IMSANZ

Internal Medicine Society of Australia and New Zealand

January 1999

From the President

General Medicine: what's happening in Australia?

General physicians can provide a broad approach to the problems of the consumer and may help in curtailing medical costs. Many metropolitan hospitals in Australia have abolished Divisions of General Medicine and are entirely subspecialty based, thus removing role models who might attract young people into the specialty of general medicine. For example, in Sydney the only remaining teaching hospitals with large, active, admitting general medical units are Concord and Liverpool hospitals. Fortunately, these hospitals remain committed to the training of general physicians. The lack of general medical units in teaching hospitals exacerbates the existing and increasing problem of providing physician services in rural Australia.

Tamworth is a fairly typical rural town in Australia, about 400 kms from Sydney. With a population of 35,000 people, it actually serves a population base of 250,000 people. Currently, Tamworth Base Hospital has eight subspecialist physicians (including three paediatricians) and two general physicians (one with an interest in gastroenterology and one with an interest in cardiology). Both of the generalists are likely to retire in the not too distant future and there seems to be no prospect of being able to replace them. This scenario is common throughout rural Australia. Indeed, it has proven difficult to establish and maintain specialist practice across the field of specialities in a rural setting. Currently there are not nearly enough medical specialists resident in rural Australia to satisfy the needs of the rural populace.

Federal and State or Territory governments are increasingly focussing on the need to get the medical workforce "right"; the right numbers, the right balance of skills and the right geographic distribution. We may never get it "right", but we are working towards minimising workforce

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imbalances. Significant shortages in service provision in a particular specialty, such as general medicine, cannot be remedied quickly, and may be delayed by 10-20 years. We have increasingly come to realise that selection processes for medical schools and postgraduate training should be structured so as to encourage participation by students from rural areas. Training programs should include a rural medical service component, including a placement in a rural area. It is envisaged that the Royal Australasian College of Physicians (RACP) will mandate a six month period of attachment to a rural/regional hospital during training, either by rotation or short-term placements. The current guidelines for basic physician training state that at least six months of the three year training will be in a general medical unit and that no more than six months may be spent in any one subspecialty. Perhaps at least one year in general medicine might encourage more basic trainees to consider a career in generalism? The number of suitable posts for advanced physician training in Australia is not defined, and so there is no direct control over the number of trainees entering general internal medicine or indeed any other medical subspecialty.

The RACP is currently undertaking a major review of training which is likely to lead to significant changes in the approach to the training of physicians, taking into account workforce issues. Workforce data currently suggests that the problem is not one of absolute numbers of physicians in Australia. It reflects maldistribution of physicians, both geographically and across the internal medicine specialities.

In 1995, survey data showed that whilst rural and remote areas accounted for 29% of the total population of Australia, only 12% of specialists were located in a rural or remote area. 14% of all physicians practise outside of metropolitan areas. Specialists require a reasonably large rural area with associated facilities, such as base hospitals, to function. RACP data suggests that city-based physicians providing services to country areas spend only 1-2% of their working hours doing so, and Australia wide, only 7% of specialist physicians are involved in such work. Physicians who are resident in rural areas can clearly provide better services than those who visit occasionally. The Commonwealth Government recently provided funding to the RACP to establish an integrated Rural Workforce and Advanced Training Program.

Maldistribution problems across the different medical subspecialties are largely a result of training opportunities being linked to the service needs of particular institutions. The RACP has no direct control over numbers entering physician training. Any way of adjusting the number of trainees in these areas will not be evident for about eight years after graduation, when most specialists begin to practise independently in their area of speciality.

There are shortages in the area of general internal medicine in Australia, and the current general physician workforce is older than the subspecialist workforce. The importance of generalism lies not only in rural areas, but also in metropolitan areas. Perhaps the generalist has a different philosophical approach to medicine than the subspecialist, but both generalist and subspecialist play crucial roles in the overall delivery of quality health care.

Robin Beattie,
President IMSANZ.

Major source: "Workforce in Australia" RACP draft document 23-10-98.

ANNUAL GENERAL MEETING

The Annual General Meeting will be held at 8.00 am on Wednesday, 12 May, 1999 at the RACP Annual Scientific Meeting, Perth.

If you are attending the ASM please make the effort to attend and take the opportunity of meeting your new Council.

IMSANZ Annual Scientific Meeting
Perth
Tuesday 11 May 1999

9:00 am	**Workshops (see below)**
10:30 am	Morning Tea
11:00 am	**Advanced Trainee Presentations**
12:30 pm	Lunch (& presentation of Roche Prize)
1:30 pm	**Lecture**: "The Lethargic Patient" (Dr P Greenberg)
2:15 pm	**Interesting Case Vignettes** (Drs M McComish, D Prentice, S Dimmitt)
3:00 pm	Afternoon Tea
3:30 pm	**Workshops (see below)**
5:15 pm	**Council Meeting**
7:30 pm for 8:00 pm	**Dinner** at "Altitude 9"

Wednesday 12 May

8:00 am	**Annual General Meeting**

Workshops:

Nephrology – "management of advancing renal disease"
- evaluation and management of renovascular disease (Dr M Thomas)
- evaluation and management of severe glomerulonephritis (Dr B Hutchison)

Contemporary management of advanced malignancy
- pain control strategies (Dr D Bridge)
- management of oncological emergencies (Dr J Trotter)

IMSANZ Evidence Based Medicine (EBM) Meeting

30 October - 1 November 1998

Adelaide

I celebrated my silver anniversary in December having married shortly after graduation. Given that clinical knowledge and perhaps performance is inversely proportional to physician's year of graduation from medical school, the Adelaide EBM weekend served to revitalise and update!

EBM is the integration of three components:

1. Individual clinical skill and expertise.

2. Current research and "best evidence", critically appraised for its validity and clinical applicability.

3. Applying this to the individual patient's unique biology, values and wishes.

Evidence based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. Increased individual expertise is reflected in many ways but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights and preferences in making clinical decisions about their care.

