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Interventions to halt child abuse in Aboriginal communities

Fiona J Stanley, Dorothy A Scott and Melissa O'Donnell

To the Editor: The recent editorial by Ring and Wenitong[1] about interventions to prevent child abuse in the Northern Territory highlights the importance of treating the causes as well as the symptoms. This is true not only for children in remote Aboriginal communities, but for all children across Australia.

Child abuse and neglect is not a "new" national emergency. In 1966, Bialestock[2] wrote in the Journal:

> This situation should be considered as a national emergency as lethal to the lives of potential Australians as is a war. Immediate allocations of revenue to prevent this situation should be made if the[se children] . . . are to be allowed to grow into adults able to live in dignity and to work to contribute to our economy. We must not sentence these children to a lifelong need for State support.

There are no reliable prevalence data, but Australian Institute of Health and Welfare data indicate that there were 266 745 notifications of suspected child abuse and neglect in Australia last year, double the number 6 years ago. About one in five of these notifications were "substantiated". Over 25 000 children are in state care at any one time, an 82% increase in the past decade.[3] Our child protection systems are at risk of imploding under the strain. These systems are also potentially dangerous, with high levels of multiple placements contributing to the very high prevalence of mental health problems among children in care.[4]

The contributory factors are well known. Children with disabilities, chronic health problems, difficult temperaments and externalising behaviours, families where there is domestic violence and parental mental health or substance misuse, and communities characterised by poverty, unemployment, higher residential mobility, and a low adult to child ratio are at much greater risk.

We must close the gap between what we know and what we do. A public health approach is needed to reduce the risk factors, using population-based measures of child abuse and neglect, and tapping the potential of universal health, welfare and education services as platforms for primary and secondary prevention.

In relation to health services, the adequate provision of universal maternal and child health services, including sustained nurse home-visiting programs, is vital. General practitioners and mental health and drug treatment services using child-sensitive and family-centred approaches also have a major role to play. These interventions have also been shown to improve overall outcomes for children in education, health, and social and economic participation. Hence, economists have suggested that they are the most cost-effective intervention for a nation.[5]

Now is the time to ask whether governments are really serious about preventing child abuse and neglect.

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Radiographers' role in radiological reporting

Wayne J Nuss

To the Editor: I congratulate the Journal for publishing the article by Smith and Baird on the radiographer's role in radiological reporting.[1] It demonstrates the Journal's objectivity by providing an opportunity to examine a health service model that, if carefully implemented and evaluated, may enhance outcomes in diagnostic imaging within a clinically useful timeframe.

It is quite understandable that the Royal Australian and New Zealand College of Radiologists (RANZCR) would move quickly to defend its professional jurisdiction. However, in their editorial published in the same issue of the Journal,[2] Kenny and Andrews, representing the RANZCR, seem to have overlooked the contribution of the Smith and Baird article to the development of new models of health care delivery. Further, their defence ignores the reality that, in the Queensland public hospital system, for example, diagnostic imaging is conducted in 108 centres but radiologists are only present at eight of those centres.

The past three decades have seen rapid technological change, resulting in an array of diagnostic and interventional imaging modalities and providing a challenge to 21st century radiologists. However, plain radiographic images were being interpreted by non-radiologists for two or more decades before the medical specialty evolved.[3] Alerting rural general practitioners and junior medical officers in emergency departments to abnormal features on plain films is a work practice that radiographers have always performed. Image interpretation in plain radiography is a skill they are exposed to every day of their working lives. Formal postgraduate training would develop that skill and formalise the practice.

The nurse practitioner model developed because of identifiable health care service deficiencies, particularly in vulnerable, underserved communities.[4] Similar service gaps exist in diagnostic imaging. The maldistribution of radiologists in Australia will never change, for economic and lifestyle reasons. There will never be a radiologist to supervise, advise, report findings and communicate results of plain radiographs at 3 am in a provincial hospital — nor in a metropolitan emergency department, for that matter. The radiographer will be there, however. It is time that due recognition be given to radiographers and enhanced training provided. The RANZCR, as the responsible body of medical professionals, owes it to the communities that they are unable to serve.

