



IMSANZ

INTERNAL MEDICINE SOCIETY of Australia & New Zealand

APRIL 2005

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From the President...

Dear IMSANZ Member,

This will be my last letter as president and with it inevitably comes some reflections on the path the society has travelled during the last 2 years, and also on the path that we may choose to follow in the future.

Looking Back

It is with great satisfaction that, with assistance from IMSANZ Council and many of our members, we have made a number of great ideas a reality. Those that have given me most pleasure as President were as follows:

Rise in trainee membership

We have witnessed growing numbers of physician trainees who have become associate members of IMSANZ and who, in joining up, are acknowledging their interest and commitment to a career in general medicine. From December 2002 to 2004, the numbers of associate members rose from 18 to 50, a 250% increase. To these fine young folk I bid welcome and congratulations and hope that your association with IMSANZ is meeting your needs as professionals, that you continue to remain as full members, and that some of you will come to seek a position on council and give of your talents and energy to advancing the practice of general medicine.

New young faces on council

There has been an injection of fresh young blood into council affairs with the election of advanced trainees and fellows such as Leonie Callaway, Patrick Gladding, Nicole Hancock, Christian de Chanéet, Peter Nolan and Alasdair MacDonald. Having such articulate, innovative minds sitting on council and participating in various committees and forums has strengthened our standing in the eyes of the upcoming generation of physicians, and imparted vigour and a fresh outlook on many of the resolutions we have adopted across a range of policy areas.

Creating a directory of advanced training positions in GIM

We now have a listing of many (if not most) of the training positions available to advanced trainees in hospitals throughout Australia and New Zealand. Each listing contains information on the clinical schedules, staffing, CPD resources, specialty exposure and environmental attractions that the position has to offer, as well as contact details of the local general physician if further information is required. Data from the recent accreditation survey of advanced training sites in general medicine, conducted by the SAC in General Medicine, will be used to complement the information which will appear in the 2005 version of the directory to be released on CD at the May ASM in Wellington. At previous ASMs

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these CDs have been snapped up by trainees within the first few days.

Formulating our own training curriculum:

The production of a training curriculum for trainees wishing to specialise in general internal medicine represents a milestone in our history. We now have a document which clearly specifies the qualities and skills that are required of a competent

general physician which can be used to inform the reforms in training and assessment of general trainees that are being undertaken as part of the college's Education Strategy. While this Strategy has its detractors (some of whose criticisms I share and would like the college to address), the opportunities it has given us to have a fundamental say in how general physicians should be trained have been invaluable. The potential to further refine and embed this curriculum within the training program will be enhanced by ongoing involvement of a number of IMSANZ councillors in the various working groups of the Implementation Action Group, as detailed in the article by Phillippa Poole, Chair of the IMSANZ Curriculum Writing Group, in this issue.

Establishing Research Fellowships

I was very pleased to see Council, on February 12 this year, endorse the recommendation that Dr Alison Mudge, advanced trainee in general medicine at the Royal Brisbane and Women's Hospital in Brisbane, be awarded the 2005 IMSANZ Research Fellowship worth \$10,000 (see profile this issue). This award recognises young members who are pursuing postgraduate studies in health services research, clinical epidemiology or quality improvement science. There is no doubt that healthcare systems around the world have increasing need of clinicians who are skilled not only in the clinical management of individual patients but who are also able to identify and realise system changes in healthcare delivery that produce better patient outcomes combined with efficient use of limited resources. International experience clearly shows that it is generalist physicians who have taken the lead in this new area of thinking, and it is important that IMSANZ promotes such endeavours in this region of the world.

