real Australian successes in the area of harm reduction have arguably occurred *despite* federal and state policy rather than because of it. Individual positions taken by clinicians such as Dr Alex Wodak, in the face of severe opposition and at times intimidation, account for much of this success. The sad reality is that the "Tough on drugs" approach currently pursued in Australia seems doomed to soon fuse with the Americans' globally denounced "War on drugs".

Real harm reduction can hardly be said to have been given a "fair go" in the past decade, with 85% of the total drugs budget in Australia committed to law enforcement — the paltry remainder split between research and treatment.[2] While harm reduction strategies have been widely implemented in response to the problems associated with injecting drug use, such strategies have not been nearly as popular in our responses to other types of drug use. Harm reduction is yet to be embraced as an effective response to the problems associated with the so-called "party drugs", despite mounting evidence of its efficacy in Europe.

Any premature triumphalism on the subject of harm reduction ought to be eschewed. Australia's recent heritage is quietly being betrayed at a federal level. A little-publicised federal report recently called for a move *away* from harm minimisation and harm reduction.[3] This is despite evidence indicating that functional drug use is emerging as "normal" rather than deviant behaviour among many Australians.[4] Clearly, we must redouble our efforts to ensure that harm reduction becomes a central part of Australia's public policy stance.

In an era in which it often seems easier to succumb to the whims of our larger neighbours than to resist them, it becomes even more important that doctors and health professionals, and particularly the younger generation of researchers, stand firm. We are, after all, standing on the shoulders of giants.

1 Ritter AJ, Wodak AD, Crofts JN. Reducing drug-related harm: Australia leads the way. *Med J Aust* 2004; 181: 242-243.
2 Wodak A, Moore T. Modernising Australia's drug policy. Sydney: University of New South Wales Press, 2002.
3 House of Representatives Standing Committee on Families and Community Affairs (HRSCFCA). Road to recovery: report on the Inquiry into Substance Abuse in Australian Communities. Canberra: AGPS, 2003.
4 Duff C. Drugs and youth cultures: is Australia experiencing the 'normalisation' of adolescent drug use? *J Youth Stud* 2003; 6: 433-446. ❏

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IN REPLY: Caldicott and Duff raise a very important question: is the federal government intending to soon terminate Australia's national drug policy of harm minimisation? This view can be supported by numerous and recent unambiguous speeches by senior government ministers, including the Prime Minister. The government would like Australians to believe that it is implacably opposed to a harm-minimisation approach to illicit drugs.

However, a different view appears when federal government funding allocations are examined. For example, the government allocated $215 million to the Illicit Drug Diversion Initiative over 4 years (in addition to a previous allocation of $221 million).[1] The intention of this Initiative is to divert selected drug offenders from the criminal justice system to drug treatment. These efforts are, in our view, highly commendable, reducing the use of expensive and largely ineffective custodial punishment and increasing the use of less expensive and more effective drug treatment. They are, however, irreconcilable with a "zero tolerance" or "Tough on drugs" approach to illicit drugs. Another example is AusAID's recent leadership in the introduction of harm-reduction measures to control HIV epidemics among injecting drug users in Asia.

It is also worth noting that the Ministerial Council on Drug Strategy (Australia's paramount official drug policy-making body since 1985) has repeatedly and recently endorsed a national drug policy of harm minimisation.

The present federal government, unlike its predecessor, frequently and stridently attacks emotionally charged symbols of harm reduction, such as the proposed prescription heroin trial or the Medically Supervised Injecting Centre in Sydney. However, as the allocation of substantial funding to the Illicit Drug Diversion Initiative demonstrates, in most respects it is very much a case of business as usual.

1 Australian Government Department of Health and Ageing. National Illicit Drug Strategy. Available at: http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pubhlth-strateg-drugs-illicit-index.htm (accessed Nov 2004). ❏

Consensus statement on diabetes control in preparation for pregnancy

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TO THE EDITOR: The "Consensus statement on diabetes control in preparation for pregnancy"[1] presents a counsel of perfection that is, regrettably, a cry in the wilderness in this most imperfect of all imperfect worlds. None will deny that the glycaemic target specified would represent a wonderful achievement in a woman attending in early pregnancy. Unfortunately, we are far from achieving this goal, for a variety of reasons.

