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INTERNAL MEDICINE SOCIETY of Australia & New Zealand

DECEMBER 2004

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From the President...

Dear IMSANZ Members,

"Another year over and what have we done...?" sang John Lennon. Answer, in so far as IMSANZ is concerned: heaps! Everywhere you look you see members of this society engaged in a diversity of activities that embody the strength and vitality of our discipline. The article in this issue from our Pacific correspondent, Dr Rob Moulds, is a terrific illustration of just how important (and interesting) the practice of internal medicine is in countries such as Fiji. And we are no less active here in Australia and New Zealand, as the following examples demonstrate.

1. **Creating new career opportunities for general physicians.** Just scan the RACP and IMSANZ websites to see the numbers of new positions for consultant general physicians that are springing up everywhere throughout Australia and New Zealand. Vacancies exist in Bathurst, Gold Coast, Hervey Bay, Grafton, Woollongong, Armidale, Newcastle, Wagga Wagga, Perth, Adelaide, and Auckland and Nelson in NZ. Some involve interesting new models of specialist care that espouse a generalist approach to care delivery and co-ordination. One such example is the ad for 5 general physicians at Flinders Medical Centre in Adelaide to staff a new Assessment Unit and Acute Medicine Service which will provide comprehensive, general physician-led medical care to all acutely unwell medical patients.

2. **Reforming the training program with a view to creating more general physicians.** There has been a seismic shift in the attitude of the college towards restoring equity of training opportunities for trainees who aspire to become general physicians. This is in no small way due to the efforts of Les Bolitho, Rick McLean and Geoff Metz who, at senior levels of the college hierarchy, have brought an awareness (and increasing acceptance) of the need for a more even balance between the numbers of general physicians and pure subspecialists. At the level of curriculum development, Phillippa Poole, Andrew Bowers, Peter Greenberg and Leonie Callaway have designed a curriculum that, for the first time, explicitly states the knowledge, skills and attitudes of general physicians which will guide the way training in general medicine is provided and assessed. At the level of hospital training programs, efforts are being taken by folk such as Peter Nolan (Qld), Aidan Foy (NSW), David Russell (Vic), and Di Howard (NT) towards creating regional trainee recruitment and training schemes that provide a training path for general physician trainees which involve rotations in both metropolitan and regional hospitals.

3. **Expanding the opportunities for professional development in general medicine.** Various councillors together with local members

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are engaged in organising a host of educational events for 2005 including the Wellington RACP ASM, the inaugural IMSANZ Annual Scientific Meeting which will be held in Alice Springs in September next year, the Victorian Rural Physicians meeting, the various New Zealand regional conferences, and RACP state scientific meetings. This is in addition to a number

of workshops aimed at improving specific skills of the general physician such as the Cardiology Skills for Rural Physicians meeting recently held in Brisbane and the Evidence-based Practice Workshop last month in Melbourne (with involvement of myself, Paddy Phillips, Peter Greenberg and Don Campbell). The Resources section of our website is to be redesigned with the aim of mounting a rapid-response critically appraised practice topic page which will attempt to get synopses of new important research results relevant to the general physician quickly on-line. A separate 'Practice Improvement Tips' page will provide evaluated strategies for improving practice efficiency in both hospital and clinic settings.

4. Promulgating policies aimed at advancing and sustaining general physician practice. This issue of the newsletter contains an abridged version of the National Rural Health Policy (NHRP) Sub-committee of the Australian Health Ministers Advisory Council (AHMAC) Taskforce. This document has been co-authored by a number of IMSANZ members and incorporates many of the recommendations that IMSANZ has made in recent times about how to boost the supply of general physicians in rural and remote areas, and better support those already practising in such areas. At the current moment, one of the most important tasks that IMSANZ has ever undertaken is the development of a 5-year action plan that sets out, in clear terms, the goals and methods that the IMSANZ membership has collectively decided are the means for restoring the proper role and position of the general physician within the Australian and New Zealand healthcare system. As this newsletter goes to press, the draft plan has been electronically sent for review and comment to all members who have provided us with e-mail addresses. The feedback received will be used to revise the document prior to its public launch at the IMSANZ annual general meeting in Wellington in May next year. As much of December and January is usually down-time for most of us, I hope that everyone takes the opportunity to examine and think about this document as much depends on getting it right. Your future, and that of general medicine, will be influenced very significantly by the actions contained in this document. Circumstances have never been as good as they are now for resurrecting the status of general medicine and we must do everything we can in making the most of this opportunity. Anyone without e-mail who would like a hard copy of this document please contact the secretary.

5. Building an academic base for general medicine. This issue contains an article which attempts to help those of us wanting to do research. It is inspiring to note that one of the successful CSSP projects reported in a supplement of the Medical Journal of Australia in May this year was the Brisbane Cardiac Consortium, led by general physicians from three Brisbane hospitals. There are no doubt many general physicians who are involved in research in one form or other – as site investigators for multi-centre clinical trials, as sponsors of quality improvement projects, as mentors of physician trainees undertaking research activities. Opportunities for general physicians to contribute to research can only but increase as more interest is shown in determining the most effective and efficient ways of providing care for ageing populations with multiple problems.

So what might be some of the predictions for the New Year? I suspect that the role of general physicians in providing acute medicine in hospital, acting as 'hospitalists', or case managers, and assisting subspecialists in the care of those aspects of their patients' illnesses that lie outside their field of expertise, will come to the fore. A letter from an intensivist at St. George hospital reproduced on page 3 gives a hint of things to come. The need for more general physicians in outer metropolitan and regional hospitals will become a major public issue, as will the plight of rural and remote communities who find themselves increasingly unable to access any form of specialist medical care. Governments at both state and federal levels will be looking to the college and IMSANZ for tangible assistance in remedying this situation. The recent (bad) publicity given to the perceived limitation of access, on the part of the RACS, to positions in its training program for eligible trainees, in the face of clear population need to train more surgeons, is something the RACP will want to avoid at all cost. The review of the college training program and the start-up of the conjoint committees with specialty societies will raise a number of operational issues which will challenge orthodox views and not be easily resolved.

Enjoy the festive interlude and get ready to hang on to your seats for an interesting ride in 2005.

IAN SCOTT
President, IMSANZ



AN INTENSIVIST'S PLEA FOR BETTER MEDICINE

(The following is an edited version, reproduced with permission, of an e-mail received from Prof. George Skowronski, intensivist at St. George Hospital, Sydney.)

Dear Prof McLean,

I'm not sure if you're the right person within the RACP hierarchy to contact for this, but it seemed to me you might be. I have followed for some time developments within the UK College (of which I am also a Fellow) in relation to what they have termed "acute medicine". In Australia we have had something of a debate about the US concept of "hospitalists" - a closely related idea. There were a couple of editorials and some correspondence involving Ken Hillman and Paddy Phillips in the MJA in 1999, but it went no further. We're also now discussing the role of Medical Emergency Teams and so on. In all this the RACP is silent (at least as far as I know).

