IMSANZ

INTERNAL MEDICINE SOCIETY *of Australia & New Zealand*

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From the President...

Dear All,

The past four months have been busy with committee meetings and teleconferences covering a wide range of topics and aspects of general internal medicine. There are many exciting challenges and future opportunities.

IMSANZ Secretariat

I would like to welcome Cherie McCune who has rejoined the IMSANZ secretariat after several years on leave. Her expertise is most welcome. Lyn Abery resigned from her position in August 2002 and Cherie has been busy catching up with the changes and implementing new policy.

International Congress of Internal Medicine 2002, Kyoto, Japan

I was fortunate to attend the International Congress of Internal Medicine, in Kyoto Japan in May 2002 (see separate report in this newsletter). Dr Robin Mortimer, President RACP, and Dr Geoff Metz were the official Australian and RACP delegates. Prof Napier Thompson, Chair of the Adult Medicine Division has been appointed to the executive of the International Society of Internal Medicine.

The College council has supported the recommendation to submit a bid to the ICIM 2004 meeting in Granada, Spain to hold the 2010 ICIM in Australia. The College has decided to seek tenders and expressions of interest from suitable venues to hold the ICIM, which hopefully would attract 2000-3000 general physicians from a global audience. There are many aspects to ensuring this is a successful International meeting and planning is in progress.

The RACP Annual Scientific Meeting, Hobart May 26-28,2003

IMSANZ has been invited by the RACP ASM Scientific Program Committee to develop and organise the Adult Medicine Division ASM for days two and three of the RACP ASM in Hobart on May 27 and 28, 2003. The College is organising Monday May 26, 2003.

The IMSANZ education committee has been able to convince a number of Societies to hold symposia during days two and three of the ASM. The program is evolving with an excellent faculty and will be announced in the near future. I would encourage all IMSANZ members to support the RACP ASM, and adopt it as "our own" IMSANZ meeting for the year.

The Dinner will be at Mures, on Tuesday May 27 from 7pm. The seating is limited to 180 guests. Please book early as the dinner is open to all attendees at the ASM. I have included a provision for Advanced Trainees to be guests at the Dinner where the IMSANZ Roche Advanced Trainee Award presentation will be made. Please encourage your ATs to commence preparation of their papers for the Award.

(continued on page 2)

As you turn the pages...

General Medicine Forum

The College has convened a General Medicine (GM) Forum in Sydney on Thursday March 20, 2003 to be held at the Stamford Sydney Airport Hotel to allow ready access for invited guests.

The aim of the Forum is: "To provide an overview on the key issues confronting General Medicine in Australia and New Zealand, and to outline strategies that the RACP could implement, or recommend to other bodies, to address those issues".

This forum will include a general review of GM, and will examine potential solutions to encourage the re-establishment of GM in tertiary centres and the role of GM in future urban and rural workforce requirements. Invitees will include representatives of federal and state government health departments, and College members including medical workforce, specialist advisory committee and physician training coordinators, HPU personnel and executive staff. It will be organised in a similar manner to the National Rural Summit which was held in Shepparton in April 2002. Ian Scott has developed several questionnaires to assess training and employment opportunities in urban and rural hospitals.

Medical Workforce Advisory Committee and Rural Taskforce Meeting

After ten months of hibernation and inactivity there was a joint meeting of the Medical Workforce Advisory Committee (chaired by Charles Mitchell), and the Rural Taskforce (Prof Rick Mclean as Interim Chair) on October 24, 2002. The College has now acknowledged the need to be an active and leading proponent of the medical work force planning and distribution in Australasia. The global marketplace has a serious undersupply of medial students and appropriately trained doctors and there is open competition between countries for medical graduates and trained clinicians, leading to 'poaching ' between countries, especially by developed countries in desperate circumstances such as Australia. The relative maldistribution of the medical workforce in Australia - the paucity of doctors in rural and remote regions and the abundance and maldistribution in urban and tertiary centres needs to be addressed. However, there is no easy solution.

The National Rural Summit Report from the Shepparton meeting in April 2002 was officially presented and accepted. Rick Mclean and the newly appointed Rural Taskforce will now process and implement the recommendations from the report. A teleconference is scheduled for November 26, 2002.

RACP Specialties Board

The Specialties Board met on Friday October 25 under the leadership of the new chairman A/Prof John Kolbe. There was spirited discussion and involvement from all in attendance.

The Health Policy Unit presented information on the current state of the Clinical Support Systems Program (CSSP) projects. The College has found that clinicians, in partnership with administrators and consumers, applying management strategies and best available evidence can improve the quality of care. The CSSP model has been successfully tested through four consortia around Australia. The information and models are being refined and will be available for implementation in all hospitals.

It has been strongly suggested Advanced Trainees should be appointed to all Special Society councils and Specialist Advisory Committees. There is vigorous debate whether ATs should be involved with all SAC business but discretion can be exercised.

A mechanism has been developed for the endorsement by the College of position papers and guidelines issued by the Special Societies. These guidelines include adequate consultation during writing and development of these papers with all interested parties, the inclusion of appropriate evidence based papers, and a sunset clause for revision of the recommendations from these papers (eg five years' expiry date).

Appointment to Specialty Board

The suggestion to appoint representatives from the Societies for four years arises from the need for continuity of personnel and corporate memory within the Specialties Board. Each Society has been asked to consider if this is appropriate and nominate individuals willing to take on this commitment which consists predominantly of twice yearly meetings and occasional teleconferences. Two members (currently Les Bolitho and Michael Hooper, from ANZBMS) of the SB are appointed to the Adult Medicine Division Committee to represent the Special Societies, and this involves additional meetings.

Adult Medicine Division Committee

The Adult Medicine Division Committee met on November 7 and 8, 2002.

Australian Medical Council Accreditation is in progress. The College will be the official body accredited as a training organisation and will incur the majority of the cost, estimated at $150,000. The College will be in contact with each of the Specialist Advisory Committees and there will be critical appraisal of the training program and supervision of trainees.

ICIM 2010

The College has indicated there will be ongoing support for submission of a bid to hold the ICIM in Australia in 2010. There is a budget allocation to assess the requirements and research. There will be criteria for selection of the preferred city and convention centre in the near future.

Professional Indemnity Insurance.

There is an alliance of the Committee of Presidents of Medical Colleges (CPMC) developing and refining models for the longterm reform of medical indemnity. This is a complex issue and will require significant quality and safety improvement issues and changes to tort law. There will be a symposium at the RACP ASM in Hobart on Monday 26, 2003 to present the current state of PII developments.