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Alan Rodger

To the Editor: On the basis of the recent traumas experienced by the United Kingdom in rolling out its Modernising Medical Careers program, you warn the Royal Colleges to “resist political pressure to solve medical manpower problems created by governments”.[1]

Kenny and Andrew,[2] representing the Royal Australian and New Zealand College of Radiologists (RANZCR), clearly link the need to cope with increasing demand for diagnostic imaging with the drive to allow non-medical staff to develop roles previously reserved for the medically qualified — and they oppose much of this.

Meanwhile, Smith and Baird[3] argue cogently — and supported by evidence, rather than conjecture — that there is a place for allied health professionals with appropriate training and education to take on some of the more traditional medical roles.

Each group could be arguing from a position of self-interest. The representatives of the RANZCR (surprisingly) do not mention reimbursement of radiologists,[2] while university teachers advocate a wider role for their institutions.[3] The arguments are further mired by the assumption that role development or delegation is and should only be driven by unmet service demand.

That need not be. Smith and Baird,[3] in describing many of the UK developments, correctly assume that service demand is a driver, but that is not always the case. In diagnostic and therapeutic radiography in many parts of the UK, such as Scotland, the process of role development is seen as a natural progression in training and work practice that allows individuals to develop the skills they are capable of using. This is not merely a process reserved for areas of understaffing. In fact, medical staff have extra roles — in training, mentoring and supervising. They are also able to free up time for more demanding medical work. Notably, resistance to such change (of which I see very little in therapeutic radiography) is not confined to medical staff: major opposition is often expressed by radiographers and their managers.

Thus, the process of role development of *all* clinical staff requires close cooperation between all professional and educational bodies. That is a proper role for a medical college — rather than that of a trade group protecting its patch or resisting change.

Personally, I find it highly enjoyable to practise with experienced, motivated nursing and allied health colleagues who have been trained to perform these enhanced tasks.

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Towards the appropriate use of diagnostic imaging

Lizbeth M Kenny, Stacy K Goergen and Catherine J Mandel

To the Editor: The views of Mendelson and Murray[1] regarding inappropriate use of diagnostic imaging and how it might be reduced are timely and important. Unless governments, doctors, the medical imaging industry and consumers acknowledge the significant barriers to Mendelson and Murray’s proposed changes, the number of inappropriate tests will grow.

The authors argue that radiologists need to be more active in vetting requests. This is often hindered by the lack of relevant clinical information from referrers about the indications for tests. Broadhurst et al[2] found that 34% of unselected Australian requests for shoulder ultrasound contained “no tangible information to assist the radiological examination”.

Surveys of doctors in the United Kingdom found that their knowledge of the radiation delivered by various imaging tests, relative to that of a chest x-ray, was poor.[3] This lack of knowledge makes it difficult, if not impossible, for doctors to inform patients about the risks and benefits of an imaging test.

The Quality Use of Diagnostic Imaging (QUDI) Program of the Royal Australian and New Zealand College of Radiologists was set up in 2004 to develop a knowledge base of evidence-based best practice in radiology. To date, it has commissioned over 25 quality-related projects in areas such as development of information for consumers, best practice standards for radiology requests, and audit–feedback analysis of radiation dosage in paediatric computed tomography. The QUDI Program and the National Institute of Clinical Studies have sponsored fellowships in evidence implementation, training radiologists in the art and science of supporting clinicians’ use of evidence-based, appropriate diagnostic imaging. The results of QUDI projects are used in strategies to improve the use of radiology.

The Australian Medical Association is advocating that general practitioners have access to magnetic resonance imaging, arguing that it would reduce costs and radiation exposure.[4] However, this does not address the issue of appropriate consultative referral, and has the potential to simply add to the burgeoning diagnostic imaging budget rather than directly benefiting patients.

A multifaceted approach to change is required, involving the referrer, the consumer and the entire radiology industry. This must be based on best-practice, patient-focused use of radiology. Radiologists are central to providing advice on the most appropriate imaging procedures and reducing the burden of inappropriate imaging. This is likely to require changes to practice and to legislation.

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Oliver R Frank

To the Editor: The authors of the editorial “Towards the appropriate use of diagnostic imaging”[1] canvass possible strategies to improve the appropriateness of requests for diagnostic imaging. One strategy that research suggests may be effective is feedback provided by the providers of diagnostic services.[2,3] Discussion of the feedback could, and should, be supported by federal government funding, perhaps via Divisions of General Practice, and should attract continuing professional development points for the general practitioners involved.