With the decline in general medicine, increasing super-specialisation, the ascendancy of procedural medicine, the changing inpatient population, etc, I've become increasingly conscious, as an intensive care physician, of a widening gap between the sort of inpatient care I'm used to providing and that available outside the teaching hospital ICU. Many of my intensivist colleagues agree, and we talk about "ICU outreach" services. The general wards are now full of frail, elderly, acutely sick and unstable patients, yet the "physicianly model" of care for this population has hardly changed in 50 years, with consultants pontificating on ward rounds or by phone, and most of the day-to-day care provided by poorly supported and inadequately trained juniors flitting between the wards and the outpatient clinics. (Am I being too provocative?). Events like the Campbelltown/Camden debacle, notwithstanding the political overtones, have only served to reinforce these concerns.

I think the UK College has done a commendable job in confronting some of these issues and wonder whether the RACP should take a lead in advancing a similar debate here. This would include, for instance, medical issues in the surgical patient, acute multi-organ problems (often poorly managed by a 'committee' of single-organ-doctors), medical urgencies and emergencies, acute fluid/electrolyte/acid-base disorders, etc. I would contend these areas have never been particularly well taught or supported in physician training (apart from the intensivists of course), whereas I think some of the ambulatory stuff once used to be, before many of the teaching hospitals privatised outpatient clinics to save money.

While any changes would need support from the single organ specialties, the first step would be for them to acknowledge that they're actually not very good at it, for both cognitive and logistic reasons, and that something needs to change. Is this an opportunity for a rebirth of general medicine? Should we encourage the development of a new specialty of "hospital medicine" or "acute medicine"? If so, how? Should this niche be filled via the Intensive Care College or the Emergency Medicine College rather than the RACP, or perhaps in combination? Is it something we don't want at all in Australia? What about undergraduate training in this kind of medicine?

Maybe the RACP has absolutely no interest in all of this. If so I apologise for wasting your time. But if there is any interest I'd be keen to participate in any discussions.

Cheers,

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Dear Prof Skowronski,

Thankyou for your interest in this whole concept of acute in-patient medicine and who is best served to provide it. Clearly there will be debate on how you define acuity and complexity and at what level the intensivist or physician should assume primary responsibility for care. I have argued along with Paddy Phillips in the MJA article you refer to (MJA 1999; 171: 312-314) that the general physician is ideally placed to deal with those parts of the continuum of patient care that lie outside the provenance of emergency medicine and intensive care. The inpatient situations you list can be appropriately managed by the well-trained general physician, and the presence of general physicians in hospitals who can co-ordinate aspects of medical care of surgical patients and the many different co-morbidities of elderly patients is, we believe, becoming a necessity.

How do we progress a constructive dialogue? I think a discussion on this topic between representatives of my society, the Intensive Care Society and the Australasian College for Emergency Medicine, with input from RACP, might be the next step. We should be trying to build an alliance with the aim of developing integrated care and referral/transitional care guidelines, reviewing the training curriculum of each group and how they can be developed to better promote greater liaison between our three groups, and defining the role of subspecialist physicians in this continuum.

The time is ripe to make inroads on the compartmentalised, disjointed (and in many cases omitted) care that we are currently providing in many of our hospitals, especially in outer metropolitan and rural areas. Our efforts, as I'm sure you'll agree, should be directed at improving overall patient care and not be undermined by professional turf wars. I look forward to progressing these ideas with you and others.

Regards,

Ian Scott FRACP, MHA, MEd
President, IMSANZ

Postscript

The CEO of the college has been approached by Rick McLean with the proposal that a meeting of representatives from IMSANZ/RACP, Intensive Care Society and Australian College of Emergency Medicine be convened early in the new year to discuss this issue further.



(L to R) Heidi, Portugese AT, Prof Jaime Merino, and Patrick Gladding.

I had the privilege of attending the 7th European School of Internal Medicine recently in the coastal town of Alicante, Spain. The school is the innovation of Professor Jaime Merino and is endorsed by the European Federation of Internal Medicine (EFIM). The work of Dr Chris Davidson, a General Physician/ Cardiologist from the UK has been integral to its creation and organization.

Alicante, like many coastal Mediterranean towns, has a long history beginning with Carthaginian settlement. Little remains of this period but the grand Santa Barbara castle which overlooks the town from an oppressive pinnacle of rock is testament to Alicante's glorious medieval period. The modern town was once the gravitational centre for northern European tourists, seeking its sunny beaches, temperate climate and cheap living. However as with many such tourist meccas it has become overdeveloped, with little in the way of natural structures left near the coast. Tall apartment blocks obscure most views inland, and loom over the sun-worshippers on the beaches.

The meeting is a semiformal affair attended by representatives from most European countries. This year delegates attended from Finland, Sweden, Belgium, Switzerland, Holland and Italy to name a few. More recent years have seen attendances from Slovakia and the Czech republic. This year was the first year that doctors from Estonia had attended, their country being new to the EU. For those interested the Lancet has published an interesting review of the status of healthcare in Estonia in the last month. Other non-European countries were also represented such as Israel, United States and New Zealand.

The meeting was entitled "Hot Topics in Internal Medicine". Lectures covered a breadth of issues in medicine, but time precluded a comprehensive coverage. Excellent reviews of the management of atrial fibrillation, the pleiotropic effects of statins and malnutrition within hospitals caught everyone's attention. Occasional presentations were esoteric with an hour dedicated to the many different types of porphyria.

The format of the meeting was heavy on clinical presentations and most appreciated this medium for presenting new material. Local physicians presented clinico-pathological correlations that allowed delegates to voice their opinions over differential diagnoses.

Professor Merino spent time reviewing the more important and pressing issues for EFIM:

- Training
- Revalidation
- Maintenance of professional standards/Professionalism
- The establishment of a standardized European Internal Medicine examination (scheduled for 2005)

The European Federation will offer a course for trainees interested in performing clinical research. This is scheduled to occur for the first time in 2005 in Paris. Also promoted was the relatively newly established journal of the Federation, dedicated to Internal Medicine.

Thankfully, balanced against the lectures and clinical presentations was a well-organised social schedule. On our first night we were honoured with a visit to Santa Barbara castle, given an official mayoral welcome and entertained by a Spanish college band, singing songs dating back to the Spanish civil war. The following night we were further spoiled with a performance by a group of Andalusian singers and dancers.

These occasions were an excellent opportunity to discuss our backgrounds, working conditions and training issues across Europe and the world. The European Working Directive has radically altered conditions for training in Europe. It was written by the newly developed EU government in Brussels and placed a limitation on hours worked for the benefit of employees across Europe. There was apparently no intention that it would cover doctors' employment. However, in two test cases in the European court, litigation was settled in favour of the defendants, doctors, who had exceeded the Working Directives hours because of service commitments.