Creating a long term vision for strengthening GIM training and practice

The long awaited IMSANZ position statement "Restoring the Balance: An Action Plan for Ensuring the Equitable Delivery of Specialist Services in General Internal Medicine in Australia and New Zealand 2005-2008" is to be discussed at the April meeting of the Adult Medicine Division Committee (AMDC) of the RACP, and will be publicly launched at our AGM in Wellington. This is a major development in that IMSANZ has put together a blueprint, with explicit timelines, for the achievement of a number of key reforms in regards to upgrading general medicine units in teaching hospitals, reforming the training program, improving general medicine services and training opportunities in regional and rural areas, and advocating for better remuneration in private practice. Importantly, feedback was sought on an earlier draft of this document from all members of IMSANZ that we were able to contact via e-mail, and thus the final document reflects the views of the large majority of our membership. I thank those members

who provided substantive comments on earlier drafts. A number of strategies listed in the document have already been activated and a progress report, together with feedback from the AMDC meeting, will feature in the September newsletter.

Undertaking continuing professional development activities

IMSANZ has developed a strong profile in organising scientific meetings and other forms of CPD for its members as well as for much of the fellowship in general.

RACP ASM: The 2003 and 2004 RACP ASMs for which we organised much of the Adult Medicine scientific program were successful in terms of both overall attendance and profit-raising for the college. However, despite this, we were aware that less than a fifth of our own members were regular attendees, IMSANZ had lost its own identity within the program (the IMSANZ days that used to be held just prior to the RACP ASM were highly popular), the opportunity to generate income for the Society had been foregone, and the work required of IMSANZ councillors to procure presentations from Specialty Societies for the RACP ASM was becoming more onerous.

As a result, and in line with the thinking of the Specialties Board which questioned the aims, format, and intended audience of the RACP ASM, it was decided that IMSANZ would not formally involve itself in the organisation of future ASMs beyond May 2005 unless there was major restructuring of the meeting and IMSANZ was afforded the capacity to have its own scientific program with separate badging under the IMSANZ logo and separate registration form, with profits from the day returning to IMSANZ. At a college workshop entitled 'The Future of the RACP ASM' held on February 4, it was agreed that, subject to ratification by the Board of CPD, a new format would be trialled at the 2006 Cairns ASM which condensed the Trainees Day and Skills Day into 1½ days (to be termed Professional Skills) and allowed an IMSANZ day to be held in conjunction with a program of mixed specialties, with the whole meeting running from Saturday midday through to Tuesday afternoon. A shorter meeting was seen to be more attractive to busy physicians.

IMSANZ ASM Alice Springs September 1-4, 2005: In addition, IMSANZ has embarked on having a three day scientific meeting in Alice Springs in September to provide an educational program specifically designed to meet the needs of the general physician, particularly those practising in regional and rural areas. Registration brochures will be available to all attendees at the Wellington RACP ASM. The program features interstate and New Zealand speakers, including a number of IMSANZ members giving succinct, practical talks and workshops within their areas of special interest. It promises to be a great meeting surrounded by a unique and inspiring landscape, with many cultural and scenic attractions. Steve Brady and Diane Howard are to be congratulated on their efforts in organising the program and I encourage you to book early as the number of hotel rooms available will be limited.

CATs Library: IMSANZ is aware of its responsibility to assist our members, independently of RACP, in accessing useful resources for continuing professional development. It is with pleasure that I announce the initiation of the Critically Appraised Topics (CATs) Library which now features on our website and which is

explained, along with other CPD initiatives, in an article later in this issue. One of the most recently posted CATs is reproduced as the CAT for this newsletter. We welcome feedback from members on the usefulness of these initiatives in regards to their everyday clinical practice.

Consulting on important policy areas, documents and guidelines

One measure of the esteem in which our society and general physicians are held by the medical community, including RACP, and other professional groups is the frequency with which we have been consulted for opinion and feedback in the drafting of important policy documents and guidelines. These will be recounted in my annual report in May so I will not detail them here but suffice it to say that college bodies, other specialty societies, government health departments, and consumer support groups have all referred draft documents to our office for consideration by members of council. While such consultancies have increased our workload, they are vital to enhancing our standing as a society of expertise and advocacy. In a similar vein, IMSANZ has been invited to nominate representatives for a number of influential college committees and government advisory bodies, with many of our councillors stepping up to the mark and volunteering themselves to lend assistance. I sincerely thank them for giving of their time out of already busy schedules.