Victorian Rural Physicians' Network

The Victorian Rural Physicians' Network executive held a farewell dinner in Ballarat in November for Prof David Simmons who has resigned from his position as Foundation Chair, Department of Rural Health, University of Melbourne, Shepparton. He will return to New Zealand and continue research in diabetes and related conditions from Auckland University and will be located in Hamilton.

The annual VRPN meeting and dinner will be in Daylesford on March 17-19, 2003. A stimulating clinical and medico-political meting is assured and all physicians are welcome to attend. The dinner will be held at the Lakehouse Restaurant – a Victorian institution and is highly recommended.

Rural Medicine Advanced Trainee Program in Victoria: Interviews were held in September following a recruitment campaign to advertise the advantages of training in rural Victoria. Appointment of ten ATs to positions has been made – six on rotation with Melbourne hospitals and four in full time rural clinical hospital based practice. We are currently awaiting the outcome of the Phelan paper on involvement in ambulatory care. We welcome further enquiries for next year's program from interested ATs.

Publications

There is a review article in the September Internal Medicine Journal published by Alex Cohen, Peter Greenberg & Ian Scott about the renaissance of General Medicine in Australasia. Congratulations to all involved in the history of IMSANZ.

Newsletter

The IMSANZ Newsletter has been welcomed by many members as a significant advance and provides promotion for IMSANZ and General Internal Medicine activities. However, there is a continuing need to source articles, CATs, and evidence based reviews for each publication. Please forward appropriate material to the Editors. There will be two issues, in June and December, each year to ensure adequate notification of forthcoming meetings and activities. The costs of producing the Newsletter represent a significant expenditure of Society funds and will need to be reviewed in the light of other Society commitments if there is only limited support for the publication of the Newsletter. Please support your Editors and the Society and provide articles and information on a regular basis.

There are many activities and issues currently being addressed by IMSANZ council. Please contact your local representatives or the IMSANZ executive if there are issues with which you need assistance.

May I take this opportunity to wish you and your families a safe, happy and healthy Christmas and New Year.

LES BOLITHO
lbolitho@netc.net.au

ADVANCED TRAINEES

You are encouraged to submit an abstract for presentation at the IMSANZ Roche Advanced Trainee Award to be held at the RACP Annual Scientific Meeting in Hobart Tuesday 27 May 2003 at 2.00 pm

This award is open to all Advanced Trainees from Australia and New Zealand, with preference given to members of IMSANZ.

A prize of $1000 will be awarded for the best presentation.

IMSANZ encourages submission of research and cases written up by Advanced Trainees as part of their advanced training.

Case reports may be acceptable although the onus is on the author to demonstrate the significance of the report.

This is to be an oral presentation which should be timed to no more than 12 minutes with three minutes discussion time.

Details are available from the RACP website – www.racp.edu.au/asm or IMSANZ at imsanz@racp.edu.au.

Closing date for submissions is Monday 31 March 2003

Please note abstracts must be electronically submitted via the website and mark for the attention of the IMSANZ Roche Award.

TRENDS IN UNDERGRADUATE MEDICAL EDUCATION

The need for change:

Undergraduate medical education aims to produce broadly educated medical graduates with an appropriate foundation for further training in any branch of medicine, but with appropriate attitudes, knowledge and skills to function as preregistration interns[1].

The health care environment these graduates enter has changed markedly in the last two decades from one that was individually and biomedically-focussed, to one that is charged with delivering a broad range of effective interventions to populations. Advances in information and communication technology have also transformed practice. As the population ages, these new paradigms need to be applied to cases of increasing complexity. All graduates must, therefore, be personally and professionally equipped to identify the need for, and be motivated to acquire, new knowledge and skills.

The core undergraduate experience is being questioned in the light of doctor shortages (particularly in rural areas) and the high costs and length of medical training. The traditional (Flexnerian) medical curricula was six years long; the first three being "preclinical" and strongly science-based, and the latter three, "clinical". As well as the lack of clinical exposure in the early years, this type of curriculum was criticised for being too didactic, not learner-centred, unresponsive to change, lacking in options, city hospital-based and too focussed on acutely sick individuals. As more medical knowledge was "stuffed" into the curriculum, students who could rapidly learn and recall facts for examinations were favoured, rather than those with a deep learning approach necessary for understanding. Despite the curriculum overload, students were not arriving in the workplace with the appropriate work skills.

Changes in education:

A better understanding of the way adults learn, and attempts to address the shortcomings outlined above have resulted in major changes to all medical curricula in Australasia in the past ten years. There has been a shift away from traditional curricula to those that are far more student-centred, with explicit learning outcomes. Some schools have been far quicker to adopt change and/or have been more radical in approach (e.g Newcastle). While much of this change has been accomplished by key faculty with assistance from medical education units, some impetus is external. For example, the Australian Medical Council has, since 1995, accredited all medical schools in Australasia on a cyclical basis, and now has 75 standards (based on best educational practice) that schools must meet. Worldwide, there has been a convergence in approach to medical education, stimulated by organisations such as Britain's General Medical Council that published "Tomorrow's Doctors" in 1993, recently updated (http://www.gmc-uk.org/med_ed/tomdoc.htm)). The World Federation for Medical Education (http://www.sund.ku.dk/wfme.htm), and consortia such as the Universitas-21 group (http://www.universitas.edu.au) are other in uences on Australasian medical education. Some of the major trends are:

Problem based learning:

McMaster and Maastricht adopted problem-based learning (PBL) curricula in the 1970's, followed by the University of Newcastle, NSW. PBL may be defined as "the learning that results from the process of working towards the understanding or resolution of a problem". Problems were carefully selected to cover a range of common and/or important clinical situations. Problems are designed to address and incorporate specific aspects (called domains), such as the scientific basis of medicine, interpersonal and clinical skills, population health, and ethical/legal issues. PBL may begin on day one of medical school before any significant basic science or clinical learning. Brie y, students work in a small facilitated group, starting with a short description of a clinical presentation ("trigger"). The group then creates a list of hypotheses and learning issues, and decides on an approach. Students then embark on self-directed learning, using the many resources available to them, before reporting their findings back to the group. Learning objectives may then be reformulated for another round of independent study. There is often a small quota of lectures, practicals and clinical sessions carefully designed to supplement student learning. Comparison with traditional curricula show PBL described as "engaging, difficult, useful" versus traditional as "irrelevant, passive, boring"[2]. Graduates from the PBL tracks know less basic science, but have better recall at a later date. Most schools now have some form of learning based on clinical problems. The basing of teaching on cases is not, however, new! Osler, in 1903, stated there should be "no teaching without a patient for a text, and the best teaching is that taught by the patient himself".

