IMSANZ

Internal Medicine Society of Australia and New Zealand *July 1999*

From the New President

As I embark on my two years as President of IMSANZ and put together this first contribution to the Newsletter in this role, the words of the late Chilean Nobel Literature Laureate, Pablo Neruda, come to mind.....

....And something ignited in my soul,
Fever or unremembered wings
And I wrote the first bare line,
Bare, without substance....

Firstly, I would like to recognise formally, the outstanding contribution which Rob Beattie, my predecessor, made over the last two years and to thank him for this, on behalf of IMSANZ. I would also thank the retiring Council members for their contributions with special mention to Peter Wakeford in his role as Secretary.

I am a committed general physician, with strong philosophical beliefs in the need for an approach to the practice of medicine which focuses on the organism rather than an organ. I like to think of generalists as the Decathletes of medicine. Being one gives me great satisfaction in my day to day work.

I see the next two years as a period of consolidation for IMSANZ, with the main focus being on:

(a) the re-establishment of General Medicine as having a central role in secondary health care delivery, with emphasis on cost-effectiveness, particularly with the generalist's skills in dealing with multi-system disease and holistic health care. This role has been undermined in both main and smaller provincial centres.

b) advanced trainee issues for prospective general physicians so that more will see this option as a desirable sub-specialty. There are also important workforce issues for generalists which necessitate attracting more

As you turn the pages.....

advanced trainees.

I believe we need to continue to build up the culture of IMSANZ, which has so far mainly been through our regular scientific meetings. I would like all IMSANZ members to link up to email to help us discuss and progress educational, social, and political issues. Please use the website – European Generalists are most impressed with it.

In addition, I believe there are major advantages in expanding our global contact with generalists, not only in Europe and North America, where there are vast resources to be tapped into, but also in places like Fiji and other Pacific nations, and Sri Lanka, where opportunities exist for helping with the development of general medicine.

I would also like to see IMSANZ embrace projects in areas where generalists have strengths (eg secondary health care delivery for indigenous people) which would raise our profile. A major problem we still have is to inform the world exactly what a general physician is.

An opportunity exists, too, for IMSANZ-coordinated research initiatives. This could include work for drug companies which could generate revenue for the group. We lack vigorous research in the area of general medicine.

I invite members to bring issues to my attention so that IMSANZ can fulfil its role. This can be by phone call, letter or email (see below). One of the difficulties for IMSANZ is getting recog-nition by decision-makers. The group can be helped in this regard by Craig Patterson, Director, RACP Health Policy Unit. Les Bolitho had a useful discussion with him in Perth, and further meetings are planned. Craig is very keen to assist us.

IMSANZ is helped greatly by the considerable skills of Cherie McCune at the Secretariat, and I am most grateful to her.

I look forward to the next two years with considerable enthusiasm, and thank you for the opportunity I have been given to lead the group.

Neil Graham (Tauranga)

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From the Past President

IMSANZ provides the framework for general physicians to rally together and to reassert the importance of general internal medicine in the provision of quality and cost-efficient healthcare services. We now have 460 members and we must continue to encourage input from the whole membership if IMSANZ is to flourish. This can be directed to Council or the Newsletter, or perhaps just by attendance at meetings.

In the last year there has been obvious and increasing support for generalism, both within Australasia and around the world. Our advanced trainees now number 58, up from 41 last year, and second only to the cardiologists in absolute number. Council has continued to encourage successful basic trainees to consider a career in general medicine. Unfortunately, the larger metropolitan hospitals still pay little more than lip-service to support for generalism, and it will take more concerted efforts from the RACP, Government and IMSANZ before general medical units are reintroduced into the Australian tertiary care hospitals.

IMSANZ has established scientific meetings on the day before the RACP ASM. In 1998, for the first time, Council held a second scientific meeting, a weekend workshop on Evidence Based Medicine in Adelaide. This meeting attracted 50 members and was educationally valuable and socially rewarding. The Perth meeting in May 1999 was a great success thanks to the excellent efforts of Simon Dimmitt. New Zealand continues to hold two scientific meetings each year. A scientific meeting is planned for Manly on 16-17 October (see details page 7) and a major meeting will be held in Fiji next year (see page 4). Council has continued to support the ideas of Evidence Based Medicine and we were very pleased to have the benefit of Prof David Sackett's wealth of experience at the Adelaide meeting. Our thanks go to Prof Paddy Phillips and his department at Flinders for allowing us to have David's services at that meeting.

I have pleasure in congratulating Neil Graham on his election as President of IMSANZ. The Vice-President is now Les Bolitho, the new Secretary is

Kingsley Logan. Michael Kennedy continues as Treasurer. It is not always easy to attract physicians to serve on Council and some have had to serve for longer than the Constitution suggests they should. I extend my thanks to departing members who have all served Council well. Cherie McCune at the Secretariat continues to provide excellent services to Council and is very helpful providing members with information about IMSANZ and its objectives.

Members are reminded that the "Guidelines for Members" booklet, the "General Physicians are Specialists in Adult Medicine" pamphlets and the Newsletter are all in evolution. Comments and suggestions will always be gratefully received. Council is grateful to Peter Greenberg and Ramesh Nagappan for their excellent efforts in gathering information for the Newsletter.

IMSANZ has maintained contact with similar organisations around the world. Our problems, including difficulty in encouraging advanced trainees into general medicine and the maldistribution of physicians between cities and rural areas, are common to most countries.

Council now has a representative on the editorial board of the RACP journal. Members of IMSANZ are encouraged to nominate themselves as reviewers of books, manuscripts etc for the MJA. The Australian Prescriber is happy to accept short reports or commentaries from generalists for publication

IMSANZ has agreed to take an active role in the preparation of the College Australasian Self Assessment Program questions for generalists in the future.

Some of you will have read, and perhaps been alarmed by, the suggestion that hospitals should be staffed by full-time "hospitalists". (see page 23) IMSANZ is preparing a response to this proposal. Now is the time to speak out if you have views on this issue.

My sincere thanks go to the many people in IMSANZ who have assisted me over the last two years. I am sure that the enthusiasm and vigour of the new Council will serve IMSANZ well in the future.

Rob Beattie (Hobart)

General Internal Medicine in History

"Specialism is inevitable, and having accepted it we must examine its limitations ..... disease is no specialist. Patients do not consult us because certain organs are affected, but because they feel ill."

Sir Heneage Ogilvie 1948.

FORTHCOMING EVENTS

New Zealand

Rotorua: 25 - 27 August 1999 - RACP/IMSANZ Annual Scientific Meeting - see program page 8

Australia

Sydney: 16 - 17 October 1999 - IMSANZ Scientific Meeting. See program page 7.
Mailing will be sent to all members late in July.

Adelaide: 1 - 5 May 2000 - RACP Annual Scientific Meeting
2 May 2000 - IMSANZ Annual Scientific Meeting

Elsewhere

Montreal: 23 - 26 September 1999 - Royal College of Physicians and Surgeons of Canada and Canadian Society of General Internal Medicine.

Arizona, USA: Headache Symposium, 22 - 24 October 1999 American Association for the Study of Headache.

Fiji: 29 September - 1 October 2000 - IMSANZ Scientific Meeting. This will be a great meeting and we are hoping to have international speakers and international delegates. It will be held at the Shangri-La Fijian Resort on Yanuca Island which offers excellent facilities in an idyllic setting. The preliminary program will be in the January 2000 Newsletter.

IMSANZ Annual Scientific Meeting
Perth, May 1999

The meeting commenced at the relatively civilised time of 0900. Those of us from the Eastern states had little difficulty with the morning sessions due to the time difference - most were awake by 0400 (0600 EST)!

Workshops

Management of Advanced Renal Disease

Dr Brian Hutchison from WA presented cases and clinical information regarding management of patients with severe glomerulonephritis. The value of renal biopsy in determining management and prognosis were discussed. Non-specific treatments of progressive nephritis was also evaluated. This emphasised the importance of pre and post renal factors as well as renal disease and the management of complications. Precise blood pressure control with ACEIs will limit proteinuria. Management of co-existing conditions such as hypercholesterolaemia, vascular disease, smoking and diabetes is required. The management of uraemic complications, eg anaemia, hypertension, cardiovascular disease, osteoporosis and other bone diseases and general nutrition was explored.

The second area was reno-vascular disease. This was presented by Dr Mark Thomas from WA. He explained the need for careful evaluation of patients with deteriorating renal disease. Procedures including surgical interventions are only required in a small number of patients. Exemplary control of blood pressure, proteinuria and associated diseases will reduce the rate of progression of renal disease.

The contemporary management of advanced malignancy

The management of oncological emergencies by Dr James Trotter was stimulating. He discussed superior vena cava obstruction and hypercalcaemia.

Dr Doug Bridge discussed pain-control strategies which were both practical and useful. The careful assessment of the type of pain, the co-morbidities and the assessment of the origin of the pain (somatic, visceral or neuropathic) results in appropriate medication and management.

Advanced Trainee Presentations

The IMSANZ - ROCHE AUSTRALIA AWARDS

There were four advanced trainee presentations, which were well presented by participants.

Dr Orla Morrissey from St Vincent's Hospital, Melbourne won the Award, with a paper on *'Emergency Reversal of Warfarin using Fresh Frozen Plasma - Development of a safe, rapid and effective dosing schedule'.* This demonstrated a reduction in number of units of FFP required.

Other papers were presented by Dr Tony Ryan, Townsville - *'Resolution of Serositis with Warfarin in Phospholipid Syndrome'*, Dr Marilyn Hassell, Cairns - *'Leptospirosis in Far North Queensland'* and Dr Nat Lenzo, Fremantle -*'Technetium-99M MIBI Spect Imaging in Management of Acute Chest Pain in the Emergency Department'*.