Internal Medicine training in Europe is either principally Internal Medicine with a subspecialty, or early divergence into either pure Internal Medicine or a medical subspecialty. Training is generally as least as long as that experienced in Australasia, with the exception of the UK where a trainee intern year does not exist. Remarkably in Denmark training is so prolonged that medical students leave medical school at about the age of 28 years. Nowhere did conditions seem as bad as in Italy where advanced trainees in Internal Medicine are still considered "students" and therefore have very poor representation on employment issues. This has led to a level of pay so meagre that many are still reliant on parental support until their late thirties.

The meeting was an excellent forum in which to discuss issues of training. One hopes that with standardisation and unification occurring across Europe, the lot of those who have the most to gain will improve. The strong emphasis on presenting clinical cases gave us all a chance to improve our presentation skills. Remarkably all the Europeans apologised before their talks for their poverty of English, but then proceeded to present fluently and eloquently. I wish to thank IMSANZ for giving me the opportunity of attending the VIIth Annual European School of Internal Medicine and would recommend it highly to anyone who wishes to attend. I have only one added word of advice.... learn a little Spanish before leaving!

PATRICK GLADDING

FENWICKE, R. (Ed).

In Practice: *The Lives of New Zealand Women Doctors In The 21st Century*

Auckland: Random House. 2004 - NZD\$29.99

A physician poet colleague recommended this compendium. It was duly added to the birthday book request list, and proved itself up to the mark as a stimulating, and extremely interesting read; well-edited for a book of this type. The fourteen contributors are well-known New Zealand women doctors: three GPs, two surgeons, two physicians, a paediatrician, pathologist, psychiatrist, public health specialist, sports physician, breast physician, and obstetrician and gynaecologist respectively.

The women invited by Fenwicke were medical undergraduates at the University of Otago in the mid to late 70's. They document their experiences from childhood, into medical school in the heady days of free education and feminism, through specialisation, and into practice. They relate how they existed in systems where most of the doctors were male, and how they combined medicine with family life and a raft of outside activities. Papaarangi Reid and Erihana Ryan offer valuable Māori perspectives. Papaarangi explains the young Māori women's code to "make the personal the political" - making a personal stand in one's own sphere of influence in order to make a great difference collectively.

In reading this book I felt privileged to share the feelings of these women as they laid open their lives, though good and dark times. The honesty, commitment and resilience they demonstrate is humbling, but strengthens and encourages the reader through the realisation that many others have similar experiences and survive. Another feature was the flexibility of these women's medical lives, and how prepared they seem to be to make changes in their career directions, and be comfortable with those decisions. Several have ended up in clinical leadership positions, perhaps motivated by a desire to make a greater contribution to the health of their patients.

General physicians will be heartened by the contribution from Robyn Toomath, general physician, endocrinologist, medical administrator and co-founder of FOE (Fight the Obesity Epidemic). When faced with a need to cut 20 hours per week of clinical work to accommodate an administrator role, she dropped her general medicine commitments. In her words: "to my amazement I found I really missed the camaraderie of working with a team on the ward. I missed reassuring frightened and sick people that all would be well and I missed the intellectual exchanges with the bright and eager registrars on word rounds. So to everyone's surprise (and relief) I engineered a return to general medicine...".

Through their accounts the contributors are concerned to encourage the current generation of women medical students, and to "breathe new life into how we can all try to make the personal the political." While the contributors were undoubtedly chosen because they have been successful and have survived the system, the stark reminders of the particular barriers these women faced, and the fights they won are timely, and challenge the next generation to continue the efforts. Papaarangi Reid, in particular, challenges the current complacency in New Zealand society.

Scattered through the contributions are highlighted inserts concerning the medical workforce, health statistics and society in general. These inserts provide a commentary on the societal changes occurring through the late 20th century, and a context for the women's personal insights. The women are very quick to acknowledge and name their, mainly male, mentors. A very minor drawback is that, at 189 pages it left one wanting more; now surely that is a sign of a good book!

Proceeds of the sales go to establish the Women Doctors' Fund at the University of Otago.

PHILLIPPA POOLE



IMSANZ would like to welcome the following New Members:

- Dr Carl Eagleton, Wellington, NZ
- Dr Sok-Hui Goh, Myrtle Bank, SA
- Dr Basim Nona, Palmerston North, NZ

A warm welcome is also extended to our New Associate Members:

- Dr Richard Everts, Nelson, NZ
- Dr William Harrison, Auckland, NZ
- Dr Vignakumar Ganesamoorthy, Hamilton, NZ
- Dr Jamil Ahmed, Auckland, NZ
- Dr Derek Luo, Auckland, NZ
- Dr Chandi Perera, Canberra, ACT
- Dr Alasdair Patrick, Auckland, NZ

Intensive lipid-lowering with atorvastatin 80mg provides greater protection against major cardiovascular events than pravastatin 40mg

Citation: Intensive versus moderate lipid-lowering with statins after acute coronary syndromes. Cannon CP et al. NEJM 2004;350:1495-1504.

Three-part Clinical Question: In patients hospitalized for acute coronary syndromes, does more intensive (versus moderate) lipid-lowering with statins result in better outcomes?

The Study: Multicentre (349 sites, 8 countries), double-blinded, randomized controlled trial with intention to treat analysis. Mean follow-up 24(18-36) months.

Patients: 4162 randomized, 78% male, mean age 58.2yrs, 91% white, 18% prior AMI, 11% previous CAGS, 18% diabetes, 37% smokers.

Included: Patients at least 18 years old who had been hospitalized for an acute coronary syndrome (AMI or high risk unstable angina) in the preceding 10 days; total cholesterol \leq 6.21mmol/L (or \leq 5.18mmol/L if already on long-term lipid-lowering Rx).

Excluded: Unstable patients (patients enrolled after PCI if one was planned); co-existing condition which rendered life expectancy to $<$ 2yrs; therapy with statin at 80mg/day at time of index event or other lipid lowering Rx that could not be discontinued prior to randomization; concomitant use of strong cytochrome P450 inhibitors, risk of QT prolongation; prior PCI within 6/12, CABGS within 2/12 or CABGS scheduled; serious hepatic disease; unexplained CK elevation $>$ 3 times normal or over 177umol/L.

Protocol: Pravastatin 40mg group (N=2063): Standard medical and interventional treatment (including aspirin +/- clopidogrel or warfarin) + Pravastatin 40mg in a blinded double-dummy fashion. Atorvastatin 80mg group (N=2099): Standard medical and interventional treatment + Atorvastatin 80mg in a blinded double-dummy fashion.