Earlier teaching of clinical skills:

Clinical skills are now learned in the first two or three years, integrated with PBL or other integrated courses. The teaching takes place both in skill laboratories and in controlled clinical settings. Early clinical skills teaching provides context for the learning of basic sciences and allows for the acquisition of basic skills before immersion into busy clinical attachments.

Outcomes-based education:

Learning outcomes describe what a student should be able to do at the end of the course of study, whether this is the entire medical programme, or a one hour bedside tutorial. Learning outcomes focus teaching and learning, guide appropriate assessment, and inform evaluation of teaching effectiveness. Assessment is increasingly based on standards, with defined criteria to be met before, for example, a "pass" or "distinction" is awarded. A range of assessment types (including direct observation of core competencies) is used to ensure that students have achieved all the desired programme outcomes. To assist students in determining their progress towards the desired outcome, formative assessment opportunites must be available.

Length and location of training:

The pressure to produce graduates more quickly, coupled with better curriculum design, has resulted in some shorter courses. There are now graduate schools at Queensland, Flinders, and Sydney and specific graduate tracks at several other schools. Five year courses are the norm in the UK, but are, as yet, uncommon in Australasia. Learning is increasingly community-based, and most schools are forming rural clinical schools or at least rotating their students into rural areas for significant parts of the programme. Evidence suggests that students in these settings do no worse than their colleagues in the teaching hospitals, and may do better[3].

Interprofessional learning:

The best way to educate students to work in health care teams is, as yet, unclear. Recently in Auckland, we held a one-week educational experience for 250 second year medicine, nursing and pharmacy students working in interprofessional groups to address particular Maori health issues. Early indications are that this was a very positive learning experience for all, including the Maori community and the faculty.

Flexible learning:

Computer and web-based technology is being used increasingly for academic management, the provision of learning resources and assessment. The development of quality multimedia packages is expensive and it is felt that these will not form more than a minority of undergraduate teaching experiences. The reuse of these packages (learning objects) is being encouraged by consortia such as Universitas-21, and the world's first International Virtual Medical School (IVIMEDS).

The student profile:

Schools are looking at innovative ways to recruit and retain students from Maori, Torres Strait and Aboriginal nations, although progress remains slow. Students from rural backgrounds are twice as likely to work in rural areas longer term and are being actively recruited in some schools[4]. To ensure that medical students have the right mix of academic, critical thinking and interpersonal skills to take their place in the modern workforce, schools use tests such as the UMAT (undergraduate entry) and GAMSAT (graduate entry), or interviews, to complement academic scores for eligibility for entry.

Many schools have a significant cadre of fee paying overseas students, contributing to the financial viability of the faculties. The increased class sizes and special needs of many of these students put extra strain on teachers, health care settings and on patients. Student fee increases (particularly in NZ) have placed a heavy financial burden on many students - the impact of which has not been fully realised.

IMSANZ and medical education:

In order to achieve their missions, medical schools are dependent on quality clinical teachers, particularly those who use a broad, integrating approach rather than excessive attention to narrow areas. Universities have not always recognised adequately the huge contributions made by their clinical teachers nor kept them well informed of educational developments[5]. One of the ways that universities can assist those interested in improving their educational skills is in the provision of "teach the teacher" type courses. Opportunities for taking post graduate degrees and diplomas in clinical education are increasing. There will be a session at the RACP/IMSANZ Meeting in Hobart in May 2003 and it is hoped that many of you will attend and share your experiences as well as learn a few tips!

Because of the holistic approach afforded by general physician practice in a wide range of cases, IMSANZ members are ideally placed to continue to inform and contribute greatly to the training of Australasia's doctors of the future.

1.General Medical Council. Tomorrow's Doctors. Recommendations on Undergraduate Medical Education. London. The Education Committee of the General Medical Council;1993.

2. Nandi PL, Chan JN, Chan CP, Chan P, Chan LP. Undergraduate medical education: comparison of problem-based learning and conventional teaching. Hong Kong Med J 2000; 6:301-6

3. Worley P, Silagy C, Prideaux D, Newble, D, Jones, A. The parallel community curriculum: an integrated clinical curriculum based in rural general practice. Medical Education 2000;34: 558-566.

4. Woloschuk W, Tarrant M. Does a rural educational experience in uence students' likelihood of rural practice? Impact of students' background and gender. Medical Education 2002;36: 241-47.

5. Allen RK. Ars gratia artis and the morganatic marriage; 'let us not to the marriage of two minds…'. Int Med J 2001;31:554-5.

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FORTHCOMING MEETINGS

2003 - 2004

2003	**March 1-2**	NSW Rural Physicians' Network For information: Katrina Moore on 02 9256 9605 or email Katrina.Moore@racp.edu.au
	March 14-16	Victorian Rural Physicians' Network, Daylesford. For information: Grant Phelps at grant@ballaratgastro.com.au or Les Bolitho at lbolitho@netc.net.au
	March 20	General Medicine Forum Stamford Airport Hotel, Sydney (by invitation)
	March 27-29	IMSANZ New Zealand Annual Meeting Napier, Hawkes Bay – see display advertisement on page 9
	April 3-5	American College of Physicians - American Society of Internal Medicine ASM, San Diego For information visit www.acponline.org
	May 7-10	Canadian Society of Internal Medicine Annual Scientific Meeting, Toronto, Ontario. For information: CSIM Secretariat Office 774 Echo Drive, Ottawa, ON K1S 5N8 Tel: 613-730-6244 Fax: 613-730-1116 Email: csim@rcpsc.edu Website: http://csim.medical.org
	May 26-28	RACP ASM, Hobart – see display advertisement on the next page
	September 3-5	RACP New Zealand Annual Scientific Meeting Rotarua. In conjunction with IMSANZ, NZ Rheumatology Association and the Faculty of Rehabilitation Medicine.
	October 4-5	IMSANZ Scientific Meeting planned for Fiji – details to be advised

2004	**May**	RACP Annual Scientific Meeting, Canberra
	September 26 – October 1	International Congress of Internal Medicine (ICIM) Granada, Spain

RACP

ANNUAL SCIENTIFIC MEETING

The RACP ASM Adult Medicine Program is being co-ordinated by IMSANZ and represents a unique opportunity for the College members with a diverse range of interests and expertise to meet together and share expertise and knowledge between Specialities. The Societies have been invited to present symposia at the ASM to encourage the recognition of the central role of the College in all our activities.

