MEDICAL EDUCATION
AND HARD SCIENCE
Medical education in Australia is a work in progress. Self-directed and problem-based learning have all but displaced didactic teaching. Some of our medical schools are now graduate-entry entities, and all have changed their entry requirements to a combination of academic excellence and performance at interview.

Curricula have been trimmed and made more cohesive. The hard sciences — anatomy, biochemistry, physiology, pathology, pharmacology and microbiology — now make room for behavioural and social sciences. These changes have been made to produce “a well-rounded professional [who] demonstrates: knowledge, clinical competence, lifelong learning, evidence-based practice, interdisciplinary teamwork, balance between disease management and disease prevention/health promotion . . .”* as well as communication skills and compassion!

But what do doctors think of all this?

Medical students in the UK and Australia have called for more, not less, hard science. At a crowded session at the national conference of the Royal Australasian College of Surgeons, a plenary panel of academics and surgeons lamented the downgrading of anatomy in medical courses and called for its revival, and a medical student’s account of his limited exposure to anatomy, his questioning of social sciences, and his sharing of the charades of problem-based learning was followed by thunderous applause clearly reflecting the audience’s sentiments on modern medical education.

Accommodating the wishes of medicine’s many splinter groups is unrealistic, but academia needs to consult with the profession more widely and counter the scepticism with solid educational evidence garnered not with soft but hard science.

*<www.hc-sc.gc.ca/hpbp/healthcare/pubs/social_accountability/index.html>
TO THE EDITOR: We report a case in which routine use of transesophageal echocardiography (TOE) during cardiac surgery almost certainly prevented a patient’s death. This is important, as the Australian Government Department of Health and Ageing has recently decided that TOE during routine coronary artery cardiac surgery should not attract a Medicare benefit as there is no Level 1 or 2 evidence of its efficacy.1

A 65-year-old man with critical aortic valve stenosis and severe left ventricular dysfunction, requiring an intra-aortic balloon pump, was scheduled for mechanical aortic valve replacement. He had been in atrial fibrillation intermittently, but was in sinus rhythm for the 24 hours before surgery and his heparin had been at therapeutic levels since balloon pump insertion 36 hours before.

Like most cardiac anaesthetists in Australia, we routinely perform TOE during cardiac surgery. Following induction of anaesthesia, TOE examination confirmed severe aortic stenosis and poor left ventricular function, but the left atrial appendage was not specifically examined and a routine preoperative transthoracic echocardiogram had shown no other abnormalities. With the patient on cardiopulmonary bypass, the diseased valve was replaced. Before weaning the patient from bypass, a TOE examination showed a large free 2.5 cm mass in the left atrium resembling thrombus (Box [a]). The surgeon then reported having invaginated the left atrial appendage while de-airing. While the patient was still on bypass, a large organised clot was removed from the left atrium (Box [b]) — this had presumably developed sometime during the preoperative period. Subsequent separation of the patient from bypass was uneventful, and he made a good recovery.

The thrombus would not have been suspected or found without the TOE, and almost certainly would have migrated from the left atrium into the left ventricle following the return of cardiac output, and would likely have precipitated a sudden cardiac arrest with acute valvular obstruction.

Despite the lack of Level 1 or 2 evidence, most cardiac anaesthetists and surgeons consider TOE an invaluable diagnostic and monitoring tool, particularly for assessment of left ventricular function and filling. While TOE has not rendered the Swan–Ganz catheter obsolete, it provides similar information with fewer complications.

This case is a dramatic illustration of the usefulness of TOE during cardiac surgery, but less dramatic examples occur much more frequently.

The Department of Health and Ageing decision not to support TOE (except in valve repair or replacement) seems shortsighted. While we support the Department’s evidence-based approach, it would be interesting to know how many procedures listed in the Medicare Benefits Schedule would withstand the same scrutiny. Randomised trials are difficult to perform, but, at the very least, TOE has excellent peer consensus, strong anecdotal evidence and large series reviews supporting its routine use in cardiac surgery.