Plenary Session

Dr Peter Greenberg presented a provocative lecture entitled "The Tired Patient". 30% of his new office patients are referred for assessment of symptoms of tiredness, lethargy and loss of interest.

Careful assessment of history, physical examination and a limited range of investigations are required in tired patients. Elimination of the major causes of tiredness - eg. cardiac failure, anaemia, hypothyroidism and diabetes leaves many with unexplained symptoms, most of whom improve spontaneously. A biopsychological model is preferred. The labelling of a patient with "Chronic Fatigue Syndrome" may lead to a plethora of secondary problems. Many clinicians in the audience were sceptical of "CFS" as a specific entity.

Case Vignettes

These were presented by Drs Michael McComish, David Prentice and Simon Dimmitt. There was interesting and lively interaction, especially in a presentation on "Dyspnoea and Temporal Arteritis".

The Dinner

The IMSANZ Dinner was held in the evening at Altitude 9 at the Boulevard Hotel. Over 70 members of IMSANZ and their partners attended.

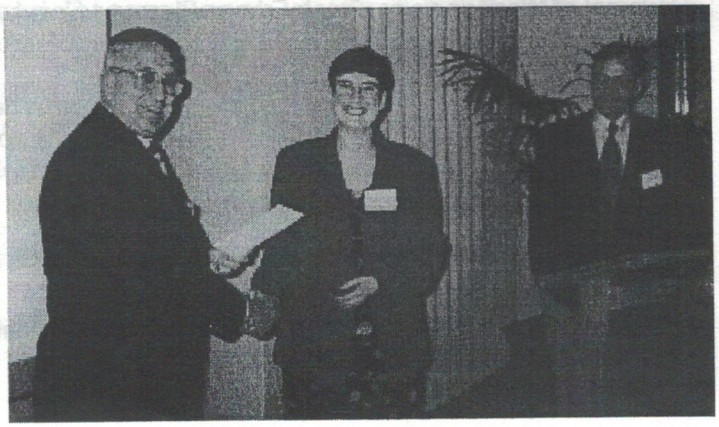
We extend our thanks to Dr Simon Dimmett and his colleagues who organised a most enjoyable and successful meeting.

We are looking forward to the IMSANZ 2000 Meeting to be held in Adelaide during the RACP ASM (see page 4). Dr Mark Morton and Professor Paddy Phillips will be convenors.

Les Bolitho (Wangaratta)

IMSANZ ASM
Advanced Trainee Presenters

Left to Right: Nat Lenzo, Tony Ryan, Marilyn Hassall, Orla Morrissey



Presentation of the Roche Advanced Trainee Award

Left to Right:
Mr Alan Feeney, Roche,
Dr Orla Morrissey
and Dr Rob Beattie

SEMINAR TO BE HELD 16 and 17 OCTOBER 1999

QUARANTINE STATION, MANLY

This 2-day conference will include:

Speaker	*Topic*
Prof Gordon Stokes	*Arterial pulse waves and new approaches to treating hypertension*
Dr Bridget Wilcken	*Hyperhomocysteinaemia - Background*
Prof David Wilcken	*Hyperhomocysteinaemia – Who should by tested? What will it mean?*
Dr Ian Fevre	*Management of Chronic Hepatitis B and C*
Dr Michael Buckley	*Molecular Biology – What a Physician needs to know in 2000AD*
Prof Rick Day	*COX 2 Blocking Agents – are they all they are meant to be?*
Neil Graham	*The role of long acting β2 agonists in the treatment of obstructive airways disease*
Ramesh Nagappan	*Illustrated Clinical Quiz*

The historic Quarantine Station is located in Sydney Harbour National Park, Manly, sitting high on North Head.

This unique venue has original accommodation, restored and available to those who would like to stay on site. Accommodation is as basic as it was for our forebears (if they were first class passengers!). There are no ensuite bathrooms, necessitating a walk down the verandah, but the view is unsurpassed and the sunrises are magic! There are a number of 4 and 5 star hotels in Manly for the less adventurous.

There will be a guided walk of the Station on Saturday afternoon and dinner on Saturday night. Single day registration will be available. You can walk into Manly and check out the surf or take a ride to the City on the ferry or hydrofoil.

The cost will be:

Two day meeting	$150
Single day registration	$75
Dinner	$75
Accommodation at the Quarantine Station	$75 per night
(includes breakfast and will be available Friday and Saturday night)	

A full brochure and booking form will be sent to all members in late July but think about setting aside the weekend now.

RACP ANNUAL SCIENTIFIC MEETING
25 - 27 August, 1999
ROTORUA

WEDNESDAY 25 August 1999

8.30 - 8.45 am Official Opening Address
Dr Murray McDonald, Organising Committee Rotorua
Dr Peter Leslie, NZ Branch RACP

Morning Session - Adolescent Medicine

8.45 - 10.30 am The Chronically Ill Adolescent
Growing Up with a Chronic Illness - David Bennett
Consent & Confidentiality - Peter Watson
Challenges in Management - Susan Sawyer
11am - 12.30 pm Effective Transition Programmes
"Melbourne Perspectives and Experiences" - Susan Sawyer
"Sydney Perspectives" - David Bennett

Afternoon Session - Genetics and Cancer Screening

1.15 - 3.00 pm *"Inherited cancer syndromes"* - Ingrid Winship
Parry Guilford Dunedin Group Scientific issues
"The psychological impact of predictive DNA testing in familial cancer" - Jeanne Reeve
3.20 - 4.30 pm Glaxo Young Investigators' Award
5.00 - 6.00 pm Youth Suicide - Prof G Burrows
6.30 - 8.00 pm Conference Reception

THURSDAY 26 August 1999

7.30 - 8.30 am Breakfast Meeting - Meet the Experts
Doctors Health • Clinicians as Managers • Genetic Counselling

Morning Session

8.30 - 9.15 am *"Leadership Roles in Medicine"* - Robin Youngson
9.15 -10.30 am *"Medical Managers and Hospital Reform"* - Associate Professor Pieter Degeling
11.00 -11.45 am *"Clinical Trials, Funding Research"* - Harvey White
11.45 -12.30 pm Panel Discussion

Afternoon Session

1.30 -3.00 pm ICU Update - G. Hood and L. Gailer
"Structure of Intensive Care Units and Intensive Care in NZ"
"Advances in Intensive Care Therapies"
"When should the Provincial Hospital bale out and how to do it"
3.30 - 4.30 pm Pharmac Evidence Based Workshop
4.30 - 5.00 pm AGM/Admission of New Fellows

Conference Dinner - "*Off Broadway*" show

FRIDAY 27 August 1999

8.00-9.00 am Breakfast Meeting - Meet the Experts
Evidence Based Medicine • Obstetric Physician • Clinicians as Managers

Morning Symposium - "The Obstetric Physician"

9.00 - 10.10 am Session 1 - Pre-eclampsia
9.00 - 9.20 am Essential Facts about Pre-eclampsia - Robyn North
9.20 - 10.10 am Management of a woman with Pre-eclampsia Complicated by Multisystem Disease: Case Presentation
10.30 - 12.30 pm Session 2 - Obstetric Medicine
10.00 - 11.00 am Chronic Hypertension in Pregnancy - Ray Naden
11.00 - 11.30 pm Interpretation and Significance of Abnormal Liver Function Tests and Thrombocytopenia in Pregnancy - Sandra Lowe
11.30 - 12 noon Rheumatic Heart Disease and Heart Valve Replacements in Pregnancy - Robyn North
12.00 - 12.30 pm Question the Experts on any Obstetric Medicine Issue

Afternoon Session - IMSANZ Afternoon

1.15 - 3.30 pm Evidence Based Medicine Workshop
Ian Scott (Brisbane) and Peter Greenberg (Melbourne)

Contact Kingsley Logan, Lakeland Health, Private Bag 3023, Rotorua, phone 64 7 348 1199, fax 64 7 349 7952, email nickl@wave.co.nz

AN ADVANCED TRAINING PROGRAM IN GENERAL MEDICINE IN NON-METROPOLITAN QUEENSLAND

A three-year advanced training program in General Medicine is being offered by the large provincial hospitals in North Queensland. These training programs offer many opportunities for experience and high levels of security in a training program.

The majority or all of the three-year program can be spent in larger and smaller hospitals that have been specially approved for the program by the CPT and the SAC in General Medicine. Rotation through sub-specialty units is assured, with sub-specialty procedural training available to general trainees.

The primary non-metropolitan hospitals involved will include Cairns, Townsville, Mackay and Rockhampton. Terms that will be offered will vary from hospital to hospital and may be arranged to suit the requirements of individual trainees. Terms in most of the core specialties are available, and training in echocardiography, endoscopy and bronchoscopy can be arranged.

Periods in smaller hospitals such as Mt Isa and Gladstone can be negotiated.

For further information contact:
Rick McLean (Chair CPT) 0413 875 155
Llew Davies (Co-ordinator SAC in General Medicine) 07 4957 6964
Cairns - Clive Hadfield or Peter Boyd on 07 4050 6333
Townsville - John Masson (07 4781 9779) or Justin Labrooy (07 4781 9368)
Rockhampton - Don Kane (07 4920 6256) or Arthur Ewart (07 4920 6381)
Mackay - Ian Carney (07 4954 9514) or Llew Davies (07 4957 6964)

REPORT ON EUROPEAN FEDERATION OF INTERNAL MEDICINE MEETING, FLORENCE, MAY 1999

New Zealand was represented by three physicians, Neil Graham, David Jones and Richard Rankin, at the 2nd Congress of the European Federation of Internal Medicine in Florence. Florence is a superb city to have a meeting and the Italians had obviously put in a lot of work to make sure everything ran smoothly. Fortunately the language used was English.

In the inevitable cardiovascular sessions there was a presentation on Statins. One enthusiast suggested that 90% of LDL is unnecessary and that we should aim for a total cholesterol of 2.6! In discussion it was also suggested that the low incidence of coronary artery disease in Mediterranean countries is because of regular siestas.