Looking Forward

The recognised need for more generalism in physician practice

In an article I wrote for RACP News last year (2004; 24: 10-11), I tried to indicate what I thought might be the skills and attributes required of a physician in the 21st century. I emphasised that all physicians regardless of specialty will come to require dedicated training in general medicine post-Part 1 examination, and which might include, in addition to exposure to a wide spectrum of clinical internal medicine, development of skills in quality and safety improvement, clinical epidemiology, outcomes analysis, health economics and team dynamics. It appears that others in the RACP agree with my sentiments and are actively engaged in developing innovative training programs that seek to impart a broad range of skills to the next generation of trainees.

The recent increases in private medical insurance premiums and the gnashing of governmental teeth on how to contain the rising cost of healthcare technology will, I have no doubt, lead to a demand from health managers and funders for specialist colleges to ensure their trainees are more enlightened on how to spend the limited health dollar more productively, prudently and with less margin for inducing harm. Procedural subspecialties in particular are going to have to take a good hard look at themselves but it will apply to all of us to some degree. Better ways of providing care for chronically ill people will require different models of care compared to those we have now, with less emphasis on drugs and devices, and more on multidisciplinary programs, patient self-management and community support.

Reconciling tensions between research evidence, real-world effectiveness, affordability and equity of care will become an increasingly pressing need which we will no longer be able to

regard as simply a bothersome intrusion in the way we prefer to care for individual patients in our everyday clinical practice. Growing inequities in the quality and adequacy of specialist care between urban and rural/remote communities, between the well-off and those that are disadvantaged, between large tertiary hospitals and smaller regional hospitals, and between public and privately insured patients will command proactive responses from professional societies and colleges as such inequities will no longer be tolerated by government or the public at large.

The solutions to many of these problems will come from physicians who can think broad-mindedly about systems of care, can appreciate the total health needs of different populations, and can place the results of clinical trials in a proper and balanced perspective. These attributes are the hallmark of the generalist and it is the discipline of general medicine that is best suited to fostering these skills in the next generation of practising physicians. The two 'Innovation' articles in this issue are a further testament to the drive and originality of general physicians when faced with difficult situations.

Towards a global movement in general internal medicine

Ours is not the only healthcare system in the world that is having to confront the challenges outlined above. These problems are common to all western societies and there is a growing international recognition of the need for less subspecialisation and fragmentation of care with its attendant costs, and instead a more integrated, patient-centred care continuum which gives equal emphasis to prevention and maintenance care as it does to care of acute illness.

It is therefore not surprising that societies of general internal medicine around the world have realised the synergy and force that could be used to advance our discipline if we were to come together and form a global network in which we could share insights and experiences, collaborate in training and research activities, and assist each other in lobbying our subspecialty colleagues and governments for more recognition and support. I am looking forward to meeting Eric Larson, regent of the American College of Physicians, when he gives his talk on the future of generalism at the Wellington ASM, knowing that in the US the debate on how to reinvigorate general medicine practice has become a national obsession at all levels – university, college, government, health plans and the public.

Similarly, I was very happy to accept the invitation from the US Society of General Internal Medicine (SGIM) to attend and speak at their May 2005 annual scientific meeting in New Orleans in a special session titled "The Globalisation of Internal Medicine." This will give me an opportunity to describe the Australasian GIM experience and compare our situation with what exists in other countries. Peter Greenberg has co-authored an article which is to be published in the SGIM's Journal of General Internal Medicine later this year which summarises the Antipodean system of specialist care in GIM. The organisers of the meeting are keen to formally convene a global network of GIM societies and an international congress of GIM societies is mooted for 2010. With the ICIM meeting now confirmed for Melbourne the same year, encouraging our colleagues elsewhere in the world to join us for a gathering of GIM societies 'Down Under' would make 2010 a great year for us. I will be doing everything I can to spread this idea and to offer our assistance in organising this meeting.

