In brief

Reuters/Kim Kyung-Hoon

A street vendor displays therapeutic goods such as analgesics at a stall in a street market on the outskirts of Beijing. People can also undergo medical procedures, such as laser treatment, in local shops. The Chinese government has recently announced its intention to set up a single watchdog to supervise standards for food and drug safety and quality in production, distribution and consumption.

From the NHMRC

Improving support for Australian clinical trials

Since 2007, the National Health and Medical Research Council (NHMRC) has led work to develop and implement a harmonised national approach to the ethical review of multicentre clinical trials with the objective of reducing red tape and start-up times. The goal of clinical trials conducted at multiple sites based on a common system of ethical review and research governance is in sight, in the public hospital system at least.

Over the past 2 years, the NHMRC has been working closely with government departments, industry, academia and stakeholders to implement the recommendations of the Clinical Trials Action Group. While a lot of progress has been made collectively over this time, including the development of a new clinical trials website (http://australianclinicaltrials.gov.au/home), there is still much more to be done.

Last month, the federal government announced a new initiative to continue this work (http://minister.innovation.gov.au/gregcombet/MediaReleases/Pages/SupportingAustralianleadershipinclinicalresearch.aspx) and expedite reforms to ensure that Australia maintains a competitive advantage in attracting and conducting clinical trials. The initiative includes delivering education and training in the conduct and oversight of clinical trials, developing a comprehensive interactive web portal and facilitating the further streamlining of ethics and governance review processes.

The NHMRC looks forward to working closely with stakeholders across industry, academia and the public and private sectors. It will look at ways of bringing together existing networks that support clinical trials across all fields of clinical research (http://australianclinicaltrials.gov.au/trial-websites). Examples include the Australian and New Zealand Intensive Care Society Clinical Trials Group and the proposed Australian Clinical Trials Alliance.

In the past year, the NHMRC has committed $780 million to more than 1300 new grants, including 186 grants supporting clinical trials of all types. It is currently reviewing how it supports large investigator-initiated clinical trials, given that funding from a number of sources may be required, and intends to consult further during 2013.

Clive Morris
Head

Gordon McGurk
Director

Research Policy Taskforce, National Health and Medical Research Council

doi: 10.5694/mja13.10346

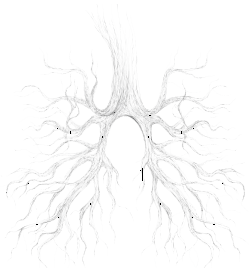
News

Improvements but Indigenous health still poor

Indigenous Queenslanders continue to die at eight times the rate of their non-Indigenous counterparts from diabetes and twice as often from circulatory diseases, and have seven times the incident rate of end-stage renal disease, despite some improvements in their health, according to the just-released *Aboriginal and Torres Strait Islander Health Performance Framework 2012 report*. The incidence rate of treated end-stage renal disease for Indigenous Queenslanders in 2008–2010 was seven times that of non-Indigenous people, with no significant change since 2001. Improvements between 2001 and 2010 include a 32% decline in avoidable mortality, a 30% decline in deaths from circulatory diseases, a 41% decline in infant mortality rates and increases in accessing antenatal care, allied health services and health assessment services. Hospitalisations for assault were seven times the rate for non-Indigenous Queenslanders and self-harm requiring admission occurred at twice the non-Indigenous rate. The report also found that Indigenous Queenslanders are underrepresented in health-related occupations.

Australian Institute of Health and Welfare. *Aboriginal and Torres Strait Islander Health Performance Framework 2012 report: Queensland.*

Bronchiectasis balancing act



The benefits of long-term macrolide treatment for patients with non-cystic fibrosis bronchiectasis must be balanced against increasing concerns about the development of resistance to both macrolides and other antibiotics, according to two studies in *JAMA*. The Bronchiectasis and Low-dose Erythromycin Study (BLESS) and the Bronchiectasis and Long-term Azithromycin Treatment (BAT) randomised trials found that the number of pulmonary exacerbations was significantly reduced by 12-month treatment with either erythromycin (BLESS) or azithromycin (BAT). "Both macrolides were superior to placebo with respect to improving lung function, and azithromycin also demonstrated significant improvement in disease symptoms and quality of life", an accompanying editorial said. Erythromycin significantly increased the proportion of macrolide-resistant commensal oropharyngeal streptococci, and azithromycin significantly increased macrolide resistance among respiratory pathogens. "The important issues for clinicians are to determine which patients with bronchiectasis should be prescribed a macrolide and which macrolide should be used", concluded the editorial.

JAMA 2013; 309: 1251-1259. doi: 10.1001/jama.2013.1937
JAMA 2013; 309: 1260-1267. doi: 10.1001/jama.2013.2290
JAMA 2013; 309: 1295-1296. doi: 10.1001/jama.2013.2780

Fewer hours do little to help interns

Reducing US interns' working hours has not increased their sleeping hours or improved their mental health, research has found. In the US, a reform of duty hours for first-year residents that took effect in July 2011 restricted shift lengths to a maximum of 16 hours. A longitudinal study compared interns serving in 2009 and 2010 with those serving after the new hours came in, surveying each group before their residency, and again in months 3, 6, 9 and 12 of their internship. The mean number of duty hours per week dropped from 67.0 to 64.3, the mean number of sleep hours per day was not significantly different (6.8 v 7.0), the mean Patient Health Questionnaire depression score did not change significantly (5.8 v 5.7) and the percentage of interns who worried about making a serious error increased significantly from 19.9% to 23.3%. "Different strategies for improving resident education and patient care may be necessary", the authors wrote.

JAMA Intern Med 2013; (online) 25 March
doi: 10.1001/jamainternmed.2013.351

Guidelines needed to kill research misconduct

Two linked essays in *PLOS Medicine* have called for national policies about, and policing of, research misconduct. The authors of one essay concluded from a literature search that few lower- and middle-income countries had reached even the stage of formal discussion of the problem. The exception was China, which has established an Office of Scientific Research Integrity Construction in response to "many accusations of misconduct". In many high-income countries, such as the United States, Canada and the United Kingdom, national policies have been developed in response to prominent cases of research misconduct. The authors noted, however, that "further research should be conducted on the effectiveness of different national strategies". They also concluded that developing an international set of guidelines was "an important step toward international cooperation in research ethics and integrity issues".

PLoS Med 2013; (online) 26 March
doi: 10.1371/journal.pmed.1001315

PLoS Med 2013; (online) 26 March
doi: 10.1371/journal.pmed.1001406

Cate Swannell

doi: 10.5694/mja13.n0415

From the MJA archives

Medical Department: June 26, 1833

Contagious disease on the convict ship *Portland*

Sir: I have the honour to acquaint you that I proceeded aboard the convict ship *Portland* and was informed by the surgeon that the guard embarked on the 28th of December, since when it appears by the sick-list 93 cases of disease have been treated on board, eight of which were *cholera morbus* and, of that number, three died. The last case of cholera occurred on the 6th of March, when the ship anchored at Lisbon but, not being permitted to communicate with the shore, proceeded to sea the next day. Several cases of typhus fever occurred during the voyage and two of the convicts and one of the crew died of that disease. Three other deaths took place from pulmonary consumption, dysentery and dropsy. The surgeon reported that every precaution had been taken to clear and ventilate the ship and there does not appear to be any contagious disease among the convicts, guard or crew. Consequently there will be no necessity for placing the ship in quarantine.

Jas. Bowman, published in "Out of the past" MJA 1954: 2 January