Firstly, and most importantly, "preparation for pregnancy" is unusual. At our clinic (King Edward Memorial Hospital, Perth), where we see up to 90 women each year whose diabetes (types 1 and 2) antedated pregnancy, fewer than 15% have been seen for preconceptional counselling, and a similar proportion have an HbA_{1c} level below 7%. Moreover, at the same hospital, the rate of unplanned pregnancy in the general antenatal clinic exceeds 50%. Studies elsewhere have shown that the rate of unplanned pregnancy in women with diabetes is the same or greater,[2] and this figure accords with our own observations. Finally, in many women of reproductive age with diabetes, glycaemic targets as recommended by the Diabetes Control and Complications Trial Research Group[3] and the recent consensus statement[1] are infrequently met. One study of young adults in a type 1 diabetes clinic[4] revealed that ". . . only 3.4% . . . achieved an average HbA_{1c} of less than 7% during 11 years of study . . . despite regular specialist physician, specialist diabetes nurse and dietitian input and repeatedly following up failed appointments". Australian findings are probably not substantially better in this group.

Unfortunately, levels espoused by the above authorities are difficult to attain outside the sequestered environment of a clinical trial. Thus, the realisation of the St Vincent declaration,[5] which sought to normalise obstetric outcome for women with diabetes, has proven elusive. Statements that recommend ideal levels of glycaemic control before pregnancy, while laudable, are unlikely to improve the high rates of miscarriage, congenital abnormality, preterm birth and perinatal mortality that we observe.

What, then, can we do? The most important intervention in the care of fertile women with diabetes is effective contraception, with the aim of preventing pregnancy until adequate control of diabetes has been achieved. Numerous studies have shown that women who plan their pregnancy and attend for preconceptional care demonstrate better periconceptional glycaemic control and, accordingly, lower rates of adverse events in pregnancy.[6] Only by raising the matter of family planning repeatedly with all our younger female patients can we hope to avoid the disappointing observation of an unplanned pregnancy, with all its adverse consequences for the woman with diabetes and her baby.

1 McIntyre HD, Flack JR, on behalf of the National Diabetes in Pregnancy Advisory Committee. Consensus statement on diabetes control in preparation for pregnancy. *Med J Aust* 2004; 181: 326.
2 Holing EV, Beyer CS, Brown ZA, Connell FA. Why don't women with diabetes plan their pregnancies? *Diabetes Care* 1998; 21: 889-895.
3 Diabetes Control And Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *N Engl J Med* 1993; 329: 977-986.
4 Saunders SA, Wallymahmed M, Macfarlane IA. Glycaemic control in a type 1 diabetes clinic for young adults. *Q J Med* 2004; 97: 575-580.
5 Diabetes care and research in Europe: the Saint Vincent declaration. *Diabet Med* 1990; 7: 360.
6 Ray JG, O'Brien TE, Chan WS. Preconception care and the risk of congenital anomalies in the offspring of women with diabetes mellitus: a meta-analysis. *Q J Med* 2001; 94: 435-444. ❏

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IN REPLY: Walters and Senaratne raise two important points — that specific preparation for pregnancy is the exception rather than the rule, and that many people with diabetes (including women of childbearing age) demonstrate poor glycaemic control.

As a first step to improving this situation, we believe it is reasonable to set a goal. We sought to alert clinicians, especially those with limited experience in this area, to the importance of optimal glycaemic control in preparation for pregnancy. We hope that the consensus statement represents a “signpost” rather than a forlorn “cry in the wilderness”.

Many opinions were sought in developing the consensus statement. Some, for reasons similar to those given by Walters and Senaratne, thought the “$HbA_{1c} < 7\%$” goal too strict, while others believed it to be far too lax. In the end, we agreed to include this figure, with the proviso that the level of glycaemia should be the best achievable for each individual patient. We must educate women of childbearing potential with diabetes and their caring health professionals about the need for preconceptional diabetes control as part of their care. In some clinical circumstances, such as assisted reproduction, the timing of conception is actually determined by the treating doctor. In this setting, optimal glycaemic control should be a prerequisite for active treatment.

Rather than taking a nihilistic view, clinicians should devote their combined talents and energy to providing optimal pre-pregnancy care to those women with diabetes who do plan their pregnancies, to promoting pre-pregnancy care (including contraception) for those who currently do not, and to assuming an advocacy role in promoting access to and funding for intensive treatment programs for all people with diabetes. ❑

The other side of the coin: safety of complementary and alternative medicine

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TO THE EDITOR: The article by Myers and Cheras[1] is a good attempt to evaluate the safety of complementary therapies. However, I have one problem with it, which may be significant.

The authors rightly state at the outset that “the critical issue in assessing any therapy is its risk to benefit”. At the end of their article they consider the “wider public safety issues” and point out that the risks of complementary and alternative medicine (CAM) are minimal compared with those of conventional therapies. I think this is not quite logical. Comparing risks of therapies does not make sense, because the “critical issue” is the risk–benefit profile. Comparing the risks and benefits of, for instance, acupuncture for severe pain versus opioids for the same type of pain would, I think, favour the latter over the former, even though the risks of acupuncture are minimal compared with those of opioids. In other words, comparing absolute risks of treatments is tempting, but meaningless.