The Evidence:

Outcome	Time to Outcome	CER*	EER*	RRR* (%) (95% CI)	ARR*	NNT* (95% CI)
Combined endpoint of death (any cause), AMI, unstable angina (requiring rehospitalisation), revascularization (PCI or CABGS) or stroke	2 years	0.263	0.224	15 (5-25)	0.039	26 (15-77)
Death from any cause	2 years	0.032	0.022	31 (0-62)	0.010	100 (50-6753)
Death from coronary heart disease	2 years	0.014	0.011	21 (-27-70)	0.003	333 (NS*)
Myocardial infarction	2 years	0.074	0.066	11 (-10-32)	0.008	125 (NS*)
Revascularization	2 years	0.188	0.163	13 (1-26)	0.025	40 (21-528)
Unstable angina requiring hospitalisation	2 years	0.051	0.038	25 (1-50)	0.013	77 (39-2133)

CER* Control Event Rate

ARR* Absolute Risk Reduction

EER* Experimental Event Rate

NNT* Number Needed to Treat for one to benefit

RRR* Relative Risk Reduction

NS* Not Significant

Comments:

- Study designed to demonstrate equivalence rather than superiority. (Short follow-up duration, small numbers of patients [eg Heart Protection Study had 21,000 participants].)
- The two groups were reasonably well matched except for peripheral vascular disease: 6.6% of Pravastatin vs 5% Atorvastatin ($p=0.03$)
- 8 patients (0.2%) lost to follow-up.
- Significant benefit shown in reduction of revascularisation procedures, unstable angina requiring hospitalisation. Although combined endpoint was used as primary outcome measure, study may have been underpowered to detect specific individual endpoints.
- Benefit of Atorvastatin was evident from as early as 30 days.
- Decrease in LDL cholesterol: Pravastatin 10%, Atorvastatin 42%; this would be predicted to translate into a 20% reduction in clinical events. It is uncertain whether all of the benefit from statins comes from reducing LDL cholesterol.
- Generally well tolerated: ALT $>$ 3x normal = 1.1% for Pravastatin, 3.3% for Atorvastatin ($p<0.001$); myalgias or \uparrow CK: 2.7% of Pravastatin, 3.3% of Atorvastatin ($p=0.23$). No rhabdomyolysis.
- Note associated editorial (NEJM 2004;350:1562-4) and Nissen SE et al., "Effect of intensive compared with moderate lipid-lowering therapy on progression of coronary atherosclerosis: a randomised controlled trial." JAMA 2004;291:1071-80.

Appraised by: Dr Simon Lam, Medical Registrar, Royal Melbourne Hospital, May 2004



LIKE TO DO SOME RESEARCH?

Love to, but how?

One of the defining properties of a profession or discipline is its demonstration of the capacity to generate and expand its own knowledge base through original investigation. Delivering the Arthur E. Mills Memorial Oration at the College Ceremony in Canberra earlier this year, Professor John Funder made a impassioned plea to all the newly conferred fellows to involve themselves in research and contribute to the advancement of medicine.¹ As someone who has conducted and published clinical studies, I felt sympathy for his call, but also reflected on another old aphorism: "Research is 10% inspiration, 90% perspiration." Yes, it does take effort and I, and I'm sure many others, have experienced the angst of wondering whether the effort spent in undertaking what is essentially a risky business was going to pay off. The good news is that, if the research question is relevant and the research is well designed and executed, there is no such thing as a 'negative' (or non-publishable) study. There's more good news in that we now know, through the efforts of the evidence-based medicine movement, how to go about doing decent research, and the message is – it's not as hard as it looks, and you do not have to be a full-time academic or trained researcher to do it.

So how much research is being done by general physicians? As chair of the IMSANZ Research Portfolio and Internal Medicine editor for the Internal Medicine Journal (IMJ), I thought I should try to get some answer to this question. So I did a quick handsearch of all issues of IMJ over the last 3 years counting all the original research articles that were authored by folk I deemed to be general physicians based on their title and institutional affiliation and also cross-checking their names against the current IMSANZ membership list. I concede this may under-estimate the GIM research output as there may be folk who publish under a subspecialty but also practice general medicine, or who publish in journals other than IMJ. Nevertheless, for what it is worth, the results (Table 1) suggest that our research output relative to other disciplines, especially for a general journal such as IMJ, is not as strong as it might be based on our relative numbers. So what's the problem?

Well it's not for lack of interest in doing research. In a survey of the IMSANZ membership in 2002 which attracted a 60% response rate,² at least half of the respondents were keen to do more research. The problems seem to be those of limited time, skills and resources, especially for those in private practice and with no or little access to trainees or support infrastructure of a public teaching hospital. There may also be uncertainty about what might be worthy topics of research given that it is difficult to equal the level of sophistication of the laboratory-based research or large-scale randomised clinical trials carried out in tertiary research institutes. But these barriers are not insurmountable.

1. Deciding what to research. In recent years whole new schools of what may be called 'implementation' research have grown up i.e. research dealing with how well we integrate the findings of clinical science into the routine practice of medicine. Clinical epidemiology, quality and safety improvement science, clinical informatics, the study of clinical reasoning, clinical systems analysis, health services research and production of systematic reviews (including Cochrane reviews) are some examples. The many clinical questions that currently remain unanswered within the realm of evidence-based medicine are prime targets for applied

research. Currently I am involved in studies looking at the appropriateness of use of CTPA scans in my hospital in diagnosing suspected PTE, of how effectively we use our outpatient clinics in reducing waiting times for new patients, and of how we can provide better care for elderly patients presenting to hospital. Many of these projects have arisen from everyday observations that suggest there might be a better way of doing things which requires scientific study to identify.

- 2. Designing a research study.** The key to success of any study is in the design. The central issues are to: 1) be as specific as you can in the question to be answered (or the hypothesis to be tested), and define your population of interest, the study factor (clinical intervention, risk factor, or aetiological factor that is being investigated), and the outcome measures (what are we going to measure that will answer our question and how to undertake such measurement); 2) define the dataset i.e. each item of data that you will need for your study and how you are going to collect it; and 3) define your method of data storage and analysis (i.e. how the data are going to be entered and analysed in a way which allows valid interpretations or deductions). There are many books and papers available which assist in study design³⁻⁶ but careful consideration of the issues mentioned using pragmatic common sense is all you need (repeat: it's not as difficult as you may think). A final caution is to scan the existing literature to ensure that your exact question has not already been answered, and which may give you ideas about how others have designed related but not identical studies.
- 3. Recruiting others to help you.** Rather than try to do all the work by yourself, and to make sure you gather enough patients or data to answer the question you've posed, invite others to join you in the effort and thus divide the labour and make use of the ideas and talents of others. Building research networks or collaborations for general physicians is something IMSANZ is keen to promote. Many folk express concerns about lacking skills in databases, statistical analysis, or sample size calculations (i.e. how many subjects do I need to study to answer my question definitively – the study 'power'). While there is now plenty of software around which can do all this,⁷⁻¹⁰ I sympathise with those who find it all a bit daunting or again feel the pressure of time which prevents them sitting down with a manual in front of a computer and working it through.

