

short durations, on circumscribed populations and under tightly controlled conditions.

A key, but often overlooked, issue is whether the results of studies are externally valid (generalisable). Indeed, the evidence base that dictates clinical practice and health policy should comprise data that are both internally and externally valid.

We do not suggest that epidemiological modelling replace longitudinal studies (in fact, modelling depends critically on robust prospective data); rather, it complements these studies by providing a means to assess their external validity.

We are also mindful of the limitations of epidemiological modelling, as outlined in our article,¹ and acknowledge the importance of ensuring rigour in the methods.

Our article dealt with generating the data needed for sound economic evaluation, by taking into account the long-term benefits, risks and costs of treatment strategies, and “real-life” health service conditions. This is distinct from the issue of whether “conditional listing” on the Pharmaceutical Benefits Scheme should be implemented for drugs that are yet to be proven cost-effective.

1. Lie D, McNeil JJ, Peeters A, et al. Epidemiological modelling (including economic modelling) and its role in preventing drug therapy. *Med J Aust* 2002; 177: 364-367. □

Screening mammography and mortality

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TO THE EDITOR: In a recent letter in the Journal,¹ Rodger writes that breast screening is unlikely to affect overall mortality and notes that this “gives the lie to the conclusions of Olsen and Gøtzsche’s overview, which are based only on overall mortality”.

English is not my first language, but according to my English-English dictionary “give the lie to” means either “to disprove” or “to accuse of lying”, and a related adjective is “mendacious”. In actual fact, however, in our Cochrane Review,² we carefully analysed both breast cancer mortality and all-cancer

mortality. We found breast cancer mortality to be an unreliable outcome that is biased in favour of screening. For deaths ascribed to any cancer, including breast cancer, we found a relative risk of 1.02 (95% CI, 0.95–1.10) for the two trials with medium-quality data,^{3–5} and a relative risk of 1.00 (95% CI, 0.91–1.10) for the only trial with poor-quality data that reported all-cancer mortality.⁶ If it were true that screening reduced breast-cancer mortality by 30%, as some Swedish researchers have claimed,⁷ then the expected relative risk for all-cancer mortality should not be greater than 0.95. These findings should raise concern rather than complacency.

Another, recent indication that things are not what they purport to be is provided by the results of the large Two-County study. A Swedish overview of the randomised trials reported a 10% reduction (95% CI, 0.73–1.11; absolute

reduction, 5.0/1000 to 4.5/1000) in breast-cancer mortality for one of the two counties,⁸ whereas the authors of the Two County study reported a 24% reduction (95% CI, 0.62–0.93; absolute reduction, 5.7/1000 to 4.3/1000),⁹ with the same type of statistics, within the same age group of women (40–74 years), and after a similar follow-up (1.2 v 1.3 million women-years).

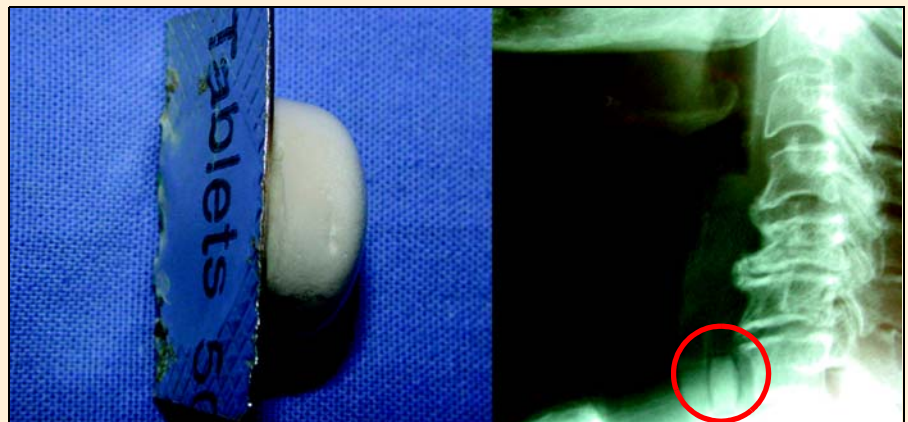
The conclusion in our Cochrane Review is: “The currently available reliable evidence does not show a survival benefit of mass screening for breast cancer (and the evidence is inconclusive for breast cancer mortality).” I would not have expected Rodger, as an editor of the Cochrane Breast Cancer Group that approved and published our Cochrane Review, to talk about “giving the lie” to our results.

Competing interests: None identified. The views expressed are mine and are not necessarily the views of the official policy of the Cochrane Collaboration.

snapshot

A bitter pill to swallow

AN ELDERLY PATIENT with diabetes presented with oesophageal obstruction after taking a regular dose of metformin. A lateral neck radiograph confirmed the presence of an obstruction in the upper oesophagus. The patient underwent rigid oesophagoscopy, at which time the tablet, complete with packaging, was removed (see Box). The patient went on to make a full recovery.



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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 response² to my editorial³ 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 review⁴ has succeeded in achieving all of this.⁵

Lastly, I reiterate my comments in the editorial³ 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 Breast-Screen 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 Reid¹ 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