These Society-hosted sessions will present current, topical and controversial issues which incorporate the latest evidence-based medicine opinions and which will in uence the direction of Internal Medicine in Australia in the coming year.

Societies and Committees presenting include:

Cardiac Society
Medical Oncology
Addiction Medicine
Bone and Mineral Society
Intensive Care Medicine
Thoracic Medicine
Gastroenterological Society
IMSANZ

Other sessions of interest include:

- Current controversies
- Managing Heart Failure in Australia: Present and Future
- Rational Prescribing and the Role of PBAC
- Future directions of the College
- Performance Assessment of Doctors
- Physician Health Issues
- Quality Assurance, CPI and competency
- Remote and Rural Health
- Risk Management Strategies
- Those who can teach: tips for busy clinician teachers

The Dinner will be held at Mures on the evening of Tuesday 27 May, 2003.
IMSANZ members are encouraged to book early as the Dinner is open to all delegates.
All Advance Trainees who present papers at the ASM will be guests at the Dinner.

Further information is available on the College website and registration papers will be available shortly. We encourage all IMSANZ members to consider attending and look forward to your support for this innovative program.

HOBART 26-28 MAY 2003

EUROPEAN SCHOOL OF INTERNAL MEDICINE

(ESIM) - Alicante 2002

Any conference that has its reception in a Castle from which the Conquistadors departed to conquer Central and South America must certainly be unique. The fifth European School of Internal Medicine fulfilled that expectation. Neil Graham and I were invited to join the Faculty as IMSANZ representatives.

The School is the brainchild of Professor Jaime Merino and has been held in Alicante for five years. This year, there were 62 registrants each selected by the Internal Medicine Society of their own country, and 25 physicians on the faculty In all, 19 countries were represented. The faculty physicians in general were participating in a regular acute general medical receiving roster. The format of the Course allows close interaction between the faculty and course registrants with case presentations, workshops and clinico-pathological conferences. Some of the faculty only stayed for a short time but those of us who came from longer distances were rapidly involved in workshops and chairing of sessions as well as lecturing.

The theme of the 2002 meeting was "Medical Emergencies". I found the wide spectrum of topics an excellent update. The high standard of case presentations included such bizarre cases as polycythaemia caused by haemoglobin Olympia (two families in the world), catecholamine toxicity secondary to clenbuterol caused by eating contaminated liver (clenbuterol is used illegally to increase lean body mass in cattle and is abused by sportsmen for the same purpose), Kawasaki disease in an adult, sarcoidosis related to the presence of renal malignancy and other rarities.

An interesting aspect of the course was the series of presentations and workshops related to medical professionalism. These sessions were chaired by Linda Blank who represented the American Board of Internal Medicine. She informed us that the topics discussed at the workshops would be available on the Professionalism Website for wider access and comment.

The social program was excellent and enjoyed by all.

Probably one of the greatest benefits of such meetings was the opportunity to meet the European registrars and members of the faculty. It appears that similar problems to ours are faced by European colleagues, nevertheless Internal Medicine is very much alive and well in Europe at the present time.

Some of the regular faculty members considered this to be the best School so far. Another is being planned for next year and I anticipate it will be equally valuable and successful.

MICHAEL KENNEDY

"MUMMY IS GOING TO SPAIN TO GET SOME BRAIN!"

…exclaimed my 8-year-old daughter after my explanation about why I was going to Alicante. My 4-year-old son nodded with understanding.

It was the 5th Annual meeting of the European School of Internal Medicine – ESIM 5.

Over 70 aspiring internists from across Europe – Estonia to Portugal – attended. Traditionally delegates from Australia, New Zealand and the United States are invited as well. It was a great privilege to be selected as a New Zealand representative. My trip was kindly sponsored by Glaxo-Smith-Kline and IMSANZ.

The event is held in the village of St Juan in Alicante at a resort complex which is owned by a medical insurance company. The meeting offers lectures, interactive seminars, case presentations and clinical pathology cases for advanced trainees. This year's topic was Emergency Medicine. Additional highlights included seminars on the Medical Professionalism Project – MPP – (see www.professionalism.org) developed jointly by the European Federation of Internal Medicine (EFIM) and the American Board of Internal Medicine/American College of Physicians. The aim of the MPP is to develop an international Charter of Professionalism and put the finishing touches after worldwide feedback on the subject. We contributed with creation of vignettes for professional ethics and behaviour and found it rather interesting to observe the cultural differences between the delegates during the ethical debates. There was also a valuable workshop looking at training in Internal Medicine across Europe and perhaps the creation of a unified European Examination Board.

Interestingly, this year almost all participants were eager to present a clinical case. Many cases were followed by heated debates about diagnosis and management, which re ected the spirit of healthy competition. Our IMSANZ team was well prepared with case presentations that were thought provoking. Even after we all went home, people continued exchanging emails about the cases.

Although the six days were packed with sessions, the atmosphere was relaxed and friendly and permitted excellent social interaction. We visited the Castle, enjoyed traditional singers and dancers, went to a theme park, to the beach and of course explored the night life. All of us made an effort to sit with someone different each time and get to know everyone. This way we made lots of friends and also managed to learn a lot about Internal Medicine training in the different countries. We felt very comfortable with the quality of our training, especially our bedside diagnostic skills and common sense approach.

Our Spanish hosts were incredibly nice and helpful, but above all, the soul of the conference was the President of the EFIM, Prof Jaime Merino, one of the finest people I have ever met. All delegates were overwhelmed by his kindness and charisma. At the Gala Dinner everyone presented him with a little spontaneous 'Thank You' speech or performance of something traditional from their country to show him their gratitude. For a moment I felt the urge to show them a Haka improvisation, but I realised I did not know enough details, so I chickened out. I just handed Prof Merino a beautiful Paua shell as a token of appreciation.

As soon as I came back home I started watching every rugby game to get the Haka right for the next conference. My 4-year- old son was impressed with how much brain I got in Spain…

TONI STAYKOVA
Advanced Trainee in Internal Medicine and Geriatrics, Auckland

IMSANZ

NZ ANNUAL MEETING **2003**

TO BE HELD AT **Napier**

THE ART DECO CENTRE OF NEW ZEALAND

27th - 29th MARCH

Come and enjoy the best of the Hawke's Bay this coming Autumn with the IMSANZ meeting in Napier. Hawke's Bay is renowned for its wonderful lifestyle and weather. Why not take time out after the conference to enjoy the fabulous wine tours, local recreational activities and visit the only mainland gannet colony in New Zealand.