ANNUAL GENERAL MEETING

of the

INTERNAL MEDICINE SOCIETY OF AUSTRALIA AND NEW ZEALAND

to be held in the

Ilott Theatre, Wellington Convention Centre

111 Wakefield Street, Wellington NZ

on

Monday, 9th May 2005 at 7.30 am

Strengthening our ties with other 'generalist' professional bodies

I have written in the past of the benefits that may come from strength in numbers – collaborating with other professional groups with whom we share interfaces in both clinical practice and health policy areas. General practitioners refer us outpatients and care for the patients we discharge to them, emergency physicians refer us acute inpatients, intensive care physicians and geriatricians consult with us on the sub-acute care of particular populations of patients. All these folk share a common characteristic – they have to manage patients in their totality, not just from the perspective of an organ-system. We need to actively reach out and forge alliances with them in redesigning processes and systems of care so that, together, we enhance the effectiveness and efficiency of the work we share in common.

John Henley from Auckland has, in previous newsletters, provided great examples of successful collaboration between internal medicine and emergency medicine at Auckland City Hospital; in the last newsletter, Dr Skronowski, an intensivist at St George Hospital, eloquently wrote on the need for more general physicians to whom he and his colleagues can refer stable but still very sick patients with multiple organ-system problems who are ready for discharge from ICU; the RACP executive is convening a multilateral meeting involving representatives from emergency medicine, intensive care medicine and IMSANZ to discuss ways for improving the 'patient journey' from admission to discharge; and a combined scientific meeting between IMSANZ and the Australian Society of Geriatric Medicine is being planned for 2007 in Adelaide, complementing frequent high-level talks between office-holders in both societies. In my own hospital, as a further example of collaboration, the departments of emergency medicine, internal medicine and geriatric medicine have been unified as a single administrative division, with subspecialty divisions linking in to this core axis. The Brisbane Cardiac Consortium Clinical Support Systems Program involved a close partnership between hospital departments of internal medicine and divisions of general practice which proved successful in optimising quality of both in-hospital and post-hospital care of patients with cardiac problems. These sorts of partnerships will become more necessary and urgent in the future, particularly if the idea of a unified, single-payer healthcare system, under the jurisdiction of either the commonwealth or the states, becomes a real possibility when John Howard's Liberal Party gains control of both houses of parliament in July.

Letting our Kiwi colleagues show us the way

Australia and New Zealand seem to have a love-hate relationship when it comes to football, cricket and politics. However, when it comes to IMSANZ and general physicians, there is nothing but mutual support and goodwill. My observations have led me to conclude that, overall, the practice of general medicine in NZ is stronger and more established than it is in Australia. Why? Because outside the one large metropolis of Auckland, the population is evenly spread out in a large number of regional centres in which general physicians have always provided the bulk of specialist care, have run the hospital medical departments, have received academic support from universities, and have influenced the planning of health services. Also, a greater proportion of advanced trainees in NZ have always chosen general medicine as their specialty and have undertaken dual training and registration (more than half compared to about a third of Australian advanced trainees in general medicine). This gives our NZ trainees greater dexterity and self-sufficiency as general physicians in meeting the needs of regional communities. As well, IMSANZ in NZ runs a diversified program of CPD with at least two general medical meetings each year, together with a combined NZ RACP/IMSANZ meeting (which is in addition to the RACP-ASM usually held in Australia). The camaraderie which I have witnessed between IMSANZ and the other Special Societies in NZ seems to me to be of a higher intensity than that I have experienced in Australia. It seems that the practice of general medicine on this side of the Tasman could benefit from the experience of our Kiwi colleagues.

In this regard, I welcome our new president, Phillippa Poole from Auckland, who will take over on May 9 and who has been NZ Vice-president during my presidential term, and is a person I regard very highly, both professionally and personally. She has energy and vision and comes to lead IMSANZ at a time of great change and opportunity. It has been a great pleasure and honour for me to lead this society over the last 2 years, I thank my many colleagues and my family for their support and kindness, and I look forward to celebrating our collective achievements with as many of you as possible at our AGM in Wellington.

IAN SCOTT
President, IMSANZ

POSTCARD FROM MILFORD TRACK

“the finest walk in the world...”