I was particularly struck by the practical approach of David Sackett, who provided the focus for the meeting. He outlined the need to practice and be guided by EBM but recognised that there were times when we had to practice "rescue medicine". There are also times when we need to recognise that optimal evidence does not exist.

EBM has evolved at a time of an exponential increase of information. The balanced and instructive program guided us through the electronic maze. We were shown that information could be rapidly accessed with key information available within seconds!

Dave Sackett, with his unique brand of enthusiasm, humour and ability to teach, went on to demonstrate that valuable information can be stored and retrieved using hand held technology (ie a paper file!). A computer is not a pre-requisite for this phase! He also highlighted evidence-based teaching methods and the need to package the patient's problem.

So how do we avoid getting trapped in the information swamp? We need to master electronic skills and develop the same critical appraisal skills we use in clinical medicine. The techniques of answering a clearly formulated question with comprehensive research were shown to be achievable in a busy clinical unit.

It is then necessary to communicate information to the patient in an understandable and digestible format.

Essential tools of the trade remain the clinical interview and examination followed by these questions:

- Who is this person?
- What is the setting?
- What bothers them?
- What are the key issues?

A search and appraisal of published evidence follows. This involves tracking down the best external evidence with which to answer our clinical questions.

The methodology was brought into focus by Rob Beattie through a case presentation and Ian Scott through a project of evaluation and audit.

A detailed list of databases of interest on the Internet is available through:

http://www.shef.ac.uk/~scharr/ir/trawling.html

Critical appraisal skills, EBM workshop information and a Critically Appraised Topic (CAT)* maker can be accessed through the updated web pages from the Centre for Evidence Based Medicine:

http://cebm.jr2.ox.ac.uk/index.extras
http://cebm.jr2.ox.ac.uk/docs/rmpform.html

Kingsley Logan
Rotorua

* see also page 8

News from the Australian RACP Specialist Advisory Committee (SAC) in General Medicine

- **Llewellyn (Llew) Davies has just taken over from Bob Nightingale as Chairman. Llew has been a consultant general physician in Mackay for 20 years. He is senior specialist physician at Mackay Base Hospital, Director of ICU at Mackay Mater Hospital and Clinical Senior Lecturer in Medicine at the University of Queensland.**

- **In 1998 there were 58 Australian advanced trainees in General Medicine registered with the SAC. This compares with 41 in 1997, 42 in 1996 and 42 in 1995!**

EBM MEETING IN ADELAIDE, OCTOBER 1998

Left: Professor David Sackett

Right: Ian Scott

Left to Right:

Rob Beattie (President)
Neil Graham (Vice-President)
Cherie McCune (IMSANZ Secretary)

Left to Right:

Don Campbell,
Michael Kennedy,
Peter Greenberg,
Mark Morton,
John Lowrey

Photographs by courtesy of Mark Morton (Adelaide)

Report on Evidence-Based Medicine (EBM) Workshop Oxford, UK 13-19 July 1998

This was organised by David Sackett and colleagues. It was a very productive workshop. Useful resource materials were handed out, including the computerised CAT *(Critically Appraised Topics) maker and the latest copy of a tutor manual in EBM. A number of workshops interspersed with small group teaching sessions looked at implementation of guidelines and forming a collaboration on studying the accuracy and reliability of the clinical examination.

I learned about:

- the infra red simulscope - a stethoscope that gives infra red transmission to up to 12 students who have infra red receivers. All can hear the same sounds being auscultated simultaneously;
- Dave's "evidence cart" - going around on ward rounds with a cart and a lap top computer with Cochrane Library, Best Evidence, and Medline, as well as other reference sources;
- performing abbreviated literature searches to inform clinical decisions at the bedside;
- ways and means by which the effectiveness of evidence based medicine can be assessed

The small group sessions were simulations of the small group teaching in EBM we do on a weekly basis at Princess Alexandra Hospital in Brisbane, whereby a member of the group presents and appraises a paper that has been chosen as relevant to a clinical question. The first introductory session looked at how to formulate clinical questions and undertake literature searches. Role playing was also used in one session which I found particularly good, in which the question for funding for a new service was debated in the setting of Chief Executive Officer (CEO), clinicians, finance managers, and patient support groups. I volunteered for the role of CEO who had ultimate power in the decision making, and deliberately stirred the pot by getting the group to think about how evidence-based practice relates to higher level functions of policy making. The following day we had a similar role play in relation to clinical guidelines. The group was divided into those for or against such decision supports. This time my role was the negative but I used the opportunity to invite replies to the oft expressed criticisms of guidelines.

There was a dinner on Thursday night at Trinity College and I was fortunate to find myself at the table of Professor David Sackett who was joined by Dr Jillian Muir-Gray, Head of the NHS R&D Centre at Milton Keynes. Dr Muir-Gray wrote the book *Evidence-Based Health Care (Churchill Livingstone 1997)*. I proposed that perhaps the next frontier of evidence-based medicine is the increasing application of industrial science, organisational psychology and medical sociology to the problems of improving clinical practice and organisational performance. Dave mentioned that David Naylor at the Institute of Clinical Evaluative Sciences (ICES) was heading a group to look more closely at the barriers to implementation of evidence-based medicine at an individual clinical, as well as institutional level.

Ian Scott (Brisbane)

* see also page 8

Comment: EBM workshops are held regularly at Oxford and at other centres in the UK, Canada and USA.

Evidence Based Medicine
Critically Appraised Topics (CATs)

A CAT is a **1 page written summary** of the first three steps of evidence-based medical practice:

1. Translate patient issues into answerable questions

2. Track down relevant evidence to answer the questions

3. Appraise evidence for its validity (closeness to the truth) and applicability (usefulness in clinical practice)

Reference: http://cebm.jr2.ox.ac.uk/docs/badenoch.html

IMSANZ members wishing to contribute to and/or receive CATs from the IMSANZ CATs Library should contact

Cherie McCune
IMSANZ Secretary
Phone: 61 2 9256 5472
Fax: 61 2 9252 3310
Email: imsanz@racp.edu.au

General Internal Medicine in History

"The practice of medicine they (ie the Egyptians) split up into separate parts, each doctor being responsible for the treatment of only one disease. There are, in consequence, innumerable doctors, some specialising in diseases of the eyes, others of the head, others of the stomach, and so on; while others, again, deal with the sort of troubles which cannot be exactly localised."

