Specialist Medical Review Council

Reasons for Decisions

Section 196W
Veterans' Entitlements Act 1986

Re: Statements of Principles Nos. 35 and 36 of 2003
In Respect of Hypertension
Matter Nos. 2005/1 & 2
Requests for Review Declaration No. 11

SUMMATION

1. In relation to the Repatriation Medical Authority (the RMA) Statement of Principles No. 35 of 2003 in respect of hypertension and death from hypertension, made under subsection 196B(2) of the *Veterans' Entitlements Act 1986* (the VEA), the Specialist Medical Review Council (the Council) declares under subsection 196W(5) of the VEA, that it is of the view that the sound medical-scientific evidence available to the RMA is insufficient to justify an amendment of the Statement of Principles to include as a factor exposure to:

> 'occupational or work related stress consequent upon working in a high demand, low decision latitude or control job' or 'job strain'.

2. In relation to the RMA Statement of Principles No. 36 of 2003 in respect of hypertension and death from hypertension, made under subsection 196B(3) of the VEA the Council declares under subsection 196W(5) of the VEA, that it is of the view that the sound medical-scientific evidence available to the RMA is insufficient to justify an amendment of the Statement of Principles to include as a factor exposure to:

> 'occupational or work related stress consequent upon working in a high demand, low decision latitude or control job' or 'job strain'.

THE SPECIALIST MEDICAL REVIEW COUNCIL

3. The Council is a body corporate established under section 196V of the VEA, and consists of such number of members as the Minister for Veterans' Affairs determines from time to time to be necessary for the proper exercise of the function of the Council as set out in the VEA. The Minister must appoint one of the Councillors to be the Convener.

4. When a review is undertaken the Council is constituted by 3 to 5 Councillors selected by the Convener. When appointing Councillors, the Minister is required to have regard to the branches of medical science expertise which would be necessary for deciding matters referred to the Council for review.

5. Clinical Associate Professor Jonathan Phillips FRANZCP was the Convener of the Council for this review. He is currently a consultant in private practice, a past Chairperson of the Committee of Presidents of Medical Colleges and the former Director of Mental Health, Department of Human Services, South Australia. The other members of the Council were:

    (i) Professor Judith Whitworth AC FRACP who is currently Director of the John Curtin School of Medical Research; Howard Florey Professor of Medical Research, and is Head of the High Blood Pressure Research Unit, at the Australian National University. Professor Whitworth is Co-Chair of the World Health Organisation / International Society of Hypertension (WHO / ISH) Guidelines for the Management of Hypertension, and is Chair of the WHO's Global Advisory Committee on Health Research; and

    (ii) Dr Charles Guest FAFPHM, Medical Director of the Health Protection Service of the ACT Department of Health and Community Care; and Visiting Fellow at the Australian National University, National Centre for Epidemiology and Population Health; and

    (iii) Professor Christopher Tennant FRANZCP who is currently Professor of Psychiatry at Sydney University, and is the Unit Head Academic Psychiatry at the Royal North Shore Hospital; and

    (iv) Professor Leonard Arnolda FCSANZ, who is currently Professor of Cardiology at the University of Western Australia, Department of Cardiology at Royal Perth Hospital. Professor Arnolda is currently the Chair of the CSANZ hypertension working group.

THE LEGISLATION

6. The legislative scheme for the making of Statements of Principles is set out in Parts XIA and XIB of the VEA. Statements of Principles operate as templates which are ultimately applied by decision-makers in determining individual claims for benefits under the VEA and the *Military Rehabilitation and Compensation Act 2004* (the MRCA)[1].

7. Fundamental to Statements of Principles is the concept of 'sound medical-scientific evidence', which is defined in section 5AB(2) of the VEA. Information about a particular kind of injury, disease or death is taken to be sound medical-scientific evidence if:

> (a) the information
>
> (i) is consistent with material relating to medical science that has been published in a medical or scientific publication and has been, in the opinion of the Repatriation Medical Authority, subjected to a peer review process; or
>
> (ii) in accordance with generally accepted medical practice, would serve as the basis for the diagnosis and management of a medical condition; and
>
> (b) in the case of information about how that injury, disease or death may be caused meets the applicable criteria for assessing causation currently applied in the field of epidemiology[2].

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1 See sections 120, 120A and 120B of the VEA and sections 335, 338 and 339 of the MRCA.

2 This has been held to mean 'information which epidemiologists would consider appropriate to take into account' see *Repatriation Commission v Vietnam Veterans' Association of Australia NSW Branch Inc* (2000) 48 NSWLR 548 (the New South Wales Court of Appeal decision) per Spigelman CJ at paragraph 117.

8. The functions of the Council are set out in section 196W of the VEA. In this case, the Council was asked (under section 196Y of the VEA) by a person eligible to make a claim for a pension, to review the contents of:

   – Statement of Principles No. 35 of 2003, in respect of hypertension and death from hypertension, being a Statement of Principles determined by the RMA under section 196B(2)[3] of the VEA ('the reasonable hypothesis test'); and

   – Statement of Principles No. 36 of 2003, in respect of hypertension and death from hypertension, being a Statement of Principles determined by the RMA under section 196B(3)[4] of the VEA ('the balance of probabilities test').

9. Specifically, the Applicant contended that there was medical-scientific evidence upon which the RMA could have relied to include 'occupational or work related stress consequent upon working in a high demand, low decision latitude or control job' or 'job strain' as a factor in Statements of Principles 35 and 36 of 2003.

10. In conducting its review, the Council must review all the information that was available to (before) the RMA at the time it determined, amended, or last amended the Statement of Principles and is constrained to conduct its review by reference to that information only[5].

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1) [3] (2) If the Authority is of the view that there is sound medical-scientific evidence that indicates that a particular kind of injury, disease or death can be related to:
   a) (a)operational service rendered by veterans; or
   b) (b)peacekeeping service rendered by members of Peacekeeping Forces; or
   c) (c)hazardous service rendered by members of the Forces; or
   d) (ca)warlike or non-warlike service rendered by members;
   a) the Authority must determine a Statement of Principles in respect of that kind of injury, disease or death setting out:
   e) (d)the factors that must as a minimum exist; and
   f) (e)which of those factors must be related to service rendered by a person;
   a) before it can be said that a reasonable hypothesis has been raised connecting an injury, disease or death of that kind with the circumstances of that service.
   b)

2) [4] (3) If the Authority is of the view that on the sound medical-scientific evidence available it is more probable than not that a particular kind of injury, disease or death can be related to:
   c) (a) eligible war service (other than operational service) rendered by veterans; or
   d) (b) defence service (other than hazardous service) rendered by members of the Forces; or
   e) (ba) peacetime service rendered by members;
   f) the Authority must determine a Statement of Principles in respect of that kind of injury, disease or death setting out:
   g) (c) the factors that must exist; and
   h) (d) which of those factors must be related to service rendered by a person;
   i) before it can be said that, on the balance of probabilities, an injury, disease or death of that kind is connected with the circumstances of that service.
   j)

5 *Vietnam Veterans' Association (NSW Branch) Inc v Specialist Medical Review Council and Anor* (full Federal Court decision) (2002) 72 ALD 378 at paragraph 35 per Branson J.

11. Under section 196W of the VEA, the Council can only reach the view that a Statement of Principles should be amended on the basis of sound medical-scientific evidence.

BACKGROUND

12. On 12 August 2003, the RMA under subsections 196B(2) and (3) of the VEA determined the Statements of Principles being instruments respectively numbered 35 and 36 of 2003 in respect of hypertension.

13. On 18 August 2003 in accordance with section 42 of the *Legislative Instruments Act 2003* the Statements of Principles were tabled in the House of Representatives and in the Senate.

14. On 20 August 2003 the making of the Statements of Principles was notified in the Gazette (No. 33, p. 2472).

15. An application dated 3 November 2003 for review of Statements of Principles numbers 35 and 36 of 2003 was received by the Council on 12 November 2003. Specifically the application was concerned with the decision of the RMA of 12 August 2003 not to include 'occupational or work related stress consequent upon working in a high demand, low decision latitude or control job' or 'job strain' as a factor in those Statements of Principles.

16. Pursuant to section 196ZB of the VEA the Council published in the Gazette a notice of its intention to carry out a review of all the information available to the RMA about hypertension, and inviting persons or organisations authorised so to do to make submissions to the Council (Gazette number 50 of 17 December 2003, p. 3832). The Council gazetted two subsequent notices as to the dates by which written submissions must be received by the Council: Gazette Notice 19 of 12 May 2004 (p. 1212) and Gazette Notice 31 of 4 August 2004 (p. 2421).

17. On 24 February 2004, the RMA under:

- subsection 196B(2) of the VEA amended Statement of Principles numbered 35 of 2003 in respect of hypertension by determining Instrument No. 3 of 2004; and
- subsection 196B(3) of the VEA amended Statement of Principles numbered 36 of 2003 in respect of hypertension by determining Instrument No. 4 of 2004.

18. On 1 March 2004 in accordance with section 42 of the *Legislative Instruments Act 2003* the amending Instruments were tabled in the House of Representatives and in the Senate.

19. On 3 March 2004 the making of the amending Instruments was notified in the Gazette (No. 9, p. 496).

20. On 6 December 2004 the Council wrote to the Applicant and the Repatriation Commission advising them of the Council's preliminary views of the scope of the review and pool of information. The Applicant and the Repatriation Commission

were invited to make written comments as to these preliminary views by close of business on 21 January 2005, and to make any oral comments at the hearing of oral submissions complementing the written submissions.

21. The Council held a meeting to hear oral submissions complementing the written submissions on Thursday 17 February 2005.

22. The Applicant submitted three written submissions, submitted written comments on the Council's preliminary views on the scope of the review and on the pool of information, and at the Council's meeting on 17 February 2005 made an oral submission complementing the Applicant's written submissions.

23. The Repatriation Commission made one written submission. The Repatriation Commission stated that it did not wish to make any further comments (other than its written submission) about the Council's preliminary views on the scope of the review and on the pool of information, save to endorse the Council's preliminary views on the pool of information. A Medical Officer with the Department of Veterans' Affairs, representing the Repatriation Commission, made an oral submission complementing the Commission's written submission at the Council's meeting on 17 February 2005.

Previous Council Review of Statements of Principles in respect of hypertension

24. The Council has previously considered the particular factor under review in a review of now revoked Statements of Principles in respect of hypertension. The Minister has appointed, and the Convener has selected, a newly constituted Council to conduct this review, to ensure that there is no apprehension of bias or prejudgement[6].

25. On 2 March 2002 the (previously constituted) Council published its reasons for recommending that the RMA consider including a job strain factor in the Statements of Principles then in force. The RMA subsequently undertook a new investigation into hypertension, as a result of which it declined to follow the Council's recommendation (as it was entitled so to do).

[6] Noting, however, that the Convener (only) was a member of the previously constituted Council as a Councillor. The Convener has only a deliberative vote (subsection 196K(5)).

26. A copy of the (previously constituted) Council's Reasons for Decision was included in the information which was forwarded to this Council by the RMA. However, the Council took the view that it should not rely on the (previously constituted) Council's Reasons, but that it should consider for itself all the information which was before the RMA when it determined, amended, or last amended the Statements of Principles under review.

27. The Council was cognisant that not all the information before it had been before the (previously constituted) Council when it had considered the issue. Importantly, the (previously constituted) Council's Reasons for Decision were drafted before the way in which the Council carries out its functions had been settled by the Courts. Thus this Council and the previously constituted Council were operating within a different legal and administrative framework when undertaking their respective reviews.