COMMUNITY-ACQUIRED MRSA EPIDURITIS IN AN AUSTRALIAN PRISON INMATE

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TO THE EDITOR: Community-acquired methicillin-resistant Staphylococcus aureus (CAMRSA) infection is an increasingly recognised cause of skin and soft tissue infection, as well as more serious manifestations, including necrotising pneumonia, endocarditis, osteomyelitis and severe sepsis.1,2 We report another serious manifestation of CAMRSA infection.

A 24-year-old Australian-born white, HIV-negative, male prison inmate was transferred to hospital. He had previously injected drugs, but not for more than 2 years. He reported a 10-day history of cervical neck pain, left-sided pleuritic chest pain and a 2-cm occipital carbuncle, which developed after a laceration on the scalp from a close haircut with barber’s shears.

Examination revealed a temperature of 37.9°C, sinus tachycardia, profound neck stiffness and signs of left basal consolidation with a left pleural effusion. There were no focal neurological signs or other signs of meningitis. Investigations revealed a neutrophil leukocytosis of 22.7 × 10⁹/L (reference range, 1.7–7.0 × 10⁹/L) with mild elevation of hepatic transaminases and hypoaluminaemia.

CAMRSA was isolated from blood cultures and a swab of the occipital carbuncle. The organism was susceptible to erythromycin, vancomycin, rifampicin and fusidic acid.

LETTERS

Transesophageal echocardiography in routine cardiac surgery

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To the Editor: We report a case in which routine use of transesophageal echocardiography (TOE) during cardiac surgery almost certainly prevented a patient’s death. This is important, as the Australian Government Department of Health and Ageing has recently decided that TOE during routine coronary artery cardiac surgery should not attract a Medicare benefit as there is no Level 1 or 2 evidence of its efficacy.1

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Community-acquired MRSA epiduritis in an Australian prison inmate

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*Advanced Trainee, †Infectious Diseases Physician, Prince of Wales Hospital, Barker Street, Randwick, NSW 2031. j.post@unsw.edu.au

To the Editor: Community-acquired methicillin-resistant Staphylococcus aureus (CAMRSA) infection is an increasingly recognised cause of skin and soft tissue infection, as well as more serious manifestations, including necrotising pneumonia, endocarditis, osteomyelitis and severe sepsis.1,2 We report another serious manifestation of CAMRSA infection.

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Examination revealed a temperature of 37.9°C, sinus tachycardia, profound neck stiffness and signs of left basal consolidation with a left pleural effusion. There were no focal neurological signs or other signs of meningitis. Investigations revealed a neutrophil leukocytosis of 22.7 × 10⁹/L (reference range, 1.7–7.0 × 10⁹/L) with mild elevation of hepatic transaminases and hypoaluminaemia.

CAMRSA was isolated from blood cultures and a swab of the occipital carbuncle. The organism was susceptible to erythromycin, vancomycin, rifampicin and fusidic acid.
A chest radiograph showed extensive left-sided consolidation consistent with pneumonia. A magnetic resonance imaging scan of the entire spine revealed asymmetric thickening and enhancement of the epidural tissue from C2 to C5, with no discrete abscess, osteomyelitis or discitis.

The patient made a full recovery after 4 weeks of intravenous therapy with vancomycin (1 g every 12 hours) and clindamycin (600 mg every 6 hours).

This is the first reported case of epidural tissue infection (epiduritis) caused by CAMRSA, and adds to the spectrum of potential clinical manifestations. In addition, this is the first reported case of CAMRSA infection occurring in an Australian prison inmate. There have been several reported outbreaks of CAMRSA in US correctional facilities.3,4 Although no similar outbreaks have been described in Australia, clinicians should be aware that correctional facilities may contribute to the spread of CAMRSA.

The most common manifestations of CAMRSA infection in the prison setting in the United States are skin and soft tissue infections, with invasive infection occurring in 1.7% of patients.4

Clinicians providing care to inmates should be aware that strategies have been identified to reduce the incidence of CAMRSA infection.3 Clinicians need to be aware of the increasing incidence of CAMRSA infection, the diverse and potentially severe manifestations, and the treatment and preventive strategies available.


