Australia's cosy relationship with the US faces testing times

DANIEL FLITTON

The Afghanistan conflict and other issues could mean trouble for Rudd.

KEVIN Rudd joked he'd throw a prawn on the barbie to mark the recent visit by Bob Gates, oblivious to the fact that the US Secretary of Defence is allergic to seafood. It was only a small snag in protocol, hardly a diplomatic incident. And besides, nothing was going to deter the Labor Government using the recent high-level talks with US officials to hammer its message — Australia's alliance with America is above politics, Labor or Liberal, Republican or Democrat.

So far, there is little evidence to signal otherwise. The plan to withdraw Australian combat troops from Iraq has been pragmatically accepted in Washington, helped because Labor has been at pains to ensure the Iraq pull-out, combined with ratifying the Kyoto Protocol, is not seen as a repudiation of the close personal ties John Howard fostered with the Bush Administration.

But Labor has not always had such a cosy attitude towards the world's great powers. Indeed, since the earliest days of Australian federation, an undercurrent of isolationist thought has suffused Australian politics — rarely gaining much support, but enough to make waves.

Way back in 1903, Labor senator William Higgs argued, "If we keep to our own territory, if we avoid interfering with foreign nations, if we refuse to be drawn into the vortex of militarism, we shall be perfectly safe in Australia."

A century later, there are obvious echoes of this sentiment. Former Labor leader Mark Latham left politics a bitter opponent of close military ties with America. "The US Alliance is a funnel that draws us into unnecessary wars; first Vietnam and then Iraq," he wrote in *The Latham Diaries*, published in 2005.

Latham wanted Labor to be the anti-war party of Australian politics, claiming New Zealand had found the right approach to world affairs. And while Latham's name is a dirty word in Labor circles these days, his concern that Australia has sacrificed its independence in foreign policy is still felt by a significant portion of the community.

Labor's pro-America faction (jeered by Latham as the "Big Macs") is now ascendant. But with Australian troops fighting in a distant conflict in Afghanistan and talk about joining the controversial US missile defence project, Rudd could yet find Australia's alliance with America stirring up political trouble at home.

Afghanistan is likely to become the focus of most discontent. The conflict has stretched over six years since the US-led invasion — and nobody is seriously talking about a quick resolution. National deployments are being measured in years, at least as long as the Rudd Government's term in office, and often beyond.

Australia has suffered few casualties, though the fighting has been intense at times. Yet polls show the public is evenly split on the merits of Australia's involvement.

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Afghanistan is not as unpopular as Iraq, but more people are beginning to question the long-term goals and costs of the operation.

The US wants an even greater commitment of international troops to stop Afghanistan from sliding into an Iraq-type insurgency. When Secretary Gates visited Canberra, he warned that the nature of the conflict is shifting. "It's kind of kaleidoscopic," he said. "Every time you twist the tube, it changes a little bit."

Gates is one of the architects of the so-called "surge" strategy in Iraq, which supporters now claim is making progress. America has already promised an extra 3000 troops will go to Afghanistan, and by drawing a direct link between both conflicts, he is making it clear the US also expects its allies to play a greater role.

"The problem is that while we were able to clear the Taliban in certain areas when we have an operation, we don't have enough force to be able to hold some of those areas. It's the same kind of problem we encountered in Iraq," he said.

Because the Taliban loses every direct confrontation with international forces, the US believes there will be more terrorist attacks in the months ahead. In January, a suicide squad struck Kabul's luxury hotel, home to many foreigners and the Australian embassy at the time. Gates also expects more random killing of school teachers and local officials, and an increased reliance on roadside bombs — all because the Taliban hopes to sap the will of the international coalition.

Could this tactic work? European countries are wavering in their commitment to Afghanistan, and Canada has decided to withdraw in 2011.

If the NATO allies fail to provide additional troops, is the current situation serious enough to warrant a further deployment of Australian troops? Will Australian politicians have the stamina to support a conflict that could drag on for years, with no end in sight? The Government has now ruled out more troops, saying Australia will increase its "capacity building" efforts, training Afghanistan's army and police.