R H ARMSTRONG
Convenor

TOPICS TO BE DISCUSSED AT THE CONFERENCE INCLUDE:

> The role of the hospice in the hospital
> A dummy's guide to endocrinology
> Is there a rational way to diagnose pulmonary embolus?
> The neurology of coeliac disease
> A mini sleep symposium on the impact of sleep disordered breathing in health and surgical management of sleep disordered breathing
> Symposium on the new ministry guide lines on the medical aspects of fitness to drive
> Modern approaches to asthma management
> Non alcoholic fatty liver disease
> Can you have too much Oxygen?
> An update on HIV/Aids treatment

HOW TO REGISTER

New Zealand - Members will receive registration information through the post. If you have not received a registration pack by November 2002, please contact: Katrena Drum on **09 367 2941**

Australia - We would like to encourage our Australian colleagues to join us for this meeting. Please contact Cherie McCune for registration information **imsanz@racp.edu.au** or **cavna@aol.com**

AUSTRALASIAN DONOR AWARENESS PROGRAM

Earlier this year I took the opportunity, along with a small number of other specialists, to take part in an Australasian Donor Awareness Program (ADAPT) workshop, held in Wellington. The workshop is designed specifically for medical specialists who have any interaction with patients and/or families where organ donation is discussed. The primary focus to date has been on intensive care specialists, however my experience, during this workshop, would suggest it has real value to all specialists in internal medicine with a generalist practice.

Intensive care specialists lead the clinical program, while issues around ethics, bereavement and grief are facilitated by Mel McKissock. The medical component focus is on the clinical issues surrounding brain death and intensive care supports of the brain dead potential organ donor, highlighting issues surrounding routine care and also pitfalls to be avoided. In this workshop, the most controversial topics discussed were the ethical and socio/political issues surrounding critical care services in New Zealand. A shortage of intensive care services results in early patient triage due to poor prognosis in an effort to meet ongoing demands for access to intensive care. For some patients, early triage is undertaken prior to brain death, where brain death may ultimately occur thereby reducing potential organ donors. Defining this as an important issue was not challenging, however actions that might have a positive impact on increasing service provision in the near future certainly was.

The dominant part of the workshop was chaired by Mel McKissock using his experience and skills to tease out issues around death, dying, bereavement and loss, and how these will impact on families of the severely injured and staff within the critical care unit. Mel has worked with the ADAPT program for many years as a component of his interest and work as a palliative care and bereavement consultant based in Sydney. It seems intuitive that positive support of the family through the process of loss and grieving will re ect well on organ donation and anecdotal evidence of a negative nature supports this proposal. Families who felt they received no support were less inclined and possibly less able to deal with concepts of brain death and subsequently agree to organ donation. Data positively supporting this hypothesis, however, is not readily forthcoming. Discussion ranged widely with hypothetical case scenarios used to raise issues, with Mel facilitating discussion within the group. Even in this small group, there was variance in the approaches of individuals and intensive care units to families of patients with a severe life threatening injury or patients with confirmed brain death, who are recognised as potential organ donors, with no single process clearly better. The discussion of people's thoughts and practice is useful to consider when reviewing your own approach to these issues.

The premise of this component of the ADAPT program is that if staff closely involved in death and grieving are better prepared and able to respond in an appropriate fashion, then affected families are more likely to respond in a positive manner to discussions and requests for organ donation.

New Zealand has an increasing demand for organ transplantation but has a static supply of cadaveric organs and an organ donation rate that is very low by international standards at 10-12 per million population.

General physicians in internal medicine in hospital practice have several roles, which could produce a positive impact on organ donation, quite separate from intensive care. Generalists can act as leaders in initiating and maintaining discussions, which facilitate an awareness of the benefits of organ transplantation and also issues around organ donation in their hospitals and their communities. The generalists can act as a source of information and education for their colleagues, support staff and the general public around these issues, which may have a real impact in improving organ donation rate. In addition, generalists are often primarily responsible for care of patients with acute non-traumatic brain injury, where a heightened awareness of organ donation and organ transplantation could also be of value.

The ADAPT program runs regularly in Australia and New Zealand and is extremely well received by participants as judged by feedback from programs held over the past twelve months. Globally, 97% of participants felt the workshop met their expectation and upon completion 95% felt better able to recognise and understand grief responses. Between 60% and 80% felt more able to diagnose brain death, more confident in educating family members and communicating to families information and news around brain death, and more able to support the families at this time of intense emotion.

I strongly recommend the Australasian Donor Awareness Program to all general physicians as a valuable contribution to their clinical practice and continuing medical education.

BRUCE KING NELSON

ATTENTION!
ALL GENERAL MEDICINE SUPERVISORS

Michael Kennedy, in his capacity as the Co-ordinator of the Specialist Advisory Committee for General Medicine (GM), wishes to bring to your attention that attendance of GM supervisors at the supervisors' workshops is unsatisfactory (approximately 25%). All supervisors are **strongly** encouraged to attend. By 2005 attendance at workshops will be a pre-requisite for undertaking supervision of trainees.

"DARE TO DREAM AND DREAM TO DARE"

International Congress of Internal Medicine, May 2002

As with all adventures the journey begins with the first step…

In December 2001 contact with the Melbourne Convention & Visitors Bureau (MCVB) led to a cascade of events. The simple inquiry from the MCVB "had we considered holding an International Congress of Internal Medicine (ICIM) in Melbourne, Australia?" led to a urry of questions and activity: "Who was the ICIM and were we members?; Where was the next ICIM Meeting?"

The International Society of Internal Medicine (ISIM) was founded in 1948 and has 54 member countries. Further investigation on the Internet and a series of emails resulted in the information that Professor Richard Larkins, President of the Royal Australasian College of Physicians, had met Professor Rolf Streuli in Switzerland in November 2001 and joined the College as the Australian and New Zealand representative body in November 2001. Hence IMSANZ, via its association with the College, was a member of the ISIM but not in its own capacity. The ISIM is an important representative international society for general physicians particularly as the interest in Internal Medicine increases globally. In the ACP-ASIM there are 130,000 members. The Japanese, Russian and European Federation of Internal Medicine societies each have about 80,000 members.

The feasibility of holding an International Congress of Internal Medicine in Melbourne, aiming to attract 3,000 to 4,000 General Internal Medicine physicians initially seemed a dream. Multiple contacts with the MCVB convinced me that it was possible for Australia and Melbourne in particular, to host an ICIM meeting. The difficult part was to convince the College to back this venture. After much discussion, the College decided that there should be a delegation sent to the ICIM Kyoto, Japan May 2002 meeting.