Traversing the heart of New Zealand's wild fiord country, the Milford Track on the south-west coast of the South Island has been long described as “the finest walk in the world” leading to the eighth natural wonder of the world, Milford Sound. Having walked it with my family last January, and having done quite a few walks in different places, I totally agree.

Our journey began in Queenstown from which we travelled by bus via the township of Te Anua to the jetty at Te Anua Downs where we boarded the launch which would take us to the northern tip of Lake Te Anua. This is where the explorer Quinton McKinnon, in September 1888, set off with his companion Ernest Mitchell to build a track up the Clinton Valley which would connect the inner lakes with Milford Sound and allow access to the recently discovered and majestic Sutherland Falls, the world's fifth highest waterfall at 1904 feet. The first expedition was an abject failure: constant rain soaked them to the skin, wet all their available firewood, and caused huge river floods which washed all their provisions away. But like all good Scotsmen McKinnon was not to be deterred. He set out again a month later and this time succeeded in crossing a pass (named in his honour) which lead to the Arthur Valley, Sutherland Falls and Milford Sound. Sadly, this great explorer, in 1892, set off in a whaleboat to the head of Lake Te Anua never to be seen again. Our launch took us past his monument located on a small island in the middle of the lake.

After disembarking at the jetty we walk all of 20 minutes (1.2km) to our first hut, Glade House where afternoon tea awaits us, followed by a short nature walk to explore the surrounding area. Next day, we get into it with a 16km walk to Pompolona Lodge (named after the scones that McKinnon himself made from mutton fat candles!). Just beyond Glade House a suspension bridge (one of about 10 on the Milford Track) crosses the scenic Clinton River and leads you into dense beech forest. One mile along you come to the site of McKinnon's first hut built in 1889 and where you can see remnants of a telephone line that was once strung along the length of the track. Shortly after a circular sidetrack takes you to the Wetland Walk, a different ecosystem all together where stagnant water in a land depression sustains mosses, ferns, peat and small shrubs and where, if you were to step off the boardwalk, you would sink to your knees in soft mush.

For the next few miles the old packhorse trail is flat and wide, then it begins to climb as it enters the west branch of the Clinton Valley. Named by pioneers ‘the Valley of the Perpendicular’ it is easy to see why as the rock walls tower up to 4000 feet above you on either side. We had rain overnight which brought out numerous temporary waterfalls which added to the majesty. The track continues through the lush beech forest until interrupted by the rubble of a huge landslide which fell in the early 1980s, so large that it blocked the Clinton River and formed the lake around which the path now passes.

A stop for lunch is made at a nearby shelter opposite the Hirere Falls, after which we walk on to a clearing in the trees which gives us the first view of McKinnon Pass. A little further on we walk by Hidden Lake where a couple of our American companions strip off and go for a (very short) dip, given that the waterfalls dropping into the lake arise from melting glaciers in the mountains above. The track re-enters the beech forest and at the 9-mile peg, exits onto another open area called the Prairie which gives great



McKinnon pass

views of the permanent icefields crowning the mountain tops. Some time later after passing one of the original shelters called the Bus Stop, we arrive at Pompolona Lodge for a well earned shower and a beer.

