

it has been relegated to the private sector in Australia, and private hospital appointments that might include cosmetic surgery have been vigorously protected by special-interest craft groups in Australia. Misconceptions by the general medical community are rife, due to both the lack of exposure to cosmetic surgical procedures and the lack of information on the subject.

The assistance of the general practitioner, together with a thorough patient history, is very valuable in determining whether cosmetic surgery is likely to have a positive psychosocial outcome. Unfortunately, the generally poor attitude of the Australian medical community towards cosmetic surgery has led to patients being afraid of a negative response when asking their GPs about cosmetic surgery. Often referrals are either not made or are made by an anonymous practitioner, which is not an ideal situation.

Liaison with surgeons who have previously treated a patient is ideal, but cooperation in this area is not always forthcoming, as some surgeons fear litigation from former patients.

With most cosmetic surgeons being shut out of the medical mainstream, access to potential patients comes through normal commercial means, such as advertising in the Yellow Pages and in magazines. It is to be hoped that in future there will be more contact between cosmetic surgeons and other medical practitioners so that the true benefits and risks of the procedures can be understood by the general medical community, who, in turn, can counsel their patients in a sympathetic manner as to whether cosmetic surgery is advisable.

1. Castle DJ, Honigman RJ, Phillips KA. Does cosmetic surgery improve psychosocial wellbeing? *Med J Aust* 2002; 176: 601-604.

2. Hodgkinson DJ. Imagined ugliness: a symptom which can become a disorder [letter]. *Med J Aust* 2001; 174: 156.

3. Macgregor FC. Social and psychological studies of plastic surgery: past, present and future. *Clin Plast Surg* 1982; 9: 283-288. □

RARE SALAMI trial revisited

Helge H Rasmussen,* Peter S Hansen,* Gregory I C Nelson†

*Cardiologist, †Director, Department of Cardiology, Level 6, Main Building, Royal North Shore Hospital, St Leonards, NSW 2065 helger@med.usyd.edu.au

According to the article by Kennedy in the Journal,¹ we failed to address the objections to the RARE SALAMI trial (the Royal North Shore and Ambulance Regional Study of a Stenting Strategy as an Alternative to Lytic/Medical Therapy in Acute Myocardial Infarction) in our account of the fate of this trial.²

Allegedly, we contravened standard advice regarding emergency cardiac care ("to attend the nearest hospital emergency department as quickly as possible").¹ However, the standard advice is to call an ambulance,³ not to go to hospital by private transport. Kennedy also claimed that the trial would interfere with "... established therapeutic networks and ongoing therapeutic relationships, including relationships with hospitals".¹ The reason we ignored such objections was that the wellbeing of networks seemed unimportant in comparison with the welfare of patients with life-threatening illness.

The issue of the risk to patients of transport time and treatment delays with the new strategy was also raised,¹ but Kennedy did not challenge the actual measured delays or other published evidence we referred to.² These suggested that mortality was likely to be reduced with the RARE SALAMI strategy. Without reference to published data, he quoted the opinions of clinicians and a municipal council to support the opposite conclusion. The northern suburbs of Sydney are not so remote or exotic that opinion based on knowledge of the "local practicalities" he referred to¹ would outweigh the evidence of published data.

We argued that complexities of treatments, patients' condition and the pressure of time precluded fully informed consent.² Allegedly, established guidelines were breached.¹ However, the ethics committee, well aware of these, waived conventional informed consent after careful deliberation. A new area ethics committee, constituted subsequently,² concurred with this decision.

Now, in the light of new evidence, the RARE SALAMI trial, as originally proposed five years ago, can no longer be done. The recently presented DANAMI II study⁴ randomised 1129 patients to treatment with fibrinolysis at local hospitals or to transportation to angioplasty centres up to 153 km away. Transport was found to be safe, and angioplasty was associated with a 40% reduction in adverse outcomes. Field triage was not tested. However, we believe the results of the DANAMI II study now preclude randomisation of 50% of patients with suspected acute myocardial infarction presenting to the Ambulance Service (and eligible for the RARE SALAMI trial) to treatment at district hospitals. Ironically, in northern Sydney, status quo reigns and 100% of trial-eligible patients are taken to district hospitals and delays in achieving reperfusion persist!

Thiemann, in a recent editorial, concluded that accrued evidence now favours

treatment of patients with acute myocardial infarction in a few high-volume centralised angioplasty centres,⁵ and that field triage and direct transport to such centres holds great promise. He also deplored the lack of research into system changes and the economic self-interest that, he believed, had stymied change in the United States. Opposition to the RARE SALAMI trial was altruistic.⁶ However, it nevertheless stopped much needed research and hence may have compromised patients' rights to optimal care.

1. Kennedy MC. Clinical trials without consent: some experiments simply cannot be done. *Med J Aust* 2002; 177: 40-42.

2. Rasmussen HH, Hansen PS, Koyama Y, et al. Trial of a trial by media. *Med J Aust* 2001; 175: 625-628.

3. Heart Attack Every Minute Counts. Information from the Heart Foundation. Available at: http://www.heartfoundation.com.au/heart/index_fr.html (accessed September 2002).

4. The Danish Multicenter Randomised Trial of Thrombolytic Therapy Versus Coronary Angioplasty in Acute Myocardial Infarction. Presented as Late Breaking Clinical Trial at the 51st Annual Scientific Session of the American College of Cardiology. Abstract available at: <http://www.meetingcast.com/acc02wc/index.php3?l=faculty#andersen> (accessed September 2002). Slides of presentations available at: http://www.danami-2.dk/newslet/apr02/apr02main_results.htm (accessed September 2002).

5. Thiemann DR. Primary angioplasty for elderly patients with myocardial infarction [editorial]. Theory, practice and possibilities. *J Am Coll Cardiol* 2002; 39: 1729-1732.

6. Ryle G. A trial of the heart. *The Sydney Morning Herald* 2001; 29 March: 11. □

Michael C Kennedy

Physician, Manly Non-Invasive Cardiac Laboratory, Level 4, 22 Darley Road, Manly, NSW 2095 drmkenn@ozemail.com.au

IN REPLY: Rasmussen, Hansen and Nelson have missed the entire thrust of my article.¹ When an individual calls a health professional for help, we can assume he or she agrees to standard treatment, but not to be placed into an experiment. Failure to inform patients that they are being placed into an experiment is a denial of basic human rights. I outlined a mechanism by which it would be possible to conduct an experiment such as RARE SALAMI that would comply with the appropriate guidelines and avoid denial of informed consent.

It is worth noting that failure to inform patients that they have been placed in a clinical experiment could also worsen our present medical indemnity crisis and lower the standing of medical research.

It has been shown how institutional ethics committees can be subjected to local pressures.² As a result, it is possible some may adopt pseudolegalistic interpretations of accepted guidelines and approve studies that would be rejected elsewhere. This is another reason why informed consent is so important. Without it some studies simply can't be done.