28. Accordingly, the Council approached its task without any preconceptions, applying the two-stage process discussed below to the entirety of the information which was before the RMA at the time it determined, amended, or last amended the Statements of Principles under review.

SCOPE OF REVIEW

29. The Council's preliminary view, as advised to the Applicant and Repatriation Commission on 6 December 2004 was as follows:

> without limiting the scope of its review of the whole of the contents of the Statements of Principles, [the Council] presently proposes to have particular regard to whether there is sound medical-scientific evidence upon which the RMA could have relied to amend the Statements of Principles in any or all of the following ways:
>
> (i) the possible inclusion of a factor in Statement of Principles number 35 of 2003…namely 'occupational or work related stress consequent upon working in a high demand, low decision latitude or control job' or 'job strain'; and
>
> (ii) the possible inclusion of a factor in Statement of Principles number 36 of 2003…namely 'occupational or work related stress consequent upon working in a high demand, low decision latitude or control job' or 'job strain'.

POOL OF INFORMATION

30. The RMA is obliged under section 196K of the VEA to send to the Council all the information that was available to it (the RMA) when it determined, amended, or last amended the Statements of Principles. That comprises all the information that was available to the RMA when it determined the original Statements of Principles in 1995, and all the information subsequently available at all times when the Statements of Principles have been amended, or revoked and replaced, up to and including that information which was available in August

2003 when the RMA determined the Statements of Principles under review**.** In other words, within 28 days after being notified that the Council has been asked to conduct a review, the RMA must send to the Council all the information in respect of hypertension which was in the possession of the RMA at the time it (the RMA) made the decision that triggered the Council's review.

31. Since the Council has previously conducted a review of the Statements of Principles then in force in respect of hypertension, the RMA did not resend the information it had previously sent for that review in September 2001 (which comprised all the information then available to (before) the RMA at the time it made the now revoked Statements of Principles). The Council had retained all that information, and took it, and the additional information forwarded by the RMA in December 2003 into account for the purposes of this review. Copies of all the information, including that sent by the RMA to the Council for its review in 2001 was made available to the Applicant and the Repatriation Commission for the purposes of this review.

32. The Council's preliminary view, as advised to the Applicant and Repatriation Commission on 6 December 2004 was that the pool of information should be identified from the information that was available to (before) the RMA when it determined, amended, or last amended the Statements of Principles, sent to the Council by the RMA under section 196K (in 2001 and subsequently in 2003) and should comprise sound medical-scientific evidence as defined in section 5AB(2) of the VEA being information which:

- epidemiologists would consider appropriate to take into account; and
- in the Council's view, 'touches on' (is relevant to) 'job strain' and has been evaluated by the Council according to epidemiological criteria, including the Bradford Hill criteria.[7]

33. In September 2004 the RMA sent to the Council (pursuant to section 196K of the VEA) the additional information available to it (the RMA) when it respectively amended Statements of Principles Nos. 35 and 36 of 2003 by determining Instruments Nos. 2 and 3 of 2004. Without deciding whether this was information which the Council should take into account for the purposes of its review of Statements of Principles 35 and 36 of 2003, the Council did not include the additional information in the pool of information, as in the Council's view it was not information that 'touched on' 'job strain'.

34. A copy of the preliminary list of the proposed pool of information was forwarded to the Applicant and Repatriation Commission, and is attached at **Appendix A.**

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[7] see Bradford Hill, A (1965) 'The Environment and Disease: Association or Causation?' *Proceedings of the Royal Society of Medicine* Section of Occupational Medicine, Meeting January 14, pages 295 to 300.

APPLICANT'S SUBMISSIONS

35. In his application of November 2003, the Applicant stated that his grounds for review were as follows:

> The failure of the RMA to give proper consideration and accord due weight to the SMRC decision (detailed at SMRC Declaration No. 6 dated 12 March 2002) that there was sufficient sound medical-scientific evidence on Job Strain to justify an amendment to SOPs 31 and 32 of 2001.
>
> The failure of the RMA to give due weight to the latest medical-scientific evidence relating to Job Strain.
>
> The RMA decision to rely on 'Researchers findings' to provide a critical review of medical-scientific information relating to stress and hypertension with a particular focus on job strain and hypertension.
>
> The slavish adherence to the 'Bradford Hill criteria', by the RMA, to deny sound medical-scientific evidence relating to Job Strain…

36. The Applicant made a number of comprehensive written submissions, all of which were taken into account by the Council. These comprised written submissions prepared on or about 3 November 2003, 12 April 2004 and 25 July 2004, received by the Council on or about 12 November 2003, 20 April 2004 and 25 July 2004 respectively. As mentioned above, the Applicant also made a comprehensive oral submission complementing his written submissions[8].

37. In summary, the Applicant's primary submission was that there was sound medical-scientific evidence upon which the RMA could have relied to have included a job strain factor in the Statements of Principles under review.

> After a great deal of research I found medical/scientific evidence that job strain does cause stress, stress leads to elevated blood pressure, elevated blood pressure leads to hypertension, and hypertension can lead to stroke, especially in high demand but low control jobs!

38. In support of this submission, the Applicant relied upon what he identified as key passages from a number of medical-science articles. These articles were before the RMA, and were contended by the Applicant to be sound medical-scientific evidence.

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[8] The discussion of the Applicants submissions set out in these Reasons is derived from the written submissions and the complementary oral submission here identified.

The passages[9] highlighted by the Applicant in his complementary oral submission at the Council's meeting on 17 February are extracted below.

– Life-Course exposure to Job Strain and Ambulatory Blood Pressure in Men by Landsbergis et al, Am J Epidemiology 2003 157: 998-1006. RMA 28214.

> These findings provide some support for the hypothesis of an effect of the cumulative burden of exposure to job strain on the systolic blood pressure (Abstract at page 998).

– The Relationship between Job Strain, Workplace Diastolic Blood Pressure, and Left Ventricular Mass, by P.L. Schnall, et al, JAMA 11 April 1990, 263(14): 1929-35. RMA 12159.

> … job strain may be a risk factor for both hypertension and structural changes to (sic) [of] the heart [in working men] (Abstract at page 1929)

– Stress and Hypertension. Kulkarni S, O'Farrell I, Erasi M and Kochlar MS. WMJ 1998 Dec 97 (11): 34-38. RMA 20009.

> Stress can cause hypertension through repeated blood pressure elevations (Abstract at page 34) … Factors affecting blood pressure through stress include white coat hypertension, job strain, race, social environment and emotional distress (Abstract at page 34). Although stress may not directly cause hypertension, it can lead to repeated blood pressure elevations, which eventually may lead to hypertension (Abstract at page 34).

– Sympathetic Activity in Experimental and Human Hypertension by Murray Esler. Handbook of Hypertension, Vol. 17. Pathophysiology of Hypertension. 1997 Chap 19. RMA 19904.

> In short, although the concept that in some patients essential hypertension may arise by psychosomatic mechanisms is not entirely unproven, there is a wealth of supporting experimental and clinical evidence. [Long-term neural effects of stress on renal function could possibly be the principal blood pressure elevating mechanism] (at page 647).

– The Adrenaline Hypothesis Revisited: Evidence for Adrenaline Release from the Heart of Patients with Essential Hypertension by Magdalena S Rumantir, et al., Journal of Hypertension 2000, 18: 717-723. RMA 19905.

> On-going stress leads to an accumulation of adrenaline which subsequently causes vasoconstriction and hypertension[10].

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9 The Council has presented the references to these passages as set out in the written submissions to it. However, the Council acknowledges its sources in acordance with the 'Author-date' system described in the Commonwealth of Australia 2002, *Style manual*, 6th edn, John Wiley & Sons Australia Ltd, pp. 187-232. The Council notes that the Applicant did not provide the page citation for any of the following extracts. Where possible, these have been sourced by the Council.

10 The Council notes that the Applicant did not provide any page reference for this citation. The Council has not been able to source the extract in the form quoted.

–National Heart, Lung and Blood Institute Report of the Task Force on Behavioural Research in Cardiovascular, Lung, and Blood Health and Disease. Dated February 1998 Pages 4, 8, 50, 64. RMA 19906.

> Three types of behavioural variables are implicated in individuals' risk for disease: … occupational stress (at page 4) …In addition, long term occupational stress, such as the strain of a demanding job that affords little opportunity for decision-making, increases risk for CHD, hypertension and stroke (at page 8) … "Job Strain" results from holding demanding jobs that offer little opportunity for employee control or independent decisions (at page 50) … In humans, increased prevalence of hypertension is associated with individuals' long-term exposure to daily stressors such as… having high-demand and low-control jobs (at page 64).

–Job Strain, Blood Pressure and Response to Uncontrollable Stress. Andrew Steptoe, et al. Journal of Hypertension 1998, 17 Issue 2, 0193-0200. Accepted 16 October 1998. RMA 19951.

> … Job strain is associated with a heightened blood pressure response to uncontrollable but not controllable tasks (Abstract at page 193).

–The effects of Environmental and Lifestyle Factors on Blood Pressure and the Intermediary Role of the Sympathetic Nervous System. T.G. Pickering. Journal of Human Hypertension 1997 Aug. 11 Suppl 1: 8918. RMA 19952.

> Occupational stress can be evaluated as job strain, which is a combination of high demands at work with low decision latitude or control (Abstract at page S9).

–Behaviour and Blood Pressure. Implications for Hypertension by Andrew Steptoe. Handbook of Hypertension, Vol. 17. Pathophysiology of Hypertension, 1997, Chapter 20. RMA 19907.

> Karasek's Demand-Control model of work stress (at page 687) … Moreover, a substantial case control study of working men aged 30-60 years has shown that exposure to job strain substantially increases the likelihood of hypertension (112) (at page 688) … Work can be a source of chronic stress (at page 692).

–Job Strain and Ambulatory Blood Pressure Levels in a Population-Based Employed Sample of Men from Northern Italy by G. Cesana, et al, Scandinavian Journal Work Environ Health August 1996, 22(4): 294-305. RMA 11362.

> Among normotensive working men the highest measure for systolic blood pressure was not found in the high-strain group (Abstract at page 294).

–Association between Job Strain and Prevalence of Hypertension: A Cross Sectional Analysis in a Japanese Working Population with a Wide Range of Occupations: The Jichi Medical School Cohort Study by A Tsutsume (sic), et al. Occupational Environ Med 2001: 58; 367-373. RMA 24408 & 22672.

The findings provided limited proof that job strain is related to hypertension in Japanese working men (Abstract at page 367).

–Association between Ambulatory Blood Pressure and Alternative Formulations of Job Strain, by P.A. Landsbergis, et al. Scand J Environ Health 20 (5) pp 349-350 (sic). RMA 7945[11].

The one unequivocal cohort study found significant increases in systolic (6.0 mm Hg) and diastolic (3.8mm Hg) blood pressure in subjects facing job strain at both entry into the study and three years later (at page 349-350).

–High Effort, Low Reward, and Cardiovascular Risk Factors in Employed Swedish Men and Women: Baseline Results from the WOLF Study, by Richard Peter, et al. Journal of Epidemiology Community Health, 1998, 52: 540-547. RMA 20920.

Findings lend support to the hypothesis that effort-reward imbalance represents a specific constellation of stressful experience at work related to cardiovascular risk. The relation was not explained by relevant confounders (for example, lack of physical activity, body weight, cigarette smoking) (Abstract at page 540).

