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IN REPLY: In his letter, Gøtzsche is clearly under the misapprehension that, in using the figure of speech "gives the lie to", I am accusing him of lying. Nothing could be further from the truth. As he quotes, I applied that phrase to his *conclusions.* In my *Australian Oxford Dictionary*[1] to "give the lie to" can mean — and it is this meaning that I was applying — "*serve to show the falsity of a supposition*".

I was replying to Gough's response[2] to my editorial[3] on breast screening. He clearly showed that breast screening was unlikely to reduce overall mortality. I agree. I believe, therefore, that Olsen and Gøtzsche are wrong in supposing that analysis on the basis of breast cancer mortality is inappropriate, and that only overall mortality should be considered. Gough argues for this better than I can.

Being an editor of the Cochrane Breast Cancer Group does not require me to accept every supposition or conclusion in a Cochrane review. The whole point in publishing a scientific paper — as part of the Cochrane Library or in a peer-reviewed journal — is to open it, after appropriate review, to public scrutiny, scientific comment and even criticism. Their Cochrane review[4] has succeeded in achieving all of this.[5]

Lastly, I reiterate my comments in the editorial[3] that mammographic breast screening detects breast cancers that are "smaller, less likely to involve nodes and, if node positive, more likely to involve fewer nodes." In other words, if the TNM (tumour–node–metastasis) system means anything, there is a better prognosis with such breast cancers than with those detected clinically. Perhaps Gøtzsche needs to add a clinical oncology perspective to his undoubted expertise in the finer details of trial methodology analysis.

Competing interests: I am Chair of the Board of BreastScreen Victoria, and a member of the editorial group of the Cochrane Breast Cancer Group.

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COMMENT: The expression "give the lie to" has shifted its emphasis over the centuries, from the very direct "accuse (someone) of lying" to the much more abstract "show or imply (something) to be false". Some modern dictionaries, such as the *Macquarie Dictionary* (1997) and *Merriam-Webster* (2000), still give both meanings; others, such as the *New Oxford Dictionary* (1998), only the second. Large British and American databases, such as the *British National Corpus*, show that the phrase is usually used abstractly: one "gives the lie to" propaganda/a claim/an argument/a theory — whether in the context of academic discussion or political debate. The validity of an intellectual position is questioned, not the integrity of the person(s) associated with it. Yet, the simplicity of the phrase "give the lie to" probably gives the lie to the complexity of the challenge it expresses. ❑

The Australian Health Care Agreements 2003–2008: reform or false dawn?

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TO THE EDITOR: The articles by Reid[1] and Paterson,[2] former bureaucratic leaders of the New South Wales and Victorian health systems, respectively, on the process for developing the 2003–2008 Australian Health Care Agreements (ACHAs) are disappointing. They offer few original conceptual insights or clear proposals.

Reid's dream is that the 2003–2008 ACHAs will see "a new expression of national health policy on which funding decisions can be based". However, he presents only old ideas, such as "ACHAs will need to extend beyond public hospital issues to incorporate primary care", and, on the perennial cost-shifting between the two levels of government, "clearer lines of financial management of care and appropriate incentives are needed". Reid laments that the focus of all previous agreements has been "narrowly limited to one aspect of healthcare…the maintenance of universally accessible public hospital care free of charge".

Paterson does propose something radical, and the core of his proposals is that "the payer must stand *behind the patient* and not *between* the patient and the provider". The way to Paterson's "outcome-enabled health system" is to "relieve the constraints that bind inputs and distort the 'production' system". Does he mean we need more doctors and nurses, or does he mean substitutes should perform some of their current activities? Patterson proposes more investment in "information and communications technology" to facilitate a gradual move to "patient-based funding". Does this mean capitation, medical savings accounts, or is he proposing non-insurable copayments? Whatever it means, there will be "no outcome-driven healthcare until the system recognises the whole patient", and this will only be achieved with "electronic patient record systems in routine and ubiquitous daily use by providers".