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Richard M Mendelson and Conor P J Murray

In reply: We thank Kenny and colleagues for their comments and congratulate the members of the Quality Use of Diagnostic Imaging (QUDI) Program of the Royal Australian and New Zealand College of Radiologists on their continuing efforts. We are also grateful to Frank for his constructive suggestion.

We entirely agree that a multifaceted approach is needed to improve the appropriateness of referral for diagnostic imaging. We believe that the majority of general practitioners are willing to be educated and guided with regard to their referring practices. However, to do so they require up-to-date guidelines that are easily accessible in electronic form, based on evidence *and consensus*, practicable and able to be integrated into their everyday desktop applications,[1] much like pharmaceutical guidelines are currently. The QUDI Program has chosen to focus on producing guidelines on selected topics, while we, with our "Diagnostic Imaging Pathways",[2] have chosen to work towards a more comprehensive clinical decision support and educational application. Of course, the two approaches are entirely complementary.

It also behoves radiologists, at an individual level, to interact with their referrers, to vet requests (ensuring that requests are appropriate and contain adequate clinical information, as emphasised by Kenny and colleagues) and act as the consultants they were trained to be. Sometimes this may be to their short-term economic detriment. However, one hopes that such short-term disadvantage would be countered in the longer term by greater professional satisfaction and a better relationship with referrers, who are likely to remain loyal to those radiologists on whom they can rely for advice and education in addition to trustworthy image interpretation.

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Maternal mortality and psychiatric morbidity in the perinatal period

Phillip M Boyce and Jodi Barton

To the Editor: Austin et al[1] bring to our attention findings from the report on maternal deaths in Australia in which 26 suicides were reported, making it one of the leading causes of indirect maternal deaths in the perinatal period — a finding consistent with the Confidential Enquiries into Maternal Deaths report from the United Kingdom.[2] These reports raise the issue of the importance and risk of maternal mental illness in the perinatal period.

While this high rate of suicide is unacceptable, it needs to seen in context: this is a rare event overall, representing a standardised mortality ratio of 1.14 per 100 000 women. This is considerably lower than the suicide rate for women in general, which ranges from 3.6 per 100 000 in the 15–19-year age group to 6.4 per 100 000 in the 25–29-year age group.[2,3] This comparison verifies the observation made by Appleby that suicide rates are low during the perinatal period.[4]

Austin et al recommend that psychosocial screening, in conjunction with ongoing mental health monitoring and clear referral pathways, should be made available to women in a maternity setting as part of the solution to preventing the "relatively high" rate of early maternal suicide. But to date, antenatal screening programs have proven costly to implement, can produce large numbers of false positives, are often poorly accepted by antenatal care providers (as they add to the administrative burden), and do not result in greater uptake of services by at-risk women.[5]

Remarkably, 40% of the suicides reported by Austin et al occurred in the first trimester, predominantly before women had attended an antenatal clinic and before any psychosocial screening. A number of the suicide cases were already under the care of mental health services, and screening may not have prevented the tragic outcomes.

We believe the answer to this problem is for appropriately resourced, accessible and publicly funded specialised perinatal psychiatric services to be put in place (including dedicated mother and baby units) so that high-risk women can be appropriately treated. In providing such services, we would need to develop appropriate strategies to engage mothers who need support from psychiatric services. This concurs with the National Institute for Health and Clinical Excellence perinatal mental illness guidelines,[6] which advocate for the identification of pertinent risk factors (such as personal and familial mental health history) and assessment of current distress (through targeted interviewing). Screening is recommended to monitor outcomes but not to dictate clinical decision making.

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Marie-Paule Austin

In reply: Boyce and Barton raise a number of points.

Firstly, with respect to their critique of the 2006 *beyondblue* postnatal depression report,[1] there are, to date, no studies assessing the cost of antenatal screening programs. Furthermore, while false positives are a feature of all screening programs, that, in itself, is not a deterrent to using antenatal screening if the rate of false positives is considered acceptable. While midwives have concerns about undertaking routine psychosocial assessment, uptake of such a program can be done through adequate training and support of staff, as now demonstrated in a number of sites around Australia.[2] With respect to the inadequate uptake of services by "high-risk" women, these are generally poor in the psychiatric clinic setting[3] and would not be expected to be different perinatally.