There were three highlights for me:

1. A session on SLE given by GRV Hughes (London) and M Schneider (Dusseldorf).

Schneider emphasised that SLE is a single disease with many facets and that each time a patient is seen he/she should be re-examined and rediagnosed. The mere presence of antibodies does not merit initiation of therapy.

Hughes gave an excellent paper on ANTIphospholipid Syndrome (see JRCPL, Vol 32, No 3, 1998). He believes that the syndrome is more widespread than most people think, with patients presenting in all sorts of ways e.g. young people with strokes, MS clinics, vascular clinics, skin clinics and mental health clinics as well as with the more usual presentations of miscarriage and thromboses.

2. Presentation by S. Lamberts (Rotterdam) on advances and treatment of neuroendocrine tumours. The high density of somatostatin receptors in these tumours makes it possible to visualise tumours and metastases, and to treat them by inhibiting hormone release or by internalisation of radionucleotide-coupled somatostatin analogues to control or inhibit tumour growth.

3. In the final session, H. R. Kimball, of the American Board of Internal Medicine, gave a fascinating paper on the evaluation of physicians in training and, of more relevance to us, the recertification of practising physicians. In the US this has been voluntary but is about to become compulsory every 10 years. It sounds a much more thorough process than our present MOPS scheme but as described, did not seem over-threatening. I presume that the RACP committees who are looking at the MOPS scheme will be investigating the ABIM process further.

There were many other papers to provide distraction from the artistic delights of Florence and I certainly would recommend the concept of the EFIM Congress to supplement our usual meetings. Their next Congress will be in EDINBURGH in MAY 2001

Richard J. Rankin (Whangarei)

IMSANZ PAMPHLETS

"General Physicians are Specialists in Adult Medicine",

Should any members wish to order these pamphlets, 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.

Implications of Time Based Consultations for Practising Physicians

We are general physicians involved in one of the Australian Relative Value Study (RVS) working parties.

The Relative Value Study (RVS) has many implications for general physicians in private practice. One of the greatest proposed changes is from the present items 110 & 116 to about 32 time-based items. The RVS assumes that time is equivalent to complexity. It assumes that there is pre service time and post service time associated with each consultation. For example a one hour consultation will have about three minutes pre service and about ten minutes post service time. This will mean that all Medicare claims can be audited in terms of precise time units and so there will be, in effect, a capping of consultation time for which a physician can claim. There are number of very good reasons, however, why a time-based consultation is inappropriate for general physicians. General consultants are asked to give a detailed considered opinion. A superficially simple consultation may have numerous complex associations in the areas of therapeutic strategies and exclusion of intercurrent, serious but totally unrelated pathology, over and above those issues which initiated the consultation. The time taken to work through such a situation may also vary between physicians although they may be of equal skill.

There are also many "real world" practical problems:

1. Only patients can quantify time and will expect the time-based bill to be a correct record of face to face consultations.
2. Patients underestimate time by about 50%
3. Time interruptions, such as calls from GPs, RMOs etc are hard to quantify, but would need to be subtracted from the consultation time.
4. There is a blurring of what a patient sees as consultation. Discussion of family matters, how the patient's new job is going and even discussion with relatives or chasing up some critical point by phoning the GP may not be seen as part of the consultation.
5. Consultation continues while an ECG is done. This will need to be subtracted from consultation time.
6. Disputes as to the time spent will erode patient confidence. Even at present one continually hears comments that "Dr X sent me a bill for (a standard 116) and only saw me for a few minutes". The patients are not aware of the effort which goes into working up aspects of their problem, both before and after the consultation. The bland assumptions that this is included in the new system by some of the wordings used is naive in the extreme, and would be very hard to prove in legal actions.
7. Inefficiency will have to become "the norm" as there are only negative outcomes of efficiency. Notes, X-rays and other matters will be reviewed only in the patient's presence and letters will always be dictated in front of the patient.

The present items have problems which tend to equalise out by the usual "swings and round-abouts".

Time based consultations may be appropriate for psychiatrists and general practitioners. The present system could be modified by possibly separating hospital and office consultations, and include a "pre procedure" item, eg: stress test, gastroscopy consultation. Anything else may have negative results for office based private practice.

Please forward any comments you have direct to IMSANZ or to Geoff Metz, RACP representative on the RVS Board.

Michael Kennedy (Manly)
Les Bolitho (Wangaratta)
Ian Smee (Wagga)

GENERAL MEDICINE IN A TERTIARY METROPOLITAN HOSPITAL

AUCKLAND HOSPITAL (N.Z.)

For many, the importance of a strong general medicine department in the smooth running of a large metropolitan tertiary hospital has never been questioned. To others such a scenario seemed no longer necessary and the helter-skelter exodus into subspecialty positions confirmed this. Many physicians working in general medicine felt disenfranchised, recognising little support for their specialty, from the RACP or even at times their colleagues. Without doubt the formation of IMSANZ was in response to this isolation.

Emergency medicine has developed rapidly, not only because of its importance as a specialty in its own right, but also in many situations to fill the void left by the absence of general physicians.

Fortunately, the tide has been turning in the last few years; the importance of general medicine is being restated, the RACP is very supportive, and many metropolitan hospitals are looking at innovative ways to cope with the enormous flux of often undifferentiated patients with multiple illnesses. The general physician (often with an interest) is part of this plan, but there must be a good balance in management between the front door and subspecialty groups. This paper outlines some of the issues facing a generalist in a tertiary metropolitan hospital.

A. CLINICAL ASSOCIATIONS

1. Emergency Medicine (EM)

The relationship between EM and general medicine has taken a little while to settle, probably because some departments were set up by EM physicians, who had little access to General Medical Physicians. For this reason, EM physicians 'saw everything' before handing on to subspecialty colleagues. However, because of the strong primary medicine sector in New Zealand and the presence of active General Medical Units such double handling of patients already assessed by GPs and requiring admission seemed inappropriate. In Auckland patients are triaged and sent directly to the general medical service if already assessed. If unreferred or acutely ill, the EM physicians will take over care before handover. The system works well. EM and the General Medicine Staff work together in resuscitation and handover is uncomplicated. Recently EM staff have done General Medical runs to improve medical knowledge, and the reverse is also starting to occur.

2. Subspecialty Groups.

There have always been mild disagreements between subspecialists and generalists as to who should look after which patient. Such concern can be alleviated by writing strict clinical criteria, as to which conditions should be handed over immediately. Rapid and appropriate referral to specialty groups solves many problems, and 'Shared or Collaborative Care' is a concept which will increase in the future, however the importance of having a designated 'Co-ordinator of Care' cannot be over emphasised and is a position taken up easily by a generalist.

3. Geriatrics

Most *acute* geriatrics in our hospital is covered by General Medical teams. There is some integration of geriatricians into the service, which enhances delivery of medical care. However the funding of acute geriatrics is separate to the funding for rehabilitation, which sometimes leads to problems in ongoing management. Close communication with our geriatric colleagues has reduced this problem.

4. Surgical Services

There appears to be an increasing demand for medical assessment of patients on surgical wards. This has

increased the workload of the medical registrars and rosters of medical consultants have been put in place to review surgical patients. This medical support has been appreciated by junior medical staff on surgical wards, who at times have felt a little vulnerable.

B. TEACHING [Undergraduate/Postgraduate]

The demands on General Medical Consultants, for both undergraduate and postgraduate teaching, are considerable. At the undergraduate level, students in 4th and 5th year receive training, and more recently 3rd year has been included in a reduced capacity. Trainee Interns (6th year) are more likely to be included in the clinical teams, and receive teaching 'at the bedside', and during acute admission days. The general physician can teach the management of undifferentiated problems, crossing subspecialty boundaries and is well placed to offer broadly based teaching, with emphasis on humanistic and diagnostic skills and the management of uncertainty. This is obviously recognised by the Medical School, which places most undergraduate students in general medical wards.

Postgraduate training in Auckland is strong with programs set up by the Medical Tutor and others in Post Grad years 1 and 2, and Registrar years. A large amount of teaching occurs in clinical settings as might be expected, although a specific program is arranged for those sitting the RACP exams, and attended by Registrars from other hospitals in the Auckland Region. The RACP supervises specialty training programs through SAC's, and moves are afoot to enhance accreditation processes relating to these programs.

All general physicians are involved in Postgraduate teaching, including some with university affiliations, who obviously have a significant commitment to undergraduate teaching.

C. BUSINESS ASSOCIATIONS

1. Administration

Auckland Hospital has been fortunate in having an administration sympathetic to clinical concerns and very willing to work with clinicians to achieve good patient care and outcomes. Clinical Directors work closely with Business Managers, which enables both to concentrate on their area of expertise. Major concerns in the past have been the failure of information technology to provide data useful for assessing outcomes. This deficiency is slowly being resolved.

2. Government Departments

With the unbundling of the 'teaching budget', a new body called the Clinical Training Agency has been formed. Funding for postgraduate teaching has now become very prescriptive, and general medicine units have had to carefully document the training modules, and ensure junior staff have protected time for teaching. with obvious rostering implications.

It seems likely however that the amount of money available to support postgraduate teaching will be less than in the past.

TRENDS IN GENERAL MEDICAL HEALTHCARE DELIVERY IN THE FUTURE

1. Assessment and Investigation Units (AIU)

It seems certain that such areas will provide a major focus for inpatient general medical care in the future. They provide facilities for urgent assessment and investigation, often negating the need for inpatient admission into general wards. Frequent ward rounds by attending staff facilitate early discharge, and we are working towards SMO cover 24 hours a day toimprove the quality of initial assessments. Such units cannot work if the bed numbers are too small (necessitating movement into the ward environment), or if ancillary services too slow or not available (x-ray, gastroscopy, echocardiogram, exercise ECGs).

