Letters

Professor Bruce Hall and the ABC

To the Editor: In 2004 the Journal published an editorial entitled "Managing allegations of scientific misconduct and fraud: lessons from the 'Hall affair' ".[1] The editorial referred to accusations made against Bruce Hall, a professor at the University of New South Wales, which were broadcast by medical journalist Norman Swan on two episodes of the "Science Show", a weekly program of the Australian Broadcasting Corporation (ABC).

Recently, a judgment was entered, with the consent of the ABC and Swan, in the Supreme Court of New South Wales in favour of Hall in his defamation case against Swan and the ABC. In addition to removing the broadcast from its website the ABC stated in court that it "regrets any overshadowing of Professor Hall's major research achievements in immune tolerance and the effects of the broadcasts on his ongoing research".[2]

Now that this judgment has been finalised, we believe it is timely, as his peers, to acknowledge the very significant contributions Hall has made to the field of transplantation over the past 30 years.[3-5] In doing so we believe it is important to stress that all of these contributions have been validated by other research groups, a process which remains the best available test of scientific integrity.

We represent 49 senior international and Australian academics and researchers in transplantation and immunology, including eight presidents of the Transplantation Society of Australia and New Zealand and three presidents of the equivalent international body, The Transplantation Society (see Box for full list of signatories). It is our sincere hope that the damage to Hall's reputation can now be repaired and that he be given the opportunity to re-establish his research career without further impediment.

Jeremy R Chapman Clinical Director of Medicine and Cancer[1]

Geoffrey W McCaughan Professor[2]

Philip J O'Connell Clinical Professor in Medicine and Director[3]

1 Westmead Hospital, Sydney, NSW.

2 A W Morrow Gastroenterology and Liver Centre, Royal Prince Alfred Hospital, Sydney, NSW.

3 Centre for Transplant and Renal Research, Westmead Millennium Institute, Sydney, NSW.

Jeremy.Chapman@health.nsw.gov.au

Competing interests: No relevant disclosures.

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1 Van Der Weyden MB. Managing allegations of scientific misconduct and fraud: lessons from the "Hall affair". *Med J Aust* 2004; 180: 149-151.
2 Jackson S. ABC settles Science Show defamation suit brought by Bruce Hall. *The Australian* 2014; 4 Mar. http://www.theaustralian.com.au/media/abc-settles-science-show-defamation-suit-brought-by-bruce-hall/story-e6frg996-1226844862688# (accessed Jun 2014).
3 Hall BM, Dorsch S, Roser B. The cellular basis of allograft rejection in vivo. I. The cellular requirement for first-set rejection of heart grafts. *J Exp Med* 1978; 148: 878-889.
4 Hall BM, Jelbart ME, Gurley KE, Dorsch SE. Specific unresponsiveness in rats with prolonged cardiac allograft survival after treatment with cyclosporine. Mediation of specific suppression by T helper/inducer cells. *J Exp Med* 1985; 162: 1683-1694.
5 Hall BM, Pearce NW, Gurley KE, Dorsch SE. Specific unresponsiveness in rats with prolonged cardiac allograft survival after treatment with cyclosporine. III. Further characterisation of the CD4+ suppressor cell and its mechanisms of action. *J Exp Med* 1990; 171: 141-157. ❑

Signatories to letter of support for Professor Bruce Hall

Associate Professor Stephen Alexander, Professor Richard Allen, Professor Tony Basten, Dr Manuela Berger, Dr Alex Bishop, Professor Steve Chadban, Professor Jeremy Chapman, Professor Toby Coates, Professor Stephen Deane, Dr Lindsay Dent, Professor John Dwyer, Dr Karen Dwyer, Associate Professor Josette Eris, Professor Randall Faull, Dr Hilton Gock, Professor Len Harrison, Professor Adrian Hibberd, Dr Kenneth Howlin, Dr Andrew Jefferys, Professor Allan Kirk, Professor Stephen Lynch, Dr Angela Makris, Professor Geoff McCaughan, Professor Ian McKenzie, Dr Mark Nicolls, Dr Masaru Nomura, Professor Philip O'Connell, Dr Karren Plain, Professor David Power, Ms Catherine Robinson, Professor Graeme Russ, Professor David Sachs, Professor Mauro Sandrin, Associate Professor Alexandra Sharland, Emeritus Professor Ross Sheil, Dr Charmaine Simeonovic, Dr Tim Spicer, Professor Graeme Stewart, Professor Terry Strom, Professor Michael Suranyi, Dr Brian Tait, Professor David Tiller, Dr Giang Tran, Professor Bernard Tuch, Dr Nirupama Verma, Professor Herman Waldmann, Professor Keryn Williams, Professor Kathryn Wood, Dr Jeffrey Wong. ◆

> "we believe it is timely . . . to acknowledge the very significant contributions Hall has made to the field of transplantation over the past 30 years"
>
> Chapman et al

> "I am not sure that mental health reform was ever 'on track'"
>
> Dignam

Getting mental health reform back on track: a leadership challenge for the new Australian Government

To the Editor: I am not sure that mental health reform was ever "on track", so getting it back there is a considerable challenge. Hickie and colleagues' aspirational document reads well,[1] but I am not sure of its basis in reality.