–Stress and the Individual. Mechanisms Leading to Disease by R. McEwen and E. Stellar. Archives of Internal Medicine, Vol. 153 pp 2093-2101. RMA 27620.

The cumulative strain on the body produced by repeated ups and downs of physiologic response, as well as the elevated activity of physiologic systems under challenge and the changes in metabolism and the impact of wear and tear on a number of organs and tissues, can predispose the organism to disease. We define this state of the organism as *allostatic load* … Stress is one of the factors that contribute to allostatic load (at page 2094).

–Work Stress and Coronary Heart Disease by C.Tennant, J of Cardiovascular Disease 2000. RMA 24507.

… work stress has clear implications for the health and welfare of employees and medico legal implications for employers (Abstract at page 273).

–BMJ 2002; 325:857 19 October 2002 Work stress and risk of cardiovascular mortality: prospective cohort study of industrial employees, Mika Kivimäki, Päivi Leino-Arjas, Ritva Luukkonen, Hilkka Riihimäki, Jussi Vahtera, Juhani Kirjonen. RMA 25388.

High job strain and effort-reward imbalance seem to increase the risk of cardiovascular mortality. The evidence from industrial employees suggests that attention should be paid to the prevention of work stress (Abstract at page 1).

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[11] The reference for this passage is; Schnall, Schwartz et al - 'The relationship between job strain and change in ambulatory blood pressure' (Presented at the Annual Meeting of the American Public Health Association San Francisco CA 1993) cited in Landsbergis et al 1994 (SMRC Folder 30, article 11).

39. The Applicant expressed concerns about the way in which the RMA had conducted its investigation, and its decision not to include a job strain factor in the Statements of Principles. In particular, the Applicant noted that not all the potentially relevant medical-science published at the relevant time had been sourced by the RMA. As examples the Applicant cited some abstracts and world wide web articles and a book (eds, Schnall et al)[12].

40. The Applicant further expressed concerns about the RMA's methodology when determining Statements of Principles, which focused upon what he submitted was a 'slavish' adherence to the Bradford Hill criteria, and the use of epidemiological criteria throughout the entirety of the process. Nevertheless, the Applicant submitted (in reply to the Repatriation Commission's complementary oral submissions), that the material upon which he relied met the criteria laid down by Bradford Hill.

41. In the Applicant's submission, the previously constituted Council's Declaration and Reasons were authoritive and should have been accorded 'due (authoritative and worthy) weight' by the RMA. The Applicant submitted that the Councils (both as previously constituted and currently) were 'specifically selected on the basis of their [the Councillors'] expertise in hypertension'. On the other hand, he submitted that the medical scientists constituting the RMA, while highly qualified and eminent, are 'not all specifically qualified in either hypertension and/or epidemiology.'

Applicant's comment on the Scope of Review and Pool of Information

42. The Applicant contended that the report of Professor Richard Gordon AO[13] provided clear evidence that the medical-science research by Professor Esler was being used in the day to day diagnosis, treatment and management of hypertension by Professor Gordon and his staff in Greenslopes Private Hospital. It was the Applicant's contention that such use satisfied section 5AB(2)(a)(ii) of the VEA, and that Professor Gordon's report should thus have been included in the pool of information.

43. The Applicant further requested that the Council consider all the key references and articles that the previously constituted Council had noted in its Reasons for Decision referable to the then Statements of Principles in respect of hypertension Nos. 31 and 32 of 2001. The Applicant submitted that some of those references should be accepted as sound medical-scientific evidence by this Council.

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12 Schnall PL Belkic K Landsbergis P Baker D (Guest Editors) January-March 2000 *Occupational Medicine The Workplace and Cardiovascular Disease State of the Art Reviews* Handley & Belfus, Inc Philadelphia.

13 who, at the time (11 June 2000) of writing the report was Director of the Hypertension Unit at Greenslopes Hospital and of the Endocrine-Hypertension Research Unit, University Department of Medicine, University of Queensland.

44. The Applicant tabled some materials (listed in **Appendix B**) that were not available to (not before) the RMA[14] (which the Applicant contended were in existence at the relevant times, and so could have been accessed by the RMA). The Council noted the Applicant's submission about these materials, but was unable to take them into account for the purposes of the review because they were not available to (not before) the RMA at the relevant times .

REPATRIATION COMMISSION'S SUBMISSIONS

45. The Repatriation Commission made a written submission (August 2004), and an oral submission complementing its written submission[15].

46. A Medical Officer with the Department of Veterans' Affairs, represented the Repatriation Commission at the Council's meeting on 17 February 2005, and was the principal author of the Repatriation Commission's written submission to the Council.

47. The Commission submitted that much of the information which had been available to (before) the RMA was of limited relevance in deciding the current review.

48. In the Repatriation Commission's submission, of that material which was relevant, most weight should be afforded to epidemiological studies. Non-epidemiological studies, e.g. those looking at physiological effects of stress, in the Commission's submission were only useful in relation to establishing biological plausibility.

49. It was submitted that there is an important distinction to be made between an effect of exposure to job strain on blood pressure as opposed to the effect of exposure to job strain in causing hypertension. It was further submitted, that any factor that does not require a permanent elevation of blood pressure should not be included as a cause of hypertension, as any temporary elevation of blood pressure is not a disease for the purposes of the VEA.

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14 Including the abstracts, web pages and book referred to in paragraph 39.

15 The discussion of the Repatriation Commissions submissions set out in these Reasons is derived from the written submissions and complementary oral submission here identified. The Council has presented references as set out in the written submissions to it. However, the Council acknowledges its sources in accordance with the 'Author-date' system described in the Commonwealth *Style manual* (as per footnote 9).

50. The Commission's submission focussed upon some of the articles discussing the the New York Work Site study[16], which the Commission submitted was the only study to use case-control methodology, and the only one to report a statistically-significant association between job strain and hypertension.

51. The Commission submitted that while it had a number of concerns about the New York Work Site Study the '…whole question of should there be a job strain factor in these Statements of Principles really boils down to the results of this study and the reliance you would place on them.' In the Commission's view 'the best evidence there is in support of this association' and 'the key piece of evidence' are the results from the New York Work Site Study as discussed in the Schnall et al (1990) article and the Schnall et al (1992) corrections paper. The Commission in its oral submission focussed upon the reporting by the authors of:

- significant odds ratio results[17] from a multiple logistic regression analysis of subjects with high job strain who underwent ambulatory blood pressure monitoring for a day. For anyone with an average work-time diastolic blood pressure determined by the ambulatory blood pressure monitoring:
    - of 85 in the day, they had an odds ratio of 3.1;
    - of 90 to 95 in the day, an odds ratio of 3.6; and
    - of 95 and above, an odds ratio of 24.4.

52. Further, the Commission submitted that in a second cross-sectional analysis, the same Schnall et al (1998) authors' notable findings included that:

    - subjects with job strain at baseline but not at three years showed decreases in blood pressure levels;

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16 Schnall PL, Schwartz JE, Landsbergis PA, Warren K and Pickering TG 1998, 'A Longitudinal study of job strain and ambulatory blood pressure: results from a three year follow-up, *Psycholosomatic Medicine,* vol. 60, pp. 697-706 (SMRC Folders 20 & 22, articles 26 & 3).

Schnall PL, Schwartz JE, Landsbergis PA, Warren K and Pickering TG 1992, 'Relation between job strain, alcohol, and ambulatory blood pressure', *Hypertension*, vol. 19, pp. 488-494 (SMRC Folder 22, article 58).

Schnall PL, Devereux RB, Pickering TG and Schwartz JE 1992, 'The relationship between "job strain", workplace diastolic blood pressure and left ventricular mass index: a correction', *JAMA,* vol. 267(9), p. 1209 (SMRC Folders 22 & 26, articles 57 & 53).

Schnall PL, Pieper C et al 1990, 'The relationship between 'Job strain', workplace diastolic blood pressure, and left ventricular mass index'. *JAMA*, vol. 263(14), pp. 1929-1935 (SMRC Folders 9 &14, articles 9 &11).

Landsbergis PA, Schnall PL, Warren K, Pickering TG and Schwartz JE 1994, 'Association between ambulatory blood pressure and alternative formulations of job strain'*, Scand J Work Environ Health*, vol. 20(5), pp. 349-363 (SMRC Folder 10, article 11).

17 Schnall et al 1990, set out the detail of these results as follows: Group 1, n=167 (67 cases and 100 controls) a cutoff point of greater than 85 mm Hg applied to the cases, an odds ratio of 3.1 (95% CI, 1.2 to 8.0); Group 2, n=145 (45 cases and 100 controls) a cutoff point of greater than 90 mm Hg applied to the cases, an odds ratio of 3.6 (95% CI, 1.2 to 10.7); Group 3, n=123 (23 cases and 100 controls) a cutoff point of greater than 95 mm Hg applied to the cases, an odds ratio of 24.4 (95% CI, 3.6 to 167.0).

- those with no job strain at baseline and job strain at three years did not show an increase in blood pressure; and
- those with job strain at base line and at three years did not have an increase in blood pressure over the three years but did have higher readings than those with no job strain at either time.

53. In the Commission's view the last two findings above are 'particularly important'. The Commission stated that this was:

> [t]hree years effectively [of] prospective evidence…It [job strain] has not influenced blood pressure in that time.

54. The Commission concluded:

> [t]here's only really the New York Worksite study giving us really any positive results or the cross-sectional data is essentially neutral. That prospective evidence, for what it is worth, is negative.

55. The overall findings of a further report of this study, at ten years of follow-up, were submitted to be of no or negative associations between job strain and systolic or diastolic blood pressure. In contrast, subjects with more than 25 years of employment, exposure to job strain for 50% of their work life, and job strain in recent years, had higher levels of systolic blood pressure at work and home.

56. While the Commission noted that the authors of the various articles reporting data from the New York Work Site study considered that their results offered some support for a cumulative burden of job strain having an effect on systolic blood pressure, the Commission considered that the mostly negative results more strongly supported the opposite conclusion.

57. The Commission submitted that there were notable methodological shortcomings with this study, particularly the potential for selection bias, misclassification and recall bias.

58. The Commission submitted that the other central study was the prospective Finnish Cohort Study[18], which found that job strain was associated with an increased risk of cardiovascular disease mortality. No association with (systolic) blood pressure was found.

59. In conclusion the Repatriation Commission submitted 'the evidence is all not very good, not convincing.' Its summary of the evidence was that only the New York Work Site study gave any positive results; the cross-sectional data was essentially neutral and the prospective evidence was negative.

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[18] Kivimaki M, Leino-Arjas P, Luukkonen R, Riihimake H, Vahtera J, & Kirjonen J 2002, 'Work stress and risk of cardiovascular mortality: prospective cohort study of industrial employees', *BMJ*, vol. 325(7369), pp. 857-861 (SMRC Folder 23, article 21); and

Aro S, Hasan J 1987, 'Occupational class, psychosocial stress and morbidity', *Annals of Clin Research,* vol. 19(2), pp. 62-68 (SMRC Folder 24, article 50).

60. The Commission's view was that the available evidence falls well short of establishing that it is more probable than not that job strain is a causal factor for hypertension, and that the evidence does no more than leave open the possiblity that job strain is a cause of hypertension.

61. In addition to its submissions about the medical science, the Commission submitted there was a problem in defining and measuring job strain:

> Job strain is not objectively measurable. Its presence relies on self-assessment, potentially made retrospectively. It is not possible to meaningfully determine a job strain dose. Assessed levels of job strain vary considerably over time, both within and between jobs. A job strain assessment at one point in time cannot be seen as an accurate measure of job strain levels over time. Individual perceptions and susceptibilities have an important impact, such that what constitutes job strain for one person will not do so for another.