Day 3 was the most challenging part of the walk - 15 km to Quinton Lodge up and over McKinnon Pass at 1100 feet. The trail takes us to the upper reaches of Clinton River past beautiful lakes called the Mirror and Mintaro and then, after yet another suspension bridge, as Mt Balloon rears into view, we start to climb 3 km of zigzag path up the side of the canyon. The surrounding bush is mainly grass, small bush and colourful wildflowers as repeated snow avalanches in springtime keep the area cleared of any large vegetation. An impressive view unfolds of the valley below as we head to the top of the pass. I was concerned that the fog clinging to the upper reaches would obscure our view from the pass itself but as luck or providence would have it, as we reached Nicholas Cirque at the top of Clinton Canyon the fog floated away, revealing three snow-capped rock-grey mountains which surrounded us against a backdrop of clear blue sky. There we paused at McKinnon Pass with a hot chocolate after quickly donning some fleeces, and admired the view, walked around a number of small mountain ponds (called tarns), read the inscriptions on an impressive stone memorial acknowledging the efforts of McKinnon and Mitchell, watched a mischievous alpine parrot (or kea) steal a glove and a lunch bag which were fortunately retrieved by one of the guides in hot pursuit, and gazed down the sheer drop on the opposite side of the pass to the distant lodge we would be staying in that night. Everyone says (and I agree) that the downhill section to Quinton Lodge is the hardest walking and takes a heavy toll on the knees. I felt like I grated 2mm of cartilage of all menisci and promised to engorge myself on glucosamine tablets when I got home. Using walking sticks to distribute the weight away from your joints certainly helps. However this stretch of the track also features some of the most scenic views which your arthralgia forces you to stop and appreciate. Towering rock cliffs, moss covered forest, alpine glacial fed streams and cascading waterfalls are nothing but enchanting. At the bottom of the pass we walk over the Roaring Burn swingbridge and trudge the final leg to the lodge. After a short rest we feel sufficiently re-invigorated to undertake the 1½ hour round trip to the three-tiered Sutherland Falls where, at its



Welcome!

IMSANZ would like to welcome the following New Members:

- Professor Rick McLean, Dubbo, NSW
- Dr Su Mien Yeoh, Eight Mile Plains, QLD
- Dr Michael Schoeman, North Rockhampton, QLD
- Dr Selvanayagi Ketharanathan, West Leederville WA

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

- Dr Jackie Griffith, Christchurch, NZ
- Dr Basim Nona, Palmerston North, NZ
- Dr Alasdair Patrick, Mt Eden, NZ
- Dr Tuck Yean Yong, Goodwood, SA
- Dr Jacqueline Griffith, Christchurch, NZ
- Dr Annabelle Donaldson, Kogarah, NSW
- Dr Timothy Bates, Darlington, WA

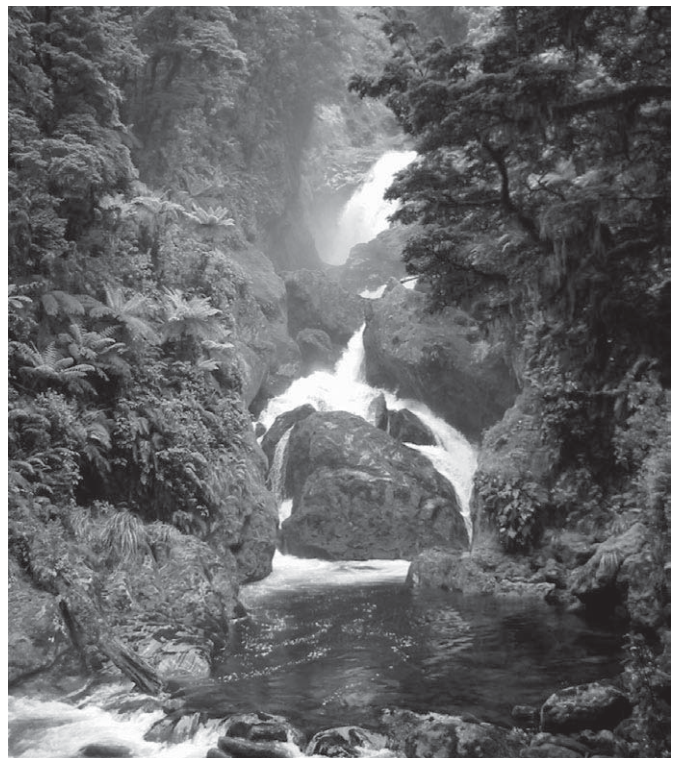
NZ Newsletter Editor

We are still seeking a New Zealand IMSANZ member to be responsible for coordinating the copy and photographs from New Zealand. You will work with the Australian Editor Michele Levinson, and have the full support of the IMSANZ Sydney office and a professional copy-editing service.

base, the swirling water vapour blasting from the point of impact soaks everything and everyone within 20 metres.