**Training our future rural medical workforce**

**Sandy Reid**

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To the Editor: The editorial by Wearne and Wakerman on the subject of rural training and its relationship to rural practice is timely.1

There is widespread belief that the rural problem lies in small country centres, and it is generally not realised that most of the regional centres, in New South Wales at least, are seriously short of both general practitioners and specialists. The statistics are highly unreliable, as many people, such as me, are listed as GPs even though we do not practise.

It seems likely that improved selection processes and the undergraduate rural training initiatives will increase student interest in rural practice. Many students express intent to practice in a rural or regional centre, but are later deflected from this by the necessity for training after graduation. Several large centres are not primary allocation centres, so a student who trained there may never get back. (The Australian Medical Students’ Association study puts the figure for rural internships as 9% of the total.)2 All too often, regional centres are understaffed, and junior staff lack adequate supervision and educational possibilities. Their negative experience is highly visible to students.

The allocation of registrars and senior resident medical officers, who supervise or make time for consultants to supervise, rests between the major hospitals and the various colleges. Regional hospitals are often low on their priority list when shortages occur. Yet there are regional hospitals that rate very highly in the quality of the training experience they provide. Regional hospitals that do not enjoy this reputation need to take active steps to improve their training and supervision or their plight will worsen.

Training packages also need to be developed for those who express an interest in rural practice so they can plan their future. This must be a collaborative process between the different seconding agencies: without such a process, much of the impetus of the undergraduate initiatives will be lost.


**Barney J McCusker**

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To the Editor: I recently had the opportunity to analyse the home post-codes of medical students at the University of Adelaide over five recent consecutive years. Although this analysis is rather simplistic, its findings are quite startling (see Box).

Between 50 and 60 students per year were from the Adelaide metropolitan area. My colleagues in the Department of Human Services tell me that we struggle every year to fill the junior posts at our metropolitan public hospitals.
A considerable number of students (25–41) were from outside South Australia. It is only natural that these students would want to go home after completing their degree, and I believe that considerable effort is made every year to encourage these students to stay and staff junior positions in our hospitals.

There has been much discussion about students from outside Australia and I will not add to the debate on this complex issue.

The most alarming feature is the small number of students from rural South Australia. This ranged from zero to three or four. Moreover, I have included in this category students whose home address was in the Adelaide Hills, which is between 5 and 20 km from the Adelaide metropolitan area.

We spend a lot of time encouraging students who grew up and were educated in cities to come to rural settings, using various schemes of bonding and financial inducement, with limited success.

After 18 years’ practice in a rural area, I am firmly of the belief that we should be starting much earlier. If a person is born and reared in the country, and has their secondary schooling in the country, it is much easier to transplanted that person back to the country after tertiary education.

If these figures of students’ home residence are representative, we will always be fighting an uphill battle to attract doctors to rural areas. This is not the fault of our universities, as they are constrained by federal regulations. I believe the solution lies in Canberra.

In our parliaments, we have proportional representation. As far as medical students are concerned, I think South Australia has disproportionate representation.

In 2003, CDAMS also commenced collecting data on interstate mobility (ie, students attending medical school in another state) among first-year medical students at the 12 medical schools. As a general principle, some level of interstate mobility brings positive benefits by fostering diversity in the medical student body and broadening educational and social opportunities for individual students. However, as McCusker rightly points out, this can create problems when interstate medical graduates choose to return to their home states (or move to other states) when they enter their intern training years.

In this regard, South Australia faces particular problems, as it has the highest proportion of students entering medicine from interstate. Box 2 shows that just under half of all commencing medical students at Adelaide and Flinders medical schools in 2003 were from other states. This may well have an impact when these students come to choose their intern training locations.

