involved in a late-term abortion.[1] None requires a reply, save for Flynn's assertion that "the Board does not currently have the power to conciliate disputes or conduct mediations".

The Board does not require statutory power to approach a hospital in a conciliatory manner so as to explore whether an impasse, involving confidentiality, can be resolved without recourse to litigation. Was the Board's only remedy to raid the hospital, trawling for evidence to decide whether there were grounds for the possible suspension or cancellation of registration of the doctors involved in the complaint?

We both agree that the relevant legislation mandated the Board, on the material before it, to investigate the charge of serious professional misconduct. Where we disagree is that, having overruled its own subcommittee's recommendation that the matter be closed, the Board failed (I maintain) in its statutory duty to promptly institute a formal hearing Had the various specialists been subpoenaed, this would have cleared them of professional misconduct, thereby preventing the considerable and unnecessary stress to these witnesses over a period of 5 years.

Paul Gerber, Retired Professor of Law
Melbourne, VIC.
p.gerber@bigpond.net.au

Gerber P. Late·term abortion: what can be learned from *Royal* Women's *Hospital* v *Medical* Practitioners *Board* of Victoria? *Med* J *Aust* 2007; 186: 359· 362. o

Medical Professionalism: it is really under threat?

George Halasz

TO THE EDITOR: Breen's timely call for a reality check on medical professionalism noted major global changes that affect contemporary doctor-patient relationships: new technology, changing market forces, evidence-based treatment protocols, and resource-driven health services and policies. ı The call by our colleagues in the United States and United Kingdom to restore "trust that the public used to have in the profession" was urgent.

Breen's thesis posits that lost trust is due to an "altered balance" of ethical issues faced by doctors because of a generational shift from the ethical principle of "beneficence" to "autonomy" to "justice" and "distributive justice".

This view contrasts with Green and Bloch's analysis of the mental health care system's ethical concerns arising from an adherence to "efficiency-driven" policies that started in many countries during the 1980s[2] They suggest the system itself is flawed.

Green and Bloch suggested that the legacy of efficiency-driven policies created two current moral compromises for our profession: first, a threat to the "ethic of agency"; second, the constraints those policies imposed on ethical principles precisely because they were not based on justice, instead being created to meet wider socioeconomic and political considerations. Their views point to the heart of the matter, beyond Breen's suggested remedy to be found in "stronger leadership", which may be necessary, but is not sufficient without an urgent update on personal medical ethics.

At the individual doctor's experience, Green and Bloch locate conflict arising from competing interest when doctors' "principle of fidelity is juxtaposing their financial interests alongside patients' needs". In the US, a study found 28% of physicians receive direct payment for consulting, lectures or enrolling patients in trials, and 94% report "some type of relationship with the pharmaceutical industry"3 To avoid the conundrum posed by the ethics of conflict of interests we face when confronted by these physician-industry relationships, or by efficiency-driven policies, risks perpetuating the very loss of trust that we need to restore.

Breen's analysis, an important step in the needed debate on medical professionalism, should account for not merely shifts in the ethical balance, but also the incremental erosion of trust. As it stands, he expressed our very Australian attitude "she'll be right". Our overseas colleagues, as well as locals, have suggested that "she won't be right, mate" when it comes to managerialism eroding the ethical foundations of medicine.[4]

George Halasz, Honorary Senior Lecturer
Department of Psychological Medicine,
Monash University, Melbourne, VIC.
geohalasz@aol.com

1 Breen KJ. Medical professionalism: is it really under threat? *Med J Aust2007;* 186: 596·598.
2 Green SA, Bloch S. Working in a flawed mental health care system: an ethical challenge. *Am* J *Psychiatry* 2001; 158: 1378· 1383.
3 Campbell EG, Green RL, Mountford J, et al. A national survey of physician-industry relationships. N *Engl J Med2007:* 356: 1742·1750
4 Charlesworth M. The new ideology of health care: ethical issues. In: Halasz G, Borenstein R, Buchanan J, et al, editors. "She won't be right, mate!" The impact of managed care on Australian psychiatry and the Australian community. Melbourne: Psychiatrists' Working Group, 1997: 104·110. :J

Kerry J Breen

IN REPLY: My recent article was submitted under the category of "For Debate", so it is pleasing that Halasz has joined the debate. I am disappointed that he interprets my view as "she'll be right" My point is that revising or repackaging existing ethical codes will not, on its own, fix any of the perceived problems of "managerialism eroding the ethical foundations of medicine". Working constructively, consistent with existing ethical codes, within our health care system, as is also suggested by Green and Bloch,[1] is more likely to achieve better outcomes for our community. As I stated and as Green and Bloch imply, this will not always be a simple matter.

I am in fierce agreement with Halasz over steps to reduce erosion of trust,2 but that was not the focus of my article.

Kerry J Breen, Physician
Melbourne, VIe.
kerry.breen@bigpond.com

1 Green SA, Bloch S. Working in a flawed mental health care system: an ethical challenge. *Am* J *Psychiatry* 2001; 158: 1378· 1383.
2 Breen KJ. The medical profession and the pharma·ceutical industry: when will we open our eyes? *Med* J Aust 2004; 180: 409·410. :J

I provision of optimal health for patients with chronic heart faiiure: a national geo-mapping

Elizabeth A Dodd

To THE EDITOR: Clark et al haw claimed to map the distribution of senices for people with chronic heart failure (CHF) against the distribution of these people. ı An examination will show that they ha\'e mapped the distribution of people likely to haw CHF, using age and Aboriginality as surrogate markers. The stated mapping of the services shows the services probably a\'ailable to these people.

A map is dra\\-TI to show us what the cartographer wants us to see[2] The authors note that high prevalence in remote regions has been shown on the maps, but they have not considered different mapping methods to provide a better representation of their results[3] This has led to an anomaly so that, when calculating numbers of people with CHF, the maps show remote areas with giant households containing between 24 and 300 people.

CHF programs were located by a snowball sampling technique, which by its nature