The last day sees us walking 21km to Mitre Peak Lodge at Milford Sound. Attractions include another stunning waterfall, Mackay Falls, in one of the wettest areas of NZ; Bell Rock, so named as it is a large inverted boulder whose centre was hollowed out by swirling water and into which you can crawl and then stand up inside; the beautiful Lake Ada with Mt Ada towering above on the far shore; and finally a fantastic view of Barren Peak over the Arthur River. We finish our walk at the 33 mile peg just before Sandfly Point (a misnomer as the sandflies are everywhere, not just there) where we board the ferry which takes us across Milford Sound, past Mitre Peak, to the lodge. The next day we take a boat cruise along the Sound to its exit to the sea and back to the lodge before getting on the bus that returns us to Queenstown.

We were very fortunate in having only a few hours of relatively light rain on two days of the track, which is very much the exception to the rule, with otherwise sunny skies giving us glorious vistas. Was there any downside? Sandflies could be



Mackay Falls

bothersome but a liberal dosing of "Bushman's" insect repellent to exposed skin and adherence to the dictum 'keep moving' solved this problem. As you carry your packs on your shoulders for days, we made sure we packed light and bought packs that were comfortable. All in all, the Milford Track is a fabulous walk in a pristine part of the world, and our Kiwi colleagues are very lucky to have such a place of tranquil beauty so close to home.

IAN SCOTT



NEW CPD INITIATIVE FOR IMSANZ MEMBERS

One of the prime functions of any professional society such as ours is to provide resources in continuing professional development (CPD) to its members. This function will become even more important under the restructuring envisaged by the Conjoint Committees of the RACP where more responsibility for CPD activities directed at any one specialty group will fall on the representative society. It is thus with pleasure that we announce the initiation of the IMSANZ Evidence-based Medicine Working Group (EBMWG) which aims to: 1) assist folk in staying abreast of new advances in practice across the spectrum of internal medicine; 2) provide tools and aids in appraising and interpreting the research literature and proprietary promotional material; and 3) deliver resources that can be used to teach principles and methods of evidence-based medicine to students, trainees and other health professionals.

The current EBMWG executive comprises Ian Scott (Qld), Peter Greenberg (Vic), and Paddy Phillips (SA). We hope that the executive will expand to include a member with interest and expertise in EBM from every state and territory in Australia and from both islands of New Zealand. A number of projects are planned or under way, and we invite interested members to e-mail or contact us via the IMSANZ secretary if they would like to volunteer their help in undertaking specific tasks.

Projects comprise the following:

1) Electronic CATs Library

The Need for Better CPD

While critically appraised topics (CATs) have been a regular feature of the newsletter we recognise their limitations in that only one or two can be published each issue and many are already outdated by the time of publication. In contrast, scores of articles of potential interest to general physicians appear in the literature every year. For this reason we thought a timely, selective electronic CATs Library was needed to meet the CPD needs of busy general physicians.

Introducing the new CATs Library

The CATs Library contains succinct (less than 2 page) critically appraised summaries of journal articles that have been published within the last 6 months and whose results, in the view of the Library editors, are likely to impact on the practice of most general physicians. Potentially eligible abstracts are retrieved from a weekly scan of the contents page of the latest issues of mainstream general medical journals (listed in appendix A) combined with alerts from independent journal-scanning services including Swetwise, BMJ updates, InfoPOEMS, McMaster Sentinel Articles, EBM On-line and ACP On-line. The full text article is then retrieved, appraised and, if deemed to be of high methodological quality and producing clinically applicable results, is then condensed as a structured summary with interpretative commentary (see CAT in this issue). Some of these CATs represent edited versions of Journal Club CATs produced by general medical registrars at Princess Alexandra and Royal Melbourne Hospitals.

The format is a little different from CATs previously published in the newsletter on the basis of feedback from some readers who requested an upfront bottom line message to engage their

interest, more comprehensive detail on the characteristics of the study presented in prose form, and reporting of main results as text rather than as tabulated formats. (There was also the technical problem of tables becoming corrupted as we converted from wordfile to pdf file in preparation for printing).

