

Older age *per se* has been well studied in the cardiology literature on management of myocardial infarction. However, in the literature on adherence to guidelines, few studies have attempted to fully identify the non-cardiac-related characteristics of those receiving guideline-discordant care. Krumholz et al reported that altered mental state is one factor, and that, of a large “real-world” cohort aged 65 or more, only 8% were considered ideal candidates for thrombolytic therapy.<sup>4</sup>

Quality healthcare involves multiple dimensions, including both personal and process factors. Practice guidelines are valuable tools to reduce practice variation, but we need to continue to evaluate whether they can be applied as broadly as may be advocated.

Surely, evidence-based guidelines can only be confidently applied to situations for which an evidence base exists. It will be important to test the application of guidelines in many settings, with attention to potential confounders, and, in particular, to outcome measures.

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**IN REPLY:** We thank Pearson for her kind comments and agree the design of our study<sup>1</sup> prevented identification of all patient factors that may, quite reasonably, impact on clinicians' decisions to administer specific treatments to older patients with acute myocardial infarction (AMI). These factors may also have precluded such patients from enrolment in clinical trials, the results of which underpin recommendations within clinical practice guidelines.

On the other hand, we know advancing age is an independent predictor of increased mortality after AMI, with several possible causes: age-related reductions in protective mechanisms (such as myocardial preconditioning),<sup>2</sup> presence of cardiac and non-cardiac comorbidities unaffected by treatments for AMI,<sup>3</sup> and — the focus of our study

— underuse of effective therapies in the absence of discernible contraindications.<sup>4,5</sup> While cognitive impairment, renal dysfunction and poor functional status may dissuade patients and/or clinicians from pursuing “aggressive” management, we have no evidence that these factors, singly or in combination, necessarily attenuate the benefits of specific interventions for AMI in patients at high baseline risk of cardiac death.<sup>6</sup> We also adjusted mortality comparisons between concordant- and discordant-care groups for multiple measures of illness severity at presentation which predict a poor prognosis.

Nevertheless, we support calls for more randomised trials of treatments for AMI and other conditions in older patients with liberal, “real-world” inclusion criteria in determining absolute risks and benefits of intervention in the presence of multiple comorbidities and impaired function.

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### A Quality Use of Medicines program for continuity of care in therapeutics from hospital to community

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**TO THE EDITOR:** Several studies have documented the high incidence of adverse events arising during hospital admission. The potential for discontinuity of care and poor communication is significant when patients are admitted to and discharged from hospitals, hence the Australian Pharmaceutical Advisory Council (APAC) has established guidelines to ensure continuity in the quality use of medicines.<sup>1</sup> A study reported in 2001 by Mant et al found very low compliance with a minimum dataset based on the APAC guidelines.<sup>2</sup> These

authors subsequently held workshops to identify problems, develop action plans and refine these strategies. However, the follow-up report, published recently in the *Journal*, reported little change in adherence to the minimum dataset.<sup>3</sup>

Why are providers failing to follow the APAC guidelines? Certainly, one cannot assume that the formulation and dissemination of guidelines will necessarily lead to their implementation.<sup>4</sup> To be effective, users must be aware of guidelines and convinced that they will add value to the way in which they work. Guidelines need to be credible and should make sense in the “real world”. Given the attitudinal barriers of some groups to the uptake of guidelines, multiple strategies are required to ensure their effective implementation. Among these is the involvement of key stakeholders in guideline development.

Who are the key stakeholders for ensuring continuity of care regarding therapeutics between hospital and the community? While Mant and colleagues report workshops involving general practitioners and hospital staff, their reports do not identify which hospital staff were involved.<sup>2,3</sup> Were clerical, pharmacy and junior medical staff included? These staff could make a critical difference in adherence to the minimum dataset. Furthermore, are these staff even aware of the APAC guidelines?

The APAC guidelines use the definition of discharge planning established by the Council on the Ageing (Victoria). This describes *people*, hospitals and community-based services working together — but the guidelines and associated minimum dataset place little importance on the patient. Patients' knowledge of their medications is discounted. Despite being mentioned in principles 4 and 6 of the APAC guidelines, patient knowledge of medication changes and satisfaction with the communication regarding medications is not considered in the minimum dataset.<sup>1</sup>

Strategies involving consumers should be explored as a mechanism for improving information exchange between hospitals and GPs. Similarly, an enhanced role for pharmacists warrants further consideration.<sup>5</sup> Certainly, further critique of the APAC guidelines and exploration of reasons for their poor uptake is important to ensure optimal patient outcomes.

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