But there is another way. Recently, a colleague of mine and IMSANZ member, Dr Nick Buckmaster, had been collecting data on consecutive patients with suspected acute coronary syndrome admitted to two community hospitals and he was trying to prove if a clinical pathway strongly promoted at one (intervention) hospital reduced inappropriate use of clexane compared to its use in another (control) hospital. Nick heard that I had access to a biostatistician and sent me his raw data in an Excel file, asking if we could make something of it. What transpired were some cleaning and transformation of the data, some additional suggestions as to patient subgroup analysis, and then statistical analysis including logistic regression which turned uninterpretable raw data on more than 400 patients into a very publishable set of results. What I suspect would have taken Nick weeks of work to do was done within a couple of days. It



was a win-win situation in that both parties had benefited from each other's contribution in producing a new insight that could inform better practice. Such collaboration early on may also yield better study design and greater potential for studying more subjects as a multi-site effort.

4. Writing up and submitting your results for publication.

This is often the hardest bit. Commonly we go as far as presenting our results at grand rounds or at a conference, but the motivation to sit down and write a well referenced article for submission to a peer-reviewed journal seems to elude us. One tip is to draft your article at the time you're designing your study – this also helps you to make your design more rigorous. The Introduction is essentially the background and rationale for your study which should involve an existing literature search as previously mentioned; Methods is the study design using the headings outlined above; the Results are what you found (I often go so far as writing the sentences leaving blank spaces in which to enter numerical data); and the Discussion is your interpretation of the findings and how they relate to the findings of others (which you've already read as part of your literature search), plus some acknowledgement of any limitations to your study. There, it's done, and with an average word limit of 2500-3000 for most journals you don't have to write much – indeed I often find the multiple revisions trying to get down to the required word count one of the most vexing tasks.

So what are you waiting for? It's immensely satisfying seeing something you've worked on in print and adding to the knowledge base. IMSANZ is encouraging advanced trainees and young fellows to undertake research with its \$10,000 research fellowship (contact the secretary for an application form), is raising awareness of published research done by general physicians through its website, and is promoting networks of general physician researchers and affiliated institutions (Table 2) who are prepared to assist members in undertaking specific research projects. We welcome suggestions as to how IMSANZ could provide more practical assistance to those wishing to add to the knowledge base of GIM.

IAN SCOTT

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APOLOGY

Regretfully there was a problem with the August newsletter design. The problem has now been fixed. Hopefully you still enjoyed the newsletter content.

Arnold Espinola, Designer

Table 1. Relative contribution by discipline to research articles submitted to IMJ for publication 2000-2003.

	Internal Med	Cardio	Endo	GE	Geriatric Med	Haem	ID	Renal	Neurol	Resp	Total
No articles (%)	14 (4%)	37 (11%)	27 (8%)	17 (5%)	16 (5%)	32 (9%)	29 (9%)	17 (5%)	29 (9%)	18 (5%)	341 (100%)
No fellows (%)	405 (13%)	531 (18%)	235 (8%)	373 (12%)	183 (6%)	177 (6%)	114 (4%)	162 (5%)	249 (8%)	252 (8%)	3027 (100%)

Data on articles kindly supplied by Virginia Savickis, editorial manager, IMJ

Data on numbers of fellows obtained from: Dent O. Clinical workforce in Internal Medicine and Paediatrics in Australasia, 2003. RACP, May 2004.

Cardio=Cardiology; Endo=Endocrinology; GE=Gastroenterology; Haem=Haematology; ID=Infectious Disease; Neurol=Neurology; Resp=Respiratory Medicine.



27th WORLD CONGRESS IN INTERNAL MEDICINE

26th September – 1st October 2004

The 27th World Congress in Internal Medicine was held in Granada, Spain from September 26 to October 1, 2004, and was hosted by the Spanish Society of Internal Medicine (SEMI - Sociedad Espanola de Medicina Interna), in conjunction with the International Society of Internal Medicine (ISIM), and the American College of Physicians - American Society of Internal Medicine (ACP-ASIM). Professor Blas Gil Extremera (Granada), was President of the Organising Committee

Nearly 3,500 physicians attended the Congress. There were 28 plenary sessions, 8 update sessions, 10 lectures, and 2 satellite sessions. There were 1290 Posters and Abstracts, and 286 oral presentations covering all aspects of Internal Medicine presented over the five days of the meeting.

Dr Alex Fisher, Department of Geriatric Medicine, Canberra Hospital presented the paper "Altered blood pressure homeostasis in older people in residential care: types, prevalence, relation to medications and falls" on behalf of A A Fisher, D G LeCouteur, M W Davis, A J McLean and M M Budge. They were awarded the prize for the Best Oral Presentation for the Congress and received a generous prize. Congratulations to Dr Alex Fisher and his colleagues.

There was a well organised social program which included the Opening Reception, tours of the Alhambra palace in the evening, and the Closure Dinner at the 'Palacio del Caprichio' attended by over 2,400 delegates and partners

The RACP/IMSANZ Bid Committee, consisting of Prof Napier Thomson, A/Prof Geoffrey Metz and Dr Leslie Bolitho, in conjunction with Caroline Thompson (Melbourne Convention and Visitors Bureau, the Melbourne Exhibition and Convention Centre) and Mr David Buckingham (Agent-General, London for the Victorian Government) was successful in the submission to hold the 30th ICIM in Melbourne, Australia from March 20-25, 2010 despite stiff competition from Turkey and Chile. We look forward to working with the College to produce a stimulating, challenging and 'International' Congress in 2010.

DR LESLIE E BOLITHO
IMSANZ
Wangaratta, October 2004

(From Page 8)

Table 2. Examples of research organisations or programs involving general physicians.

Organisation	Contact Person	Contact Details
Clinical Services Evaluation Unit Princess Alexandra Hospital, Brisbane, QLD	A/Prof Ian Scott (Director)	Tel: (07) 3240 7355 Fax: (07) 3240 7131 ian_scott@health.qld.gov.au
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Clinical Epidemiology and Health Care Evaluation Unit Royal Melbourne Hospital, Melbourne, VIC	Dr Peter Greenberg (EBM Project Director)	Tel: (03) 9342 7459 Fax: (03) 9342 8082 Peter.Greenberg@mh.org.au
Australian Centre for Evidence-based Clinical Practice, Flinders Medical Centre, Adelaide, SA	Prof Paddy Phillips (Director)	Tel: (08) 8204 6061 Fax: (08) 8204 5268 Paddy.Phillips@flinders.edu.au
Department of Medicine University of Auckland, NZ – Involvement in systematic reviews	A/Prof Phillipa Poole	Tel: 64-9-373 7599 Fax: 64-9-373 7555 p.poole@auckland.ac.nz
Mood Disorders Research Foundation Perth, WA	A/Prof Simon Dimmitt	Tel: (08) 9224 1474 Fax: (08) 9224 1477 sdimmitt@bigpond.com
Cunningham Centre for Rural and Remote Health Research Toowoomba, QLD	Dr Peter Nolan	Tel: (07) 4688 5482 Fax (07) 4688 5481 Nolan8@bigpond.com.au