Given their experience as senior health system administrators, it is a pity

neither Reid nor Paterson provide any explicit suggestions that recognise the key factor that will determine the outcome of the ACHAs. This is the policy gridlock that any federal system almost inevitably imposes.

A recent issue of the *Journal of Health Politics, Policy and Law* was devoted to health politics and policy in a federal system. The editor, Petersen, concludes with a view relevant to Australia: "You can love it, you can hate it, but ...federalism thwarts uniformity and universalism, frustrates responsiveness and policy analysis, limits large scale innovation while churning more localized mills of idea generation and promotion, and offers a permanent employment plan for health policy researchers".[3]

Parts of Australian health arrangements certainly need an overhaul. An example is general practice. This sector, differently organised and financed, could deliver much more to the community, the rest of the healthcare system, the Federal Government and to general practitioners themselves. Change in this sector would not depend on improbable cooperation between levels of government, and would be more manageable than the multifarious whole-of-system reforms about which Reid and Paterson speculate.

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Pertussis: adults as a source in healthcare settings

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TO THE EDITOR: In their article describing an outbreak of *Bordetella pertussis* infection, Spearing and colleagues report an adult contact who was infected with *B. pertussis* and was treated with roxithromycin.[1] In our experience, this is common practice in Australia, where roxithromycin is a frequently used macrolide antibiotic.

We are currently preparing a systematic review (registered with the Cochrane acute infections group) of the effectiveness of antibiotic therapy for treating pertussis. We have found no studies of the effectiveness of roxithromycin for either treatment or contact prophylaxis for pertussis infection. *B. pertussis* is sensitive *in vitro* to roxithromycin but 2–4-fold less so than to erythromycin.

While relying on the class effect of macrolides in eradicating *B. pertussis* and using roxithromycin in preference to erythromycin because of its lower side-effect profile may seem logical, there is no evidence to support this practice. In contrast, there is at least one study showing the efficacy of clarithromycin as an alternative to erythromycin for the treatment of pertussis.[2]

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IN REPLY: As we mentioned in our article, erythromycin is the drug of choice for treatment and prophylaxis of pertussis in people of all ages.[1] Several statements can be made about the use of macrolides in this condition.[2]

Firstly, erythromycin has been shown to decrease the duration of illness when given early in pertussis infection and to eliminate *Bordetella pertussis* from the nasopharynx.

Secondly, erythromycin therapy for index cases has been shown to reduce the rate of secondary cases of pertussis in households in uncontrolled studies.[3] However, in a recent randomised placebo-controlled study, while erythromycin reduced the incidence of culture-positive pertussis in household contacts there was no reduction in respiratory symptoms.[4]

Thirdly, clarithromycin and azithromycin have been shown to be at least as effective as erythromycin in treating pertussis in two small comparative studies.[5]

As Massie et al point out, there are no clinical studies of the use of roxithromycin in this condition, and laboratory in-vitro sensitivity studies suggest roxithromycin may be inferior to erythromycin.

Roxithromycin is the most widely used macrolide in Australia, but it requires a leap of faith and extrapolation to prescribe this drug for prophylaxis or treatment of pertussis. In the one case in our series where roxithromycin was prescribed, this was not our decision. We would have recommended erythromycin on the basis of the available clinical evidence.

Vaccination is preferable to antibiotic prophylaxis for long-term control of pertussis.

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Boundaries of medicine

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TO THE EDITOR: Van Der Weyden has asked a provocative question about the relevance of what he calls "medicine's homage to health".[1] In so doing, he pays his own homage to a world where boundaries are sharp and healing becomes reduced to a matter of applying "bioscience to matters of mind and body".

While I daresay many editors of biomedical journals would share his view, he is only highlighting an age-old tension. Indeed, Crookshank wrote in 1926 about the Ancient Greek schools of Cos and Cnidus, and of their debate about doctrines of the natural/descriptive and the conventional/aca-