Effective implementation of thromboprophylaxis strategies

We recently completed an audit of thromboprophylaxis for surgical patients at a major oncological centre. Despite a high awareness of the risks, over 50% of our patients were not receiving their risk-appropriate prescriptions of low molecular weight heparin. Correct use of mechanical prophylaxis was achieved in over 80% of patients. The practice of thromboprophylaxis varied substantially between different clinicians. Often no clearly designated doctor, surgeon, or anaesthetist was responsible in the team for implementing prophylaxis.

Patients should be classified into the risk categories suggested by the National Institute for Health and Clinical Excellence (NICE) at the earliest opportunity, such as in pre-assessment clinics, with local hospital protocols suggesting the most suitable prophylactic strategy and who should implement it. This will give a greater number of patients the benefit of evidence-based risk reduction.

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MULTIMORBIDITY’S MANY CHALLENGES

A research priority in the UK

Further to the three research areas Fortin et al identify for investigation, four additional aspects of multimorbidity are also relevant. Firstly, acute conditions also contribute to comorbidity, and there is no reason for their exclusion. Secondly, comorbidity is of particular relevance to primary care, which is person focused and not disease focused.

Thirdly, research on the mechanisms through which comorbid conditions interact is important for understanding the genesis of multimorbidity as well as its management; and fourthly, the implications of comorbidity matter in the assessment of quality of primary care and its financial restitution. The current financial incentives for general practitioners to provide high quality care focus almost exclusively on single conditions, increasing the likelihood of fragmented care.

Measuring comorbidity with the adjusted clinical group can help with all of these issues [1]. In the United Kingdom current specific collaborative research initiatives are focusing on multimorbidity in primary care, including the National Institute of Health Research’s School for Primary Care Research, founded in October 2006 as a partnership between the leading academic centres for primary care research in England [2]. The school’s main aim is to increase the evidence base for primary care practice, and one of its five core research programmes focuses specifically on comorbidity research.

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POLITICAL ILLITERACY

Many, but not all

While doctors’ current lack of political activity irritates Tudor-Hart, he wonders whether newer members of the profession may be less reticent than their forebears.

I hope so: a handful of us intend to stand at the next general election. We know that medical practitioners standing on an independent health ticket can be successful in getting elected to parliament—not once but twice in Dr Richard Taylor’s case.

A recurrent theme of some of my correspondents has been the supposition that an election campaign would have to be coordinated by the BMA or the LMCs, but I question that. A loose confederacy of independents would be far harder for existing politicians to combat and would introduce a long overdue diversity and excitement into national politics. Rudolph Virchow would be proud of us if we formed an effective parliamentary bloc.

Imagine if every constituency had an independent health candidate. You never know—we might win.

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Competing interests: SF is taking steps to stand at the next general election.

1 Hunter DJ, Why are so many people politically illiterate? BMJ 2007;334:1007. (12 May.)