Associated with such units is the upgrading of ambulatory medicine - something quite difficult to achieve in the context of a busy acute general medical service, but very important in overall patient care and in training.

2. Reducing Inpatient Waiting Lists

General Medicine has always had concerns that the hospital does not run a full 24-hour service. Although obviously there are acute rosters to cope with admissions, ancillary (and even subspecialty) services often run at reduced capacity over weekends. This leads to poorer patient care and longer bed stay. These issues, although difficult to solve (eg. inability to shift work medical staff and financial restrictions) are important, and innovative suggestions to enable the hospital to truly function in a seven day capacity are needed.

Similarly, an aggressive campaign to ensure prompt referrals to subspecialty units and responses to imaging and pathologyrequests is mandatory.

3. Continuing Education

Our unit has recognised that it is almost impossible to do ward service for 12 months of the year and maintain health, enthusiasm and sanity. For that reason, all staff have several months when they are off the ward, when they can go on holiday, (and hence not put added load on colleagues) and concentrate on teaching, quality assurance and paper work. This 'time off the ward' has proven beneficial for morale and also provides sick leave cover.

4. Hospitalists vs Part-Time

Our unit has a wide mix of individual work structures, including full time, part time/university, part time/private and even locum. The smallest commitment is half time. All staff are expected to be present in the morning to do post-acute rounds and ward work,

Although there has been a trend towards 'hospitalists' (see also page 23) recently, the mix between hospitalists and part time involvement has advantages.

These include a more reasonable roster with more feet on the ground (15 providing 7.5 FTA), less chance of burn-out because of reasonable rosters and time off, and a more varied mix of clinicians with differing interests which can benefit the unit as a whole. With committed clinicians, there appears to be no loss of clinical support for the unit.

Summary

After a period of isolation, general physicians are once again receiving the recognition they deserve, as co-ordinators of care, and providers of high quality, cost effective medicine to a large group of patients.

Their special attributes have been highlighted in many documents recently and will not be repeated.

General Medicine is an academic specialty in its own right and probably one of the most difficult to practise well. We must all continue to encourage younger physicians to train in general medicine and build for the future. But above all we must look after our patients with skill and compassion. This is how we will be judged by our colleagues and the community at large. We have an opportunity in the next few years to firmly entrench general medicine in the ethic of all hospitals, including tertiary teaching hospitals.

The success of general medicine is in our hands!

John Henley (Auckland)

General Medicine in Adelaide

Adelaide is a city where general medicine still maintains a strong presence in both public and private sectors. This situation should continue provided enough trainees decide to pursue a career in general medicine.

There is still a perception by some that there is not a bright future for training in general medicine. Like most departments in public hospitals, there are inevitable cost pressures impacting on general medical services and administrators looking to downsize departments. In one public hospital in Adelaide this has led to the loss of dedicated general medical units which have merged with subspecialty units. However, there are still dedicated general medical units at the Royal Adelaide, Lyell McEwin and Modbury Public Hospitals and general physicians practise at all the major metropolitan hospitals.

General medical units in Adelaide continue to play a major role in teaching medical students and training physicians. There has been a trend for both Adelaide and Flinders Universities to move medical students out of tertiary referral centres for much of their teaching. This has resulted in general physicians in the smaller metropolitan public hospitals taking a bigger role in training.

There is still a great demand for general physicians in Adelaide. In the last 10 years all physicians who have completed their training in general medicine have been offered appointments as either full-time consultants or visiting medical specialists at public hospitals in Adelaide. In several private hospitals, emergency departments have been established which have required a roster of physicians to look after patients admitted to the hospital. These acutely admitted patients are largely looked after by general physicians. Surgeons, orthopaedic surgeons, obstetricians and gynaecologists still seek out general physicians to help manage their pre- and post-operative problems.

There is also an interesting trend emerging in some hospitals where general medical and acute patients are admitted under sub-specialty units. Some of these units are now employing general physicians to manage their general medical patients. This seems to recognise the fact that it is often not desirable for patients to be managed by a collection of subspecialists.

The major area of concern is that some physician trainees are still discouraged from embarking on a career in general medicine. This seems foolish, given the continued demand for general medical services. I do not know of a general physician in Adelaide who goes out of his way seeking work. Like the rest of Australia, the average age of general physicians in Adelaide is much higher than our sub-specialist counterparts. I fear that as their children finish school and leave home (I was once told that consulting hours are proportional to school fees!) some will wish to reduce their work load. As I have all ready mentioned, over the last 10 years all new available general physicians have immediately taken up consultant positions. As the current group of physicians approach retirement, there will continue to be a need for newly trained general physicians. If retiring physicians are not replaced general medical units will become smaller.

Currently there are only three dedicated advanced trainees in general medicine in Adelaide. Hopefully there will be more after the forthcoming FRACP exam. Advice is available on advanced training in Adelaide from Dr Jeff Faunt (RAH), Prof Paddy Phillips (FMC), Dr Bill Jeffries (Lyell McEwin) and myself (Mark Morton, Modbury Public Hospital). Co-ordinated training of general physicians in Adelaide is possible and can be designed to meet the needs and interests of trainees.

There are also opportunities for general physicians in rural South Australia. Although we do not have large rural populations or large regional centres like the eastern states, there are very few physicians in the country. There are general physicians in Port Lincoln, Whyalla and Mount Gambier. These physicians are very busy and there are some other rural areas (eg The Riverland) that could easily support a resident general physician. Many general physicians in Adelaide visit country areas and are kept busy by rural general practitioners.

After four years I am now retiring from the IMSANZ Council. I am pleased to report that Prof Paddy Phillips will be taking over as South Australian metropolitan representative.

Despite some setbacks, general medicine continues to have a strong influence on medical practice in Adelaide. There is no doubt that there is a need for general physicians. It is important that we encourage our trainees to look to a rewarding (and often very busy) career in general medicine. In this way, not only will general medicine thrive, but should continue to grow into the next millennium.

Mark Morton (Adelaide)

RURAL ADVANCED TRAINING PROGRAM

Have your trainees expressed interest
in a career in rural medicine?

Advanced Trainees in any of the adult medicine or paediatric
training programs are now able to do part of their training
in a regional or rural hospital.

Contact:
Dr Rick McLean
Chair, Committee for Physician Training
0413 875 155
or
Dr David Forbes
Chair, Committee for Paediatric Physician Training
08 9340 8122

Lateral thinker? Creative? Artistic?

Let it all out and win a prize!

Design a slogan for the back of IMSANZ T-shirts and send it to the IMSANZ Secretariat by the end of September

The RACP Examination and the General Physician

This examination, which every aspiring physician must pass to complete basic training and progress to advanced training, is broad-based.

The written paper tests a wide range of medical knowledge across virtually all medical disciplines. The clinical examination, especially the long cases, tests the capacity to assess patients with a range of clinical co-morbidities. Every endeavour is made to ensure that patients have a number of active medical problems, so that breadth of knowledge and management skills are assessed. In short cases, clinical skills are observed, as well as how the candidate interacts with the patient.

A consultant general physician is ideally equipped to be an examiner. Many of the patients used, particularly in the long cases, are similar to those seen in practice, with subtle interplays of multiple clinical problems. There is often a requirement to reconcile diagnostic and management problems in a patient with complex clinical issues. The skills needed for short cases are exactly those used in daily practice.

Being an examiner and preparing candidates for the RACP examinations is enjoyable.

I have been involved in RACP examinations for the past 17 years. My own clinical skills have been much improved as a consequence.

I urge you all to become involved in the RACP examination process, if at all possible, and in whatever capacity you feel comfortable. The RACP and our young trainees need our input. We all stand to gain!

Jon Douglas (Brisbane)

Report on IMSANZ Meeting Dunsborough, February 1999

Twenty members of IMSANZ attended a meeting in Dunsborough, in the south-west corner of Western Australia.

Topics included:

- infectious disease cases • lipids • cardiac failure • nuclear investigations in "PUO"
- depression in the medically-ill • dementia • risk management • obstetric medicine
- the implications of recent studies concerning the relationship between precise blood pressure and diabetic control in maturity-onset diabetes.

The convivial surroundings and small numbers led to intensive and rewarding discussion about each topic. Participants were eager to make the meeting an annual event at varying sites around south-western Australia.

Michael McComish (Perth)

HONOURING SOMEONE EXTRAORDINARY
A TRIBUTE TO DR GLEN BRAND, FRACP
IMSANZ MEMBER AND INAUGURAL COUNCILLOR

Glen Brand is one of those unique individuals who is blessed with piercing intelligence and awareness, total selfless and tireless application. His love for procedures and practical technology is balanced by personal holiness, deep humility, and a sense of balance. This allows his prodigious energy and skills to be applied effectively and with justice.

To have worked with him this last six years has enriched me both as a physician and as a person. Peter Greenberg asked me to write something about Glen when he heard that Glen intends to go into pastoral care. Glen, being the complete physician he is, could not bear the thought that our holistic approach to clinical medicine still fell short of the complete, as we could not necessarily reach the person's spiritual life. Hence his decision. At risk of being thought facetious, I decided to offer a balanced and prudent tribute. The following poem is offered to give us some insight into this giant of a man.

THE ESSENCE OF THE PHYSICIAN
Is "sense"
Expelling any pretensions
of invincibility or indispensability,
Firmly dispels unnatural vexations
by studied thoughtful humility,

Profoundness of insightful nous
by inquiry, listening and feeling,
Patiently instructive and focused,
Defines the problems dealing,

Considered but not opinionated
truth seeking but not judgemental,
Trust earned in ways unthreatened
with weighted empathy not paternal,

Piercing quality and clarity,
An afterglow of processes honed,
in extremes of circumstance and locality,
Lone rangers but not alone,

A buoy in noisy clinical climes
muddied by poignant suffering -
magnified by these confusing times -
who offers learned buffering,

Bothers to accept the unacceptable
- a master in problem solving,
An expert skilful in being capable
Turned to by all when floundering,

To all in the physician co-fraternity,
Excellence within our midst,
One, true to the essence especially
his eminence our acknowledgment submit.