1 Myers SP, Cheras PA. The other side of the coin: safety of complementary and alternative medicine. *Med J Aust* 2004; 181: 222-225. ❑

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IN REPLY: We stand by our statement that “the critical issue in assessing any therapy is its risk to benefit”.[1]

Ernst appears to miss the point made in the subsequent two sentences — that this assessment is available for conventional medicine, but not yet for complementary and alternative medicine (CAM) therapies and products. In the absence of such data, society must be able to make an assessment of health practices and medicines based on their overall risk. Ernst himself has made significant contributions to this literature, and in fact three of his articles[2-4] were cited in our review.

The second criterion of the Australian Health Ministers’ Advisory Council Criteria for Assessing the Need for Statutory Regulation of Unregulated Health Occupations asks the question: Do the activities of the occupation pose a significant risk of harm to the health and safety of the public? Answering this question for the currently unregulated CAM professions involves consideration of the “wider public safety issues”. This forms part of the determination about the appropriateness of occupational regulation. The two comments juxtaposed by Ernst to make his point are not mutually exclusive. While awaiting the risk–benefit analysis, society will need to make decisions about the absolute risks.

1 Myers SP, Cheras PA. The other side of the coin: safety of complementary and alternative medicine. *Med J Aust* 2004; 181: 222-225.
2 Ernst E. Manipulation of the cervical spine: a systematic review of case reports of serious adverse events,1995-2001. *Med J Aust* 2002; 176: 376-380.
3 Ernst E, White AR. Prospective studies of the safety of acupuncture: a systematic review. *Am J Med* 2001; 110: 481-485.
4 White A, Hayhoe S, Hart A, Ernst E. Adverse events following acupuncture: prospective survey of 32 000 consultations with doctors and physiotherapists. *BMJ* 2001; 323: 485-486. ❑

Arrogance

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To the Editor: Patient arrogance definitely does exist and can complicate the process, described by Ellard, of "diagnosis, prognosis and therapeutics".[1]

I believe this state of affairs has arisen for two reasons. Firstly, from the evolution of "informed consent" linked to "patients' rights" — principles that need no elucidation. Secondly, as a consequence of the explosion of media and technology. Television has given us a surge of medical programs, especially of the so-called "reality" type, and technology has made information easily available on the Internet.

Unfortunately, patients become Internet surfers and surfers become patients. When they then present with symptoms, it is often armed with some knowledge — albeit of dubious quality and veracity. If the doctor does not provide a very accepting ear to these proffered "medical data", the patient often stops listening, becomes intransigent, and tends to prefer the media- or technology-generated opinion, including the suggested treatment for the semi-self-diagnosed disorder or illness.

I am reminded of one of Groves' subtypes of "hateful patients", namely "entitled demanders". He wrote, ". . . they use intimidation, devaluation and guilt induction. . . . The patient may try to control the physician. . . . Such patients often exude a repulsive sense of innate deservedness as if they were far superior to the physician."[2]

In my own practice, I had one such patient who would arrive and immediately intimidate my secretary by literally throwing his Medicare card on the desk in front of her and ordering her to turn off the radio that was tuned quietly to ABC FM. She has now retired, but, even 2 years later, says she will always remember him!

It takes considerable tact and skill to deflect and reduce the hostility of an arrogant patient so that he or she can ultimately benefit from the consultation. Perhaps it is best done by keeping in mind the fundamental principle *primum non nocere*.

1 Van Der Weyden MB. Arrogance [From the Editor's Desk]. *Med J Aust* 2004; 181: 409.
2 Groves JE. Taking care of the hateful patient. *N Engl J Med* 1978; 298: 883-887. ❏

Breaking bread together

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To the Editor: You recently commented on the closure of public hospital common medical dining rooms in the 1960s and 1970s.[1] Traditionally, these common rooms were a place where residents and senior medical staff met.

The closure of these facilities had more serious consequences than the loss of "breaking bread", as you quaintly put it. The daily meeting between residents ending their shifts and those starting work allowed discussion about the sickest patients — after the dining room closure, such discussions became much less effective. Helpful comments and advice from senior staff were no longer available. New medical advances and the strengths and weaknesses of the system were previously subjected to keen analysis, but all this medical "shop talk" was lost. More importantly, the closure of medical dining rooms contributed greatly to the loss of hospital *esprit de corps*, which included a sense of belonging to a worthwhile institution to which most of the medical staff were sincerely dedicated.

Medical dining rooms had a century-old history in the main state hospitals. I suspect that their closure had more to do with a Jacobin ideological mindset in health departments rather than being an "efficiency" move. Medical staff were not allowed to put tables together in the new refectory, as to do so might appear elitist. I remember going into the small staff room of my hospital at that time to have afternoon tea — a service provided to both lay and medical staff — only to be told by the medical administrator that "non-recoupable foodstuffs were no longer to be served to the medical staff". Meanwhile, the cleaners in their room next door were enjoying their hospital biscuits!