Repatriation Commission's comments on the Scope of Review and Pool of Information

62. The Commission stated that there were no other factors it wanted the Council to consider apart from job strain.

63. The Commission concurred with the Council's proposed pool of information.

REASONS FOR THE COUNCIL'S DECISION

The Council's Task

64. In conducting a review the Council follows a two-step process. It first identifies the pool of information, ie by identifying from all the information that was available to the RMA when it determined, amended, or last amended the Statements of Principles the sound medical-scientific evidence (as that term is defined in section 5AB(2) of the VEA (see paragraph 7 above)) which touches on (ie is relevant to) the issue of whether a particular kind of injury, disease or death can be related to service.

65. The second step requires the Council to determine whether the sound medical-scientific evidence in the pool of information:

    a. points to (as opposed to merely leaves open)[19] the relevant possibility (whether job strain (if found to exist in a particular case) could provide a link or element in a reasonable hypothesis connecting hypertension or death from hypertension to relevant[20] service[21]). The Council had to find that the hypothesis contended for was reasonable, and not one which was 'obviously fanciful, impossible, incredible or not tenable or too remote or too tenuous'[22].

    b. concerning job strain (if found to exist in a particular case) could provide a relevant connection between hypertension or death from hypertension and relevant[23] service according to a standard of satisfaction 'on the balance of probabilities', or as being 'more probable than not'.

66. In these Reasons the association for both the reasonable hypothesis test (paragraph 65a.) and the balance of probabilities test (paragraph 65b.) are respectively referred to as the 'relevant association'.

67. It was with these tests firmly at the forefront of its collective mind that the Council considered the sound medical-scientific evidence in the pool of information and the submissions made by the Applicant and the Repatriation Commission referable to the contended factor.

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19 See full Federal Court decision at paragraph 49 per Branson J.

20 Relevant service here refers to operational, peacekeeping and hazardous service, and warlike and non-warlike service as those terms are defined in the VEA and the MRCA.

21 See *Vietnam Veterans' Association of Australia (NSW Branch) Inc v Specialist Medical Review Council and Anor* (2002) 69 ALD 553 (Moore J decision) per Moore J at paragraph 29.

22 See the full Federal Court decision in *Repatriation Commission v Bey* (1997) 79 FCR 364 which cited with approval these comments from Veterans' Review Board in *Stacey* (unreported 26 June 1985), all of which were in turn cited with approval in the Moore J decision at paragraph 33.

23 Relevant service here refers to eligible war service (other than operational service), defence service (other than hazardous service), and peacetime service as those terms are defined in the VEA and the MRCA.

68. In forming its judgement of whether the sound medical-scientific evidence pointed to the relevant association, the Council was conscious that the reasonable hypothesis test is 'a test of possibility'[24] and 'an unusually light burden'[25]. If the reasonable hypothesis test was found not to be satisfied, the balance of probabilities test necessarily could not be met.

Scope of Review

69. The Council decided to confine its attention to those matters identified in paragraph 29 above.

Pool of Information

70. As mentioned above, the first step for the Council was to determine the pool of information from the information that was available to (before) the RMA when it determined, amended, or last amended the Statements of Principles, as sent to the Council by the RMA under section 196K (in 2001 and subsequently in 2003).

71. As set out in paragraph 32 above, the Council's preliminary view was that the pool of information should comprise sound medical-scientific evidence as defined in section 5AB(2) of the VEA being information which:

- epidemiologists would consider appropriate to take into account; and
- in the Council's view, 'touches on' (is relevant to) 'job strain' and has been evaluated by the Council according to epidemiological criteria, including the Bradford Hill criteria.

72. The Council's final view on the pool of information was that it should comprise the sound medical-scientific evidence the Council had identified on a preliminary basis (Appendix A). In reaching this decision the Council took into account the written submissions and complementary oral submissions and considered whether any of the information to which it was referred, including the references and articles referred to in the Reasons for Decision[26] of the previously constituted Council, should be in the pool.

73. The Council noted that 15 of those articles were included in the preliminary (and so final) pool of information. The Council decided not to include the remainder of those articles in the pool because they did not satisfy the test set out in paragraph 71 above. The Council notes that 2 articles were not sent to the Council by the RMA pursuant to section 196K. Accordingly, the Council assumed that these articles were not before the RMA when it determined the Statements of Principles under review.

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24 See full Federal Court decision at paragraph 49 citing with approval Spigelman CJ in the New South Wales Court of Appeal decision at paragraph 111.

25 See full Federal Court decision at paragraph 55 per Branson J.

26 See the previously constituted Council's Reasons for Decision at paragraphs 54-55 and listed at paragraph 61, and at paragraph 56 and listed at paragraph 62.

74. The Council considered Professor Gordon an eminent and very reputable specialist, however it was considered that his report did not constitute sound medical-scientific evidence as defined in the VEA. Without deciding the issue, the Council considered it may have been information which would serve as a basis for the diagnosis and management of a medical condition in accordance with generally accepted medical practice. However, the Council did not consider that the necessary element in section 5AB(2)(b) that the information meet the applicable criteria for assessing causation currently applied in the field of epidemiology had been satisfied (ie, a report about the Applicant's individual circumstances would not be considered appropriate to be taken into account by epidemiologists). As noted above, the article[27] on the 'adrenaline hypothesis' co-authored by Professor Esler (as referred to by Professor Gordon) was included in the pool of information.

75. The Council noted the Applicant's reference to articles and a book which were not available to (not before) the RMA (see Appendix B). As mentioned above, the Council is unable to (and so did not) consider information which was not available to (not before) the RMA at the relevant times.

THE COUNCIL'S ANALYSIS OF THE INFORMATION BEFORE THE RMA

Should There Be A 'Job Strain' Factor?

76. Having settled the pool of information, the second question for the Council to consider was whether the sound medical-scientific evidence in the pool of information points to a potential job strain factor as a link or element in a reasonable hypothesis connecting hypertension to relevant service (see paragraphs 64, 65 and footnote 18) (and if so, whether the relevant association exists on the balance of probabilities).

77. Notwithstanding the issues raised by the Applicant which do not deal with the information (see paragraphs 35, and 39-41), the only basis upon which the Council can review the contents of a Statement of Principles is by reviewing all the information that was available to (before) the RMA when it determined, amended, or last amended the Statements of Principles, in order to ascertain whether there was sound medical-scientific evidence upon which the RMA could have relied to amend either or both of the Statements of Principles.

78. The Council considered all the evidence in the pool. However, given the large number of articles in the pool, the Council in these Reasons focuses upon its analysis of those articles which it considered most pertinent to the issues before it.

79. Ultimately, matters of weight are questions for the Council in the exercise of its expertise and scientific judgement, noting, as did the Applicant, that the

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[27] Rumantir, MS, Jennings, GL, Lambert, GW, Kaye, DM, Seals, DR and Esler MD 2000, 'The 'adrenaline hypothesis' of hypertension revisited: evidence for adrenaline release from the heart of patients with essential hypertension', *Journal of Hypertension*, vol. 18(6), pp. 717-723 (SMRC Folder 20, article 44).

Councillors are appointed to a particular review because of their specialist expertise in the particular condition (in this case hypertension).

Does the Sound Medical-scientific Evidence Point to the Relevant Association?

The Karasek Model

80. Karasek, R et al (1981) (1)[28] developed a 'high demand, low latitude model' which posited an association between job strain and increased coronary heart disease (CHD) risk. The commencement point for the authors was that research had indicated that pyschosocial stress may be an independent risk factor for the development of coronary heart disease, with associations said to have been found between coronary heart disease and heavy workload, and coronary heart disease and job dissatisfaction. The relative effects of individual and environmental characteristics as determinants of stress-related illness, however, remained unknown (at page 694).

81. Karasek et al:

> [p]ropose[d] a model which postulates that psychological strain, and subsequent physiological illness, result not from an aggregated list of both 'stressors' but from the interaction of two types of job characteristics. Strain results from the joint effects of the demands of the work situation (stressors) and environmental moderators of stress, particularly the range of decision-making freedom (control) available to the worker facing those demands… when demands are high and decision latitude low, we hypothesise that mental strain and increased CHD risk may arise (at page 695).

82. Decision latitude incorporates a range of elements, including control over the use of skill, time allocation and organisational decisions (page 697).

83. Karasek et al concluded that:

> [p]sychologically stressful job demands are associated with subsequent cardiovascular disease … low intellectual discretion was significantly associated with the CHD indicator, and shows a consistent, but not significant association, in the case-control study: low personal schedule freedom, in combination with high job demands, was significantly associated with CHD in the case-control study, and revealed consistent but not significant associations with the CHD indicator (at pages 699 – 700).

The observed effects of job characteristics were said to remain statistically significant[29] after controlling for generally accepted risk factors such as age, smoking, education and obesity.

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[28] The numbers in brackets after the authors of cited articles refer to the articles listed at pages 38 and 39 of these Reasons.

[29] As context dictates when discussing the medical-scientific evidence the Council uses: the word 'significant' and 'significance', or the words 'statistical significance' as technical statistical terms in relation to whether a difference or relationship exists. That is, the difference or relationship is unlikely to be due to chance alone. Last JM (ed) 2001 *A Dictionary of Epidemiology,* 4th Edition, Oxford University Press, p. 31, 168 & 173.

84. Karasek et al claim that their analysis of the coronary heart disease risk indicators provided overall support for the job strain theory. However, they noted there was a slight 'drop off' among the highest strain group in the prospective data, which was not observed in the cross-sectional analysis. They ascribed this to the loss of some participants from the study who fell into the lowest decision latitude category.

85. The authors analysed whether other factors (than job strain) explained the association for which they contended. They rejected the suggestion that those who work in high strain jobs are more susceptible to coronary heart disease and the suggestion that job changes during the follow-up period could have distorted the findings, saying that 'job change out of stressful jobs may have masked even stronger job/ coronary heart disease associations' (at page 702).

86. Their conclusion, therefore, was that:

> [l]ow decision latitude or environmental constraints on the worker's ability to decide how to respond to environmental demands appears to be an independent CHD risk factor … Decision latitude may represent a stress moderating factor with risk reducing consequences, instead of a job stressor (at page 702).

Council's analysis

87. The Council noted that the development of the Karasek model was part of a wider body of research on the role of psychosocial factors such as environmental stress in the etiology of cardiovascular disease and hypertension. The Karasek job strain model focuses on features of the work environment which may trigger disease. There are a number of articles in the pool of information discussing the Karasek model relating the interaction of two job characteristics (ie high demand, low decision latitude) and health status.

88. The Council noted that the Karasek model requires that both the characteristics of that model must be present to justify a finding that job strain is present in particular cases. Satisfactory identification and measurement of job strain are necessary preconditions to determining whether there is a relevant association between job strain and hypertension. The Council considered that the issue before it was made very difficult because job strain is an ill-defined concept. The Council considered that the sound medical-scientific evidence in the pool of information did not identify a satisfactory, objective measurement of job strain.

89. The Council noted too that the Karasek study focused on coronary heart disease, and not hypertension as a separate risk factor for coronary heart disease. The Council was of the view that it is very difficult to extrapolate that findings referable to coronary heart disease necessarily related to hypertension. In addition, the six-year follow-up did not separately report hypertension.

