

cal Tribunal is misleading.¹ The HCCC chooses its peer reviewer in any matter, investigates, recommends that the Board take action (or not), prosecutes matters at a hearing (or not) and is the only complainant allowed to appeal.² Clearly, the skills, methods, and decisions of the HCCC and the Board must be beyond reproach.

The HCCC selects peer reviewers to consult during the investigation of a complaint.³ They are paid to report on documents and to appear as witnesses before any committee or tribunal of inquiry — either before an in camera PSC of the Board or at a Medical Tribunal, chaired by a judge in open court. Peer review reports, which are legally privileged and generally inscrutable, may be selectively biased. My own involvement (as a complainant disallowed appellant standing from the PSC, and as an occasional consultant to a complainant and to the defence in other, separate psychiatric complaint matters) has led me to conclude that some peer review reports are inconsistent with minimal professional requirements or even duplicitous. Blind faith in a system comprising these two statutory bodies and an anonymous peer reviewer is inappropriate.

The NSW Administrative Decisions Tribunal (ADT) has judged disclosure of the membership lists of HCCC peer review panels to be in the public interest. In 1999, the ADT inquired into the selection of the list of psychiatrist peer reviewers when dealing with an application for disclosure based on the *Freedom of Information Act 1989* (NSW).⁴ The list proved to have evolved over an unknown period, through unknown differing methods (such as recommendations from unidentifiable practitioners or staff), for unknown precipitating reasons, and at unknown times. There was no general awareness within Medical Colleges or other medical associations of the selection process or of the members who may be thus empowered. This, when we know that, as a profession, we cannot be uniformly sensible, ethical or emotionally stable. The HCCC and the NSW Medical Board are thus vulnerable to corrupt influence.

The NSW Parliamentary Committee on the HCCC has sought submissions from the public and has been conducting an inquiry since November 2001 to determine necessary improvements to the functioning of the HCCC. I believe professional bodies need to take a resolute lead, declare their intentions, identify their roles, consult with their members and heed their responses. Ideally, each will clarify its policies and procedures for regulation and will demand

proper functioning from the agencies with statutory responsibilities.

1. *Medical Practice Act 1992* (NSW), No. 94, Section 87.
2. Hidden J, Supreme Court of NSW, 15 December 1995. *Shoulder v NSW Medical Board & anor*.
3. Adrian A, Commissioner, Health Care Complaints Commission. Guidelines for peer reviewers. An available commission document. Surry Hills, NSW: HCCC, July 2001.
4. *Dawson v Commissioner, Health Care Complaints Commission* [1999] NSWADT 57. Available at: <http://www.lawlink.nsw.gov.au/adt> (follow links to ADT decisions, 1999 [General Division], Page 2, No. 57). □

Brian C McCaughan

President, New South Wales Medical Board,
Gladesville, NSW.
MAL@doh.health.nsw.gov.au

IN REPLY: A Medical Board's role is to protect the public by ensuring that appropriate standards of conduct and practice are maintained by registered medical practitioners. In New South Wales, the NSW Medical Board administers the disciplinary provisions under the *Medical Practice Act 1992* (NSW). Included in this legislation is the Medical Tribunal/Professional Standards Committee (PSC) model that has been the subject of comment in recent correspondence. It is important to note that the Medical Board, the Health Care Complaints Commission (HCCC), the Medical Tribunal and PSCs are all independent bodies in their own right.

The Medical Board welcomes constructive comment on the system and its administration. It meets regularly with the major parties (HCCC, United Medical Protection, and the Australian Medical Association [AMA] as the doctors' professional body) to discuss the workings of the disciplinary system, to identify problems and shortcomings, and to develop solutions.

Inevitably, there will be aspects of the process that participants do not like — who enjoys being taken to court, in any circumstances? As in all legal and quasi-legal processes, the parties are unlikely to uniformly praise the impartiality or quality of witnesses, experts, and the judiciary. Processes are in place to minimise the possibility of conflict of interest, or the perception of bias. On the rare occasion when a panellist is challenged, a conservative approach is generally taken, and a replacement found.