Secondly, the authors report that "a number of the suicide cases were already under the care of mental health services, and screening may not have prevented the tragic outcomes". This overlooks one of the key attributes of routine psychosocial assessment in the primary health care setting — that it encourages communication and monitoring *across* the primary (eg, midwifery) and mental health sectors. Thus, while some women may be lost to psychiatric follow-up during pregnancy, most will attend antenatal appointments, thus providing their health care network with an opportunity for ongoing psychosocial review.

Thirdly, while we agree with Boyce and Barton that "targeted interviewing" (as described in the UK National Institute for Health and Clinical Excellence guidelines) is important, "psychosocial assessment", as undertaken in some Australian maternity settings, aims to assess the broad number of psychosocial risk factors that may contribute to the mental health outcomes of a woman and her infant. This point has been identified as a key issue in the 2007 *beyondblue* national action plan for perinatal mental health briefing document.[4]

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In the wake of hospital inquiries: impact on staff and safety

Peter C Arnold

TO THE EDITOR: I compliment Dunbar and colleagues on their analysis of the systematic problems underlying whistleblowing "scandals" at four Australian hospitals.[1]

I disagree totally, however, with their major conclusion. I refer to their endorsing the recommendation from the President of the General Medical Council of the United Kingdom that "… if there's a risk to patients … we expect people to pipe up, but pipe up locally". Attempting to put this recommendation into practice is itself the root cause of the problem.

The many and varied obstacles to locally notifying one's concerns about a colleague's performance are almost insurmountable; any permutation or combination might apply in a particular location. On the part of the whistleblower, obstacles might include fear of their confidence being breached, being suspected of professional envy or of being a troublemaker, a concern for job security or about failure to be promoted, a reluctance to rock the boat in their own working environment, or fear of being victimised at work. On the part of the chief executive officer or equivalent local person to whom the report is made, obstacles might include their potential affront at a slight on their responsibility for overall management or for having appointed the person to whom the notification refers, personal friendships and even family relationships (especially in smaller centres), reluctance to have to inquire into a senior staff member's work, or financial implications (as in the case of Bundaberg Hospital[1]).

I suggest that, instead of trying to overcome such awkward and off-putting obstacles locally, performance concerns should be taken directly to a statutory body with responsibility for overall standards of health care and with absolutely no "conflicts of interest" in specific local situations.

In New South Wales, at least, and specifically in relation to doctors, Section 86E of the *Medical Practice Act 1992* provides that persons may notify the medical board of professional performance matters, namely "any matter that the person thinks indicates that the professional performance of a registered medical practitioner is unsatisfactory".

This avenue avoids all the pitfalls involved in attempting to resolve the matter locally, affords the potential whistleblower a recognised means of having their concerns given serious consideration, and reassures the whistleblower that the matter is in the hands of a responsible body with statutory authority and with tried and tested methods of dispassionately assessing the situation.

The whistleblower would then have no need to "go public", with the devastating results so well described by the authors.

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1 Dunbar JA, Reddy P, Beresford B, et al. In the wake of hospital inquiries: impact on staff and safety. *Med J Aust* 2007; 186: 80-83. ❑

James A Dunbar, Prasuna Reddy, Bill Beresford, Wayne P Ramsey and Reginald S A Lord

IN REPLY: Dr Arnold raises the difficulties involved in bringing poorly performing colleagues to notice and proposes that reporting doctors to a medical board is the best option.

There are difficulties in relying solely on medical boards. First, doctors have a very high threshold for referral to a medical board, so poor performance may not be reported. Even serious cases of poor performance can go unreported for many years.[1] Second, there are many cases of remediable poor performance[2] that require a different approach. In the United Kingdom, local procedures are managed by medical directors as part of their contract. The *Good Medical Practice* guidelines issued by the General Medical Council make it clear that all doctors have a responsibility to report poorly performing colleagues.[3] If the medical director then fails to act, the hospital's insurance could be invalidated and the medical director would appear before the General Medical Council.

A number of Australian jurisdictions, including the Australian Capital Territory, New South Wales and Queensland,[4,5] have made substantial progress in developing local procedures that offer the best opportunity for remediation of doctors where possible, and for discipline by the medical board where not. With these procedures, we can assure patients of safety while maintaining as many doctors as possible in the workforce.