90. Another fundamental difficulty which the Council considered affected the weight to be accorded to the findings of the study was that the analysis of job demand was dependent upon the self-reporting of the participants. This is necessarily subjective, as the participants know their hypertensive status, and may

retrospectively ascribe it to job strain. This is likely to bias the results towards finding a positive association between job strain and hypertension.

91. The Council came to, and remained of, this view despite the comments of Schnall et al (2) (1994) that the Karasek Job Content Questionaire was designed to assess objective job characteristics. The authors there stated that the:

> Concerns about the subjectivity of perceptions in self-report data are substantially addressed by 11 job strain studies in which national averages of job characteristics for a particular job title are assigned to individuals having that job title, thereby effectively excluding the subjective component of reported job characteristics data (at page 320).

92. Overall, the Council considered that the study had lost sensitivity and specificity, and was at best weak evidence in support of an association between job strain and hypertension (as opposed to coronary heart disease as to which the Council makes no comment).

Work Site Blood Pressure Study in New York

93. The Council considered the following series of articles on the Work Site Blood Pressure Study (and work history substudy) in New York to be seminal:

Schnall et al 1990 (3)	original cross-sectional analysis - seven worksites (time 1).
Schnall et al 1992 (4)	correction letter to 1990 article.
Schnall et al 1998 (5)	3 year follow-up analysis - eight worksites (time 2).
Landsbergis et al 1994 (6)	work history substudy; cross-sectional analysis - eight worksites.
Landsbergis et al 2003 (7)	work history substudy 10 year follow-up analysis - ten worksites.

94. The Schnall et al (3) study was of working men (n=215) drawn from seven New York work sites each employing at least 150 men. To maximise the generality of the findings the selected work sites and departments included a wide range of 'blue-collar' and 'white-collar' occupations.

95. This case-control study took as its starting premise the Karasek et al conclusions that the combination of high psychological demands and low decision latitude were risk factors for coronary heart disease, and sought to ascertain whether job strain was associated with increased workplace diastolic blood pressure and left ventricular mass index (LVMI) (at page 1929).

96. The study (referred to by the authors as Time 1 data) was controlled for age, body mass index, race/ethnicity, current smoking status, alcohol consumption,

type A behaviour, worksite, 24-hour urine sodium excretion, education, and physical demand level of job. It was found that job strain may be a risk factor for hypertension and structural changes of the heart (at page 1929).

97. It was found that the strength of association between job strain and hypertension becomes stronger (odds ratio of 3.6 compared to odds ratio of 3.1) when 'having hypertension is defined by repeated casual work-site blood pressure measurements…in combination with work-time ambulatory blood pressure (ABP) measurements' compared to when having hypertension is defined by 'repeated casual work-site blood pressure measurements alone.' High levels of psychological demand and low levels of perceived control (decision latitude) must both be present for job strain to occur. Neither component on its own related to blood pressure after controlling for age (at page 1934).

98. Controlling for the above variables (see paragraph 96) in subjects (n=151) never treated for hypertension but exposed to job strain, it was found that electrocardiographically determined left ventricular mass index was, on average, 4.7 g/m^2 greater than in those not exposed. For subjects aged 30-40 years, exposure to job strain was associated with a 10.8 g/m^2 left ventricular mass index compared with those not exposed (at page 1933).

99. However, the strength of the positive association claimed by Schnall et al was over-stated. In a published correction letter Schnall et al (4) (1992) stated:

> In practice, the upper body limit for body mass index (BMI) was 32.5 kg/m^2 instead of 30 kg/m^2, as published (at page 1209).
>
> Finally we should have noted that the first worksite (typographers) was our pilot study and that the upper limits for blood pressure (160/105 mm Hg) were applied at the recruitment stage and not at screening (at page 1209).
>
> After correctly merging the echocardiographic data, we no longer find a significant effect of job strain on left ventricular mass index (LVMI) among the 30- through 39-year-olds (at page 1209).
>
> When we replicate the identical analysis to that reported in the article, the main effect of job strain on LVMI is 5.4 gm/m^2 (P=.10, two tailed; n= 146). However, when three subjects with a past (but not current) history of antihypertensive treatment are included, we observe a 7.3 gm/m^2 elevation in LVMI for subjects on high-strain jobs (P=.03, n= 149) (at page 1209).

100. The authors concluded that if their model were correct, job situations where the level of work demands exceed the individual's ability to control or deal with those demands creates a challenge that activates the sympathetic nervous system and leads to an elevation of blood pressure at work. Further, the authors speculated that long term exposure (over years) to job strain ultimately results in sustained elevation of blood pressure that causes structural change in the cardiovascular system (at page 1935). The authors in the correction letter claim that they believe that the corrected analysis, in conjuction with an ‘in press'

publication[30] continue to support the existence of a relationship of job strain to hypertension and left ventricular mass index (at page 1209).

101. A similar group of authors in Schnall et al (5) investigated men from eight New York work sites who wore an ambulatory blood pressure monitor for 24 hours. They completed a 3 year follow-up (Time 2 data) of most of the original subjects (n=195) recruited at Time 1 (at page 697). On this occasion the authors replicated the original Time 1 cross-sectional analysis, using the Time 2 cross-sectional data. The second part of the study was a longitudinal analysis first to test their prediction that those;

- who were in high job strain jobs at both Time 1 and Time 2 would exhibit higher ambulatory blood pressure at Time 2 than those exposed to job strain at only one of the assessments; and
- in high strain jobs at both Time 1 and Time 2 would exhibit a greater increase in ambulatory blood pressure than those who did not have a high job strain at either assessment.

This was based on a theory of 'cumulative exposure'. Secondly, based on a theory of 'parallel change', the authors expected to see an increase in ambulatory blood pressure among those whose job situation changed from non-high strain at Time 1 to high strain at Time 2, and a decrease in ambulatory blood pressure among those whose job changed from high strain to non-high strain (at page 697).

102. In the cross-sectional study using the Time 2 data it was found that those in the high strain jobs had higher systolic ambulatory blood pressure at work, at home, and during sleep, and higher diastolic pressures at work and home. The magnitude and direction of the effects were similar to those reported at Time 1 (at page 703).

103. After controlling for age, body mass index, race/ethnicity, current smoking status, and alcohol consumption status, men classified as having high strain jobs had work and home systolic ambulatory blood pressures that were on average 6 to 8 mm Hg higher than men not having high strain jobs. Sleep systolic ambulatory blood pressure was 5-7 mm Hg higher among those in high strain jobs. Their work and home diastolic ambulatory blood pressures were also higher at both assessments (2 to 5 mmHg) (at page 700).

104. In the longitudinal study it was found that those without job strain at the time of the initial study and the follow-up three years later had the lowest average ambulatory blood pressure at both times. Those with chronic job strain had the highest ambulatory blood pressure at both times. The two groups whose job strain status had changed had intermediate blood pressures on both occasions (at page 701).

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30 Schnall, PL, Schwartz, JE, Landsbergis, PA, Warren, K & Pickering, TG 1992, 'Relation between job strain, alcohol, and ambulatory blood pressure', *Hypertension*, vol. 19, pp. 488-494 (SMRC Folder 22, article 58).

105. The findings discussed above were presented by the authors in Table 5 (at page 702):

Adjusted[a] Mean Change in Ambulatory Blood Pressures over 3 Years (mm Hg), by Job Strain Change Group Location

	df	Job Strain (Time1, Time 2)				Significance of *F* test
		No-No (N=138)	No-Yes (N=17)	Yes-No (N=25)	Yes-Yes (N=15)	
Work						
Systolic BP	186	1.0	1.0	-5.3*	1.3	14
Diastolic BP	186	0.9	0.0	-3.2**	0.6	.07
Home						
Systolic BP	166	-0.7	-1.0	-4.7*	1.1	.26
Diastolic BP	166	0.4	-0.4	-3.3*	1.7	10
Sleep						
Systolic BP	129	0.1	-1.3	-1.9	0.4	.96
Diastolic BP	129	-0.6*	-3.6	-0.4	0.5	.17

[a] based on a repeated-measures analysis that controls for race/ethnicity as a between-person factor and age, body mass index, current smoking status, and alcohol consumption status as within-person factors. Systolic BP analyses also control for a curvilinear (quadratic) effect of age. Note that the changes reported in this table do not necessarily equal the corresponding differences between Time 1 and Time 2 adjusted means reported in table 4; this analysis assumes that the coefficients of the covariates are equal at Time 1 and Time 2, due to a lack of any significant Time-by-covariate interactions (see text). * $p < .05$: ** $p < .01$ for test of H_o, group mean = 0.

106. The authors concluded that those in high strain jobs have substantially higher systolic ambulatory blood pressure at work, at home, and during sleep, (11 – 12 mm Hg systolic ambulatory blood pressure) and higher diastolic pressures at home and work (6 – 9 mm Hg diastolic ambulatory blood pressure). That the results were replicated from the initial study to the follow-up was claimed to constitute important evidence of an association between job strain and ambulatory blood pressure (at page 703). By way of illustration of the size of the difference, it was said to be larger than the estimated effect of ageing 25 years or gaining 50 pounds in weight.

107. Issues which the authors suggested may weaken their conclusions were that the sample of those in the chronic strain group was very small in size (8% of 215=17 & 8% of 151=12). While the results seemingly supported the cumulative exposure theory (i.e. that greater and continued exposure is associated with higher ambulatory blood pressure), consistency would have predicted an increase in ambulatory blood pressure at the three-year follow-up, after controlling for age and changes in weight. This did not occur. The authors speculated that beyond some point, additional exposure to job strain in a chronically exposed population may result in little or no additional increase in ambulatory blood pressure – 'a saturation effect' (at page 703).

108. The authors' initial prediction that changes in job strain would be associated with comparative changes in ambulatory blood pressure (the parallel changes theory), however, was not uniformly vindicated. Those participants in the study who experienced job strain at follow-up, but not at the time of the initial study, did not demonstrate an increase in ambulatory blood pressure. Their blood pressures, however, were higher at both times than the group unexposed to job strain at either time. In contrast, those exposed to job strain at the initial study,

but not at follow-up, had a statistically significant decrease in ambulatory blood pressure at work and home (5/3 mm Hg), the effect of which was comparable in magnitude, but opposite in direction, to the effect of ageing 15 years or gaining more than 40 pounds (page 703).

109. The authors considered a possible explanation of the difference between those transitioning to an exposure to job strain (who showed little or no increase in ambulatory blood pressure), and those no longer exposed to job strain (who showed a statistically significant decline in ambulatory blood pressure) was that the increase in decision latitude in the second group was substantial, and far exceeded the decline in latitude in the former group.

110. That there may be a latency period for the effects of job strain to become manifest was an alternative possible explanation. It was considered the follow-up may have been too soon after the initial study for any changes to have become evident.

111. In conclusion, the authors considered that the study and follow-up provided 'modest, but indirect' support for job strain impacting on blood pressure, with hypertension being the mediating cause for the increased risk of coronary heart disease as found by Karasek et al. The authors considered their findings were unlikely to be affected by confounding. If anything, they considered their outcomes were likely to have underestimated the impact of job strain, given that measurements were only taken at outset and follow-up three years later, without assessing participants' exposure to job strain prior to entry into the study (at page 704).

112. The article by Landsbergis et al (6) is based on the same New York Work Site Blood Pressure Study. It sought to analyse how the different formulations of job strain (a combination of demands and decision latitude) might affect the relationship with ambulatory blood pressure and hypertension. This article seemingly provides qualified support for the relevant association. The focus of the analysis was again said to be to ascertain whether blood pressure was a possible biological mechanism linking job strain and cardiovascular disease.