Herodotus ~ 430 BC
Herodotus. The Histories
Penguin Classics 1996. Page 114

FORTHCOMING EVENTS

New Zealand

Wanganui: 26 - 27 March 1999 - IMSANZ Meeting
Contact: Dr Guy Taylor, Wanganui Hospital
Private Bag 3003, Wanganui, 5020 NZ
See also page 10

Rotarua: 25 - 27 August 1999 - RACP Annual Scientific Meeting and IMSANZ Meeting.
Contact: Jackie Grant, Lakeland Health, PO Box 3023, Rotarua. Phone: 64 7 349 7955 x 8640.
Fax: 64 7 349 7952. Email: nickl@wave.co.nz

Australia

Perth: 11 May 1999 - IMSANZ Annual Scientific Meeting
12 May 1999 - IMSANZ Annual General Meeting
(see also page 3)
12 - 14 May 1999 - RACP Annual Scientific Meeting

Sydney: 16 - 17 October 1999 - IMSANZ Scientific Meeting.
This meeting will cover areas of particular importance to practising general physicians. It will be held at the Quarantine Station in Sydney Harbour National Park, Manly. This unique, historical venue is in a fabulous location on the shores of Sydney Harbour.
Contact: Cherie McCune, IMSANZ Secretariat

Elsewhere

San Francisco: 29 April - 1 May 1999 - Society of General Internal Medicine.
Contact: www.sgim.org

New Orleans: 22 - 25 April 1999 - American College of Physicians, American Society of Internal Medicine

Florence: 12 - 15 May 1999 - European Federation of Internal Medicine.
Contact: www.efim.org

Montreal: 23 - 26 September 1999 - Royal College of Physicians and Surgeons of Canada and Canadian Society of General Internal Medicine.
Contact: Mary Dallimore. Email: mary.dallimore@rcpsc.edu

Fiji: October 2000. IMSANZ Scientific Meeting

IMSANZ Wanganui 99 - Practical Skills

The 1999 New Zealand IMSANZ conference will be held in Wanganui on 26 and 27 February 1999 and will focus on acquiring practical skills to improve our clinical practice.

Originally thought to mean "big inlet", Wanganui probably means "long waiting". It was named by a Taranaki Maori chief on his travels southward. After a somewhat shaky history, Wanganui prospered and has many fine buildings and parks dating from around the turn of the century. Wanganui has a reputation for sporting and outdoor events - apart from running, a long walk around Virginia Lake, a cruise on a paddle steamer, a ride on a jet boat or a Canoe trip are some of the attractions. Camping and mountain biking complement an active extra-curricular program and makes an extension of your stay worthwhile.

The conference has as its theme "practical skills" and comprises practical workshops on:

- Cardiac dysrhythmia
- Vasculitis
- Dermatology update
- Renal failure

The invited speakers include:

Dr. Mark Simmonds - Interventional cardiologist
Dr. John O'Donnell - Immunologist
Dr. Marius Rademeyer - Dermatologist
Dr. Tom Thompson - Internist with renal focus

There will also be a session on **controversies in medicine**, to continue the theme established in Nelson last year. **Free paper presentations** will complete the academic program. A business meeting of the New Zealand chapter of IMSANZ will precede the conference dinner.

The meeting is approved for RACP MOPS credit points.

Registration is now open and those interested may contact:

Dr. Guy Taylor, Consultant Physician
Department of Medicine, Wanganui Hospital
Private bag 3003
Wanganui 5020
Tel : 64 6 348 1234
Fax: 64 6 348 1304 or 348 1206

General Internal Medicine in Canada

Greetings from the Canadian Society of Internal Medicine (CSIM). Although I would have preferred to deliver this message personally, perhaps in the depth of our winter, 1 am nevertheless very pleased to contribute to your newsletter.

CSIM is a relatively young National Specialty Society existing only since 1984. It began out of the recognition of the growing role of General Internal Medicine (GIM) in the University faculties, plus the increased numbers of community based consultants.

In Canada, Family Medicine has the foothold on primary care, a position strongly supported and endorsed by our society. This contrasts with our American GIM colleagues who has staked out primary care as their area of expertise, but are now having to deal with the rapid growth of family medicine plus the burgeoning surplus of subspecialists.

We train our residents to be consultants and to deliver concomitant care with family physicians. Our expertise, like yours I'm sure, is in the cost effective, technology restrained approach to common internal medicine problems with our unique expertise being in the assessment of the growing population of patients with multiple or poorly differentiated internal medicine problems. We have debated for the past several years on the proper training period for this and have before our Royal College's Main Specialty Committee the proposal that although residents may be certified and practice GIM after four years of training, to receive a certificate of special competence in GIM will require five years training; three years of core training plus two in GIM.

In Canada we have 1,200 general intemists, plus 4,200 subspecialists. However only 17% of the latter group are greater than 55 years in age compared to 40% of the former, and therefore we anticipate a growing disparity in the number of subspecialists versus generalises. This challenges our consultation role as subspecialists will inevitably move to smaller centres where general intemists have often been the sole consultants and also will move into the smaller community hospitals within large urban cities.

We therefore are addressing this by improving the quality of our residents through an improved and expanded Residency Training Program as discussed above, by expanding the image of awareness of our society and General Internal Medicine in general, by becoming more involved in Provincial physician resource committees, and developing stronger links with family medicine.