But these efforts are beset by what is now an increasingly familiar conundrum — figuring out how to foster local self-reliance when the security situation is so bad.

Last week was an example of just this kind of problem. Australian soldiers had to fight off a number of Taliban attacks while attempting to build a patrol base for the Afghan army.

In opposition, Labor consistently argued that Australia could be a close partner to America without always agreeing with Washington.

Afghanistan could well prove to be the test of that conviction.

Daniel Flitton is diplomatic editor.

The bitter pills of drug trials

Successful tests on new drugs are trumpeted far and wide by a proud pharmaceutical industry, but its many failures are quietly swept under the carpet. This potentially dangerous secrecy can, and must, be stopped, writes **Ben Goldacre**.

THE international medical journal *PLoS Medicine* has published a study which combined the results of 47 trials on some antidepressant drugs, including Prozac, and found only minimal benefits over placebos, except for the most depressed patients.

It has been misreported as a definitive nail in the coffin, but this is not true. It was a restricted analysis but, more important, on the question of antidepressants, it added very little. We already knew that selective serotonin reuptake inhibitors (SSRIs), one of the commonly prescribed drugs for treating depression, give only a modest benefit in mild and moderate depression.

But the real story goes way beyond the question of Prozac.

This new study — published, paradoxically, in an open-access journal — tells a fascinating story of buried data and of our collective failure, as a society, over half a century to adequately regulate the colossal global $550 billion pharmaceutical industry.

The key issue is simple. In any situation, to make any kind of sensible decision about which treatment is best, a doctor must be able to take into account all of the available information. But drug companies have repeatedly been shown to bury unflattering data.

> **"Companies often move the goalposts and change the design of a trial after the results are in, to try to massage the findings."**

Sometimes they bury data that shows drugs to be harmful. This happened in the case of Vioxx and heart attacks, and SSRIs and suicidal thoughts. Such stories feel, intuitively, like cover-ups. But there are also more subtle issues at stake in the burying of results showing minimal efficacy, and these have only been revealed through the investigative work of medical academics.

One example came just in January. A paper in *The New England Journal of Medicine* dug out a list of all trials on SSRIs that had ever been registered with the US Food and Drug Administration, and then went to look for those same trials in the academic literature. There were 37 studies which were assessed by the FDA as positive and, with a single exception, every one of those positive trials was written up, proudly, and published in full.

But there were also 33 studies which had negative or iffy results and, of those, 22 were simply not published at all — they were buried — while 11 were written up and published in a way that portrayed them as having a positive outcome.

The new study published in *PLoS Medicine* analysed all the data from the FDA, using the Freedom of Information Act to obtain the results of some of the trials. That medical academics should need to use that kind of legislation to obtain information about trials on pills that are prescribed to millions of people is absurd. More than that, it breaks a key moral contract between patient and researcher.

When a patient agrees to participate in a clinical trial, they give their consent on the understanding that their information will be used to increase the sum of our knowledge about treatments, to ensure that other people in the future will be treated more effectively. Burying unwelcome results is an unambiguous betrayal of their trust and generosity.

And yet we have known about this happening for a long time. The first paper describing "publication bias" — where studies with negative results tend to get forgotten — was in 1959. And there are two very simple and widely accepted solutions, which have been discussed in the academic literature at length since the 1980s, but which are still not fully in place.

The first is obvious. Nobody should get ethical approval to perform a clinical trial unless there is a clear undertaking that the results will be published, in full, in a publicly available forum, and that the researchers will have full academic freedom to do so.

Any company trying to silence academics should be named and shamed, and even attempting to do so should be a regulatory offence.

That's the butch solution. But there is also a more elegant one, which is arguably even more important: a compulsory international trials register. Give every trial an ID number, so we can all see that a trial exists, they can't go quietly missing in action, and we know when and where to look if they do.

The pharmaceutical industry is very imaginative, after all, and registers also help to manage some of the other less obvious ways in which they distort the literature.