113. With respect to those employees included in the high strain group, their systolic blood pressure at work was significantly higher (6.7 mm Hg; ≈ 0.89 kPa) than that of other employees. Work diastolic blood pressure was also found to be significantly higher (2.7 mm Hg; ≈ 0.36 kPa) (at page 354). For low decision latitude and high demand jobs, however, there was found to be a significant association with systolic blood pressure, but no significant association with diastolic blood pressure (page 356).

114. The authors concluded that:

> [a]ll four formulations of high job demands and low job decision latitude (our operationalisation of the concept of job strain) were significantly associated with elevated ambulatory systolic blood pressure. However, associations with diastolic blood pressure and risk of hypertension appeared to be more appropriately modelled as the sum of two significant main effects. The components of decision latitude (each in combination with high demands) were also significantly associated

with outcome … the impact of job strain, at least on systolic blood pressure, is consistent and robust across operationalisation of this psychosocial risk factor (at page 360).

115. Limitations noted by the authors included the cross-sectional design of the study, and potential selection biases (that participants with elevated blood pressure choose high strain jobs, and may have Type A behaviour, anger, anxiety and other pre-disposing personality traits), chance and self-reporting of job strain. The threshold requirement that participants be at their work site for at least three years was a mechanism designed to reduce the selection bias of hypertensive persons selecting high strain jobs.

116. The authors identified further research which needed to be done in order to confirm their findings - prospective studies; a greater number of female participants; different racial mix; more objective characterisation of job demand; and other variables such as 'social support, job insecurity, physical exertion, and hazardous environmental exposures and their relation to job strain and illness' (at page 361).

117. The same authors, Landsbergis et al (7), when presenting a subsequent analysis also provided the table below (Table 1 at page 999) that presented the relationship between the 'Work Site Blood Pressure Study in New York' and their 'Work history substudy':

Numbers of eligible subjects entering the Work Site Blood Pressure Study in New York City, New York, and participation in the work history substudy, 1985-1995.

Time at entry	Year of entry	Men (no.)	Women (no.)
Work Site Blood Pressure Study			
Time 1	1985-1988	283	25
Time 2	1988-1991	7	54
Time 3	1991-1995	6	97
Total		296	176
Work history substudy (1991-1995)			
Eligible subjects participating at time 3		222	161
Work history substudy subjects for whom data were completed (1991-1995)*			
Time 1	1985-1988	201	20
Time 2	1988-1991	6	44
Time 3	1991-1995	6	93
Eligible subjects with completed data		213	157

* All eligible subjects except four women completed the Work History Questionnaire.
The questionnaires of nine men were incomplete because of administrative errors.

118. The authors claimed that the association between job strain and ambulatory blood pressure was 'somewhat stronger' among men with a lower socio-economic status. Conversely, the fall in ambulatory blood pressure after ceasing exposure to a high strain job was 'somewhat greater' among men in that group.

119. The findings of the authors were that:

> [r]elative to men not experiencing job strain at either … entry into the study or … three years later … those exposed at both time[s] … that is, experiencing 'chronic' exposure, had substantially higher systolic (11 – 12 mmHg) and diastolic (6 – 9 mmHg) AmBP at both time[s] … these effects were greater than the cross-sectional effects at either time (6 – 7 mm Hg systolic, 2 – 5 mmHg diastolic) (at page 999).

120. The authors noted that for those men with at least 25 years' exposure to job strain, there was some support for a theory of a cumulative job strain exposure leading to increased systolic blood pressure. For those men in that category, their ambulatory blood pressure, after an exposure to job strain for 50% of their working life, was 4.8 (95% confidence interval: -3.7, 13.4) mmHg higher at work and 7.9 (95% confidence interval: 0.8, 15.0) mmHg higher at home than that of men with no prior job strain (at page 1005). It was considered that men in this category had experienced a greater duration of exposure, but also a greater stability of exposure.

121. With respect to induction periods, it was surmised that a period of more than five years was needed, with some support for a rapid recovery after the cessation of the exposure (at page 1006). However, such an association related only to systolic, but not diastolic blood pressure.

Council's analysis

122. The Council considered this study of seminal importance, agreeing with the authors that the use of ambulatory blood pressure monitoring was likely to be more accurate, and reduce observer bias.

123. The Council considered the finding of a decrease in blood pressure (at home and work, but not sleep) in persons moving from high stress to low stress jobs appeared supportive of the relevant association. Conversely, the finding that there was no change in blood pressure for those persons moving from low stress jobs to high stress jobs appeared not to support the relevant association. The Council considered uninformative (for the purposes of an assessment of the relevant association) the finding of no change in blood pressure for those persons who remained in a high stress job, while noting that those persons did have higher blood pressure readings than persons who remained in a low stress job.

124. The Council placed most weight upon the blood pressure readings from home, considering that blood pressure at work was a less reliable indicator of hypertension (as opposed to an acute increase in blood pressure), and that results obtained during sleep can be influenced by sleep patterns.

125. In the Council's view, the results of this study left open, rather than pointed to, the relevant association. The results of the prospective study detracted from the case-control study results.

126. Further, the Council had some reservations about the data - no raw data was provided; all data were adjusted. Additionally, the Council was concerned that

the experimental design of the study was insufficient to achieve reliable results. It was considered that the measured duration may not have been long enough. The timeframe of the study generally was not considered clear enough, to determine the time needed to develop or reverse particular lifestyle exposures.

127. The Council also noted that 10-year follow-up data, gathered some time ago, was not yet available for the 'Work Site Blood Pressure Study in New York' (Council notes some 10-year follow-up data is provided for the 'work history substudy' – see paragraphs 117-121). Given the issues discussed above, the Council considered the 10-year prospective data was essential in order to ascertain whether what had been observed was in fact consistent and sustained hypertension.

128. While noting that the authors stated that the job strain questionnaire provided objective information about particular work requirements (and so the inherent level of job strain), and after taking into account the comments by Landsbergis et al[31] and Schnall et al[32] the Council considered there remained a problem of self-reporting, as the participants knew their hypertensive status.

Pieper et al Meta-analysis (8)

129. This paper comprises a comprehensive meta-analysis of five investigations undertaken in the United States from 1959 – 1980 relevant to the putative association between 'job psychologic demands and decision latitude' to systolic and diastolic blood pressure (and cholesterol and smoking).

130. The subjectivity of ascribing work characteristics to particular jobs was avoided by using an objective measure for all occupations, across the entirety of the data, controlling for individual characteristics of persons in a particular profession or group.

> The major advantage is that our imputed scores are the average of many persons within a given occupation. As such, the method is perhaps less vulnerable to self report response bias. However, the scores imputed for each person are the average of that occupation's perceived job condition. To the degree that individual job perception or objective measurement of the job condition is the salient dimension in the stress-disease process, our method may fail to measure the critical aspect of the particular dimension of work (at page 487).

131. The sum of the meta-analysis overall was that there was no statistically significant impact by job strain on either systolic or diastolic blood pressure. The authors reported that none of the associations between job decision latitude and diastolic blood pressure achieved significance. Decision latitude was associated with systolic blood pressure in three of the five studies. With respect to psychological demand, the association with diastolic blood pressure was statistically opposite to the relevant association in one investigation that reached significance. Psychological demand and systolic blood pressure were

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31 (6) (1994) at page 361.

32 (2) (1994) at page 320 and see paragraph 91 above.

significantly associated in one investigation. Three studies did not support the relevant association, including one that was significant against the association.

Council's analysis

132. The Council considered this an important article as it was a large meta-analysis (n = 2,555 men) of 5 studies in total undertaken over an extended period of 21 years. The Council noted favourably the more objective and systematic way in which particular jobs were accorded a score, and considered this an improvement over the subjectivity of the job questionnaire model as discussed above (see paragraphs 90 and 128).

133. The Council noted that the authors used the interactive job strain model, with job strain only occurring when demands are high and decision latitude is simultaneously low (at page 491). The authors reported that they found no support for the relevant association.

134. The Council noted that none of the studies found a statistically significant impact by job strain on diastolic blood pressure. The results for an impact upon systolic blood pressure were inconsistent.

135. In the Council's view none of the studies considered in this article were supportive of the interactive job strain model. In the Council's view, the data must be consistent in order to 'point to' the relevant association. As mentioned above, in this article the impact of job strain on diastolic blood pressure was statistically opposite the relevant association, while the impact of job strain on systolic blood pressure was inconsistent. In the Council's view this combination of negative and inconsistent results at best leaves open the possibility of an association between job strain and hypertension.

Curtis et al (9)

136. The prospective and methodologically satisfactory study by Curtis et al reported that for men, high decision latitude (but not job demand) was associated with more than a 50% decrease in hypertension. For women, the trend for high job demand to be associated with higher mean systolic blood pressure was found not to be statistically significant (at page 1300).

137. The authors suggested a number of reasons for what they described as null findings (at pages 1300-1301). The first was that persons with hypertension at the commencement of the study in 1988 were not followed up in 1993. It was speculated that they may also have had higher job strain scores, although this could not be confirmed, as job strain questions had not been included at baseline.

138. The possibility for selection bias was also noted. If those with high blood pressure chose to leave high strain jobs, the putative association between job strain and hypertension would consequently be reduced. Occupational mobility was a third suggestion, although considered unlikely. The authors also noted that their methodology (of isolated blood pressure measurements) could lead to a loss of precision.

139. So far as the findings about men were concerned, the authors noted that while uncontrolled confounding and chance were alternative possible explanations, these were considered unlikely.

140. In conclusion, the authors said that 'the cross-sectional data used in this study preclude the inference that decision latitude is causally linked to elevated risk for hypertension' (at page 1301).

Council's analysis

141. As mentioned above, the Council considered that both components of the Karasek model, ie low decision latitude and high demand must be present and must point to the relevant association. That was not indicated by this study. Rather the Council considered that this study yielded two countervailing effects.

142. First, as decision latitude increased, job strain decreased, and blood pressure dropped. This finding was consistent with the relevant association. Conversely, however, high job demand led to decreased blood pressure, a finding negative to the relevant association. Even if the Council had considered the characteristics of the Karasek model in isolation, the findings concerning decision latitude were not statistically significant.

143. The Council shared the concerns of the authors that different terminology in this area may be leading to varying results. The authors ultimately observed:

> we observed a weak relationship between blood pressure and the components of job strain (decision latitude and job demand) … Decision latitude was inversely associated with hypertension prevalence among men, while, for women, high job demands tended to be associated with higher systolic blood pressure (at page 1301).

Kivimaki et al (10)

144. The articles by Kivimaki et al (2002) and Aro and Hasan (1987) relate to the same study. The effect of stress on health was examined both cross-sectionally and longitudinally. The objective of the study was to examine any association between work stress and cardiovascular disease, according to both the job strain and effort-reward imbalance models.

145. The study population was of 812 employees from a factory in Finland, who performed a wide range of work functions. Data were gathered by questionnaire, interview and clinical examination and physiological and biochemical measurements. The work information was obtained by questionnaire and subjective ratings of the work environment and feelings related to a person's working conditions. Importantly, therefore, levels of job strain were self-assessed. From the questionnaire results, the authors allocated persons to high job strain, low job strain and intermediate job strain groups.

146. Kivimaki et al found that employees with high job strain and high effort-reward imbalance had a two-fold higher risk of death from cardiovascular disease.