There are, however a number of areas where we have consolidated our presence. Virtually all of our University departments of Internal Medicine are actively recruiting general intemists to fill the void on the General Medicine Clinical Teaching Units where the subspecialists have slowly withdrawn from their previous roles as attending physicians. The broad base on General Internal Medicine fits very well with the administration of postgraduate and undergraduate programs, and in many sections in Canada, general intemists are becoming more involved in research programs related to medical education, decision analysis, clinical epidemiology, ethics, and preoperative risk. They have become the leaders in teaching evidence based medicine principles.

One of our major mandates as a society is to organize and facilitate continual professional development (CPD). We have organized regional meetings across Canada plus our major program within our Royal College annual meeting, but by the year 2001 will be embarking on our own national meeting. Obtaining industry support for such an initiative has often been fragmented and poorly coordinated in the past, and therefore we have developed a consortium of several industries as represented by their educational experts to work in a partnership as a group to develop high standard CPD programs. This has been a fascinating process as we move slowly to develop a feeling of trust and ownership amongst all parties. As a trial in this cooperative agreement we are developing an interactive 90 minute program focusing on type 11 diabetes through the Intemet.

Our own Royal College of Physicians and Surgeons is undertaking a massive program for the Maintenance of Certification. CSIM will be a major player in the pilot phase of this initiative, as we try to tailor the multiple different modalities of CPD to the diverse practice of our members.

This is just a brief outline of our societies activities and interests. Personally I am passionate in my commitment to the cost effective practice of General Internal Medicine and its importance as an academic discipline. We must work closely to nurture relationships with family physicians, and to work closely with our subspecialty colleagues in recognizing the unique contributions we all will make to the rapidly changing environment of health care delivery. 1 hope this will be the beginning of an effective exchange of ideas and innovative approaches as both of our societies champion the philosophy and practice of General Internal Medicine.

Brendan MacDougall
President
Canadian Society of Internal Medicine
Email: BMACDOUG@CC.UMANITOBA.CA

General Internal Medicine in Ireland

A dwindling number of general physicians play a pivotal role in the delivery of acute medical care to the Irish hospital system. More than half of the 140,000 acute medical admissions per year to Irish hospitals are to 33 general medical units. Paradoxically, as medicine becomes more successful the demand for acute medical treatment can only increase. Prior to modern intensive care many patients died during their first major medical emergency. Nowadays, however, death is an unusual outcome for any acute emergency hospital admission, even for octogenarians. The inevitable consequence of this increased survival is that patients will have many more opportunities to present again as acute emergencies. Many of these acute medical predicaments do not easily fit into any of the classical sub-speciality categories, and their efficient management requires the immediate attendance of an experienced physician with broad general skills.

As of 1998 there are 209 consultant physicians in Ireland providing care for all medical sub-specialities - only 33 of these are designated as general physicians. All but three of these general physicians work outside the Eastern Health Board. Even if it were assumed that all the cardiologists, endocrinologists, gastroenterologists, nephrologists and respiratory physicians working outside the Eastern Health Board area were also chiefly practising general medicine, there would still be only 56 consultant physicians providing the majority of the acute hospital medical care in the state. This yields a ratio of approximately two general hospital physicians per 100,000 of the population. General physicians, therefore, are major service providers and, by any standards, there are not enough of them.

The Irish Association of Internal Medicine is firmly of the view that there currently is, and will be in the a future, a need for many more general physicians in Irish hospital medicine. These physicians must be fully trained specialist physicians, accredited in general (Internal) medicine (with or without a sub-speciality interest), who will function as autonomous consultant physicians capable of taking full responsibility for their ever increasing numbers of patients. Moreover, when consultant physicians are appointed to any hospital in the future, attention should be paid to their training in general medicine in proportion to the amount of general medicine they will be expected to practice, and not disproportionately influenced by their sub-speciality credentials. Over the last 40 years general medical skills have been undervalued by the country's medical decision makers, and it may well be that when the present generation of acute general physicians retires a resource will have been lost that cannot be easily or inexpensively replaced.

John Kellet
Email: Kellet@iol.ie

(This is the summary of a 50 page discussion document prepared by Dr Kellet, Consultant Physician, Nenagh Hospital, President, Irish Association of Internal Medicine for the Irish Department of Health. The complete document can be obtained from the IMSANZ Secretariat.)

General Medicine in Sydney

For the 25 years I have been in consultant practice the NSW hospital system has lurched from crisis to crisis. There are currently eight tertiary or true teaching hospitals in Sydney and eight or so district (sometimes called peripheral) hospitals. District hospitals have between 160 and 350 beds. Precise figures on hospital activities are becoming harder to ascertain because of mergers of services and operating units and the inclusion of what were previously non-hospital community institutions in hospital calculations. Almost every year one hears of yet another hospital closing or its services being amalgamated with another.

Since the introduction of sessional payments and other funding changes tertiary hospitals have evolved to be almost exclusively staffed by staff specialists and university based academics. Visiting Medical Officers (VM0s) are an ever decreasing complement. The employment situation for medical specialists is further complicated by the fractional arrangements of the staff specialist's contract which allows for varying, and often very large, amounts of time being spent doing non-salaried (private) work. Such work is done without the financial and other risk exposure inherent in establishing and maintaining a true private consultant practice.

A recent phone survey reveals general rosters are maintained in all district hospitals and only two tertiary hospitals. I could not locate any teaching hospital with a staff specialist in general medicine. In tertiary hospitals, geriatric units appear to admit many of the patients formerly admitted to a general unit. All but two tertiary institutions have effectively removed any form of general medicine.

In addition there are senior physicians attempting, with varying success, to try and keep some form of general medicine alive in a few teaching hospitals.

From my knowledge of recent appointments at district hospitals there appear to be few general trained physicians available. Most applicants are subspecialists with varying skills and abilities to handle a general roster. I see this as a very serious problem notwithstanding the fact that many subspecialists mention an interest in general medicine.

There are good clinical, economic and educational reasons for the continuation of undifferentiated general units in peripheral hospitals and their return to tertiary ones. While registrars spend rotations in district hospitals they identify with the major teaching institution, and need to do so for future progress. Registrar training in general medicine is therefore difficult to obtain in spite of interests often expressed by Part 1 trainees. It is certainly not encouraged in tertiary hospitals.