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Human embryonic stem cells leap the barrier

T John Martin

To the Editor: The recent editorial by Penington and Mitchell[1] unreservedly supports the Victorian Government's legislation allowing "therapeutic cloning" by somatic cell nuclear transfer (SCNT) — generating an embryo by transferring an adult somatic cell nucleus (skin, muscle, etc) from an individual into a donated ovum from which the nucleus has been removed. State and federal support for therapeutic cloning has clearly been dependent upon belief in the therapeutic benefits to be obtained — a belief that the editorial does nothing to dispel.

Since the licensing system for embryo research (*Research Involving Human Embryos Act 2002* [Cwlth]) was introduced, there have been no discoveries in animal or human embryonic stem (ES) cell research that support an urgent need for therapeutic cloning. This includes references 3–8 in Penington and Mitchell's editorial, all of which fall far short of providing proof of concept of efficacy of ES cells in treatment.

A number of major problems need to be resolved before any remotely credible scientific case could be made for the need for therapeutic cloning. These include achieving prolonged, effective, safe therapy in an animal model of disease, and safe transplantation of ES cells in animals, without any tumour formation — a problem that occurs commonly,[2,3] not on the "rare occasions" claimed in the editorial. We need to understand how stable the fully differentiated phenotype is when ES cells are used to generate specialised cells. This can be explored in animal ES cells, but also in human ES cells that do not need to be prepared by therapeutic cloning. If stability is indeed shown, these cells must die eventually — how will they then be replaced? Will this require a compromise of using less "mature" cells and incurring an even greater risk of tumour formation?

If cells derived by SCNT are to be used to find "new approaches to … hitherto unyielding diseases", proof of this concept could readily be provided by studying animal examples. Crucially though, that will require resolution in animal studies of the effect of SCNT on genetic controls and epigenetic effects in the derived ES cells.

These are all scientific requirements. Proceeding to therapeutic cloning provides no scientific advance without them — and of course it should be noted that no one anywhere in the world has ever made human ES cells by SCNT.

Penington and Mitchell's editorial provides a limited view of these matters. It acknowledges the long lead times required if there is ever to be success in ES cell therapies, but does not advance even a single compelling argument in support of SCNT now.

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Jeffrey J Flaherty

To the Editor: I read with interest the editorial by Penington and Mitchell[1] in which they briefly discussed the recent legislative developments with regard to human embryonic stem cells. As a medical student, I delight at the complexity and passion that surround the stem cell debate.

How is a student to proceed through this ethical minefield? At the Australian National University, we are taught that international human rights are likely to become more important in professional regulation than classical medical ethics born of the Hippocratic Oath.[2] The International Covenant on Civil and Political Rights (ICCPR)[3] and the Universal Declaration of Human Rights (UDHR)[4] are currently used as the cornerstone for building ethical arguments and controversial legislation. However, problems with these international human rights documents include their relevance and applicability to the 21st century. The medical and technological advances made since they were introduced are mind-numbing; I doubt that stem cell research was a consideration when they were drafted.

Both Article 6 of the ICCPR and Article 3 of the UDHR state that every human being has the right to life. An individual's ethical principles must shape his or her interpretation of this statement. Moreover, ethical argument should not be confused with religious views. Australian society and its belief systems are more than ever moving further away from religion, and medical ethics should incorporate the views of the community at large.

An example of religion and international human rights opposing society's position is the termination of pregnancy. In Australian medicine there is an ethical obligation to uphold a woman's right to autonomy and wellbeing, while the exact wording of the ICCPR and UDHR is ignored to achieve a currently socially acceptable outcome. We are seeing a similar rationale with stem cell research, in that there is an ethical responsibility to "the greater good", regardless of the requirements of the UDHR and ICCPR.

I am a strong supporter of both stem cell research and a woman's right to choose. I am simply suggesting that we stop looking to international human rights covenants to be the cornerstone of legislation or to answer ethical dilemmas. I just don't think current international human rights documentation incorporates all the ethical considerations required of modern medicine. A new alternative is just what the medical student ordered.

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Paediatric diabetes — which children can gain insulin independence?