Perhaps early intervention services for young people can be "transformative", but the reference cited to support that claim says no such thing.[2] It is a summary description of people attending a new service. Surely we would wait for the outcome data before rapidly implementing the strategy.

The summing-up statement about accumulated research on suicide prevention similarly implies we are in a real position to do specific things, but the cited reference makes no such grand claims: "Evidence from seven systematic studies … indicated that *some* interventions *may* be promising" (my emphasis).[3] We do not yet know what the tools are, so the debate about whether we can afford them at scale is premature.

It troubles me that supposed leaders in the field talk of "early intervention" at the age of 16 years: where are the goals for early childhood?

Paul Dignam Child and Adolescent Psychiatrist

Child and Adolescent Mental Health Service, Women's and Children's Health Network, Adelaide, SA.

paul.dignam@health.sa.gov.au

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1 Hickie IB, McGorry PD, Davenport TA, et al. Getting mental health reform back on track: a leadership challenge for the new Australian Government. *Med J Aust* 2014; 200: 445-448.
2 Scott EM, Hermens DF, Glozier N, et al. Targeted primary care-based mental health services for young Australians. *Med J Aust* 2012; 196: 136-140.
3 Scott A, Guo B. For which strategies of suicide prevention is there evidence of effectiveness? World Health Organization Health Evidence Network synthesis report. Copenhagen: WHO, 2012. http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/publications/2012/for-which-strategies-of-suicide-prevention-is-there-evidence-of-effectiveness (accessed Aug 2014). ❑

In reply: We welcome the opportunity to respond to Dignam's four key points.

First, the commitment in 2006 to a 5-year national mental health reform process gave birth to major funding and program initiatives, such as *headspace* and Medicare funding of psychological services. However, despite new funds in the 2011 Budget and the new National Mental Health Commission, clear national targets are still not agreed.[1]

Second, detailed evaluation of individual *headspace* services,[2] as well as the national picture,[3] indicates the extent to which these new service models are engaging with young people who are experiencing significant disability but are still in the early phases of illness. We agree that further systematic evaluation of pathways to care and their impacts on longer-term outcomes are required. However, systematic evaluation of early intervention services for those with psychotic disorders provides a basis for further action.[4]

Third, our view is that systematic suicide prevention is ready for deployment at scale and we offer further evidence to support this.[5]

Fourth, early intervention applies to clinical services provided early in the illness course. The peak age of onset for most major mental disorders is 12–25 years, hence the focus of *headspace* services on adolescence and early adulthood. During childhood, we support a focus on population-based strategies for primary prevention and expansion of early intervention services for anxiety, attention-deficit and autism-spectrum disorders.[6]

Ian B Hickie Professor of Psychiatry and Executive Director[1]

Patrick D McGorry Professor of Youth Mental Health and Executive Director[2]

Helen Christensen Professor and Director[3]

1 Brain & Mind Research Institute, University of Sydney, Sydney, NSW.

2 Orygen Youth Health Research Centre, University of Melbourne, Melbourne, VIC.

3 Black Dog Institute, University of New South Wales, Sydney, NSW.

ian.hickie@sydney.edu.au

Competing interests: Ian Hickie is a Commissioner of the National Mental Health Commission and Chair of the Scientific Leadership Council of the Young and Well Cooperative Research Centre (CRC). He was previously a Director of *headspace* (Australia's National Youth Mental Health Foundation). Patrick McGorry is a Director of *headspace* and a member of the Scientific Leadership Council of the Young and Well CRC. Helen Christensen is a member of the Scientific Leadership Council of the Young and Well CRC, was previously a member of the Australian Government's E-Mental Health Advisory Group and is the developer of a number of e-health tools, including MoodGYM.