Ken Ng (Kalgoorlie)

IMSANZ Nelson (NZ) September 1998
CONTROVERSY
VITAMIN E - it's good for you, but what about after angioplasty?

The role of free radical species in the process of cell injury has been hypothesised and confirmed in many models of injury and disease. Well characterised is the role of the pathological oxidative process in arteriosclerosis, which raised the possibility of a therapeutic role for anti-oxidants in prevention and/or treatment.

Observational epidemiology supported the potential role for Vitamin E (Vit E) in coronary artery disease, finding clear differences in incidence of major cardiac events when quartiles of populations based of serum levels of Vit E are compared.

Animal models and isolated vascular specimens support the benefit of Vit E in restoring abnormal vas-cular responsiveness in isolated specimens, and reducing or preventing atherosclerotic injury in rabbit and rat models of hypercholesterolaemic vascular disease.

Human studies in cardiac disease have not been universally positive. Many primary and secondary prevention studies support benefit for Vit E supplementation to a daily dose of 100 - 400 IU. The studies generally demonstrate dose-response with studies using "low" doses showing less benefit. There is no convincing evidence of detrimental effects of Vit E in the dose ranges examined, but there is a lag time to benefit of 2 - 3 years.

Although the body of evidence is far less substantive, small studies in degenerative neurologic disease, prostatic cancer and epithelial cell healing have suggested benefits with Vit E supplementation as well.

In conclusion, Vit E supplementation at a dose of 100-400IU daily is of benefit in patients with cardiac disease. Recommendation for use however assumes other major risk factors have already been addressed and that any associated financial burden to the patient is not restrictive.

The next step is to assume a role for Vit E following angioplasty, based on the same hypothesis in arteriosclerosis plus the additional benefit of Vit E on endothelium, fibroblast activity and tissue healing. Unfortunately, clinical evidence for Vit E in this setting is not available. The anti-oxidant theory, however, is supported by the clear evidence of the benefit of Probucol in this setting.

To date, there is insufficient data to support the use of Vit E to improve outcome after angioplasty.

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Bruce King (NZ)

Do you agree with this analysis? Do you recommend Vitamin E? Are more data needed?

(Eds)

POSITIONS VACANT

LOCUM FULLTIME GENERAL PHYSICIAN/NEPHROLOGIST
Department of Medicine, Northland Health, New Zealand

Applications are invited from specialist physicians to join the department of medicine based at Whangarei Hospital from September 1999 to June 2000. Whangarei Hospital is the regional hospital providing secondary care services to the northern most part of New Zealand. Our department provides Specialist services to the entire area including five small provincial hospitals. Northland covers an area of 12,600 square kilometres with a population of 140,000.

The department has eight physicians covering the subspecialty areas of Nephrology, Oncology, Intensive Care, Geriatric Medicine, Diabetology and Respiratory Medicine. The successful applicant will work a 1:6 acute medical call roster with Registrar and House officer cover. The Renal service is rapidly growing and provides in-centre haemodialysis and CAPD programs, and is staffed by a Nephrologist.

The appointee will have a subspecialty interest in renal medicine. Responsibilities include acute medicine, visiting medical/renal clinics, overseeing patients on end stage renal failure programs and managing renal disorders in admitted and ambulatory patients. There is the possibility of a permanent position being created during the time frame of this appointment.

To be eligible, you must have a specialist qualification or be about to complete training and be registerable with the Medical Council of New Zealand.

For further information contact: Dr Alan Davis, Clinical Director, Department of Medicine, Northland Health, PO Box 742, Whangarei, New Zealand. Phone 09 4304100, Fax 09 4304117, e-mail alan@nhl.co.nz

SENIOR REGISTRAR IN INTERNAL MEDICINE
ST VINCENT'S HOSPITAL, MELBOURNE, 2000-2001

A wonderful opportunity for a trainee in Internal Medicine at, or near, completion of Advanced Training. Exposure to multiple sub-specialties including Infectious Disease, Metabolic Bone, Lipid, Stroke.

For information please contact Prof Wilma Beswick on 03 9288 2610 or Dr Robert Lodge on 03 9416 1662

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An outstanding opportunity exists for a General Physician to join Australia's first privately managed, fully integrated healthcare facility for public patients in Victoria. This new state-of-the-art facility is a regional referral hospital delivering a comprehensive range of services including general and specialty medical and surgical services, a 24-hour emergency service, coronary care, intensive care, obstetrics, paediatrics, rehabilitation, aged care and psychiatry.

We are seeking an experienced physician with broad general medicine skills whose specialty interests are in the areas of Cardiology, CCU/ICU, Rheumatology and/or Oncology. An excellent salary package including relocation assistance will be negotiated together with the opportunity for private practice. You will see this as a terrific opportunity to progress your career with a first class health care provider whilst enjoying the region's numerous outdoor activities.

Interested individuals should mail, fax or email a resume including a one page summary of your skills to Virginia Rigoni, Lyncroft Health, at the address below quoting Ref. No. M6328. Closing date for applications is 26 July 1999.
Telephone enquiries can be made on 61 3 9235 5183. Fax: 61 3 9235 5102 Email: melbourne@lyncroft.com.au
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Requirements are postgraduate qualification in the relevant specialty and a minimum 5 years experience after specialty qualification.

Remuneration package includes an excellent salary, furnished accommodation, free medical care, transport, air-ticket and a five and a half-day working week (flexible).

Please send your CV with two professional references to: Human Resources Manager, Welcare Hospital, PO Box 31500, Dubai, UAE. Fax: 971 4 820 998. E-mail: welcare@emirates.net.ae. www.welcarehospital.com

MKSAP - CD ROM
A personal view

I have been an avid MKSAP devotee since part I FRACP. It remains my concise reference and has not been superseded by the Internet. MKSAP 11 is the latest print version and MKSAP 10 the CD-ROM version, with extra multimedia clips. As I remember the advertising blurb: "800 pages of text, 500 colour images and instant feedback on self test".

It certainly pales in comparison to the 1000+ pages of print in MKSAP 11 but is useful in daily practice. In peripheral clinics I can easily access the nearest computer with CD-ROM drive and look up answers to questions, complete with references.

The self-test questions are in two panels, one for the question and one for the multi-choice responses. I found reading the question seven lines at a time in the panel was difficult. I had high hopes that the usual problem of American laboratory values for results would be easily addressed by the pop-up window with normal values. Unfortunately it said a normal prothrombin time range is the mean * SD of 20-30 volunteers, and there was no listing for fibrinogen! However, nifty features are instant feedback on self-tests and a current running score, that may not be encouraging.

The multimedia clips differentiate the CD-ROM from the print version. These are particularly strong in the Neurology and Rheumatology sections.

Overall? I already spend far too long at the computer screen and this makes things worse. On one hand I read faster and more efficiently with the print version, but on the other, the CD-ROM is more portable and has multimedia clips. We are currently awaiting MKSAP 12.

MKSAP CD ROM requires 8Mb RAM and 4 Mb space on hard drive of 486 or higher with sound card. It comes with adobe acrobat reader and quicktime.

Brandon Wong (Whangarei, NZ)

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. **Trends in the specialist workforce in internal medicine in Australia, 1981-1995.** Dent OF, Goulston KJ. Med J Aust 1999;170:32-35. The authors report changes in the supply of consultant physicians in adult medicine in Australia and project these trends into the early part of the next century. "The shift towards specialisation and away from general medicine, which occupied 39% of the workforce in 1981 but only 16% in 1995, has been accompanied by a dramatic reduction in population/physician ratios in several specialty fields".

2. **Clinical workforce in Internal Medicine and Paediatrics in Australia and in New Zealand, 1997.** Dent O. RACP Fellowship Affairs Feb 1999;18:31-46. For details of the trends for general medicine in Australia see page 24 of this newsletter.

3. **Should the College regulate the physician workforce?** Bassett M. RACP Fellowship Affairs Nov 98:18:9. In an editorial comment, Mark Bassett says that "A thorough analysis of the status and future role of the general physician, particularly in rural areas, and the effects of the loss of general physician training positions is also needed".

4. **Medical Workforce: time to take a stand.** Veitch P, Finnegan T. RACP Fellowship Affairs Nov 1998;17:77. The authors suggest that the RACP might recommend a minimum number of advanced trainees in each specialty on a population basis, particularly for understaffed specialties, and comment on the shortfall of trainees in geriatrics and general medicine.

5. **Shortage of rural physicians.** McGarity B. RACP Fellowship Affairs 1999;18:8. "General medicine has become an unpopular subspecialty because it almost completely lacks support in the teaching hospitals, there is a virtual absence of advanced general medicine training schemes and no career structure in the teaching hospital..... If the College wishes to address a shortfall in general medicine and rural physicians it needs to address the status of general medicine within the large teaching hospitals rather than tinkering with the exam".

Alex Bune, Chair RACP Medical Workforce Advisory Committee responds: "The College is currently undertaking a major review of training which amongst other things will consider a question of a period of rural training for all trainees and measures to redress the imbalance between subspecialty and general medicine".

6. **The rural patient with diabetes and cardiovascular disease.** Bolitho L. RACP Fellowship Affairs 1998;17:33-35. A "Disease management" model for diabetes involving identification, central registration on a database and a notification system is suggested. This enables a coordinated care approach within hospitals and the community to establish guidelines, achieve treatment goals and implement risk reduction strategies.

7. **Evidence-Based medicine and the Practicing Clinician.** McAlister FA. Graham I. Karr GW. Laupacis A. J Gen Intern Med 1999;14:236-242. A questionnaire was sent to all 521 physician members of the Canadian Society of Internal Medicine with Canadian mailing addresses. The response rate was 60%. The authors concluded that: "Even those physicians who are most enthusiastic about EBM rely more on traditional sources than EBM-related sources. The most important barriers to increased use of EBM by practising clinicians appear to be lack of knowledge and familiarity with the basic skills, rather than skepticism about the concept".