This was the beginning of the "doctor-bashing" era that only the older members of the public remember, and it is not unreasonable to claim that many of the public hospital problems in patient management stem from the actions of perverse individuals who undermined the cohesive and dedicated work of the medical staff, just as they did when they abolished the distinctive hospital uniforms and badges of the nurses, who had always taken pride in their own hospital traditions. A bland coloured gown was substituted to remind them that they were "health workers". No wonder there is difficulty in recruiting new staff and building a sense of dedication to such an amorphous service.

Administrators need to be reminded that good traditions should not be abolished without mature reflection on the consequences.

1 Van Der Weyden MB. Breaking bread together [From the Editor's Desk]. *Med J Aust* 2004; 181: 465. ❏

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To the Editor: I congratulate you on your column in the 1 November 2004 issue.[1] For years, I have stated that it is a problem, not only in the public hospitals, but now creeping into the private hospitals, that there is no private room available for doctors to talk among themselves. This also includes the theatres, where only one room is available for both nurses and doctors, and I think this is a giant mistake.

I remember that when I was a young doctor, consultations were arranged over lunch. Doctors talked to each other and everyone knew about the important cases in the hospital. It was a teaching and learning experience. In addition, in the afternoon, after one had finished work and was relaxing over the newspaper, again there was contact between doctors.

At St Margaret's Hospital, where I was the Medical Superintendent for fourteen-and-a-half years, between 1969 and 1984, I fought until the day I left to maintain these rooms. The dining room was lost, but at least there was a room where doctors could gather after they did their morning ward rounds. There was an enormous amount of work done and many opinions proffered in that room, and to this day many doctors tell me how much they miss that experience in the hospital they now attend.

Isn't there someone who can point out that, although the public health system is a shambles at present, we should not allow the private system to go down the same track? Sadly, it appears to be doing just that.

1 Van Der Weyden MB. Breaking bread together [From the Editor's Desk]. *Med J Aust* 2004; 181: 465. ❏

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TO THE EDITOR: Somerset Maugham noted, “At a dinner party one should eat wisely but not too well, and talk well but not too wisely”.[1]

Your recent column lamenting the disappearance of doctors’ dining and common rooms[2] precipitated a flood of warm memories of, in my case, St Vincent’s Hospital in Melbourne in the 1960s, 1970s and early 1980s.

Now based in the Latrobe Valley, Victoria, I have witnessed first-hand, over almost 20 years, much grievous political and social engineering — the abject failure of the first “privatisation” of a public hospital in Victoria and, in the custom-designed “greenfields” hospital, the near-complete lack of provision of facilities for consultant medical staff, leading to their fleeting meeting in corridors and carparks. It is unlikely that C P Snow had this in mind when he wrote of “corridors of power”.[3]

Contemporary medical staff are indeed an amorphous lot. The clinical white coat is but a memory, and often the only way to recognise a doctor, usually dressed in a manner that would suggest forthcoming involvement in a “Clean up Australia” gathering, is the fashionably appropriate half-noose stethoscope, which, akin to a saint’s halo, confers immediate status on the bearer.

Lae-nnec (my italics), who invented the stethoscope in 1819, had surely not foreseen the commercial potential of his epochal invention.

1 Maugham WS. A writerís notebook.London: Heinemann, 1949.
2 Van Der Weyden MB. Breaking bread together [From the Editorís Desk]. *Med J Aust* 2004; 181: 465.
3 Snow CP. Homecomings. London: Macmillan, 1956. ❑

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TO THE EDITOR: Your recent experience in a staff cafeteria[1] is clearly anecdotal, as are my own. I believe, however, the balance needs to be redressed.

There is little point in campaigning for “return of the doctors’ common dining room”, as, at least in the public sector, there are no funds available for this campaign. I have been very impressed with the camaraderie that exists in the staff cafeteria at Dandenong Hospital, Southern Health, because medical care is now a team approach and I have the opportunity to meet with medical students, interns, house medical officers, registrars, nurses and administrators, either over a cup of coffee provided free by the Health Service, or a meal. The staff cafeteria has been a meeting place for the team, engendering a team approach to medical care which, I believe, is appropriate to champion for the future of healthcare delivery in Australia.

1 Van Der Weyden MB. Breaking bread together [From the Editor’s Desk]. *Med J Aust* 2004; 181: 465. ❑

Correction

Re: “**Doctors in the Pacific**”, by Watters D A K and Scott D F in the 6/20 December 2004 issue of the Journal (*Med J Aust* 2004; 181: 597-601). The photo on page 599 was incorrectly ascribed “courtesy of Carolyn Bennett”. It should have read “courtesy of Carolyn Beckett”. ❑

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