Outside teaching and district hospitals, the private hospital system in NSW is less well developed than in other states. There are a number of large private hospitals that have Coronary Care Units and similar levels of care. General physicians are usually accredited in these 'institutions'. Most generalists have a subspecialty interest and many are proceduralists.

The return of general medicine to tertiary hospitals will not come from within the teaching hospitals. It can only be achieved by outside pressure from the Royal Australasian College of Physicians and political pressure. Generalists at peripheral hospitals will need to ensure that true generalists continue to be trained and that they compete successfully for appointment against subspecialists with minimal training in general medicine.

Michael Kennedy (Sydney)

General Medicine in Western Australia

In WA, General Medicine has its strengths and weaknesses which vary substantially according to geography.

At the university teaching and secondment hospitals, general or internal medicine units on each campus are staffed by between four and 12 consultants, are on regular take via emergency departments, interface well with subspecialty units and provide high quality service and teaching. Academics have an active role in general medicine at Royal Perth and Fremantle Hospitals, considerably enhancing the breadth of these units.

General physicians have a valued role at all the private hospitals where consultations are sought mostly on an ad hoc basis. In the metropolitan area, general physicians are more than fully occupied in private practice, numbering perhaps 1/30,000 population. We have rural consultant physicians, servicing up to 40,000 population/physician but with large tracts of WA not having a nearby physician.

Most metropolitan general physicians complement their practice with a subspecialty interest in which they are usually fully trained. However, this interest is in some instances not fully recognised or utilised at their tertiary centre appointment. Notable exceptions where generalists provide an exclusive service at their tertiary centre include cardiovascular, tropical and nuclear medicine.

IMSANZ in WA will "come of age" when the national meeting comes here ahead of the RACP annual scientific meeting in May. Our own local chapter of IMSANZ will meet formally for the first time, in a weekend retreat to beautiful Dunsborough at the end of summer.

The vexed issue of attracting advanced trainees to general medicine remains problematic. We are very supportive of suitable rotations for advanced trainees intending a rural career. Others are encouraged to nurture a special interest or research and subsequently decide on the balance of specially and general that suits them.

Simon Dimmitt (Perth)

The importance of being "generalist"

Dear Editor,

Attention has been recently drawn to certain advantages of having patients looked after by "generalist" consultant physicians in a recent editorial in the *Medical Journal of Australia* (1). Several potential benefits are identifiable including:

- skills in managing undifferentiated problems,
- management of conditions that cross sub-specialty barriers,
- appropriate management of significant co-morbidities,
- management of patient concerns which are not related to the primary problem,
- the generalist's integrated view of patients,
- fewer unnecessary investigations,
- fewer total consultations, and
- continuity of care over a series of episodes of illness.

These skills are being displayed, and benefits experienced by patients cared for in several of Adelaide's private hospitals which have recently set up emergency services, supported by general physicians (with or without a sub-specialty interest) and sub-specialists (with generalist skills). A total of twenty such physicians are currently rostered to three emergency departments, most providing their services to two of the hospitals, and the others to one, or even to all three.

Approximately half these consultants identify themselves as general physicians with or without a sub-specialty interest e.g. geriatrics, while the other half have generalist skills in association with their sub-specialties, which include gastroenterology, nephrology, oncology and infectious diseases.

This scenario adds a further dimension to the evolution of general internal medical expertise in Australia.

Ross Philpot FRACP

Reference

1. Scott I A, Greenberg P B. General internal medicine in Australia and New Zealand - a renaissance. *Med J Aust* 1998; 168:104-5.

This letter was originally published in RACP Fellowship Affairs, Vol 17, No. 3, July 1998.

CD Rom Review: "Best Evidence"

Best Evidence (American College of Physicians, 1998) is a compact disc containing the contents of two journals of secondary publication, American College of Physicians Journal Club and Evidence-based Medicine. Clinical articles about diagnosis, prognosis, therapy, quality of care, clinical prediction guides and health economics that pass both specific methodological standards (such that their results are likely to be valid) and clinical scrutiny for relevance are included in these journals.

This 2-stage selection procedure reduces the clinical literature by 98%. The evidence is summarised in structured abstracts. One of several hundred clinical experts add a commentary to each which provides the clinical expertise necessary to place it in context.

The disc has a very user-friendly search engine which allows topics to be searched according to the categories listed above, or as a single index term which retrieves all articles containing that term. Within seconds you can retrieve high-quality primary articles and systematic reviews about topics common to general medicine. Print, copy, edit and file functions are available by which you can use the materials any way you want.

Editorials from EBM and ACP Journal Club together with a glossary and a set of handy notes constitute very useful and practical guides to understanding and using evidence-based medicine for the busy physician.

The latest edition contains articles published up to the end of 1997. At the price of about $120 for each new disc that comes out every 12 to18 months, it's money well spent. The Australian distributor is AMA Services, PO Box 133, Nedlands, WA, 6009. (Ph: 08 9273 3000).

Ian Scott (Brisbane)

COUNCIL ELECTIONS

Under the Rules of Incorporation of IMSANZ, Council elections have to be conducted this year.

You will find nomination forms included with this newsletter.

Please complete these forms and return them to the IMSANZ Secretariat at 145 Macquarie Street, Sydney, 2000 **no later than Friday 5 March 1999.**

The success of IMSANZ depends on the energetic activities of Councillors who represent members from our two countries and from both metropolitan and non-metropolitan areas.

Australian Prescriber

Short Reports and Commentaries

The Editor of the Australian Prescriber, Dr J S Dowden, invites IMSANZ members to submit short reports or commentaries of interest to a general audience, for publication.

Contact: Michael Kennedy
22 Darley Road
Manly NSW 2095
Phone: 61 2 9977 8265
Fax: 61 2 9977 4426

Medical Journal of Australia

Book Reviews, Commentaries, Manuscript Reviews

The Editor of the Medical Journal of Australia, Dr Martin Van Der Weyden, is keen to have a list of IMSANZ members willing to assist in preparing these documents for publications.