8. **Preoperative pulmonary evaluation.** Smetana GW. New Eng J Med 1999;340:937-944.

9. **Talking about treatment: The language of populations and the language of individuals.** Steiner JF. Ann Intern Med 1999;130:618-622. This article discusses how to respond to a particular patient's questions eg about whether treatment with antihypertensive medication will reduce his/her risk for a cardiovascular event. Dr Steiner comments on how to interpret data, how to "frame" the effectiveness of treatment, and how to move from groups to subgroups within populations and hence to an individual patient. "As physicians, we need to become bilingual - ie we must speak the language of populations as well as the language of individual patients".

In an accompanying editorial "Probability at the Bedside: ("The Knowing of Chances or The Chances of knowing", Goodman SN. Ann Intern Med 1999;130:604-606), the historical basis of concepts related to "risks" and the utilisation of probabilities in medicine is reviewed. Goodman describes the unavoidable problems encountered when dealing with the concept of risks in terms of an individual patient, in contrast to that involved with groups. "To parallel Steiner's conclusion, patients know that when their life is at stake, regardless of the chance of survival, they end up 100% alive or 100% dead".

10. **Optimal decision-making and general medicine.** Niall J. RACP Fellowship Affairs Nov 1999;18:7. John Niall comments on the linkages between general and special physicians in teaching hospitals and the value of generalists. He does not support the suggestion to have an easier entry exam into general and geriatric medicine to encourage trainees in these years, given the complexity of the task.

11. **Acute Medical Admissions and the Future of General Medicine.** Scottish Intercollegiate Working Party. Royal College of Physicians of Edinburgh 1998 (www.rcpe.ac.uk/public/acute.html).

This report reviews patterns of acute medical admissions in the UK and Scotland. In recent years alternatives to the traditional model of acute medical receiving for 12-24 hours, eg acute receiving units, medium-stay emergency admission wards, medical receiving rooms and triage units are discussed. Also reviewed are admission alternatives such as chest pain units and urgent (ie <24 hour) medical outpatient appointments.

"The continuance of general internal medicine is a fundamental element of medical care within the framework of developing specialties and training programmes. Career structures must continue to reflect this ..... It is essential that our colleges foster and maintain the concept of General Internal Medicine and of the General Physician".

The Hospitalist Movement

Hospitalists are physicians specialising in acute hospital medicine who only care for hospitalised patients. They return patients to the care of their usual practitioners following discharge.[1,2,3,4] The movement developed in the United States as a response to a requirement for more cost efficient inpatient systems. If the hospitalist movement progresses, it is likely to accelerate an even stronger commitment to clinical pathways and management plans, clinical guidelines, risk management, and quality assurance and improvement

One downside is a significant interruption to the continuity of care when communication between inpatient and outpatient providers deteriorates. Another possible outcome of more "general hospitalists" is that there may be fewer subspecialty consultations with an impact on sub-specialty units and their trainees.

The antipodes are not immune from this development. Hillman[5] reviews the changing role of acute-care hospitals, and sees the hospitalist as a "move back to the generalist physician". In his view, however, "the equivalent in Australia is probably the intensive care or emergency physician".

It is time for consultant general physicians in Australia and New Zealand to note the opportunities and threats that the hospitalist movement poses.

For a detailed and somewhat tongue-in-cheek account of a new breed of "ists" (eg "screenist", "officist", "hospitalist", "intensivist" and "psychiatrist"), see Manian's observations about continuity of care.[6]

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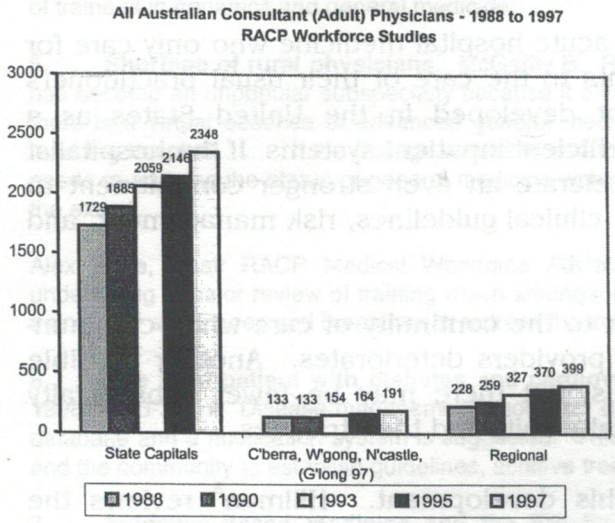
4. The potential size of the hospitalist workforce in the United States. Luri JD, Millar DP, Lindenaeuer PK, Wachter RM, Sox HC. Am J Med 1999; 106:441-445

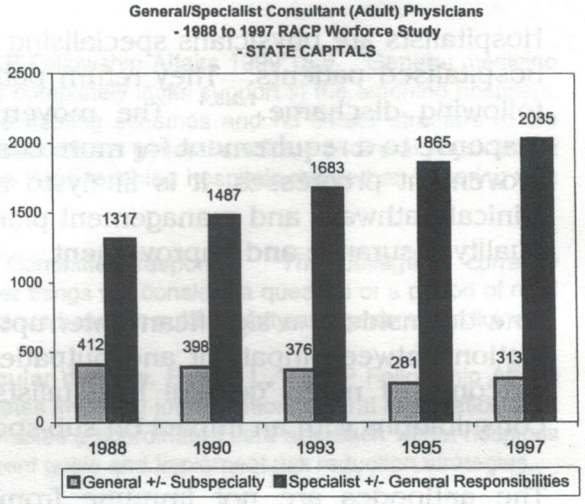
5. The changing role of the acute-care hospitals. Acute-care hospitals are moving away from their central role in the health care system and becoming specalised institutions for the care of a particular kind of patient. Hillman K. Med J Aust 1999;170:325-328.

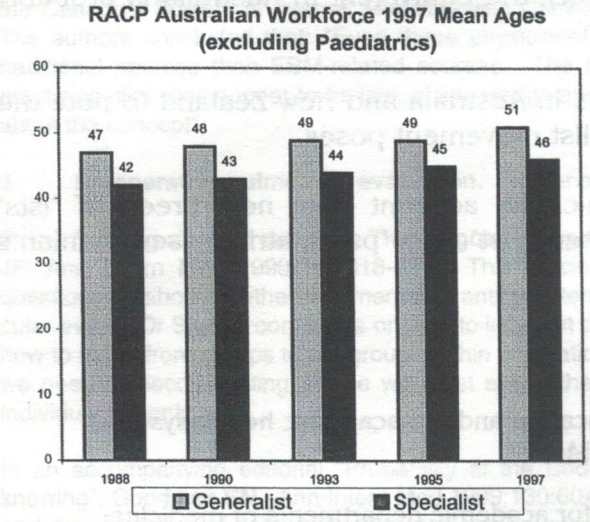
6. Wither continuity of care. Manian FA. New Eng J Med 1999;340:1362-1363.

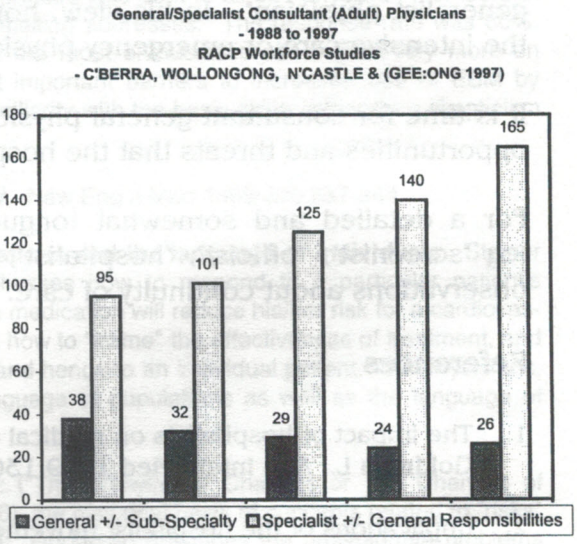
Peter Greenberg (Melbourne)

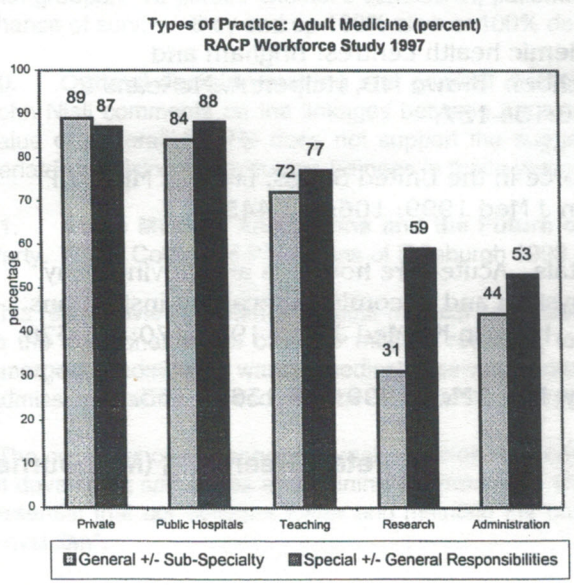
EXTRACT FROM RACP WORKFORCE STUDIES: 1988-1997