Box 3 sets out state averages for first-year students with a rural background. The figure for South Australia as a state suggests that it is reasonably comparable with other states. However, there is a sizeable gap between the rural student cohorts at Flinders and Adelaide medical schools: in 2003, 26% compared with 12%, respectively, were from a rural background. All medical schools in Australia have committed their energies to a range of collaborative programs, together with the Australian Department of Health and Ageing, aimed at ensuring a sustainable medical workforce that is equitably distributed across the nation.
Cancer in adolescents and young adults: treatment and outcome in Victoria

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TO THE EDITOR: We read with interest the article by Mitchell et al and the editorial by Cole on comparatively adverse outcomes in adolescents and young adults with cancer.¹,² The improvements in cancer survival, most remarkably demonstrated in children, have failed to similarly benefit older adolescents and young adults, a population with a higher and increasing incidence of cancer.³ Most authors advocate increasing research, networking resources and information, enhancing support for clinical trials and facilitating participation in them. Recently announced funding for a comprehensive cancer-care program for adolescents and young adults at the Peter MacCallum Cancer Institute in Melbourne is a welcome step towards these goals.

The specific emotional and psychosocial needs of this age group are also poorly addressed within traditional models of care.⁴ Patients in this group express strong preference for peer support, opportunities to be cohorted with each other and access to specific support services.⁴ The short and long term sequelae of cancer, as well as of its treatment, in adolescents and young adults create particular challenges for both healthcare professionals and the broader community. In December 2003, an entire issue of the European Journal of Cancer was dedicated to adolescent oncology — this science, clinical care and the needs of the patient population.⁵ An important development in the United Kingdom has been the establishment of eight “teenage cancer units” with a comprehensive approach to all aspects of care.⁶ Preliminary research in Australia and New Zealand by one of our group (JE) highlights gaps in service and support perceived by consumers, concerns yet to be addressed by appropriate policy and funding.⁷

The paediatric model of care has provided not only excellent survival but also an exemplary family-centred and comprehensive support system. The recent emphasis on the transition process for adolescents with a variety of chronic illnesses has highlighted systemic differences between the paediatric and adult models. Some paediatric oncologists, especially in the United States, have proposed raising the upper age limit for eligibility to childhood cancer units as a solution. A more realistic approach, particularly in Australia, requires establishing specialist facilities operated in partnership between (preferably collocated) adult and paediatric units, with subspecialisation of the multidisciplinary workforce, an age-appropriate environment and peer support from groups like the Australian Organisation for Young People Living with Cancer (CanTeen). This approach is capable of addressing all of the above issues, from better science through to psychosocial expertise appropriately targeted for age.

The ideal number and distribution of such centres/partnerships should be guided by the paediatric track record for balancing centralisation and quality with access and family focus.


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To the Editor: It has been claimed that patients are missing out on the most effective current treatments if they are not given an opportunity to enrol in clinical trials. Such statements are misleading and have the potential both to create concern in those without access to trials and to reduce the likelihood of true informed consent for involvement in trials.

Trials are, by definition, just that — trials. Treatment in the “innovative” arm(s) may result in worse outcomes. The finding that those involved in trials have a better outcome (eg, 5-year survival) may have numerous explanations. It is unlikely that the innovation is an adequate explanation for the finding — confounding factors such as selection bias, adherence to best current practice, and intensity of monitoring are more likely explanatory factors.

Furthermore, it is important to focus on other outcomes of therapeutic endeavour, such as quality of life, and the impact of the illness on other family members. Patients who live some distance away from tertiary referral centres or trial centres may have a greater adverse effect from involvement in a trial than other patients who live close to such centres.

Well designed trials are a crucial part of advancing medical therapeutics. However, the recent editorial by Cole and the article by Mitchell and colleagues in the Journal have been picked up by the news media as demonstrating that only through involvement in clinical trials can patients get best-quality care. It is not surprising that this is the way the message has been received. The truth is importantly different. It is only through the conduct of clinical trials that best practice can be defined. However, patients anywhere in the country should be able to access current best-practice treatment even if they do not want to be involved in a clinical trial. Encouragement to participate in clinical trials should be based on arguments about the “greater good” and not about issues of quality of care. To use the latter as the basis for argument must be seen as coercion and as unethical.