Contact: Peter Wakeford
31 Dowe Street
Tamworth, NSW 2340
Phone: 61 2 6766 1544
Fax: 61 2 6766 9110

IMSANZ PAMPHLETS

"General Physicians are Specialists in Adult Medicine",

There are still some of these pamphlets available.

Should any members wish to order these they cost A$25 for 100 pamphlets and can be ordered from the Secretariat at 145 Macquarie Street, Sydney, 2000. It would be appreciated if New Zealand members could send payment in Australian dollars.

OSTEOPOROSIS FOR GENERAL PHYSICIANS

Over 30 members of IMSANZ were hosted by Merck Sharp & Dohme to an evening meeting in Melbourne in November 1998 on "Osteoporosis for General Physicians". The guest speakers, Dr Peter Ebeling and Associate Professor Ego Seeman, both highly regarded in the field, were able to interface research findings with day-to-day clinical problems.

Ego Seeman gave the background to the declining role of vitamin D in post-menopausal osteoporosis, but did note that many elderly people may still require vitamin D supplements as they may actually be vitamin D deficient. He emphasised that bone mineral density and bone strength are not necessarily synonymous. It was a little disconcerting to hear that no trial of adequate power has shown conclusive reduction in hip fractures with any medication, despite the importance and frequency of this clinical problem.

Peter Ebeling concentrated his presentation on corticosteroids and osteoporosis. He reminded the audience of the multiple levels of activity of corticosteroids, eg. reduction in pituitary and gonadal function and emphasised the potential for rapid development of osteoporosis with corticosteroids, eg. within the first six months.

The venue, the restaurant "Jacques Reymond" was a delightful choice. The educational value of the meeting, however, was diminished a little by the organisation being removed from IMSANZ control by Merck Sharp & Dohme. This prevented the planned "workshop" format, feedback sheets, awarding of MOPS points etc. These concerns need to be addressed and the format needs to be clearly annunciated before similar meetings, sponsored by pharmaceutical companies, are planned.

Bob Lodge (Melbourne)

Wanting to join IMSANZ?

It appears that a considerable number of general physicians in Australia and New Zealand have not yet joined IMSANZ. Perhaps this is largely due to physicians feeling "over committed" with specialist societies and other professional activities?

We wish to invite all physicians practising general medicine to seriously consider joining IMSANZ. Please feel free to contact a Councillor near you (see list on page 1) or the Secretariat to obtain an application form.

Please give this Newsletter to a colleague who has not yet joined.

RACP NEW ZEALAND ANNUAL SCIENTIFIC MEETING NELSON 2-4 SEPTEMBER 1998

Nelson turned on a display of fine, warm weather for visitors attending the RACP Meeting, providing them with full opportunity to see Nelson and its immediate locale at its best.

The opening symposium chaired by Dr Harvey White with Dr Paul Armstrong, University of Alberta, Canada, as the main speaker, focused on "Out of hospital thrombolysis". Support speakers including Dr Andrew Hamer, Cardiologist, Nelson and Dr Dennis Pezaro, General Practitioner, Wanaka, to add their clinical perspective. A panel discussion closed this first session and allowed full and open interacton with the audience. A consensus type series of decisions was reached, although it is acknowledged that not all are supported by high level evidence based data. The discission focused on the acute management of myocardial infarction at a stable base with appropriate medical staffing and monitoring. With all consensus decisions there was a disclaimer that local physicians should adapt this according to their own geographical staffing and support facilities.

Question 1: Which thrombolytic agent?

Both streptokinase and double bolus rPA were discussed and their relative merits debated. Whilst the two bolus rPA is attractive it was agreed that the only secure evidence available regarding follow-up therapy included intravenous heparin by infusion which adds potential complexities to the delivery of thrombolytic agents and initial follow up therapy to patients with acute myocardial infarction some distance from base hospital.

Question 2: Is there a time cut off?

In discussion it was felt that a transport time of less than 30 minutes to the nearest base hospital meant that the patient should be rapidly transported and thrombolysed in hospital. In the 30-60 minute time period it was felt that the decision relates to the local environment. For greater than 60 minutes it was felt that immediate thrombolysis and later transport to hospital was appropriate, if there was a suitable peripheral venue.

Question 3: How much monitoring and for how long?

Minimum monitoring included continuous rhythm, frequent non-invasive blood pressure monitoring, either manual or automatic, and trancutaneous oxygen saturation at least on an intermittent basis. This required on site medical and nursing staff able to interpret these recordings and to respond appropriately with immediate therapy if required. The question of duration of monitoring post thrombolytic therapy was debated with general but not universal agreement on a 60 minute time frame prior to transportation.

Question 4: How to transport?

The only universally agreed recommendation was that transport should include appropriate levels of paramedical staff able to interpret and respond to changes in cardiac rhythm and blood pressure, and if necessary initiate and continue advanced life support activities. The question of road vs air was felt to be region-specific based on geography and availability of services. Related to these points there was extensive discussion as to the future advances in the management of acute myocardial infarction along with review of the data regarding thrombolysis vs acute coronary angiography/angioplasty, recognising the limitation of the latter for a great many regions of New Zealand.

The other presentations of the first day were very clinically orientated and well supported by excellent speakers.

The Glaxo-Wellcome Young Investigators' Award was won by Dr Merlin Thomas of Dunedin presenting "Increased thromboticvascular events following cholesterol elevation". It was difficult for the judges to compare studies in clinical medicine with elegant experiments in basic science. Dr Thomas received a cash award along with a trip to the Australasian RACP Meeting in Perth to re-present his paper.

The next symposium discussed "HIV Medicine". Dr Peter Piggot from Sydney discussed the clinical assessment of dyspnoea in the HIV patient, followed by Dr Rod Ellis-Pegler from Auckland providing an update in therapies for HIV. The respiratory theme continued with Dr Piggot again presenting "Long term respiratory complications in HIV patients".