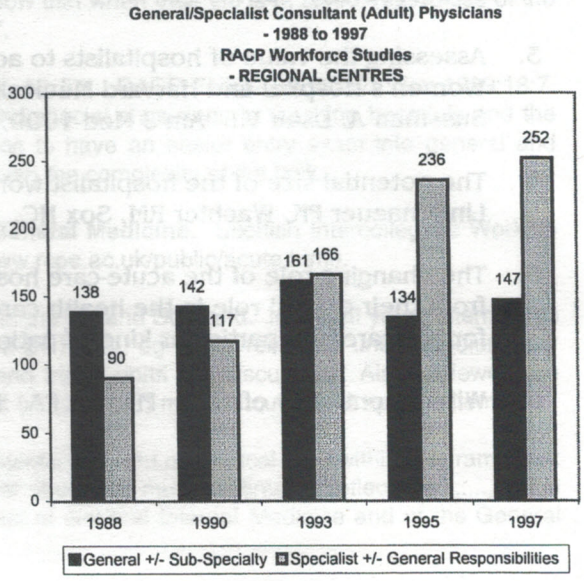












NB: Comments on these data would be welcome! (Eds)

Critically Appraised Topics (CATS)

IMSANZ is about to launch a new initiative in evidence-based medicine that aims to assist clinicians, managers and policy-makers to make optimal decisions using the best available scientific evidence. A series of critically appraised topics (CATS) is to be mounted on the IMSANZ web site which can be accessed and downloaded by any interested health care professional. These topics will encompass a diverse range of clinical and policy issues that are considered current sources of controversy, are relevant to large numbers of people (be they patients, providers or managers), or have significant resource implications. Diagnostic and screening tests, therapeutic interventions, prognostic and aetiological factors, health economics, and quality of care constitute the core subjects of interest. It is hoped that this initiative will accelerate the transformation of quality research into clinical practice and health care management, and promote further discussion and research in areas where uncertainty persists as to the most appropriate course of action.

Briefly, the proposed format is as follows:

1. A brief title indicating the issue to be examined, the author(s) responsible for synthesizing the CAT, the date of submission, and acknowledgement of any assistance received from external sources in undertaking the work.
2. A clinical or managerial vignette that serves as both the source of the question to be posed and the context to which the results and discussion will need to apply.
3. A 3-part question that details:
   i) the population of relevance (i.e. who the question is referring to);
   ii) the study factor being examined (i.e. the clinical or managerial intervention or strategy whose effectiveness in comparison to others is being assessed, or the causal or prognostic factor whose predictive value is being gauged); and
   iii) the desired (or undesired) outcome or result that is considered to be of prime importance (i.e. clinical outcome such as correct diagnosis or prevention of death or disease event, or managerial outcome such as change in resource utilisation). Each CAT will be indexed as belonging to one of the main subject areas mentioned above.
4. The literature search strategy used to find the evidence being presented, and definition of the type of evidence source used (i.e. primary source such as an original research study, or secondary source such as a review article).
5. The evidence itself presented in a structured format, noting whether it is from a primary or secondary source, and detailing the study design and objectives, population and setting, intervention or manoeuvre being assessed, main outcome measures and methods of analysis, and main outcome results expressed in clinically meaningful quantitative terms.
6. Critical appraisal of study methods in determining validity of results.
7. Conclusions about the extent to which study results usefully answer the question originally posed.
8. Commentary from an invited expert in the field about the CAT's accuracy and utility, how it relates to the larger body of evidence and clinical experience, and the clinical and resource implications for Australian and New Zealand practice of applying this evidence.

We are inviting readers to submit CATS for consideration of publication. Fellows may attract MOPS points in undertaking such work, and general physician trainees could regard such efforts as research projects for meeting training requirements. Hopefully the dissemination of CATS relevant to internal medicine will improve practice and augment the scientific credentials of our Society. We look forward to hearing from you. Please forward your contributions to the address below.

Ian Scott (for the IMSANZ CATS Editors)
Department of Internal Medicine,
Princess Alexandra Hospital,
Ipswich Road, Brisbane. 4102.
e-mail: scotti@health.qld.gov.au
(PS if using e-mail, please send as Office 97 Word document)

An example of a Critically Appraised Topic is given on the next page.

Send a CAT to publish in the January 2000 Newsletter!

Want more on CATs? See http://www.urmc.rochester.edu/smd/Medicine/res/cats/cathome.html **and** http://163.1.212.5/cats/catsearch.html

Critically Appraised Topic (CAT) - example

A 54 yr old male engineer presents with increasing exertional dyspnoea, ankle swelling, lethargy, and weight gain. He suffered an anterior Q-wave myocardial infarction four years previously which was complicated by heart failure. He also has a past history of hypertension, type 2 diabetes and chronic obstructive lung disease. He has not had any recent angina and stopped smoking 10 years ago. His current treatment consists of lisinopril, digoxin, frusemide, glipizide, aspirin, simvistatin and anginine.

Clinically, he has a raised JVP, soft fourth heart sound, and moderate pedal oedema. He is normotensive and there are no abnormal chest signs. ECG shows sinus rhythm, septal Q waves and partial right bundle branch block; chest x-ray shows moderate cardiomegaly. A recent echocardiograph reveals moderate LV dilatation and dysfunction with estimated ejection fraction of 30%.

Clinical Question

In symptomatic patients with moderately severe LV dysfunction due to coronary artery disease, is mortality reduced by prescribing b-blockers in addition to other standard therapies?

Literature Search

Using keywords: *heart failure* and *b-blockers,* the easiest, quickest and most accessible evidence sources were searched first, comprising *Best Evidence, Cochrane Library, QuickScan Reviews of Internal Medicine, Journal Watch* and *PubMed.* If there had been no suitable hits, then a more formal search of Medline could have been undertaken.

Retrieved Articles

Best Evidence and Cochrane Library yielded a 1996 meta-analysis of low-dose b-blockers in idiopathic or ischaemic dilated cardiomyopathy which described intermediate outcomes of QOL + haemodynamics, plus two trials (Packer et al NEJM 1996 and Aust/NZ HF Research Gp Lancet 1997) which reported improved survival and less hospitalisation with carvedilol but relatively small numbers (1400 patients combined) and no subgroup analyses. Quickscan Reviews yielded a second meta-analysis of randomised trials reported in *JACC July1997* which searched *MEDLINE 1/75 - 2/97* and analysed 17 trials with 3039 pts. including two carvedilol trials with 3/12 to 2 year F/U, and conducted separate analyses of effect for ischaemic and non-ischaemic pts; carvedilol vs other b-blockers; and cause of death. This article appeared to be the most helpful and was selected for critical appraisal. (Total search time = 10 mins)

Critical Appraisal

1. Did the review address focussed clinical questions?
Questions addressed in the review:
1. Is there a mortality benefit when b-blockers added to standard therapies in patients with heart failure?
2. Is the significant benefit recently reported with carvedilol same or better than that for other b-blockers?
3. Is the benefit, if confirmed, attributable to a reduction in sudden deaths or in deaths due to progressive heart failure?
4. Does the benefit extend to both ischaemic and non-ischaemic causes for heart failure?

2. Were inclusion criteria used to select studies appropriate?
Criteria seem appropriate: Randomised comparison of b-blocker with placebo control; study duration of three months; history of CHF; study drug b-blocker without ISA; mortality reported and separable into control and active drug deaths on the basis of intention to treat; no drug crossovers planned before reporting of mortality. 3039 patients (1723 randomised to b-blocker; 1316 to control)

3. Is it likely that important studies were missed?
Search was extensive but negative publication bias is always a concern: MEDLINE search 1/75 to 2/97; reference list of all articles obtained were examined to identify additional studies; abstracted studies from presentations at national meetings if meeting study design; requests to peers for study identification.

4. Was methodological quality of included trials assessed individually and the trials weighted accordingly?
Not stated but all trials used randomisation, and although not explicitly stated it was implied all patients were followed up. No weighting or quality score to individual trials, but data pooled using averages of effect weighted

by inverse of variance. Data were abstracted from each article independently by two reviewers using a standardised format.

5. Were results similar from study to study?
Summary odds ratio (OR) and rate-difference calculated for each principle outcome of interest relating to each of the four research questions. Results presented as point estimates 'blobbogram' and in tabular form with deaths/sample size and summary OR with 95% cofidence interval. Chi-square test of homogeneity used to show that differences in study results for total mortality could be explained by chance alone.

6. How sensitive were results to changes in the way the review was done?
As one trial accounted for 18% of deaths and 36% of patients, all analyses performed with and without data from this report. Summary odds ratio calculated for both fixed effects and random effects methods. Total mortality OR recalculated inputting open-label deaths. Patient subgroups were also analysed separately and compared. ***No sensitivity analyses were done based on changing selection criteria for study inclusion.***

7. What were the overall results? Were results of pooled data interpreted with common sense and in context? How precise were the results? Were the results clinically important? Were there potential harms and costs?
The table summarises the main findings suggesting survival benefit from all classes of b-blocker in patients with both ischaemic and non-ischaemic cardiomyopathy. The benefit derives from reduction in deaths from both sudden arrhythmia and pump failure. Carvedilol however seems to confer the greatest benefit with other b-blockers by themselves not showing a statistically significant effect. Subgroup analyses (not shown) showed no differences in benefit according to age, sex, LV ejection fraction, NYHA symptom status, or concomitant use of ACE inhibitors.

Study Factor	***OR (95% CI)***	***$NNT_{9\ mo}$ (95% CI)***
All cause mortality	**0.69 (0.54-0.88)**	**35 (22-84)**
All cause mortality		
(+open label deaths)	0.75 (0.59-0.96)	41 (23-179)
Cardiac mortality	0.68 (0.53-0.89)	33 (21-82)
Nonsudden cardiac death	0.58 (0.4-0.83)	
Sudden cardiac death	0.84 (0.59-1.2)	
Ischaemic cause	0.69 (0.49-0.98)	35 (22-84)
Nonischaemic cause	0.69 (0.47-0.99)	35 (22-84)
Carvedilol	**0.54 (0.36-0.81)**	**26 (14-63)**
Noncarvedilol	0.82 (0.6-1.12)	50 (25-213)

OR = Odds ratio; NNT = Number needed to treat

8. Do the results apply to <u>this</u> patient given all his circumstances?
Potential problems of: publication bias; follow-up of less than 12 months; accuracy of distinction between sudden and non-sudden cardiac deaths limited by accuracy of each trial's classification; very few studies of patients with severe (NYHA IV) heart failure; and very few patients older than 70 years.