Why would anybody from Wangaratta, North Eastern Victoria consider organizing an International Congress of Internal Medicine in Melbourne? Being adventurous and willing to explore the new ventures and possibilities is perhaps a little easier outside the confines of metropolitan existence. Also, the last 25 years has seen a gradual decline in General Internal Medicine (GIM). There is a growing interest and resurgence in the role of the general physician which will require significant enhancement of the profile of GIM; rebuilding of General Medical Units and tertiary teaching centres; and highly visible role models and enthusiastic mentors to ensure that General Medicine attracts quality trainees.

The aim of attending the ICIM meeting in Kyoto in May 2002 was to assess the scientific merits, organization and structure of the meeting and if feasible to present an expression of interest in hosting the ICIM in Melbourne in 2010 or 2008.

The opening ceremony was impressive but an organisational nightmare due to the high level of security. The Emperor and Empress of Japan officially opened the ICIM. Only those with official clearance were admitted to the Main Hall. The rest, approximately 700 of us watched the ceremony on a big screen in an adjacent hall. Forty minutes of the Opening Ceremony was conducted entirely in Japanese, without subtitles. (Those in the main hall had access to translation). We met informally with members of the ISIM executive at the reception following the opening ceremony and they were enthusiastic and supportive of Australia hosting an ICIM in 2010. They acknowledged our expression of interest and will welcome a formal presentation in Granada, Spain in 2004.

The Presidential address by Joseph E. Johnson III, President ICIM explored the expanding role of General Internal Medicine in the global setting. The combined project from the ABIM Foundation, ACP- ASIM Foundation, and EFIM - " Medical Professionalism in the New Millennium: A Physician Charter" was presented to enthusiastic acclaim. This was published jointly in Annals of Internal Medicine (136:243- 246) and The Lancet (359:520-522). The Charter deserves widespread attention, dissemination and discussion.

The content and format of the conference was excellent; plenary sessions, scientific presentations and innovative and educational update sessions. The organisational and social aspects of General Internal Medicine were well covered. I attended excellent symposiums including one on "What are the core competencies for tomorrow's Internal Medicine internists" and a plenary lecture on "Patient safety and medical error reduction – a universal challenge". Both these topics were highly relevant to our situation in Australasia. There were multiple concurrent scientific sessions, paper presentations and poster sessions. The Japanese Society of Internal Medicine held concurrent sessions in Japanese. (The primary language of the ICIM is English).

Geoff Metz and I joined 250 conference delegates on the trip to Nara to visit the Shinto temples and Buddhist Shrines - an excellent time for networking and exploring Japanese custom and culture. In the evening we joined a reception held by the Royal College of Physicians of London near the conference centre with Ian Gilmore, Charles Hind (now President of the ISIM), Chris Davidson and selected members of the Royal College of Physicians and EFIM. This allowed further discussion and networking opportunities. On another occasion, we had a superb dinner at an authentic Japanese restaurant in the hills with Professors Paul Zimmet and Bernard Zinman.

We met with Professor Rolf Streuli who also strongly supported an expression of interest by the RACP for holding an ICIM

(continued on page 12)

Profs. Bernard Zinman & Paul Zimmet, Diabetes Experts

IMSANZ MEETING REPORT

Dunedin, August 2002

The second New Zealand IMSANZ meeting of the year, held in the southern city of Dunedin, was a repeat of last year's innovation. The meeting was the combined annual scientific meetings of the RACP, the Cardiac Society of Australia and New Zealand (CSANZ) and IMSANZ. This follows last year's combined meeting with the Paediatric Society, Palliative Care Group and Geriatricians.

For a generalist, the formula works well. We have an opportunity to choose areas outside our own sub-specialty interest to broaden and update our knowledge. Rotating the sub-specialties with whom the RACP combines its annual meeting, offers those members of special societies not otherwise likely to attend RACP meetings, an opportunity to interact with the college.

The IMSANZ opening day programme combined topics related to the CSANZ meeting with medical information topics. Great use was made of local talent and the presentations were informative, beautifully presented and useful.

Controversies in medicine continues to be fun. Presenters spoke on subjects of their own choice, well researched, well presented, and again thought provoking.

The IMSANZ dinner is a "not-to-be-missed occasion." Pinot noir was the avour of the night. Our southern colleagues are obsessed with Central Otago wines. I am unable to comment, but the food and company were great.

The Monday and Tuesday programmes, IMSANZ/CSANZ/RACP moved through lots of material invaluable to physicians practicing in general medicine. Cardiovascular risk, lipids and evidence based medicine, echo assessment of myocardial viability, statins and inflammation, lifestyle intervention, metabolic syndrome, acute coronary syndrome topics and controversies in cardiology. With the Young Investigator's Awards and free papers grouped under the heading Heart Failure, Ischaemic Heart Risks and Valve Disease, it was a full programme. This meeting also launched the Cardiac Rehabilitation Guidelines with an impressive introduction from Professor Norman Sharp and some fascinating New Zealand film archive material.

Overall impressions - Cardiologists continue to be in love with acronyms. Their evidence base is huge, but they are still arguing about what the implications for clinical practice are. Lifestyle interventions are very worthwhile. Population based change is incredibly important.

Finally, the RACP dinner. Held on a cold and misty night at Lanarch Castle. I am not in love with bagpipes in a confined space. Haggis, I am pleased to report, may not be a safe food (*New Zealand Herald 27.08.02*) but the sight of our esteemed cardiology colleague, Harvey White, charging the length of the banquet hall, dressed in a kilt and waving a cutlass, was not to be missed.

DENISE AITKEN
Rotorua

(continued from page 11)

meeting in Australia in 2010 and requested an Australian member on the executive of the ISIM. Considerable thought was given to this request by Robin Mortimer and he later invited Professor Napier Thompson to be the Australian RACP delegate on the ISIM executive. (Both Geoff Metz and I would have welcomed the opportunity to be involved with the ISIM and see this as an enthusiastic new venture in international relations. However, perhaps this is Robin Mortimer's way of acknowledging the role of the College on the ISIM and involving a senior RACP executive member with an outside perspective on Internal Medicine. At least Australia and IMSANZ, via the College, are making progress in the ISIM).

Dr Mortimer will be submitting his ICIM report to the RACP executive and I would surmise he would be supportive of the ICIM being held in Australia in 2010. IMSANZ will need to be actively involved in the organisation and presentation of the Congress. The success of the proposed Melbourne meeting will clearly depend on the cooperation of the College and all the Special Societies. There will need to be a local scientific organizing committee. We should endeavour to make the content of the meeting widely accessible with subtext or pre-prepared translations of lectures. We would need to be aware of the late afternoon drift away from the conference due to fatigue. There was poor attendance at the sunset sessions in Kyoto. Tours and cultural events are an important part of an international meeting and need to be included.