Improving access to specialist medical services in rural and outer metropolitan Australia

Recently, the National Rural Health Policy (NRHP) Subcommittee of the Australian Health Ministers Advisory Council (AHMAC) released a discussion paper "Improving access to specialist services in rural Australia."¹ Production of this report was recommended during the course of the 2004-2006 Health Care Agreements, based on the concern that inadequate access to specialist services in rural and remote areas may result in poorer health outcomes due to missed detection or delayed treatment of serious and chronic conditions. Representatives from IMSANZ assisted in the drafting of this paper, which encapsulates a call to Australian health ministers for new models of general specialist training and service delivery. Below is an abridged version, with emphasis (in bold) on aspects relevant to general physicians, which I hope will stimulate further discussion and feedback from our readers. Please forward your comments to Prof Rick McLean, Chair, RACP Rural Taskforce, or the IMSANZ members of the Taskforce: Les Bolitho, Grant Phelps and Bob Ziffer.

Ian Scott

The common issues

The available evidence points to a serious and continuing shortfall of medical specialists in rural areas and, increasingly, outer metropolitan sites. Indigenous communities and remote areas experience the largest gap between health need and available services.

The absence of strategic plans for the provision of specialist services in most jurisdictions, the disjointed response through Commonwealth, State and Territory funded programs to address issues of access to specialist services, and the absence of any workforce planning on the part of the Medical Colleges leads to a perplexing series of initiatives without clear direction, goal or coordination.

The lack of clear responsibility by any one agency for the ongoing supply of Australian graduate specialists and linking of workforce with demand and need, and the ongoing growth of subspecialisation, point to a continuation of shortages in rural and outer metropolitan areas and reliance on overseas trained specialists into the future. While these issues are on the agenda of the Medical Colleges, little progress is being achieved. In particular, the demand for more 'generalist' specialists is at odds with the predominant emphasis on the part of Colleges and metropolitan hospitals to produce subspecialists.

The attitude of metropolitan tertiary hospitals to their responsibilities for clinical support for rural areas and backup for the fragile rural specialist workforce is at best variable and often limited to fly in fly out services. Their role is crucial to improving access to and availability of rural specialists as the rural health services are unable to address the issues in isolation.

In improving access to specialist services there is considerable consensus and commitment amongst the State and Australian government representatives on the actions required. The difficulty will lie in implementation and particularly the approaches to integrate the respective government funding and programs.

Preferred model for specialist service provision

•There was consensus support for a focus on a strengthened resident specialist service based on "**hub and spoke**" or "**networked**" service delivery. In general, the model focuses on having a full range of core specialties in a rural area of 20,000 to 50,000 population including Medicine.

The "hub" population may vary with the degree of remoteness, with some towns of less than 20,000 developed as "hubs". The need for specialists will be influenced by the availability of, and policy towards, procedural general practitioners (GPs). The intent of the model is that resident specialists based in regional centres (population 50,000 or more) will be the primary source for outreach services and be supplemented by visiting subspecialists. As the size of the population served extends beyond 20,000, some subspecialties become increasingly viable, and at a population of 50,000 a full range of subspecialty clinical practice is possible. The associated clinical service levels can be considered in terms of the approximate population base, although proximity to other towns and community morbidity will lead to variations.

Core resident specialist services

Agreement around the most appropriate service model is important in order to harness effort and direct resources. Recruitment of resident and visiting specialists has not been coordinated or integrated with an overall service model for rural and outer metropolitan areas. The absence of strategic management of specialist services has placed regional managers in a difficult position in determining priorities and has led to inequities in the access to specialist services.

In providing core resident specialist services (eg general internal medicine), it is generally accepted that **sustainable specialist services require a minimum of 2 but preferably 3 general physicians**. However, there is widespread support for an after hours roster that is no more than one in four. The relative numbers needed will depend on the availability of procedural GPs (including those in rural sites maintaining their skills in hospital care allowing the specialist to operate as a true consultant), nurses with special skills and allied health professionals. It is clear however that no rural or regional area would be able to support sufficient specialists to maintain such a rostering arrangement unless the **majority of subspecialists in regional areas contribute to a general specialist roster**. [This in turn has training and credentialing implications-IS].

Outreach and regional specialist services

The way in which outreach and regional specialist services are provided will vary depending on the specialty and local circumstances. For general physicians, clinics in surrounding towns may be appropriate. In some specialties, such as geriatrics and mental health, a regional multidisciplinary service may be more appropriate than outreach visits by a solo specialist. Given the increasing prevalence of patients with multiple medical problems including diabetes, cardiovascular disease, obesity and renal disease, a regional vascular service may also be appropriate.

Such regional services need to be multidisciplinary and have a preventive and early intervention role, in addition to a therapeutic one, and to work closely with resident health professionals. In general, such a role is not compatible with a private medical specialist dependent on Medicare fee for service reimbursement and requires salaried specialists or at least sessional payments.

Relationship between rural services and metropolitan specialists

In the ideal model, **specialist outreach services from metropolitan hospitals should only be provided to the larger centres in which resident specialists are based**, allowing resident specialists to provide services within their catchment area. Resident specialists should be closely involved with the planning and implementation of any visits by specialists from metropolitan areas. Much of the criticism of metropolitan subspecialists visiting small towns - as private clinics or funded through the Medical Specialist Outreach Assistance Program [MSOAP] as fly-in, fly-out services - is that this is associated with by-passing of resident general specialists in the larger regional centres who inevitably have ongoing responsibility for continuing care of patients when problems develop after metropolitan specialists have returned to the city. Resident specialists are also concerned at the de-skilling that such activities contribute to. There is an argument for considering on a case-by-case basis whether **access to visiting subspecialists should be restricted to referrals from resident general specialists**.

The role of metropolitan specialists in supporting new models of rural specialist training and service delivery

The demand for specialists outstrips the supply of doctors. There are now over 400 more advanced training specialist posts than there are Australian medical graduates. The number of training posts has increased by 28% in the past 6 years, but the number of graduates has remained relatively constant. Despite these increases, only 5% of physician trainees are training in general medicine and a further 5% are training in geriatrics. Only 3% of advanced physician training positions are reported in rural areas. By comparison, **40% of physician trainees in New Zealand are training in general medicine, with many also undertaking subspecialty training with dual certification**. One reason for this is that the Health Boards in New Zealand recognise the importance of general medicine in cost-effective service delivery and **general medical expertise is recognised as a positive attribute in securing hospital positions**.