For instance, sometimes companies will publish flattering data two or three times over, in slightly different forms, as if it came from different studies, to make it look as if there are a lot of different positive findings out there: registers make this instantly obvious.

Worse than that, companies often move the goalposts and change the design of a trial after the results are in, to try to massage the findings. This, again, is impossible when the protocol is registered before a trial begins.

This is just a taste of the tricks of their trade (although I've posted a long reading list at badscience.net if your interest is piqued). Alongside these deep-rooted, systemic problems with the pharmaceutical industry, the single issue of SSRI antidepressants, and these new findings, becomes almost trivial. Biased under-reporting of clinical trials happens in all areas of medicine. It wastes money, and it costs lives. It is unethical, and it is indefensible. But most damning of all, it could be fixed in a legislative trice.

Ben Goldacre is a medical doctor and a columnist with *The Guardian*.

Yes Minister, the buck does stop with you

MARY ALDRED

The Immigration Minister should retain his powers of discretion.

IMMIGRATION Minister Chris Evans thinks he is playing God by performing the role he has been elected to do. Evans recently told a Senate estimates committee he has too much power and had asked former Victorian public servant Elizabeth Proust to report back on the extent of it.

The role of immigration minister does, indeed, carry great power. The minister's decisions have a profound impact on the lives of vulnerable people in dire circumstances.

Evans says he is uncomfortable with that, not just because of concern about playing God, but also because of the lack of transparency and accountability for those decisions.

Evans is suggesting that unelected public servants are better placed to make a final judgement, but does not provide any example of how that would lead to greater transparency. This is not demonstrative of Kevin Rudd's declaration that the buck stops at the top.

Among the discretionary powers mooted for review are section 501 of the Migration Act, under which the minister may refuse or cancel a visa on character grounds, and section 417, under which the minister may overrule the migration tribunal in favour of an applicant.

These are not minor tasks to handball. At the heart of this issue is who gets the final say on who can stay in Australia and who cannot. For some, these decisions have life and death consequences.

Ministerial interventions are not made straight off the bat. They are a final avenue of appeal after all tribunal and court hearings have been exhausted. To use a cricketing analogy, the minister acts as a match referee only once the field umpires make their ruling. Requests are regarded seriously, and require detailed submissions from the applicant along with advice from the department.

In many cases, ministerial intervention has proved timely and necessary, notably for the seven young Afghan men granted asylum in 2001 and the Kosovo refugees in 1999.

The Galbally (1978) and FitzGerald (1988) reports on the immigration system struck a balance between a rules-based structure which had enough compassionate flexibility to accommodate discretion in exceptional circumstances. The Fraser and Hawke governments understood this, with all of the Galbally recommendations implemented by the Fraser government, and FitzGerald's key points adopted by Hawke.

Mostly, this has worked well.

But ministers are not immune to the odds of human error and there is also the potential for misuse of this discretionary power. (And distinguishing between the right to representation and a "migration industry" which feeds false hope and chokes the system with fruitless appeals has been a challenge for successive governments.) But when they get it wrong, ministers are publicly scrutinised and should be held to a higher level of accountability than public servants.

The 2004 Flood report on national security agencies noted the difficulties bureaucracies face in "talking" to one another. Assigning them additional powers of subjective interpretation would not improve a system already drowning in a quagmire of bureaucracy.

Leading Australian immigration academic James Jupp argues that where there is ministerial interest in immigration, intervention may ensue.

It follows that ministers are open to legitimate community representations and media scrutiny. While public servants are held to a degree of accountability, it is the minister who has overall carriage for the department and the consequences of its decisions.

> **"At the heart of the issue is who gets the final say on who can stay and who cannot."**

Say Evans got his wish and abdicated his responsibility. Applicants would still have their cases heard by the migration and refugee review tribunals. The panels aim to provide correct and consistent decisions, and if applicants are not satisfied they have 28 days to appeal to the Federal Court.

But as any year 12 legal studies student knows, judges are there to interpret and apply the rules, and unfortunately the full extent of human devastation cannot always be captured within the black letter of the law. Unlike bureaucracies' apparatuses, ministers have a mandate for empathy while weighing often unique circumstances that were not anticipated when sections of acts were drafted.