Heber raises concerns about an inquiry extending beyond the parameters of the original patient complaint. In a protective jurisdiction, it would be quite wrong to limit a case to what the complainant had been able to articulate. Not infrequently, a patient's unhappiness is focused on what, from a medical perspective, is relatively minor, while seriously poor conduct or

practice is not recognised as such. The legislation specifically envisages an "inquiry", which, subject to natural justice requirements, may go beyond the original complaint. To deny this would be inconsistent with the protective nature of the jurisdiction.

The issues raised by Dawson and Gorman concentrate on procedures adopted by the HCCC regarding peer review and representation before hearings. The Board understands that the HCCC has a detailed policy document, prepared in consultation with stakeholders including the AMA and United Medical Protection, regarding the selection and utilisation of peer reviewers and expert witnesses. The Board is also aware of wider concerns in the legal system regarding the use of "hired guns" as distinct from impartial peers or experts, and when concerns have been brought to its attention suggesting even a perception of bias it has taken steps to address them.

The Board and members appointed to sit on PSCs and Medical Tribunals take their roles very seriously, and do so with a sense of professional responsibility, while acknowledging the difficulty of sitting in judgement on their peers. Criticisms are carefully considered and practices changed where appropriate. At all times, the Board must ensure that it acts fairly and in accordance with its charter of public protection. □

Childhood obesity: of growing urgency

Susan Goodman,* Peter R Lewis,†
Andrew J Dixon,‡ Cheryl A Travers§

* Health Service Executive Trainee, † Director,
‡ Health Statistician, § Postgraduate Student,
Central Coast Public Health Unit, Central Coast
Health, PO Box 361, Gosford, NSW 2250.
plewis@doh.health.nsw.gov.au

TO THE EDITOR: A number of recently published articles indicate that the prevalence of overweight and obesity in children is increasing at an alarming rate on a national¹ and international² level.

Overweight children are more likely to become overweight adults and to experience chronic health problems associated with adult obesity. We report results obtained from a survey of primary schoolchildren on the New South Wales Central Coast which extends the time series from that in the article by Magarey and colleagues (1985 and 1995 data)¹ to the year 2000.

We undertook a cross-sectional study of children at a Central Coast primary school

Prevalence of overweight and obesity in children aged 7–11 years for 1985, 1995 and 2000

Sex	Year	Number	Overweight (%)	Obese (%)	Overweight + obese (%)
Boys	1985 ¹	2425	9.7	1.5	11.2
	1995 ¹	457	11.6	3.7	15.3
	2000	141	16.3	9.9	26.2
Girls	1985 ¹	2443	11.0	1.9	12.9
	1995 ¹	430	17.2	6.3	23.5
	2000	127	21.3	7.1	28.4

in November 2000 as part of a community study. This study was approved by the Central Coast Health Ethics Committee.

All children in each class were asked to take part. With parental consent, weight and height were measured in children from all class groups (aged 7–11 years) by child health nurses using standardised procedures. Children were classified as overweight or obese using the standard international cutoffs for body mass index.³ They were compared with data obtained during the 1985 Australian Health and Fitness Survey (AHFS85) and the National Nutrition Survey of 1995 (NNS95).¹

A total of 268 children (127 girls, 141 boys) were surveyed (average of 25 girls and 28 boys of each age). This represented a 70% response rate. The Table shows that the incidence of overweight and obesity in Australian children has continued to increase, with relative risks for the increase between 1985 and 1995 of 1.37 (95% CI, 1.07–1.75) for boys and 1.82 (95% CI, 1.49–2.22) for girls, and relative risks for the increase between 1995 and 2000 of 1.71 (95% CI, 1.21–1.43) for boys and 1.21 (95% CI, 0.87–1.67) for girls. Our findings indicate a marked increase in proportions for boys in only five years since NNS95. While the increase for girls was not statistically significant, the pattern is consistent.

Thus, the incidence of overweight and obesity in Australian children is steadily increasing. Importantly, according to the 1996 Census Socio-Economic Indexes for Areas,⁴ the school we surveyed is situated in an area ranked in the middle quintile for relative socioeconomic disadvantage (state and national average), and is immediately adjacent to one 4th- and several 1st-quintile and 2nd-quintile areas. We believe our findings are representative of the Australian population of children.