Decision made to prescribe b-blockers in this case as the estimated mortality benefit using combined death rate in control patients of 12.1% was:

	RRR%	**ARR%**
Carvedilol	47.7	5.8
Other b-blockers	16.2	2.0

Concerns about *potential harm in long term*: worsening CHF, exacerbation of COPD, hypoglycaemia unawareness, inducement of heart block. These concerns could be allayed to some degree by examining inclusion/exclusion criteria of individual trials, baseline characteristics and relevant subgroup analyses.

Conclusion

This meta-analysis supports more deliberate consideration of b-blockers in a wide spectrumof patients with CHF. (Since this critical appraisal was undertaken, a more recent meta-analysis has been conducted which further strengthens the case for use of b-blockers in heart failure [Circulation 1998; 22: 1184-91]).

Ian Scott (Brisbane)

Evidence-based Medicine on the Wards
A Report from an Evidence-based Minion

I often hear people say, "Real doctors don't have time for evidence-based medicine." In fact, practising evidence-based medicine while you work doesn't take much time at all - just motivation. I did it as a house officer (intern), and you don't get much busier that that. Once you get into the right frame of mind, it is hard not to work in an evidence-based way, and it is lots of fun.

How can you get started practising evidence-based medicine?

Evidence-based medicine uses information from high-quality clinical studies to answer questions about patients in your care. For newcomers, all this evidence mumbo-jumbo can seem intimidating and can cause you to lose sight of the goal - treating patients more effectively. Fortunately, there are plenty of ways to learn all the essential information relatively painlessly. First, excellent books and articles that can help are available (1-24) as well as some evidence-based textbooks (25-*2* 7).

Second, Increasing numbers of courses are being offered by institutions worldwide which teach the process of asking answerable questions about patients, finding, and appraising relevant articles quickly, and synthesising data into 1-page summaries called critically appraised topics (CATs). Courses are also available that are aimed specifically at medical students. Good examples are the Oxford and the Manchester Conferences on Critical Appraisal for Medical Students (http:// cebm.jr2.ox.ac.uk/ docs/cams.html). For information about other courses, see the Web sites at the U.K. Centre for Evidence-Based Medicine (http://cebm.jr2.ox.ac.uk) and McMaster University in Canada (littp://hiru.mcmaster.ca/ebm/).

How can you carry out evidence-based medicine as a house officer or student?

In the beginning, don't be too ambitious. Practice evidence-based medicine only when you are in the mood. When you see a new patient, try to ask yourself one question about their treatment, diagnosis, or prognosis. Choose the problems you find most interesting and go searching.

First, search the databases that have articles already selected for quality, such as Best Evidence and the Cochrane Library. I can usually find a useful article in one of those sources in a couple of minutes. Subscriptions to these databases are cheap enough for you to put them on your home computer, allowing you to do searches when you want and not when the library is open. If you need to use MEDLINE, PubMed, which is produced by the U.S. National Library of Medicine, is available on the Internet for free (http://www.nlm.nih.gov/PubMed). PubMed includes a feature designed to tackle clinical problems and uses search filters developed at McMaster University to optimize retrieval of clinically applicable studies (28).

Photocopy the articles you find while you are digesting your lunch and read them during clinical meetings when everyone else is asleep. Don't forget to write a CAT and file it for easy reference. The U.K. Centre for Evidence-Based Medicine has produced a computer program called CAT-maker that helps you create CATs and calculates such clinically useful statistics as relative risk reduction and numbers needed to treat. Try to write one or two CATs per week. It is better to have a few completed CATs than a dozen incomplete searches. Persevere: Your skills will increase quickly.

If you want to keep up-to-date with the journal literature, subscribe to "secondary review" journals like *Evidence-Based Medicine or ACP Journal Club* that have already screened for high-quality articles. These two journals are published bimonthly; therefore, you need only read six issues during your house-officer year to stay on top.

Once you have found the evidence, don't forget to apply it to your patient. Remember to incorporate your patient's ideas as well as advice from local experts into your decision. Doing what

is best for your patient may not always match the best evidence.

How can you convince your superiors to practice evidence-based medicine?

When you are the most junior member in a team, it can be hard to get your bosses to listen to the great evidence you've found. My advice is to be subtle. Find articles that agree with your bosses' approach. Their response may be "Who needs evidence-based medicine to show that?" But you are bolstering their image as evidence-based clinicians, and you've learned something. Use mock uncertainty: "I'm not sure whether diclofenac is better than pethidine (meperidine) for ureteric colic. Can you help?" This will make your bosses feel needed and will allow you to chat about evidence-based medicine. All house officers have to make presentations: Use them as opportunities to present good studies you have found. As an added bonus, you will find talks easier to give, and your audience will be more interested. Photocopy, your CATs and post them somewhere readily visible, or hand them out to your team as "an interesting article I found." However, don't expect miracles or sudden conversions - just work at creating a cheerful, inquisitive environment that supports the practice of evidence-based medicine. Bosses are like supertankers: They take a little time to turn, but once they're heading in your direction, you can't stop them.

What happens if your boss disagrees with the evidence?

Remember that evidence-based medicine doesn't provide absolute answers; it simply gives some numbers to help doctors make decisions. A lot of other factors need to be taken into account. Medicine is an art, and evidence-based medicine is just one of the tools used to create the whole picture. Bosses have lots of experience in patient care: Hear what they have to say before you write them off as being from the Stone Age. After all, they are ultimately responsible for their patients, so the decision has to be theirs. Remember to keep things in perspective; there will be other opportunities.

So what is possible?

Since graduating 18 months ago, I have produced over 400 CATs, and I currently write about one CAT for every day I work. I'm not special either. There are several junior doctors and students who are practising evidence-based medicine in the United Kingdom. Bob Phillips and Nick Shenker are two, and together our experiences have prompted us to write a radically new type of medical handbook titled *Evidence-based On-Call.* The book is aimed at junior doctors and will cover more than 70 medical and surgical topics. With the assistance of about 50 contributors from North America, Europe, and Australia, we propose to provide a synopsis of the best evidence available on each topic. We are currently looking for additional contributors and reviewers and would welcome any offers of help.

To be an evidence-based doctor doesn't require a superhuman effort. Whatever the amount of evidence-based medicine you practice, it's worth the trouble. It keeps you thinking, keeps you up-to-date, and keeps medicine fun.

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How to read a paper
The basis of evidence based medicine
by Trish Greenhalgh
BMJ Publishing Group

Is it possible to write a medical book for the true believers, the skeptics and the "atheists"? In the developing discipline of evidence-based medicine (EBM), this deceptively humble book comes close to providing something for everyone.

Trish Greenhalgh has the necessary background to provide an accessible guide to the EBM discipline by combining her dual roles as a doctor (in General Practice) and as an academic (in Evidence-based Practice and Policy at University College London Medical School). She states early in the book that EBM must not be "applied in a vacuum" and then gives repeated examples of its value and utility in clinical practice. Frequently, familiar clinical trials are used to illustrate the strengths and risks of EBM - a definite comfort for the novice endeavouring to understand the principles of EBM and its statistical tools. The author is unashamedly a disciple of the Oxford guru of EBM, David Sackett, whose definition of EBM is "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients". Those of us who recently attended his EBM Workshop in Adelaide are probably just as much at risk of falling under his spell!

A strength of the book is the clear, readable style which is interspersed with humour, a characteristic which is not usually de rigeur in textbooks of statistics! Other positives are the sets of practical, how-to-do-it instructions on such topics as searching the literature, understanding simple statistics, evaluating a paper particularly the statistical aspects, and assessing the validity and applicability of systematic reviews and meta-analyses. Early in the book, the explanation with comprehensive examples of the use of Ovid as the preferred search software was a memorable highlight.

Given that much, probably too much, of our day-to-day education comes through the door in the shape of drug representatives, the author provides a timely and practical check-list to maximise the value and decrease the hype of these interactions. A worthwhile hint being the use of a drug representatives book to record the significant facts after each of these visits. At the very least, this balances the information which has been recorded on the other side of the desk! She also suggests the STEP acronym (Safety, Tolerability, Efficacy and Price) is borne in mind in these encounters to avoid unbalanced or limited discussions.

The concept of the Cochrane Library as originally proposed by Archie Cochrane is highly recommended by the author and justifiably so. Whilst not infallible nor totally inclusive, this must become a database with which we are familiar and can easily access.

Whilst there is some preparedness to critically analyse the holy grail of EBM – randomised controlled trials and meta-analyses, the book gives little space to the articulate and well considered opinions of some of the critics of EBM, eg Professor Hans Eysenck.

The readers of this book have the chance to graze, to sup frugally but contentedly at the Menu Touriste, to consume the Menu Gastronomique or if they wish to indulge themselves "in the kitchen" they can immerse themselves in a comprehensive bibliography which details the ingredients and the creation of EBM.

In summary, this is an extremely worthwhile addition to the bookshelves of those of us who need to improve patient care by learning the lessons of EBM and .... isn't that all of us?

Bob Lodge (Melbourne)

From the Editors

Peter Greenberg & Ramesh Nagappan

We apologise for the delay in publishing this Newsletter, but were keen to include some late but relevant material.

Our aim is to provide a forum for information and debate about issues concerning general internal medicine in Australia, New Zealand and elsewhere.

As before, we declare our interest in and bias towards "Evidence Based Medicine" which we believe is the academic substrate for our clinical activities, but we welcome debate on this issue as well!

We are most grateful for contributions received from members for this issue. We would like to publish CATs prepared by you (see page 25) in the next issue.

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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