Thereafter clinical vignettes in "Non-invasive ventilation" by Dr Ken White, Greenlane Hospital, Auckland, and the "Clinical utility of DLCO" by Dr Robin Taylor, Dunedin ended the first conjoint session of the RACP and the Thoracic Society of Australia and New Zealand (TSANZ).

The afternoon session was opened by Dr Peter Leslie. Geoff Robinson presented the RACP Caughey Lecture for 1998 titled " The Interface of Prescription Medicine and Illicit Drug Use". Geoff dealt with this topic extremely well particularly with respect to modern issues in this increasingly difficult area. The medicolegal theme continued with a presentation from Gaylene Phipps, MDU/Rainey Collins Wright & Co, Wellington, New Zealand., discussing the "Medicolegal Aspects of Prescribing".

The day ended with an entertaining and extremely educational debate entitles "Is polysomnography really necessary?" The debaters were Dr Alistair Neill, Dr David Jones, Dr Ken Whyte and Dr Robin Taylor and the moderator was Ian Town. The final opinion was that the indications remain clear but the utitlity controversial, given that regions with no access to polysomnography managed the patients in a fashion similarly to those with such techniques.

The final conjoint session of the RACP and the TSANZ was an outstanding symposium on "Pulmonary Embolism" chaired by Ken Whyte and opened by Dr Ian Town, Christchurch. Discussed were clinical assessment in pulmonary thromboembolism and aspects of clinical and laboratory based data which helped to differentiate those at high or low probability of having suffered this event. Dr Stephen May, Waikato, discussed "The thrombophylic states and their associated risks in investigation". "Diagnostic Imaging" was discussed by Dr David Milne, Greenlane Hospital, Auckland and "Controversies in management" by Dr Paul Occelford, Auckland Hospital. Each session generated significant discussion and hopefully allowed practising physicians further insight into the best way forward. Certainly there was no argument that low molecular weight heparin is suitable management for both deep venous thrombosis and pulmonary thromboembolism and that spiral CT was the best current test. Measurement of D-Dimers proved useful in negative but non-specific if positive.

The Friday afternoon session included TSANZ Young Investigator presentations and free papers. Throughout this meeting the Haematology Society ran a conjoint programme with excellent Australian speakers, Dr Sam Milliken and Dr Paul Vincent as well as local speakers addressing "Myeloproliferative disorders" and "Lymphoma management".

The New Zealand Geriatric Society and Australasian Faculty of Rehabilitation Medicine had a conjoint programme during the meeting. The various societies and faculties interrelated extremely well. There was full involvement of audience in all presentations with vigorous debates on contentious issues.

On behalf of the organising committee I would like to thank speakers, registrants and attendees for their active involvement.

Bruce King (Nelson)

General Internal Medicine
What's in the Journals?

Outlined below are some recent publications which discuss General Internal Medicine. Please send along relevant articles with your comments.

1. **Comparing Apples with Oranges. Johnson W. Arch Int Med 1998; 158: 1591-1592.**

   An editorial based on Donahoe's review (see 2 below). "Generalists and specialists have different but complementary roles in patient care".

2. **Comparing Generalist and Specialty Care. Discrepancies, Deficiencies and Excesses. Donahoe MT. Arch Int Med 1998; 158:1596-1608.**

   A comprehensive review with 217 references.

3. **Consultation between Cardiologists and Generalists in the Management of Acute Myocardial Infarction. Implications for Quality of Care. Willison DJ et al. Arch Int Med 1998; 158:1778-1783.**

   This was based on a chart review of 1716 patients and discusses differences in patient characteristics but no significant variations in the use of effective agents.

4. **A comparison of Generalist and Pulmonologist care for patients hospitalised with severe Chronic Obstructive Pulmonary Disease: Resource Intensity, Hospital Costs, and Survival. Regueiro et al. Am J Med 1998; 105:366-372.**

   There was no difference between the groups in resources used or in survival in 866 hospitalised patients with severe exacerbations of COPD.

5. **Specialist Adult Physicians in the Top End of the Northern Territory (NT). Weeramanhri T. RACP Fellowship Affairs, Vol 17, No 3, July 1998.**

6. **Where have the generalists gone? Wijesinha C. Aust Fam Physician. June 1998; Vol 462:27(6).**

   A lament on recent trends!

Speech Recognition Software - A User's Experience

Medicine has been one of the last fields in life to embark on the computer bandwagon. Even so, computers are catching up fast. They are no longer a luxury but rather a necessity in many aspects of our professional and personal lives.

Dictating letters, summaries and reports are an integral part of a doctor's life. In the medico-legally charged atmosphere of our work, documentation has become the order of the day.

A considerable portion of our professional time is spent dictating. Using dictation machines to record speech for manual transcription is the traditional method. The limitations are obvious.

Speech recognition software has come a long way since its inception a decade ago. Though takeoff was delayed when compared to the other developments in the field of computers, the idea of speech recognition and *voice to text* transcription is flying high and has recently reached new heights.

Over the last two years many IMSANZ members have discussed speech recognition software in personal forums as well as on the internal medicine electronic chat list (Intmedlist). A few have already established such speech recognition systems in their practice as well as at home. There are attractions for internists. For those in private practice, where overheads are steep, the financial savings are not inconsiderable.

There are many different systems. Computer magazines have major reviews of speech recognition software at least annually given the rate of growth and metamorphosis. Phenomenal development has occurred in the last few years.

As a user of speech recognition software I wish to share some of my views with the hope that it might help other IMSANZ members. I do not claim to be an expert. Please feel free to contact me by e-mail should you wish to discuss this further.

When I started using speech recognition software, I used **DragonDictate.** This was one of the first products on the market and it employed technology called "*isolated word speech*". In using this, one had to pronounce words individually and clearly, each word at a time, much like the Voice of America's news in special English broadcasts to non-English speaking audiences.