The challenge to healthcare workers is significant. The National Health and Medical Research Council's *Acting on Australia's weight*⁵ identifies goals for preventing further weight gain in adults, and eventually reducing the proportion of the adult

population that is overweight or obese, and to ensure the healthy growth of children. Recommended strategies range from national dietary and physical activity guidelines to increasing physical activity through the design of towns, transport systems and public recreational facilities. Effective strategies are urgently needed to alter food intake and physical activity at individual, school, community and population levels.

1. Magarey AM, Daniels LA, Boulton TJC. Prevalence of overweight and obesity in Australian children and adolescents: reassessment of 1985 and 1995 data against new standard worldwide definitions. *Med J Aust* 2001; 174: 561–564.
2. Chinn S, Rona RJ. Prevalence and trends in overweight and obesity in three cross sectional studies of British children, 1974–94. *BMJ* 2001; 322: 24–26.
3. Cole TJ, Bellizzi MC, Flegal KM, Dietz WH. Establishing a standard definition for child overweight and obesity worldwide: international survey. *BMJ* 2000; 320: 1240–1243.
4. Census of population and housing: Socio-Economic Indexes for Areas (SEIFA), New South Wales. Canberra: Australian Bureau of Statistics, Aug 1996. (ABS Catalogue no. 2033.1.30.001)
5. National Health and Medical Research Council. Acting on Australia's weight. A strategic plan for the prevention of overweight and obesity. Canberra: Commonwealth Department of Health and Family Services, 1997. □

“Order effect” in the provision of medication information

Abilio C de Almeida Neto,* Timothy F Chen,†
Joyce H L Chan‡

*Research Academic, †Lecturer of the practice of pharmacy, ‡Research Scientist, Faculty of Pharmacy, College of Health Sciences, Building A15, University of Sydney, Sydney NSW 2006
abilio@pharm.usyd.edu.au

TO THE EDITOR: One concern that medical practitioners and pharmacists have about patient counselling is the uncertainty about the amount of information which should be given to patients, especially regarding possible adverse reactions to medications.¹ Studies have found that providing information on possible adverse reactions can affect patients' willingness to take the medication.¹

Research in cognitive psychology provides clear evidence that the order in which information is presented has a significant influence on judgement. Information

Two descriptions of a fictitious medicine for treatment of diabetes

A: Diabetic Medication

This medication is effective; it lowers sugar levels. It makes one feel better and boosts energy. It may cause nausea and headache.

B: Diabetic Medication

This medication may cause headache and nausea. It boosts energy and makes one feel better. It is effective; it lowers sugar levels.

received first is likely to have a disproportionately large effect on judgement, the “primacy effect”.^{2–4} Despite clear evidence supporting the “order effect” in diverse areas, research has not been undertaken to investigate whether the order effect is present in medication information.

To test the hypothesis that differently ordered sequences of the same information about a drug can result in different judgements,⁵ 804 subjects were presented with a short description of a fictitious medication. The descriptions were presented in one of two formats (Box): (A) positive–negative (therapeutic benefits followed by potential adverse reactions) or (B) negative–positive order (potential adverse reactions followed by therapeutic benefits). The surveys were randomly distributed to university students, mindful of the limitation of extrapolating the data to the general population. Subjects rated the medication (from very bad to very good) and the likelihood of taking the medication (from very unlikely to very likely) on seven-point Likert scales. For analysis, we used the independent sample *t* test, which is robust and therefore considered suitable for this analysis.

Of the 804 completed questionnaires, 403 were in the positive–negative order and 401 were in the negative–positive order. Participants given the positive–negative description of the medication rated it more positively (mean, 4.43; SD, 1.02) than those given the negative–positive description (mean, 3.70; SD, 1.62) ($P < 0.001$). Similarly, participants reported a higher likelihood of taking the medication when information was presented in the positive–negative order (mean, 4.23; SD, 1.62) compared with the negative–positive order (mean, 3.54; SD, 1.66) ($P < 0.001$).

We found that the order of presentation of medication information significantly affected judgement of the medication. Subjects rated the medication more favourably when positive information was presented first. These results suggest a