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In reply: Thomson is correct in stating that patients involved in clinical trials have better 5-year survival rates when compared with patients not recruited into clinical trials. There may, as Thomson points out, be numerous possible explanations for this finding. Nonetheless, this improvement in survival is well documented and has been recognised for some time.

Although it is becoming increasingly important to focus on other therapeutic outcomes, such as quality of life, it is incorrect to assume that involvement in clinical cancer trials equates to impairment of quality of life and an increase in adverse effects. In fact, the primary end-point of numerous clinical cancer trials is improved quality of life.2

We agree with Thomson when he states that patients anywhere in the country should be able to access current best-practice treatment. We agree that best-practice treatment can only be defined through the conduct of clinical trials. Well designed clinical trials are necessary, and indeed crucial, to the advancement of cancer therapy. In the context of adolescents and young adults with cancer, the lower than expected improvement in survival may be explained, in part, by a low rate of participation in clinical trials.3 There is no doubt that participation in late-phase clinical trials provides a “benchmark” and ensures the provision of quality medical care. Rural and regional settings should not, a priori, be a barrier to trial participation. Adequate infrastructure and support should be available for such centres to participate.

Greater cooperation between all adult and paediatric clinicians involved in the care of adolescents and young adults with cancer is essential to ensure that the inequity in survival is corrected.


Thyroid nodules and thyroid cancer

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To the Editor: Mackenzie and Mortimer presented a useful review of the management of thyroid nodules and thyroid cancer.1 In their section on follow-up, they did not mention premature menopause — a clinically relevant side effect of radioactive iodine therapy which seems underinvestigated in the literature and not necessarily considered during post-radioiodine management. Its impact was highlighted by the recent general-practice presentation of a 42-year-old woman with a small thyroid nodule. She had been previously well except for a 5-year history of treated hypothyroidism secondary to Hashimoto’s thyroiditis. Investigation revealed a 2 cm papillary thyroid carcinoma, which was managed by total thyroidectomy and clearance of anterior-compartment cervical lymph nodes. Five of 21 nodes...
had deposits of papillary carcinoma. The patient was treated with a standard course of radioiodine.

She presented 6 weeks after completing the radioiodine therapy with sudden onset of symptoms of oestrogen deficiency (delayed menstruation, flushes, tiredness and vaginal dryness). Her menstrual cycle had been previously normal, and she had no family history of premature menopause. Investigations confirmed typical menopausal hormone levels (follicle stimulating hormone, 48 IU/L [menopausal range > 30 IU/L]; and oestradiol, <150 pmol/L [menopausal range, 70–200 pmol/L]). Symptoms resolved after she began hormone replacement therapy.

A recent retrospective cohort study found that radioiodine treatment may predispose to early menopause. The patient had not been told of the possibility of this complication, and her surgeon was unaware of the link.

Two clinical lessons arise. The first is that discussion about premature menopause should be a routine part of pre-treatment counselling for women of late reproductive age contemplating thyroid ablation. Secondly, as hospitals and general practitioners are increasingly choosing to share care of patients with cancer, all stakeholders should consider the possibility in follow-up strategies.

The human oocyte appears to be relatively radioresistant, with an LD\textsubscript{50} calculated at <2 Gy. The ovarian dose from remnant ablation is much lower than this (32–162 mGy for a 4 GBq dose of radioiodine). However, it is possible that the ageing ovary is more radiosensitive. The article by Ceccarelli and colleagues, quoted by Russell, shows that the proportion of women with amenorrhoea in a group treated with radioiodine for thyroid cancer was identical to the proportion among controls up to the age of 47 years. The proportions then diverged so that, by the age of 51 years, 29% of treated women were still having menstrual cycles, compared with 49% of control women.

It is difficult to be sure that Russell’s 42-year-old patient had radioiodine-induced amenorrhoea. Her amenorrhoea may be temporary, and withdrawal of hormonal treatment may be warranted to investigate this.


Olympic medals or long life: what’s the bottom line?