The forces favouring the growth of metropolitan subspecialists at the expense of rural generalists are multiple: increasing subspecialisation, concerns about safe working hours, increasing feminisation of the medical workforce, lifestyle choices, issues around schooling, spouse occupation, and concerns about being unable to re-enter the metropolitan workforce in later years.² This has led to an increasing dependence on overseas trained doctors (OTDs) in rural and regional areas. Other western countries are experiencing similar demands and Australia is now competing with these other countries in recruiting such persons.

It is generally acknowledged that a positive rural experience during training assists in a decision to enter rural practice.

While most specialist colleges have attempted to establish and fund some rural and regional specialist training posts, they are few in number. Also, the growth in numbers of metropolitan subspecialist training posts has depleted the available pool of trainees, and metropolitan hospitals in turn have withdrawn a number of rural rotations because of vacancies within their own ranks. In addition, many rural centres do not have the critical mass of specialists required for accreditation for training. An added complication results from increased dependency of rural areas on overseas trained specialists, who, if not recognised by the Australian college, are unlikely to be approved as supervisors.

City based specialists are in a position to make a major contribution to provision of specialist care in rural areas through their influence on the career patterns of younger medical graduates, their expressions of support for generalist specialists, and their control over access to subspecialty training posts on the part of trainees wishing to pursue a generalist career in rural areas.³

It is critically important to the future of Australian health care that **the Universities, teaching hospitals and Colleges which embrace the concepts of excellence accept the challenge to extend their responsibility for such excellence beyond the limits of the city**, and to understand that different models of physician training and service provision will be required if this is to be achieved.

New models of service provision

New models of service provision establishing more formal networks between metropolitan and outer metropolitan/rural areas need to be considered in addition to the traditional 'fly in-fly out' model. Although the nature of the networks will depend on the organisational structure of the services provided through the state health departments, they should, where possible, build on the links established by the creation of the Rural Clinical Schools and University Departments of Rural Health, through which 25% of medical students from each metropolitan medical school are required to undertake 50% of their clinical training in rural medicine. The links between the University medical schools and the metropolitan tertiary referral hospitals are already well established.

Examples of the new models are:

1. Agreements to assist with provision of specialist services based on hospital or university departments rather than individuals:
 - The tertiary hospital department recruits an additional specialist and each member of the department rotates to the rural area for periods of up to one year.
 - For specialties in which full time 24 hour cover is not required, the tertiary hospital department agrees to provide a regular outreach service for a number of days per week or month as required.
 - The tertiary hospitals/Universities support and staff a rural/remote department in a particular specialty.

2. Longer periods of outreach visits in which the visiting specialist may:

- Contribute to student supervision and training.
- Undertake a locum for the rural specialist either for leave or for continuing education.
- Undertake an exchange with the rural specialist to enable him/her to augment their skills in a metropolitan hospital.
- Undertake a practice review for rural specialists (an activity supported in the CPD programs of most specialist colleges).

3. Cross appointments of all rural specialists to tertiary hospitals to facilitate participation in CPD activities, opportunities for rural specialists to spend several weeks every two or three years in a tertiary hospital, and professional liaison either by telephone, videoconferencing or personal attendance.

4. A more coordinated approach to selection of advanced trainees and to accreditation of rural training posts to ensure that an appropriate proportion of trainees selected for advanced training are those with an interest in rural training and practice, and that rural training opportunities are not withdrawn when city vacancies occur.

5. Formal, co-ordinated regional efforts involving college, rural clinical schools and local specialists in setting up schemes for recruiting and training specialist trainees in rural practice.⁴

All of these initiatives have occurred informally at different locations and different times. Some have been more successful than others and sustainability can be a problem when the initiative has been introduced informally. These initiatives could be supported by funding currently available through different state and Commonwealth programs that at present operate independently rather than as components of an integrated strategy. These include the federally funded MSOAP, the Support Scheme for Rural Specialists (SSRS), and the Advanced Specialist Training Posts (jointly funded with the states).

Potential barriers

The barriers to new models of care are probably not predominantly those of funding. However, the chronic inability to recruit staff has led to reductions in the budgets of many rural health services. If rural residents were to gain access to specialists comparable to that of city residents, costs would inevitably increase. With the increasing tendency to salaried positions, this increase would be felt largely by State and Territory governments.

The commitment of the metropolitan hospitals however may be the most difficult to obtain. However, many medical schools, colleges and tertiary referral hospitals already have substantial commitments to assist development in overseas countries. Such initiatives are professionally stimulating and can be financially rewarding for the institution. It would be unfortunate if similar commitments could not be obtained to improving the health of rural and remote Australians. At the same time, the creation of the rural clinical schools has considerably reduced the teaching load but not the budgets of the metropolitan clinical schools, and it may be reasonable to ask for some assistance with teaching in return.

A further problem is the degree of specialisation in the tertiary hospitals, which has resulted in many specialists being fearful of undertaking the more general work required in rural areas without the range of diagnostic and clinical support available in the cities. However, **a swing back to promoting generalist skills** in tertiary hospitals will become more necessary to meet the needs of an ageing population with increasing incidence of co-morbidity, accelerated further by workforce shortages and economic pressures.

Workforce Planning and Distribution

Initiatives required to ensure adequate training of specialists able to meet the health needs of residents of rural, regional and outer metropolitan Australia will include:

- **Maintenance or re-establishment of general specialist units in tertiary hospitals.**
- **Requirements for subspecialists to maintain generalist skills and contribute to care of patients from outside their subspecialty.**
- **Opportunities for general specialty trainees to be exposed to emergency departments and intensive care units,** and to rotate through subspecialty units to gain skills in the management of acutely ill patients to prepare them for practice in areas with insufficient populations to support units fully staffed by specialists in those fields.
- **Creation of salaried positions with academic responsibilities in teaching and research for generalist specialists** in metropolitan and regional hospitals.
- **More appropriate triaging and referral of patients to subspecialists.**
- **Review of financial incentives and Medicare rebates** that disproportionately reward procedural specialists in comparison with non-procedural specialists such as general physicians and geriatricians.

Conclusion

There is considerable consensus amongst jurisdictions on the most effective and sustainable model that will improve access to specialist services in rural Australia.

Agreement on a model will assist to:

- integrate and coordinate the direction of specialist support programs
- provide a basis for engagement with Medical Colleges on supply
- provide a basis for engagement with tertiary hospitals on clinical support required
- form a foundation for strategic service planning
- structure services to address special needs of remote and indigenous communities.

AHMAC Rural Health Policy Sub-committee

April, 2004

One of the “joys” of working in a country like Fiji is coming to terms with the lack of resources. One’s initial response is horror – how can you treat patients only with the drugs on an Essential Drug List which is just that? Most new drugs are simply not available.

Having commenced life as a clinical pharmacologist as well as a general physician, and having chaired the Drug and Therapeutics committee at the Royal Melbourne Hospital for more years than I care to remember, I am very familiar with the evaluation of drugs, and sympathetic to the need to limit drug availability on financial grounds. However I have not had the experience previously of treating patients from such a restricted drug list.