IMSANZ can be leaders within the College and ensure the future and prosperity of General Internal Medicine. The opportunity to host an ICIM is a distinct possibility and would enable the College and IMSANZ to showcase the important role of Australian GIM and medical research to the international medical community.

In the words of Raold Dahl in Willy Wonka and the Chocolate Factory 'we are the music makers and the makers of dreams'. We can in uence the future of direction of medicine in Australia and New Zealand.

I look forward to further developments and discussion and welcome your comments.

LES BOLITHO
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Geoff Metz & Robin Mortimer at Convocation, ICIM, Kyoto

Outlined below recent publications of relevance to general internal medicine. Please send along additional publications and/or comments.

Outreach and improved access to specialist services for indigenous people in remote Australia: the requirements for sustainability. Gruen RL, Weeramanthri TS, Bailie RS. J Epidemiol Community Health 2002;56:517-521. Tarun Weeranmanthri and his colleagues outline and discuss a model for a specialist outreach service to support primary health to overcome barriers to health care faced by the indigenous population in Australia's top end. The benefits of specialist outreach and the requirements for sustainable specialist services are discussed in relationship to a functioning model.

Is volume related to outcome in health care? A systematic review and methodologic critique of the literature. Halm EA, Lee C, Chassin MR. Ann Intern Med 2002;137:511-520. In order to maintain the "breadth" needed for general internal medical practice, cognitive and procedural "depth" skills could become compromised. This systematic review of 272 studies, of which 135 met the inclusion criteria, includes 27 clinical procedures. It confirms the high volume/better outcome association. Differences in casemix and care processes between high and low volume providers, however, accounts for some of the differences of quality of care. Furthermore, the magnitude of the association varies considerably.

The paradox of the parts and the whole in understanding and improving general practice. Stange KC. Internat J Qual Health Care 2002;14:267-268. In this editorial, Stange focuses on the need to include measures of the integrative and prioritising functions of general practice as well as disease-specific indicators. This argument is also valid for consultant general internal medicine.

Perioperative management of the hospitalized patient. Michota FA, Frost SD. Med Clin N Am 2002;86:731-748. This is a worthwhile review of the role of the consultant physician in preoperative evaluation with special attention to pulmonary risk assessment, delirium, myocardial infarction, pulmonary complications and venous thromboembolism. The July 2002 issue of Medical Clinics of North America (Vol 86 [4] July 2002) is devoted to hospital medicine and includes chapters on hospitalists, pain management, end of life care, medical error and quality improvement.

Mentoring in medicine: keys to satisfaction. Ramanan RA, Phillips RS, Davis RB, Silen W, Reede JY. Am J Med 2002;112: 336-341. This reports responses to a mailed questionnaire about mentoring to staff at the Harvard Medical School. Because of a low response rate from fellows and house officers, the analysis was limited to respondents who were instructors or assistant professors. Respondents who were being mentored were asked to indicate their degree of satisfaction with a number of specific characteristics of mentoring. This paper also reviews and discusses broader aspects of mentoring in a medical context.

What is an academic general internist? Career options and training pathways. Levinson W, Linzer M. JAMA 2002;288: 2045-2048. This summarises USA position descriptions, training pathways, rewards and challenges for those considering a career in academic general medicine.

Guideline-discordant care in acute myocardial infarction: predictors and outcomes. Scott IA, Harper CM. MJA 2002;177: 26-31. Ian Scott compares recommendations of clinical practice guidelines to actual clinical practice in 607 consecutive patients admitted to a public and a private community hospital in Ipswich between July 1997 and December 2000. Death is commoner amongst those with discordant-care and mortality was inversely related to the level of guideline concordance.

Clinical trials without consent: some experiments simply cannot be done. Kennedy M. MJA 2002;177:40-42. Michael Kennedy discusses a proposed trial which was never conducted. The study was designed to compare stenting with optimal medical therapy for patients with acute myocardial infarction in North Sydney, but did not proceed because of opposition from within the profession and the community. Michael Kennedy discusses ethical issues at the level of the patient and the community in terms of "informed consent".

Leaving gatekeeping behind – effects of opening access to specialists for adults in a health maintenance organization. Ferris TG, Chang Y, Blumenthal D, Pearson SD. N Engl J Med 2001;345:1312-7. It has been stated that an important role for primary care physicians is "gatekeeping", or the prior approval of referrals to specialists. In a capitated, multispecialty group practice in the USA there was little evidence of substantial changes in the use of specialty services by adults in the first 18 months following the elimination of gatekeeping.

General internal medicine in Australasia. Cohen A, Greenberg P, Graham N. Intern Med J 2002;32:495-497. This paper discusses the history of IMSANZ and its predecessors.

***Medical Professionalism in the new millennium:a physician's charter. Medical Professionalism Project. Lancet 2002;359:520-522. Also Annals of Internal Medicine 136;243-246.** This project has been directed at providing an action agenda related to the principles and responsibilities of medical professional practice. The accompanying editorial in the Annals comments: The underlying premise and motivation for the Charter is that changes in the health care delivery systems in countries throughout the industrialised world threatens the values of professionalism… Many physicians will recognise in the principles and commitments of the charter the ethical underpinning of their professional relationships, individually with their patients and collectively with the public.

PETER GREENBERG
Melbourne

Combined HRT as primary prevention of CHD...

After more than five years of treatment combined HRT does not provide primary prevention of CHD and is associated with a small but significantly increased risk of invasive breast cancer. The routine use of combined HRT for primary prevention of CHD cannot be advocated and its use in the prevention of osteoporotic fracture and treatment of peri-menopausal symptoms needs to be balanced against its small risk of harm.

Citation/s:

Risks and benefits of estrogen plus progestin in healthy postmenopausal women: Principle results from the Women's Health Initiative randomized controlled trial. JAMA 2002; 288(3): 321-333

Lead author's name and fax: Writing Group for the Women's Health Initiative Investigators

Three-part Clinical Question: In post-menopausal women with an intact uterus is combined HRT (conjugated equine oestrogen 0.625mg/d & medroxyprogesterone acetate 2.5mg/d) safe and effective primary prevention for reducing CHD (fatal and non-fatal AMI) compared with placebo.

Search Terms: PubMed Clinical Queries: therapy/specific "HRT and CHD"

The Study:

Double-blinded concealed randomised controlled trial with intention-to-treat.