While the idea of voice to text was very welcome to the untrained typist, especially those who used two fingers and two thumbs, the pitfalls of isolated Word speech technology soon became evident. Dictation became laborious and tedious. OOL (Occupational Overuse of the Larynx) syndrome became a real entity and essentially sealed the fate of **DragonDictate.**

The program may still be useful for generating items such as pathology and radiology reports where formatted reports are possible. For example one could program a macro to say "basal carcinoma" and the previously set macro would type a paragraph of text to describe basal cell carcinoma.

Then came **NaturallySpeaking** technology. This entails one to speak in exactly the same way as we would to a colleague or on the telephone. It overcomes the inherent pitfalls of *isolated word speech.*

In between were many programs, often very affordable in price (eg. Kurzweil's Voicepad; IBM Simply Speaking Gold etc), which have now been overtaken by programs such as **Dragon NaturallySpeaking, IBM Via-Voice, Phillips Free Speech.**

In the earlier versions of **NaturallySpeaking** (such as **NaturallySpeaking personal edition**) the facility for macro was not available. Macro is a great advantage when dictating letters. For example you might dictate "Andy Smith". If the macro had been previously programmed, the machine would type "Doctor Andrew John Smith, FRACP, Consultant Physician, Royal Melbourne Hospital, Melbourne, Victoria, Australia", all by selecting the macro key (in this case "Andy Smith").

These earlier editions of **NaturallySpeaking** (such as personal edition) suffered another drawback. They did not have a *medical suite* as provided in **DragonDictate**. Many feared that important medical words would not be recognised. In my experience, medical words contained in the normal vocabulary provided by the personal edition are more than adequate for most letters.

Most medical letters will need some degree of programming of medical terminology or addition of words to the vocabulary of the application. This does not involve any special skills and occurs as one dictates more and more letters. Even after 20 or 30 letters, the application would have added the special terminology one commonly uses.

The older **NaturallySpeaking** personal edition seemed a perfect tool to many. The speed and ease with which one can dictate letters using this is still adequate for most users in homes and small offices.

However modern engines for speech recognition technology have fast overtaken any such worries about speed, recognition accuracy, incorporation of medical terminology and include a degree of "*best guess*" choice of words. The "*best match technology*" is a system by which the application chooses the best and the most appropriate word for the context, even if the person dictating may not have been clear.

Dragon professional edition with *medical suite* is just about the state of the art in this technology. This encompasses all the good attributes of **NaturallySpeaking** and **DragonDictate**. You can speak at a natural speed, have the advantage of medical vocabulary built into the medical suite and have a facility for macro. What is more, these applications have a "*text to speech*" mode; after dictation the user may listen to the dictation as the machine reads it back, albeit with a Yankee accent!

Whatever program one chooses to buy, the initiation phase takes time. Apart from the mandatory "reading the passage that appears onscreen", which takes about an hour or two, one has to start dictation. It is only after about 20-30 letters that one gets to enjoy these applications.

The hardware requirements are pretty stiff for the latest applications. While a Pentium 166 with 64 Mb RAM would easily handle the older **Dragon Naturally Speaking - personal edition**, the manufacturers recommend a minimum of Pentium 200 with 128 Mb RAM for the **professional edition with medical suite**. This gets the best out of the "*best match technology*".

Perseverance and patience usually overcome problems with accent, diction and idiosyncrasies of dictation. The dictation, however, has to be clearly spoken into the microphone. Speech recognition is not for those who swallow parts of words and leave it to poor typists to figure out what may have been said!

You may wish to visit the following websites for a start:

http://www.dragonsys.com
http://voicerecognition.com/1998/products/dragon/medicalsuite.html
http://voicerecognition.com/1998/products/dragon/upgrades.html
http://www.richspeaking.com/order.html
http://www.naturallyspeaking.com/frameset/product-frame.html

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Extract from draft "Physician Workforce in Australia" RACP 1998

7.2 General/Sub-specialist physician maldistribution

The College should identify current and projected general and subspecialist physician workforce deficiencies and actively promote these specialty areas to basic trainees, interns and undergraduates.

The RACP can help to increase the attractiveness of general physician training and rural practice by:

- lobbying administrators of major urban teaching hospitals to create or retain departments of general medicine;
- publicising and promoting those teaching hospitals that have appointed a Director of General Medicine;
- providing scholarships to assist advanced trainees in General Medicine to undertake longer-term placements in rural and regional hospitals;
- providing assistance with business and career planning for regional and rural practice; and,
- providing assistance in organising locum services and continuing medical education opportunities for regional and rural practitioners.

The College will continue to encourage the development of financial incentives through the Medicare system for the currently under-valued, non-procedural areas of clinical practice.

From the Editors

Peter Greenberg & Ramesh Nagappan

We are pleased to bring you this Newsletter on behalf of IMSANZ, with best wishes for 1999! There are several references to "Evidence Based Medicine" (EBM) which we believe is the academic substrate of general internal medicine.

The Perth RACP Annual Scientific Meeting from 11 - 15 May 1999. **11 May 1999 will be IMSANZ day.** We hope many generalists will congregate in Perth for what promises to be an excellent meeting. See you there!

Please note that a "free standing" IMSANZ meeting will be held in Sydney in October (see details on page 9).

The IMSANZ Newsletter is published *twice a year.* We welcome contributions from physicians and advanced trainees. Job vacancies and advertisements for locums can be published. Please feel free to contact us with your thoughts and comments and give us some feed-back concerning the contents and style of the newsletter. Tell us what you want!

When submitting material for consideration for the IMSANZ Newsletter please send your submissions in **IBM PC format** in Microsoft Word, Excel or Publisher applications. Please submissions to either Peter Greenberg (*Peter.Greenberg@nwhcn.org.au*) or to Ramesh Nagappan (*ramesh@igrin.co.nz* or *ramesh@nhl.co.nz).*

Should you wish to mail a diskette please do so in a 3.5" IBM format.

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http://www.racp.edu.au/imsanz