147. High job strain and low job control were risk factors for cardiovascular mortality, after adjusting for age and sex. However, after additional adjustment for occupational group, job control was no longer a predictor of mortality. After further adjustment for behavioural risk factors, there was not a statistically significant association.

148. At the five-year follow-up, work stress was not found to be associated with blood pressure.

149. The authors considered the relevant strengths of their study were a long follow-up period, comprehensive questionnaires, and controlling for a large set of potential confounders.

Council's analysis

150. The Council acknowledged the strength of the study and thought it had been well conducted. The Council considered its relevant primary strengths were as identified by the authors, and particularly the long follow-up, and way in which it controlled for confounders. The Council considered that it did not support (or point to) an association between job strain and hypertension.

151. The authors' conclusions were that the relevance of job control was its link with low socio-economic status, and that low socio-economic status (and all that entails) was a predictor for cardiovascular disease. While that may well be so, it does not support an association between job strain and hypertension. Further, the findings were not statistically significant so far as job strain and hypertension were concerned. The study mostly considered cardiovascular disease rather than hypertension. As mentioned above, cardiovascular disease is not synonymous with hypertension.

Aro and Hasan (11)

152. The Aro and Hasan (1987) article reported upon the same study.

153. What the authors called the load appraisal score (made up of 'subjective ratings of the environmental loads and feelings related to a person's working and living conditions' (at page 63)) was not related to a risk of hypertension. What the authors called a stress symptoms score (comprising 'a wide spectrum of somatic symptoms, disturbed affects and other psychic disturbances' (at page 63)) 'seems to convey a slight excess risk of hypertension' (at page 66).

154. The authors concluded that:

> [t]he associations between the indices of stress and biologically defined morbidity (myocardial infarction, total and CHD mortality) and non-behavioural risk factors (serum lipids, **systolic and diastolic blood pressure**, maximal oxygen uptake) **were non-existent or weak** (emphasis added).

Council's analysis

155. The Council noted that the focus of this study was not a potential association between job strain and hypertension. It focused upon cardiovascular disease

and not hypertension. To the extent that it did deal with job strain and hypertension, the finding was that any association was non-existent or weak. Accordingly, the Council considered that the paper at best left open the possibility of the relevant association.

Melamed et al (12)

156. Melamed et al (1997) reported on a study of 1859 men without cardiovascular disease, who had participated in the Cardiovascular Occupational Risk Factors Determination in Israel (CORDIS) study. The Melamed et al study was based on data collected from 1985-1987, and tested the association between reported intensity of life events and blood pressure (and serum lipid levels, risk behaviours, and psychological distress symptoms). The authors controlled for the following possible confounders: age, weight, smoking, leisure time physical exercise, alcohol consumption, physical work and job strain. Job strain, used as a predictor in other studies, was used as a confounder in this study.

157. Job strain was negatively associated with systolic blood pressure (p=0.040) and diastolic blood pressure (p=0.061). The authors' conclusion was that there was no association between job strain and blood pressure.

158. The authors noted the inherent subjectivity resulting from self-assessment of job strain. This is an issue which the Council had identified in all the available studies using the mechanism of self-report questionnaires.

Council's analysis

159. The Council considered this a strong negative study (ie against the relevant association). It was a powerful study because of its size.

160. The Council was particularly persuaded by this study, which found no association between job strain and blood pressure, even though it was conducted on the basis of self-report questionnaires. As the Council has discussed above, self-report questionnaires are inherently subjective, and may tend to overstate positive results. Despite that inherent defect, however, the results here remained negative (i.e. that there was no association between job strain and blood pressure).

THE COUNCIL'S CONCLUSIONS ON WHETHER THERE SHOULD BE A 'JOB STRAIN' FACTOR

161. The Council, having closely analysed all the information in the pool, placed particular weight on the articles discussed in detail above. The critical question for the Council was whether the sound medical-science 'points to, as opposed to merely leaves open, the possibility of the[33]' relevant association.

162. The Council considered its task a very difficult question of judgement. As can be discerned from the discussion above, there were some data which appeared to suggest an association between job strain and hypertension. Upon closer

[33] see full Federal Court decision at paragraph 49 per Branson J, and paragraph 65 of these Reasons

analysis, however, the Council considered that the findings in even the apparently most positive study (the New York worksite study) were inconsistent. In addition, the studies were beset with problems about how to measure job strain.

163. In the Council's judgement, those articles in the pool of information that found no association, and particularly Melamed's, were more persuasive and consistent than those articles that reported some seemingly positive findings. The Council considered it particularly telling that despite the bias of self-report questionnaires, which inevitably suggest an association between job strain and hypertension, the findings in the Melamed study were that no association existed.

164. While the Council considers an association between job strain and hypertension is possible, it does not consider that the medical-scientific evidence before the RMA at the relevant times points to the relevant association. Rather, the possibility of an association is, in the Council's view, left open.

165. The Council is aware that its decision is different from that of the previously constituted Council, which as noted in paragraph 25 above, had remitted the issues back to the RMA for reconsideration under section 196W(4) of the VEA, with directions for the RMA to reconsider information in support of 'three biological markers of stress in hypertension' including the adrenaline hypothesis, as well as having regard to other key references identified in the previously constituted Council's Reasons for Decision[34].

166. The previously constituted Council, however, had noted that it considered the adrenaline hypothesis was only one of several 'links in the chain' of a possible relationship between job strain and hypertension, and went on to note that the seemingly positive papers then relied upon by the Applicant in fact provided only qualified support, or inconclusive results. The previously constituted Council ultimately concluded that the adrenaline hypothesis alone would not in its view justify an amendment to the then Statements of Principles in respect of hypertension. Rather it considered the three biological makers were equally powerful, and in combination, constituted sufficient sound medical-scientific evidence to justify the RMA amending the Statements of Principles, then in force[35].

167. The Council agreed with the previously constituted Council that a possible relationship between job strain and hypertension is biologically plausible. Biological plausibility is one of the Bradford Hill criteria[36]. Subsequent to the decision of the previously constituted Council, the full Federal Court has decided that 'applicable epidemiological criteria for assessing causation', such as the Bradford Hill criteria, apply 'at the stage of step one, not step two[37]', i.e., at the

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34 see the previously constituted Council's Reasons for Decision at paragraph 1

35 ibid at paragraphs 44-50.

36 see Bradford Hill, A (1965).

37 see the full Federal Court decision at paragraph 47 and at paragraphs 53 – 55 per Branson J.

stage of determining the pool of information, not when determining 'whether there is *'sound medical-scientific evidence'* that **indicates** that the particular kind of injury, disease or death **can be** related to operational service rendered by veterans'[38].

168. As noted in paragraph 73 above, the Council took into account 15 of the articles considered important by the previously constituted Council, and relied upon by the Applicant in this review. However, the Council did not consider those articles pointed to the relevant association. On the contrary their impact was diluted as the pool of information contained a number of negative studies, which were not available to the previously constituted Council. The pool of information for the Council was thus different from that which was before the previously constituted Council.

169. While always cognisant that the reasonable hypothesis standard is a low threshold and an unusually light burden, the Council's conclusion was that the sound medical-scientific evidence and particularly those articles closely analysed above, did not point to (as opposed to leave open) job strain as a potential link or element in a reasonable hypothesis connecting hypertension with relevant service (see paragraphs 64 and 65 and footnote 19).

170. Accordingly, the Council concluded that the sound medical-scientific evidence available to (before) the RMA at the relevant times was insufficient to justify amending the reasonable hypothesis Statement of Principles (number 35 of 2003) to include a job strain factor.

171. Having reached this conclusion, the Council necessarily found that the sound medical-scientific evidence available to (before) the RMA at the relevant times was insufficient to justify amending the balance of probabilities Statement of Principles (number 36 of 2003) to include a job strain factor.

DECISION

172. The Council made the declarations summarised in **paragraphs 1 and 2** above.

EVIDENCE BEFORE THE COUNCIL

Documents

173. The information considered by the Council (being the information that was available to (before) the RMA and sent to the Council by the RMA in accordance with section 196K of the VEA) is listed in **Appendix C**.

174. As mentioned above, the information upon which the Applicant and the Repatriation Commission relied (being information which was available to (before) the RMA and sent to the Council by the RMA in accordance with section 196K of the VEA is listed in **Appendices D and E** respectively.

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[38] ibid at paragraph 48 per Branson J.

175. The information to which the Applicant referred (being information which was not available to (not before) the RMA, and so was not considered by the Council in reaching its decision) is listed in **Appendix B**.

Articles cited in the Council's analysis

of the Information before the RMA

1 Karasek, R, Baker, D, Marxer, F, Ahlbom, A & Theorell, T 1981, 'Job decision latitude, job demands, and cardiovascular disease; a prospective study of Swedish men', *Am J Public Health*, vol. 71, no. 7, pp. 694-705. (RMA ID No. 24184; SMRC folder 22, article 9)

2 Schnall, PL, Landsbergis, PA, Pickering, TG & Schwartz, JE 1994, LETTER: 'Perceived job stress, job strain, and hypertension', *American Journal of Public Health*, vol. 84, no. 2, pp. 320-321. (RMA ID No. 11320; SMRC folder 13, article 40)

3 Schnall, PL et. al 1990, 'The relationship between 'Job strain', workplace diastolic blood pressure, and left ventricular mass index'. *JAMA,* vol. 263, no. 14, pp. 1929-1935. (RMA ID No. 5553 and 12159; SMRC folders 9 and 14, articles 9 and 11 respectively)

4 Schnall, PL, Devereux, RB, Pickering, TG & Schwartz, JE 1992, 'The relationship between 'job strain', workplace diastolic blood pressure and left ventricular mass index: a correction'. J*AMA*, vol. 267, no. 9, p. 1209. (RMA ID No. 8465 and 25846; SMRC folders 22 and 26, articles 57 and 53 respectively)

5 Schnall, PL, Schwartz, JE, Landsbergis, PA, Warren, K & Pickering, TG 1998, 'A longitudinal study of job strain and ambulatory blood pressure: results from a three-year follow-up'. *Psychosomatic Medicine*, vol. 60, pp. 697-706. (RMA ID No. 20740 and 24190; SMRC folders 20 and 22, articles 26 and 3 respectively)

6 Landsbergis, PA, Schanall, PL, Warren, K, Pickering, TG and Schwartz, JE 1994, 'Association between ambulatory blood presure and alternative formulations of job strain', *Scand J Work Environ Health*, vol. 20, no. 5, pp. 349-363. (RMA ID No. 7945; SMRC folder 10, article 11)

7 Landsbergis, PA, Schnall, PL, Pickering, TG, Warren, K, & Schwartz, JE 2003, 'Life-course exposure to job strain and ambulatory blood pressure in men'. *American Journal of Epidemiology*, vol. 157, no. 11, pp. 998-1006. (RMA ID No. 28214; SMRC folder 30, article 7)

8 Pieper, C, LaCroix, AZ, Karasek, RA 1989, 'The relation of psychological dimensions of work with coronary heart disease risk factors: A meta-analysis of five United States data bases', *American Journal of Epidemiology*, vol. 129, pp. 483-499. (RMA ID No. 23846; SMRC folder 22, article 21)

9 Curtis, AB, James, SA, Raghunathan, TE, & Alcser KH 1997, 'Job strain and blood pressure in African Americans: the Pitt County Study', *American Journal of Public Health*, vol. 87, pp. 1297-1302. (RMA ID No. 24405; SMRC folder 23, article 57)

10 Kivimaki, M, Leino-Arjas, P, Luukkonen, R, Riihimake, H, Vahtera, J, & Kirjonen, J 2002, 'Work stress and risk of cardiovascular mortality: prospective cohort study of industrial employees', *British Medical Journal*, vol. 325, no. 7369, pp. 857-861. (RMA ID No. 25388; SMRC folder 23, article 21)

11 Aro, S & Hasan, J 1987, 'Occupational class, psychosocial stress and morbidity'. *Ann Clin Res*, vol. 19, no. 2, pp. 62-68. (RMA ID No. 25629; SMRC folder 24, article 50)

12 Melamed, S, Kushnir, T, Strauss, E & Vigiser, D 1997, 'Negative association between reported life events and cardiovascular disease risk factors in employed men: the Cordis Study'. *Journal of Psychosomatic Research*, vol. 43, no. 4, pp. 247-258. (RMA ID No. 12589; SMRC folder 16, article 71)

Appendices

Appendix A	Preliminary list of the proposed pool of information, as advised to the Applicant and Repatriation Commission by letters dated 6 December 2004 (see paragraph 34 of the Reasons), and the final pool of information (see paragraph 72 of the Reasons).
Appendix B	Material that was not available to (not before) the RMA[39] (which the Applicant contended was in existence at the relevant time, and so could have been accessed by the RMA).
Appendix C	Information available to (before) the RMA and sent to the Council by the RMA under section 196K.
Appendix D	Information upon which the Applicant relied (being information which was available to (before) the RMA and sent to the Council by the RMA in accordance with section 196K of the VEA).
Appendix E	Information upon which the Repatriation Commission relied (being information which was available to (before) the RMA and sent to the Council by the RMA in accordance with section 196K of the VEA).