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3 Rickwood DJ, Telford NR, Parker AG, et al. *headspace* — Australia's innovation in youth mental health: who are the clients and why are they presenting? *Med J Aust* 2014; 200: 108-111.
4 Orygen Youth Health Research Centre. Early psychosis feasibility study report. March 2011. Canberra: National Advisory Council on Mental Health, 2011. http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-e-earlypsy-toc (accessed Jun 2014).
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6 Cappo D, McGorry P, Hickie I, et al; Independent Mental Health Reform Group. Including, connecting, contributing: a blueprint to transform mental health and social participation in Australia, 2011. http://www.patmcgorry.com.au/sites/all/files/BLUEPRINT%20-%20Release.pdf (accessed Jun 2014). ❑

> "our view is that systematic suicide prevention is ready for deployment at scale"
>
> Hickie et al

A land half won: pain and the modern world

To the Editor: We thank Ashby for highlighting the need for multimodal treatment of persistent pain.[1]

He rightly suggests that we may never have sufficient specialist resources to meet the needs of people with chronic pain and that development of greater capacity in primary care needs to be a priority. This is a key recommendation of the National Pain Strategy,

which calls for adoption of evidence-based interdisciplinary treatments supported by two-way communication between tertiary and primary care.[2] However, the simplistic suggestion that modern pain specialists are polarised into centralists and peripheralists is completely at odds with contemporary training and examination requirements for Fellows of the Faculty of Pain Medicine.

Although the alternative (passive) therapies that Ashby describes may be helpful to some people, evidence-based treatments, such as cognitive behaviour therapy, constitute far more useful and responsible medical practice. There is also good evidence that patients who engage in active self-management strategies do much better over the longer term than those involved in passive strategies.[3]

However, while basic and clinical pain research remain seriously underfunded, gathering good supporting evidence for effective therapies will be difficult. The degree of funding neglect is striking: in the United States, cancer research gets more than 50 times the funding of pain research, although the prevalence of chronic pain conditions is greater than the combined prevalence of cancer, heart disease and diabetes.[4] Obtaining comparable data for Australia is difficult as there is no National Health and Medical Research Council classification for pain as a research area.

Michael J Cousins Director and Professor[1]

Lesley Brydon Chief Executive Officer[2]

1 Pain Management Research Institute, Kolling Institute of Medical Research, University of Sydney and Royal North Shore Hospital, Sydney, NSW.

2 PainAustralia, Sydney, NSW.

lesley.brydon@painaustralia.org.au

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1 Ashby MA. A land half won: pain and the modern world [editorial]. *Med J Aust* 2014; 200: 305-306.

2 National Pain Summit initiative. National Pain Strategy: pain management for all Australians. Sydney: PainAustralia, 2010. http://www.painaustralia.org.au/the-national-pain-strategy/national-pain-strategy.html (accessed Aug 2014).

3 Blyth FM, March LM, Nicholas MK, Cousins MJ. Self-management of chronic pain: a population-based study. *Pain* 2005; 113: 285-292.

4 Institute of Medicine. Relieving pain in America: a blueprint for transforming prevention, care, education, and research. Washington, DC: National Academies Press, 2011: 5-24. http://www.iom.edu/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-transforming-Prevention-Care-Education-Research.aspx (accessed Jul 2014). ❑

In reply: The pioneering work of Cousins and colleagues is internationally recognised, and I agree that the Faculty of Pain Medicine training is world-leading; it is first-rate and well balanced.

The peripheralist–centralist debate was actually the subject of a dedicated session at the 2011 Spring Meeting of the Faculty of Pain Medicine.[1] It is perhaps an oversimplified polarisation of a more complex interface in science and practice. However, it is my observation that many patients with persistent pain go on looking for solutions that they never find because they are not assisted in confronting the reality of the absence of drug or procedural solutions to their persistent pain problems after multiple treatment "failures".

I certainly do not advocate so-called passive therapies and, for instance, strongly advocate the roles of physiotherapy and exercise physiology. The benefits of cognitive behaviour therapy have been extensively reported. However, a relative absence of psychodynamic work means that the cracks in damaged lives are often only papered over, without enduring healing and change.

I gave but one example of an active, alternative, holistic community-based approach worthy of consideration,[2] as evaluation of novel approaches is surely always useful in such a challenging field.

Michael A Ashby Director of Palliative Care

Royal Hobart Hospital, Hobart, TAS.

michael.ashby@dhhs.tas.gov.au

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1 Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists. 2011 Spring Meeting. http://www.fpm.anzca.edu.au/events/older-events/2011-spring-meeting (accessed Aug 2014).

2 Ashby MA. A land half won: pain and the modern world [editorial]. *Med J Aust* 2014; 200: 305-306. ❑

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