Mark F Harris, Ivan N McGown and David M Cowley

To the Editor: A recent editorial in the Journal suggested that blood could be sent overseas for genetic testing for maturity onset diabetes of the young (MODY).[1]

We are pleased to be able to point out that genetic testing, including clinical and laboratory support with full gene sequencing for both MODY1 and MODY3 and for neonatal diabetes (mutations in SUR1 and Kir6.2), is available in Australia. Testing for MODY2 and for a number of other disorders of the pituitary–adrenal and pituitary–gonadal axis in children is also available.

We are happy to receive specimens and referrals from clinicians who would prefer to use an Australian clinical laboratory accredited by the National Association of Testing Authorities. More information is available via: <http://www.mater.org.au/Home/Services/Pathology.aspx>.

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Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers

Mark T Clayer

To the Editor: A recent *MJA* Supplement discusses prognostic and end-of-life communication for health professionals on the basis of a systematic literature review and an expert advisory panel.[1] It is usually the case that malignant disease is diagnosed after biopsy, and this is usually undertaken by a surgeon. In a consecutive series of 100 patients presenting with a lesion in a bone with no past history of malignancy, the lesion was the presenting feature of systemic malignancy in 44 of those patients.[2] Hence, it is usually the surgeon's role to advise the patient (and caregivers) that the patient has a terminal disease and, in some cases, the prognosis can only be measured in weeks. It will be obvious that this can be a significant shock to all, particularly when there was no prior indication that malignancy was a possibility.

I note that not one of the 35 experts was a surgeon. I also note that surgery as palliation is given virtually no role other than a brief mention in Box 11, despite the well documented role of surgery.[3] It has been my experience that the most common question asked by patients with the diagnosis of a terminal malignancy is about the role of surgery; the question "Why can't you just cut it out?" is a universal feature. This has not been addressed.

It is my sincere hope that further expert advisory panels addressing this area become truly multidisciplinary and include perhaps the most relevant discipline — surgery.

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Josephine M Clayton, Karen M Hancock, Phyllis N Butow, Martin H N Tattersall and David C Currow

In reply: We agree that the content area of these guidelines is very relevant for surgeons, as for all health professionals involved in the care of adult patients with advanced life-limiting illnesses and their caregivers. Surgical representation on our expert panel would have been very useful. We agree that surgery has an important role in terms of palliative treatment options that may be available for certain clinical circumstances.

The issue of how to respond to the question "Why can't you just cut it out?" is an important one. We believe that the principles outlined in these guidelines would be relevant when responding to this question, but would welcome specific suggestions from Clayer and other surgeons about how they respond to such patients. We would hope to include these suggestions along with other input from surgeons in any future update of these guidelines.

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Relapsing polychondritis or ANCA-negative Wegener's granulomatosis?

Weekitt Kittisupamongkol and Wanla Kulwichit

To the Editor: In their recent Snapshot, Sharma and colleagues reported an interesting case of a woman presenting with prolonged fever and inflammation of external ears, nose, and throat.[1] On the basis of negative antineutrophil cytoplasmic antibodies (ANCAs), a diagnosis of relapsing polychondritis was made and the possibility of Wegener's granulomatosis "ruled out". Corticosteroid and azathioprine were given to the patient accordingly.

However, patients with Wegener's granulomatosis can present with limited otolaryngological symptoms with or without positive ANCAs.[2,3] As a rule, ANCAs are present in 90% of patients with the generalised form of the disease, but in only 60% of those with the limited form.[4] Conversely, some cases of relapsing polychondritis can have a positive test result for ANCAs.[4] A case has been reported of a Wegener's granulomatosis patient with otolaryngological manifestations that led to an initial diagnosis of relapsing polychondritis, but who subsequently developed pulmonary and renal involvement.[3]

While a routine biopsy to exclude Wegener's granulomatosis in patients with inflammatory otolaryngological symptoms may not be practical, with a limited period of follow-up, a diagnosis of relapsing polychondritis should be made cautiously and only provisionally. This is true even in cases such as the patient described by Sharma and colleagues with 6 months of illness and 7 months of follow-up, as pulmonary and/or renal manifestations could take years to follow. We believe that negative ANCAs should never be used to rule out Wegener's granulomatosis, especially in its limited form.