[39] Including the abstracts, web pages and book referred to in paragraph 39.

APPENDIX A

SMRC Folder Numbers	SMRC Article Numbers	RMA ID	Title
21	5	21216	Adamis, D & Ball, C 2000, 'Physical morbidity in elderly psychiatric inpatients: prevalence and possible relations between the major mental disorders and physical illness', *International Journal of Geriatric Psychiatry*, vol. 15, pp. 248-253.
25	54	25691	Adsett, CA & Bellissimo, A & Mitchell, A & Wilczynski, N & Haynes, RB 1989, 'Behavioral and physiological effects of a beta blocker and relaxation therapy on mild hypertensives', Psychosomatic *Med,* vol. 51(5), pp. 523-536.
24	8	25672	Aivazyan, TA & Zaitsev, VP & Salenko, BB & Yurenev, AP & Patrusheva, IF 1988, 'Efficacy of relaxation techniques in hypertensive patients', *Health Psychology,* vol. 7 (Suppl), pp. 193-200.
10	5	8469	Albright, CL & Winkleby, MA & Ragland, DR & Fisher, J & Syme, SL 1992, 'Job strain and prevalence of hypertension in a biracial population of urban bus drivers', *American Journal of Public Health,* vol. 82(7), pp. 984-989.
25	33	25712	Albright, GL & Andreassi, JL & Brockwell, AL 1991, 'Effects of stress management on blood pressure and other cardiovascular variables'*, International Journal Psychophysiology,* vol. 11(2), pp. 213-217.
15 and 12	21 and 34	12399 and 10985	Alderman, MH 1994, 'Non-pharmacological treatment of hypertension', *The Lancet*, vol. 344(8918), pp. 307-311.
13	35	11314	Alexander, CN & Schneider, RH & Staggers, F & Sheppard, W et al 1996, 'Trial of stress reduction for hypertension in older African Americans: sex and risk subgroup analysis', *Hypertension*, vol. 28(2), pp. 228-237.

23	1	25611	Alfredsson, L & Hammar, N & Fransson, E & de Faire, U & Hallqvist, J & Knutsson, A & Nilsson, T & Theorell, T & Westerholm, P 2002, 'Job strain and major risk factors for coronary heart disease among employed males and females in a Swedish study on work, lipids and fibrinogen', *Scand J Work Environ Health*, vol. 28(4), pp. 238-248.
23	16	25546	Allen, K & Shykoff, BE & Izzo, JL 2001, 'Pet ownership, but not ace inhibitor therapy, blunts home blood pressure responses to mental stress', *Hypertension*, vol. 38(4), pp. 815-820.
24	13	25667	Alroe, CJ 1991, 'LETTER; Stress and hypertension: a case', *Medical Journal of Australia,* vol. 154(4), p. 291.
17	30	13258	Andren, L & Hansson, L & Bjorkman, M & Jonsson, A 1980, 'Noise as a contributory factor in the development of elevated arterial pressure', *Acta Med Scand*, vol. 207, pp. 493-498.
25	16	25729	Anonymous 1998, 'Stress and cardiovascular disease: a report from the National Heart Foundation of Australia. Stress Working Party', *Medical Journal of Australia*, vol. 148(10), pp. 510-514.
24	57	25622	Anonymous 2001, 'Stress management to reduce blood pressure', *Harvard Women's Health Watch*, vol. 8(12), p. 1.
24	50	25629	Aro, S & Hasan, J 1987, 'Occupational class, psychosocial stress and morbidity', *Annals of Clinical Research*, vol. 19(2), pp. 62-68.
30	65	27789	Astin, JA & Shapiro, SL & Eisenberg, DM & Forys, MA 2003, ' Mind-Body Medicine: State of the Science, Implications for Practice', *The Journal of the American Board of Family Practice*, vol. 16(2), pp. 131-147.
24	12	25668	Aviram, A & Silverberg, DS & Carel, RS 1987, 'Hypertension in European immigrants to Israel--the possible effect of the holocaust', *Israel Journal Medical Science*, vol. 23(4), pp. 257-263.

24	51	25628	Baba, S & Ozawa, H & Nakamoto, Y & Ueshima, H & Omae, T 1990, 'Enhanced blood pressure response to regular daily stress in urban hypertensive men', *Journal of Hypertension*, vol. 8(7), pp. 647-655.
22	34	22676	Baker, B & Paquette, M & Szalai, JP & Driver, H & Perger, T & Helmers, K & O'Kelly, B & Tobe, S 2000, 'The influence of marital adjustment on 3-year left ventricular mass and ambulatory blood pressure in mild hypertension', *Archives of Internal Medicine*, vol. 160, pp. 3453-3458.
24	60	25619	Barnes, V & Schneider, R & Alexander, C & Staggers, F 1997, 'Stress, stress reduction, and hypertension in African Americans: an updated review', *Journal National Medical Association*, vol. 89(7), pp. 464-476.
15	9	12579	Barrett-Connor, E & Palinkas, LA 1994, 'Low blood pressure and depression in older men: a population based study', *British Medical Journal*, vol. 308, pp. 446-449.
13	9	11366	Barringer, TA 1997, 'The tension in hypertension', *Archives of Family Medicine*, vol. 5, pp. 50-51.
23	15	25547	Batey, DM & Kaufmann, PG & Raczynski, JM & Hollis, JF & Murphy, JK & Rosner, B & Corrigan, SA & Rappaport, NB & Danielson, EM & Lasser, NL & Kuhn, CM 2000, 'Stress management intervention for primary prevention of hypertension: detailed results from Phase I of Trials of Hypertension Prevention (TOHP-I)', *Ann Epidemiol*, vol. 10(1), pp. 45-58.
16	45	13087	Baum, A 1990, 'Stress, intrusive imagery, and chronic distress', *Health Psychology*, vol. 9(6), pp. 653-675.
16	67	12874	Beilin, LJ 1997, 'Stress, coping, lifestyle and hypertension: a paradigm for research, prevention and non-pharmacological management of hypertension', *Clinical and Experimental Hypertension*, vol. 19(5&6), pp. 739-752.
20	10	20921	Beilin, LJ & Puddey, IB & Burke, V 1999, 'Lifestyle and hypertension', *AJH*, vol. 12, pp. 934-945.

26	12	25921	Belkic, K & Emdad, R & Theorell, T 1998, 'Occupational profile and cardiac risk: possible mechanisms and implications for professional drivers', *International Journal Occupational Med Environ Health*, vol. 11(1), pp. 37-57.
24	20	25660	Belkic, KL & Schnall, PL & Landsbergis, PA & Schwartz, JE & Gerber, LM & Baker, D & Pickering, TG 2001, 'Hypertension at the workplace--an occult disease? The need for work site surveillance', *Adv Psychosomatic Med*, vol. 22, pp. 116-138.
24	17	25663	Bennett, P & Carroll, D 1990, 'Stress management approaches to the prevention of coronary heart disease', *British Journal Clinical Psychology*, vol. 29 (Pt 1), pp. 1-12.
23	9	25576	Benotsch, EG & Christensen, AJ & McKelvey, L 1997, 'Hostility, social support, and ambulatory cardiovascular activity', *Journal Behavioural Medicine*, vol. 20(2), pp. 163-176.
29	39	27647	Benson, H & Stuart, E & Friedman, R & Eisenberg, DM & Delbanco, TL & Chalmers, TC 1994, 'LETTER, Cognitive therapy for hypertension', *Annals of Internal Med*, vol. 120(1), p. 91.
23	13	25549	Bjorntorp, P 2001, 'Do stress reactions cause abdominal obesity and comorbidities?', *Obesity Reviews*, vol. 2(2), pp. 73-86.
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APPENDIX B

SMRC Folder Numbers	SMRC Article Numbers	Title
Submitted at hearing	Feb05	Belkic, K et al 2004, REVIEW 'Is job strain a major source of cardiovascular disease risk?' Scan J Work Environ Health, vol. 30(2), pp. 85-128, cited by Applicant 17 February 2005, Oral submission to the SMRC.
Not Submitted		Cropley, M Steptoe, A Joekes K 1999, Job Strain and psychiatric mobidity, *Psychol Med*, vol. 29(6), pp. 1411-1416. Cited by Applicant 17 February 2005, Oral submission to the SMRC, Auscript Hearing transcript, p. 22.
Not Submitted		Lawyers Weekly 2004, Virginia, USA, 12 March.
Submitted At hearing		Schnall, PL 2005, Selected references and abstracts, Job Stress Network, pp. 1-5, viewed on 8 February 2005, http://www.workhealth.org/references/refschn.html, and cited by Applicant 17 February 2005, Oral submission to the SMRC.
Submitted at hearing and 32	Feb05 and 35	Schnall, PL, Belkic, K, Landsbergis, P & Baker, D (eds.) 2000, The workplace and Cardiovascular Disease, OCCUPATIONAL MEDICINE: The State of the Art Reviews, Hanley & Befus, vol. 15, no. 1, January-March, pp. 1-334, (particularly) pp. 51-68 and 233-238, 253-256 and 312-321. Cited by Applicant 12 April 2004, at Attachment and Reference 33, p. 1, Submission to the SMRC, pp. 1-29.
Submitted at hearing and 32	Feb 05 and 24	Bradford-Hill, A 1965, 'The Environment and Disease: Association or Causation?' Proceedings of the Royal Society of Medicine Section of Occupational Medicine Meeting January 14, Royal Society of Medicine Section of Occupational Medicine, pp. 295-300. Viewed 15 October 2003 at http://www.edwardtufte.com/tufte/hill, and cited by Applicant 12 April 2004, at Attachment and Reference 21, pp.1-6, Submission to the SMRC, pp.1-29.

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APPENDIX C

SMRC Folder Numbers	SMRC Article Numbers	Title
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APPENDIX D

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APPENDIX E

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