The Study Patients: Post-menopausal women 50-79 years with an intact uterus**.**

Control group (N = 8102; 7608 analysed): Placebo for an average of 51/2 years.

Experimental group (N = 8506; 7968 analysed): Daily conjugated equine oestrogen (0.625mg) and medroxyprogesterone (2.5mg)

The Evidence:

Outcome	Time to Outcome	CER	EER	RRR*	ARR*	NNH
CHD (fatal or non-fatal AMI)	**66 mths**	**0.016**	**0.020**	**-25%**	**-0.004**	**250**
	95% CI			-50% to 0%	-0.008 to 0.000	NNH 125 to ∞
Invasive breast cancer	**66 mths**	**0.016**	**0.021**	**-31%**	**-0.005**	**200**
	95% CI			-57 to -6%	-0.009 to 0.000	NNH 110 to 1103
Global Index (CHD, invasive breast cancer, stroke, PE, endometrial cancer, colorectal cancer, hip fracture, or death due to other causes)	**66 mths**	**0.082**	**0.094**	**-15%**	**-0.012**	**82**
	95% CI			-25% to -4%	-0.021 to -0.004	NNH 48 to 276

***Negative values equate to risk increase of stated outcome. CER=control event rate; EER=experimental event rate; RRR=relative risk reduction; ARR=absolute risk reduction; NNH=number needed to harm**

Comments:

This was a well designed study that enrolled 16 608 post-menopausal women who had not had a hysterectomy. In line with earlier studies it demonstrated a non-significant increase in CHD events within the first year of treatment (NNH: 446 over 12 months) and this was not reduced with longer therapy. There was an improvement in lipid profile in the treatment group reinforcing the caution that must be used in interpreting the significance of interim end-points. The increased risk in CHD was similar for subjects with and without a past history of CHD. Hip fractures were reduced (NNT: 403 over 5 years) and colorectal cancer lower (NNT: 336) in the treatment group though more stringent analysis after adjustment for repeated measures did not find this difference significant. The increased risk of invasive breast cancer was particularly marked after more than 3 years of treatment and particularly so in those women with prior HRT use (NNH: 78). These results do not relate to women without a uterus on oestrogen therapy alone and a trial investigating this is currently in progress.

Appraised by: Graeme Maguire and members of the PAH Department of Internal Medicine EBM Journal Club - Monday, September 02, 2002 Email: Graeme_Maguire@health.qld.gov.au Update By: September 2003

The effect of addition of nicorandil to "optimal" medical management on occurrence of AMI and hospitalisation with chest pain in patients with stable agina...

Nicorandil is effective in reducing the combined outcome of fatal and non-fatal AMI and acute admission with cardiac chest pain when used in addition to current optimal medical management. Use of nicorandil is associated with an increased incidence of GI side effects.

Citation/s:
The IONA study group. Effect of nicorandil on coronary events in patients with stable angina: the impact of nicorandil in angina (IONA) randomised trial. Lancet 2002; 359: 1269-75
Lead author's name and fax: The IONA (Impact of Nicorandil in Angina) Study Group
Three-part Clinical Question: In a patient with ischaemic heart disease, would the addition of nicorandil to usual therapy reduce subsequent risk of death, AMI or admission for ischaemic chest pain.
Search Terms: PubMed Clinical Queries - therapy, specific, nicorandil AND angina

The Study:
Double-blinded concealed randomised controlled trial with intention-to-treat.
The Study Patients: UK residents. Men > 45/women > 55 yrs with history of AMI, CABG or IHD confirmed by angiography or positive exercise test. If IHD without AMI/CABG then must have been 'high risk' as defined as LVH on echocardiography/LVEF < 45%/ED dimension > 55mm/diabetes & hypertension/other vascular disease. Excluded if on a suphonylurea.
Control group (N = 2561; 2561 analysed): Usual management (approx) 90% on aspirin, 90% nitrates, 60% beta- blockers, 60% statins, 50% calcium channel blockers, 30% ACEI.
Experimental group (N = 2565; 2565 analysed): Usual management + nicorandil 10mg bd for 2 weeks then 20mg bd.

The Evidence:

Outcome	Time to Outcome	CER	EER	RRR	ARR	NNH
CHD death, non-fatal AMI or hospital admission for cardiac chest pain	**18 mths**	**0.155**	**0.131**	**15%**	**0.024**	**42**
	95% CI			3% to 28%	0.005 to 0.043	NNH 24 to 207
All cause mortality	**95% CI**	**3 to 28%**	**0.005 to 0.043**	**NNT 24 to 207**	**0.007**	**143**
	95% CI			-9 to 37%	-0.005 to 0.019	NNH 54 to ∞
GI adverse events	**18 mths**	**0.052**	**0.076**	**-46%**	**-0.024**	**-42**
	95% CI			-72 to -20%	-0.037 to -0.011	NNH -95 to -27

Comments:
Individual endpoints of fatal AMI, non fatal AMI or admission for ischaemic chest pain showed no significant difference between the treatment and control group. The relative low rate of these required the *pre hoc* use of a combined endpoint to provide sufficient power for the study. This was re ected in a small absolute risk reduction but with a larger relative risk reduction. Unfortunately safety could not be accurately assessed. The definition of serious events was not provided. GI events were greater in those on nicorandil (194 vs 132). Non-serious adverse events were not prospectively collected though withdrawals were comparable. It should be noted that withdrawals from the treatment and control groups appeared high at 32-39% by the end of the study. There was no assessment of quality of life, health utility or health service utilisation (eg LOS) making an economic evaluation and comparison with other interventions for IHD difficult.

Appraised by: Graeme Maguire, Internal Medicine, Princess Alexandra Hospital, Brisbane - Tuesday, June 11, 2002 Email: Graeme_Maguire@health.qld.gov.au Update By: June 2003

The editors would like to acknowledge the valuable editorial assistance given by Dr Peter Hawkins MBBS, FRACP in the editorial preparation of the CATs.

FROM THE EDITORS

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

We are most grateful for contributions received from members.

The IMSANZ Newsletter will now be published twice a year in June and December.
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 feedback concerning the contents and style of the newsletter.
Tell us what you want!!

The editors gratefully acknowledge the enthusiastic and creative input of Cherie McCune, IMSANZ secretary.

When submitting text material for consideration for the IMSANZ Newsletter please send your submissions in PC format in Microsoft Word, Excel or Publisher applications. Images should be submitted as JPEG or TIFF format at 300dpi and no less than 100mm by 70mm in size.

Submissions should be sent to either:

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

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