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Discordance between level of risk and intensity of evidence-based treatment in patients with acute coronary syndromes

V Michael Jelinek

To the Editor: Scott and colleagues have shown that Australia is no different to the rest of the world in applying evidence-based treatment predominantly to patients at lower risk.[1] They suggest that therapy may be withheld from high-risk patients because of overestimation of the risk of treatment, underestimation of the actual absolute risk of non-treatment, and consideration of cost-effectiveness and social inequalities.

I suggest that their data support the concept that the patient at highest risk who misses out on evidence-based treatment may in fact be being managed with kindness and wisdom. Such a patient is old, has comorbidities, can be frail, and may be taking 10 pills or more per day, so questions of optimal prognostic therapy must be balanced against quality-of-life factors.

There is abundant evidence that patients at highest risk do not receive the maximum amount of therapy. I suspect the kindness and wisdom factor is underestimated in clinical decision making. What we need now is some good qualitative data — market research — to help explain this phenomenon before we intensify the evidence-based mantra.

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1 Scott IA, Derhy PH, O'Kane D, et al. Discordance between level of risk and intensity of evidence-based treatment in patients with acute coronary syndromes. *Med J Aust* 2007; 187:153-159. ❑

Ian A Scott

In reply: Jelinek rightly draws attention to the need, when caring for patients with acute coronary syndromes, to distinguish disease-related risk from age-related risk arising from frailty, comorbidity, physical disability, cognitive impairment, depression, social isolation, age–treatment interactions, and quality of life. All these factors affect treatment goals in older patients and may, as we conceded, justify withholding certain treatments in individual cases. However, even after accounting for "wise compassion", under-treatment is still likely because:

- our treatment eligibility criteria excluded patients with advanced comorbidity or who declined treatment;
- population-based studies of risk–benefit trade-offs argue for more intense treatment use in patients ≥ 75 years,[1,2] in whom absolute risk reductions exceed those in younger patients by as much as 10%;[3] and
- all four key treatments at discharge (aspirin, β-blocker, angiotensin-converting enzyme inhibitors or angiotensin II receptor blockers, and statins) can be administered as once-daily, single tablet formulations, which are usually well tolerated.

Given that a third of patients presenting with acute coronary syndromes are aged 75 years or older, for whom 30-day risk of death or myocardial infarction exceeds 20% and who account for 60% of all deaths related to myocardial infarction,[4] we recommend, similar to expert bodies,[4,5] judicious (not mantra-driven) use of evidence-based treatments in all eligible older patients.

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Hospital utilisation among people born in refugee-source countries

Joy L Mendel and Claire E Brolan

To the Editor: We refer to the study reported by Correa-Velez and colleagues, which found lower hospital utilisation rates among patients from refugee-source countries compared with the Australian-born population in Victoria.[1] As noted by the authors, there is a dearth of evidence on the use of health services by refugees. Their 6-year investigation stands as a singular study of its kind in Australia, and we recognise its potential to inform policy on refugee health care. However, we argue that the authors' conclusion that "the Refugee and Humanitarian Program does not currently place a burden on the Australian hospital system" cannot be drawn from the data collected in the study.

Refugee groups have health needs related to histories of torture and trauma, and associated somatic symptoms.[2] Furthermore, refugees have often been exposed to diseases that are infrequently encountered in the general Australian population. Considerable time is required to train health professionals to diagnose and treat such complex clinical presentations. In addition, adequately servicing the special needs of this patient group requires the provision of appropriately qualified interpreters. When an interpreter is required during a clinical consultation, additional time is often needed to gain clarity. Interpreters can also be difficult to source, which places added time and resource pressures on health care administrative staff and budgets.

Correa-Velez et al do refer to the “multiple barriers that prevent refugees from adequately accessing health care services”. Further research is required to comprehensively assess the reasons why, given the complexity of their health care needs, refugees are not accessing the hospital system at the same rate as other Australians. The authors suggest that reasons for an increase in service utilisation by refugees in recent years may include an increased level of familiarity with services, or poorer health status of recently arrived refugees. Previous reports have indicated that refugees tend not to utilise health care services where fundamental issues of access, such as language barriers and lack of education about the availability of health care services, have not been addressed.[2,3]

Since Correa-Velez and colleagues’ data were collected, several states, including Victoria, have developed primary health care programs for refugees, with varying degrees of success. As the Queensland Government considers a new statewide model for refugee health,[4] it is essential to ensure adequate resources are allocated for refugee and staff education programs and interpreting services.

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