The Fijian Essential Drug List (EDL) is like the Australian PBS in its function to limit prescribing. If a drug isn’t on the EDL, then you basically can’t prescribe it, as most patients cannot afford the full cost of the drug as purchased from a pharmacy. But the EDL is much more restricted than the PBS. It usually only contains one or two representatives from each drug group; for example, only one ACE inhibitor (enalapril), one H2 antagonist (ranitidine), two beta-blockers (propranolol and atenolol), and two NSAID (indomethacin and ibuprofen). Most are purchased as generics from India or Malaysia, and all must meet basic pharmaceutical standards. The EDL contains virtually no drug less than twenty years old because drugs still under patent are unaffordable. So there are no statins, COX2 inhibitors, angiotensin II receptor antagonists, long acting beta2 agonists, and no low molecular weight heparins, just to name a few.

So how handicapped do we feel in our care of patients by not having access to all these new drugs? The answer is remarkably little. There are undoubted problems – for instance the lack of a statin clearly disadvantages patients who have had a myocardial infarct or a stroke, and we see some patients with severe gastro-oesophageal reflux who are unresponsive to ranitidine and might be improved with a proton pump inhibitor- although the individual disadvantage seems relatively small when one considers the huge extra costs that would be involved if patented drugs were to be widely used. We learn to use the drugs that are available and usually in lower doses to avoid side effects.

Our lack of a sense of handicap sets one thinking about how necessary are the drugs introduced over the last twenty years.

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(From Page 12)

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Should our faith in the whole pharmaceutical industrial enterprise – the faith that we have the ability to create really useful new drugs – be seriously questioned? In other words, are we reaching (or have we already reached) the end of the road in our ability to usefully and safely chemically manipulate the human body?

There are important questions that arise if our faith in our ability to create useful new drugs is discarded: for instance, should we still have such a strong patent system?; should we continue to subsidize drugs on the PBS?

I have often wondered at the apparent equanimity of economists in accepting the patent system which so radically distorts markets. One would have thought that the proponents of the “free market” would more loudly question awarding a monopoly to manufacturers of new drugs who can then charge whatever they think the market can bear. No doubt it is a reflection of the strength of our faith in the need for new drugs that the argument that drug innovation needs protection against competition holds such strong sway.

The original basis of the PBS was to make available new drugs that were essential, but unaffordable, to most Australians. But if the expensive new drugs aren’t essential, why should they be subsidized? Few truly useful drugs have been developed in the last 20 years, and unless new products are developed which have a clear advantage and are able to withstand market forces, the patent system should be either abandoned or at least modified.

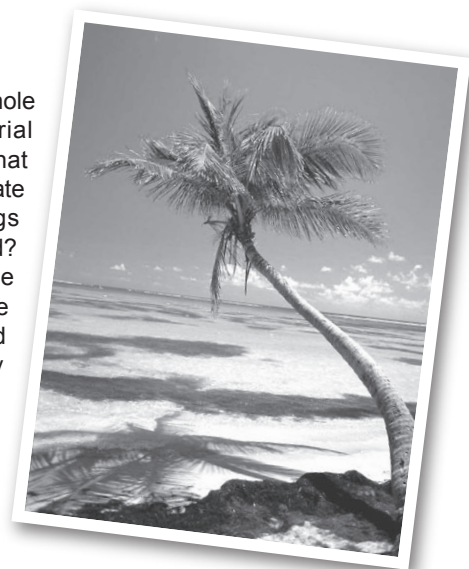
One could argue that a new drug must be shown to be cost-effective to obtain PBS listing, so that takes care of whether or not it is “useful”. However, in cost-effectiveness studies the new treatment is compared to treatments currently available, most of which themselves haven’t ever been shown to be cost-effective. So comparative cost-effectiveness doesn’t necessarily mean the new drug is useful.

Perhaps we should be limiting patent protection to innovative new agents, and only subsidize on the PBS drugs judged essential. But what government would have the strength to stand up to the combined force of the pharmaceutical industry and the medical profession?

So undoubtedly my observation that our lack of access here in Fiji to new drugs doesn’t seem to badly handicap us in our care of patients will remain just that – an observation. However I hope it at least stimulates thought on our attitudes to new drugs and how much we should pay for them.

From your Pacific correspondent,

ROB MOULDS





2005	April	American College of Physicians - Annual Session 2005 <i>14th - 16th April ~ San Francisco, USA</i> For further information visit: www.acponline.org/cme/as/2005/index.html
	May	RACP Annual Scientific Meeting <i>8th - 11th May ~ Wellington, New Zealand</i> For further information visit: www.racp.edu.aum Society of General Internal Medicine 28th Annual Scientific Meeting <i>11th - 14th May ~ New Orleans, USA</i> Visit the website: www.sгим.org/am/index.htm
	September	IMSANZ Annual Scientific Meeting 2005 <i>1st - 4th September ~ Alice Springs, Northern Territory</i> Email: imsanz@racp.edu.au
	November	Annual Scientific Meeting of the Canadian Society of Internal Medicine <i>2nd - 6th November ~ Marriott Eaton Centre, Toronto, Canada</i> Information: Canadian Society of Internal Medicine Website: http://csim.medical.org 774 Echo Drive Ottawa, ON K1S 5N8 Tel: 613-730-6244 Fax: 613-730-1116 Email: csim@rcpsc.edu

MORE (McMaster Online Rating of Evidence) Project

Other IMSANZ members might consider involvement in this "Clinical Relevance On-line Rating System", developed by the McMaster University Health Information Research Unit.

"Sentinel Readers" are emailed carefully selected recent publications to rate for both their relevance to clinical practice and for their newsworthiness. Ratings are collated and used to choose and develop evidence based materials tailored to the interests of practising clinicians.

"Sentinel Readers" also benefit directly by receiving current publications as often as they choose, by seeing the ratings and comments of their peers and by having access to highly rated "Stellar Articles".

For us this project has been educational, interesting and enjoyable.

Further details of the MORE project are available at <http://hiru.mcmaster.ca/more>.

Peter Greenberg (Melbourne)

Ian Scott (Brisbane)



NOTICE TO MEMBERS

Could you please ensure that your contact details, including email, are up-to-date.
If your details have changed, please complete this form and return to:

**145 Macquarie Street
SYDNEY NSW 2000**

Fax: +61 2 9247 7214

Or email your details to imsanz@racp.edu.au

PLEASE PRINT.

Full Name: _____

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New Address: _____

Phone: () _____

Fax: () _____

Email: _____

Specialty Interests: _____

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 is now published three times a year
- in April, August 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 Mary Fitzgerald, IMSANZ secretary.

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

Submissions should be sent to:

Michele Levinson - michelel@bigpond.net.au

Should you wish to mail a disk please do so on a CD.

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