It seems the motivating factor Evans has for abrogating responsibility is that he is uncomfortable about having to make decisions that may not please all people at all times. But that's what happens when voters choose your team to make decisions in government for them.

The process should remain open to accountability and as the PM says, the buck should stop at the top.

Mary Aldred recently completed her BA honours thesis at Monash University on the history of the Migration Act.

Healing the mind is about more than just taking medicine

PAUL VALENT

You can't treat depression without getting to the heart of the problem.

WHEN I trained in the 1960s in London my teachers told me how lucky I was to start my career in the new era of psychotropic drugs. And indeed, 10-21 days after I prescribed antidepressants, I saw severely depressed patients improve before my eyes.

Thirty years later, in emergency departments and in my clinical practice, I had opposite experiences. Patients on long-term antidepressants came out of even severe depressions before my eyes again, but this time, during our first meeting, as we touched for the first time on core problems. Such patients stopped their medications, as they no longer needed them.

Now a study by Kirsch and colleagues in the Public Library of Science (Medicine) that accessed unpublished research by drug companies suggests that antidepressants are no better than placebos except in the severest cases. Does that mean that my initial experiences with drugs were due to placebo effects?

Actually, I had puzzled over many years about the placebo effects of antidepressants. Usually the drugs had only 5-25% advantage over placebos. But in a large enough study, even the lower range was statistically significant, and the drug was deemed to be effective. I wondered why the efforts devoted to finding better drugs were not spent on research and improvement of placebo effects, which were clearly very potent.

To understand my different experiences over 30 years, the differences between drug, placebo, and specific therapies need to be addressed.

Drug therapy works on the assumption that depression is a disease, and that like an infection can clear with antibiotics, depression can clear with antidepressants. Various drugs with various biochemical effects have been claimed over the years to specifically elevate pathologically depressed moods.

Placebo, an inactive medication, is nevertheless often associated with the powerful suggestion by an authority figure such as a doctor that the medication will fix the ailment, as well as with removal to a safe problem-free environment such as a hospital, and provision of kindness and concern for how patients feel. Specific treatment for depression involves identifying a major loss and suppressed grief in relation to the loss. It involves identifying hope beyond hopelessness and despair for such a loss, and allowing the grieving process to take place with support from the therapist. It was when patients I saw in the emergency department were given their first opportunity to express their grief that their depressions turned to healthy tears.

> **"It is easier then to immerse oneself in keeping busy, rather than open a can of worms."**

It must be noted that depression refers to a variety of emotions that psychiatry and psychology have not separated clinically for treatment. Among other emotions, they include defeat, demoralisation, anguish, abandonment, frustration and betrayal. As with depression, specific treatment requires, through hope and support, recognition of the nature of the symptoms and their origins, and then dealing with them in the present context.

The reason why drug and placebo therapies are so popular is not only because of a desire for a simple solution by both patient and doctor, but also because of fear on the part of the patient that to uncover their real problems will expose their belief that their life is meaningless, a fear that may be conveyed to doctors, and even resonate within them. It is easier then to immerse oneself in keeping busy, rather than open a can of worms.

In reality, doctors and patients negotiate an amalgam of drug, placebo and specific treatments according to their capacities, and available knowledge of the times. For instance, we are much more attuned to stresses and traumas than we were in the '60s.

Benefits can be obtained in many combinations of treatments. But not addressing specific issues has costs. Patients are left in an uneasy equilibrium of being and not being themselves, while doctors chase their own tails as patients keep returning with unresolved problems.

The 12 million antidepressant prescriptions written in Australia in 2005-06 might have cured some, helped many from being overwhelmed at the time, and produced side-effects in others.

But there is no easy drug fix for psychological wounds. Kindness and suggestion can be useful stop-gap measures. But proper diagnosis and healing of root causes is still the best medicine.

Dr Paul Valent worked as liaison psychiatrist in emergency departments for 25 years. He founded and is ex-president of the Australasian Society for Traumatic Stress Studies.

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