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To the Editor: We agree with very few of the conclusions in the recent article by Mitton et al. \textsuperscript{1} It is fascinating that the authors single out elite athlete funding as being the only notable area of discretionary government spending that prevents more from being spent on healthcare. We suspect that the authors share the widely-held view within the healthcare professions that sport is an indulgence rather than a contributor to the good health of this nation.

Sports medicine is the only recognised branch of medicine in Australia that is considered an “area” of medicine (all other recognised branches being considered “specialties”), a view held by both the Health Insurance Commission and the Australian Medical Association. Therefore, an Australian athlete who suffers a sports injury and is referred to a sports physician receives lower Medicare rebates for the visit than all other patients referred elsewhere in the system, and is unable to claim any Medicare rebate if he or she requires a magnetic resonance imaging scan for an injury, again the only such example in the Australian healthcare system. \textsuperscript{2}

Injuries which occur as a result of traffic accidents, workplace accidents, falls, assaults and suicide attempts are all monitored by various government departments, with priority funding specifically directed towards their prevention. The federal government in Australia directs no funding towards sports injury monitoring or prevention \textsuperscript{3} and does not devote sufficient resources towards making the population more active. \textsuperscript{4}

The article by Mitton et al ignores the concept of efficiency (in terms of prolonging life) within healthcare spending. Health promotion and prevention of illness and injury are far more efficient ways of prolonging life than treating existing disease (compare smoking cessation programs with coronary care units). Lack of sport and exercise is an increasingly prevalent risk factor for major diseases. \textsuperscript{5} The use of elite athletes as role models may or may not contribute to a more active population—we suspect the former. We also believe that the disrespect shown within the Australian healthcare system towards sports injuries (compared with other injuries and illnesses) is a major disincentive for Australians to become more active. This is a disincentive for which we will pay a high penalty in terms of decreased life expectancy and increased healthcare costs in the future.


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IN REPLY: As Russell indicates, there are suggestions in the medical literature that radioiodine ablation of thyroid remnants in women with thyroid cancer may be associated with temporary menstrual irregularity or premature menopause. The study he quotes is retrospective and does not take into account the periods of profound hypothyroidism that necessarily precede radioiodine treatment. \textsuperscript{1}


In reply: We thank Orchard and Finch for their letter about our article comparing spending on the Sydney Olympics to expenditure on healthcare for Australia, Canada and Britain. The reason we “singled out elite athlete funding” was simply to choose a high profile expenditure as an illustration that government does indeed make decisions about priorities with the limited societal resources available. While we would strongly agree, and in fact state, that “spending more on athletics may improve the health of the population”, the necessary public debate about how societal resources should be best spent is lacking.

In our view, such a debate should be informed by the costs and wide-ranging benefits of government expenditure and be based on clearly articulated public values. Contrary to the claim that we “ignore the concept of efficiency”, it is precisely here, when costs and benefits of alternative claims on limited resources are explicitly compared (both within healthcare and across government sectors), that the notion of efficiency is addressed. Upstream investment in promotional activities may well be an appropriate way to spend health and non-health dollars — let’s just make these choices, and the underlying values, explicit.


An audit of obstetricians’ management of women potentially infected with blood-borne viruses

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To the Editor: Giles et al have “poisoned the well” for future research by attacking the obstetricians who took the trouble to help them with their study on management of hepatitis B virus (HBV), hepatitis C virus (HCV) and HIV.

Many of the discrepancies noted between current practice and the recommendations/guidelines are easy to explain:

- Failure to screen. Many obstetricians were told that it is discriminatory to screen for HIV and HCV without extensive pretest counselling. The advice is obsolete, but old habits die slowly.
- Failure to recommend caesarean section for women with HIV. Many obstetricians have never seen a case of HIV and would most certainly phone for advice if the situation arose.
- Failure to promote breastfeeding. Many obstetricians leave advice on breastfeeding to the midwives and paediatricians. However, the article does concede that mother-to-baby transmission is a theoretical risk, so patients are entitled to be informed.
- Failure to adhere to guidelines. Many obstetricians regard guidelines issued by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) as just that — guidelines, not gospel.