Where can I access the CAT Library

The CATs are posted on the IMSANZ website in the 'Resources – Members Only' section and can be viewed and downloaded as pdf files. All new postings will be notified on the IMSANZ home page under 'What's New,' and each issue of the newsletter will contain a list of all CATs that have been posted since the previous issue. At the time of printing, more than 20 CATs have been posted and it is planned to group these according to organ-system (Cardiology, Respiratory, etc). Once 12 months has elapsed from the time of article publication, CATs will be labelled 'inactive' and archived so that viewers of the Library can concentrate on summaries of recent articles and not be distracted by the presence of redundant CATs.

How can you help (and earn MOPS points) in expanding the CAT Library

But here's the rub. Producing CATs takes time and effort, and the selection of articles that go to make the CATs, if done by only a dedicated few, may be skewed by their subspecialty interests. So this is why we are seeking volunteers. The Library editors would like to invite members to volunteer for one of two tasks:

- a) to be a subspecialty editor who takes responsibility for scanning and selecting articles for conversion to a CAT within a given subspecialty area (subspecialties for which we already have a designated editor are listed in appendix B); or
- b) to be a CAT author (or reviewer) in a subspecialty of interest and to advise the subspecialty editor of articles which general physicians should be aware of but which appear in subspecialty journals not covered by our scanning process.

The proposed process for authors/reviewers would be as follows: 1) the subspecialty editor would e-mail them a selected full-text article, or a draft CAT, as a pdf file and ask them to write a CAT, or amend and/or provide a commentary on, a draft CAT, using a standardised template; 2) in order to maximise the timeliness of entries to the library, authors/reviewers would be expected to return completed work within 4 weeks of receiving it; 3) the received work would then be edited, if necessary, by the subspecialty editor before posting it on the Library; 4) a formal confirmation of the work done would be forwarded to authors/reviewers to use when submitting MOPS forms. It is envisaged that authoring a CAT will take about 45-60 minutes, and as this constitutes an active learning project, it would attract 2 credit points.

Interested? If so, then e-mail us at imsanz@racp.edu.au as to which option – subspecialty editor or author/reviewer - you wish to nominate. Please discuss this initiative with any of your colleagues who you feel may be interested in volunteering, and spread the word about how valuable a resource the Library could be for both fellows and trainees who practice general medicine, especially if they're not already an IMSANZ member.

(Continue Page 9)

We see a lot of florid disease here in Fiji. Patients tend to present late, particularly the Fijians, and I never cease to be amazed at what some patients have put up with before seeking medical attention. However I suspect the actual conditions are rather similar to those with which most IMSANZ members will be familiar – large myocardial infarcts, staphylococcal septicaemia, lobar pneumonia, pleural effusions, acute and chronic leukaemias, and strokes, just to list a few.

However there are two conditions we see reasonably frequently here with which I suspect IMSANZ members will not be so familiar – leptospirosis and amoebic liver abscesses.

My first case of leptospirosis was in 1999, soon after I had arrived for my first sojourn. I had been asked to head one of the four “teams” in the medical service straight away, which probably represented an unwarranted degree of faith by the other members of the service in my clinical abilities. However it probably more strongly showed the pressure the others were feeling, and how keen they were to share their clinical load.

I was on one of my first ward rounds, and I had been “on-take” the day before so I had quite a few new patients to see. Soon after we started the round, however, I found myself mystified by the deeply jaundiced young Fijian man lying in front of me.

He was looking a bit miserable, but certainly not very unwell, and denied any symptoms other than some rather non-specific muscle aches and pains. He had also been very healthy until just a few days before he came to the hospital.

Apart from the severe jaundice, I couldn't find anything wrong when I examined him. But it was the extraordinary biochemistry results which had me mystified. His bilirubin was sky high, but all the enzymes, including the AST, ALT and alkaline phosphatase were virtually normal – so the jaundice didn't seem to be either hepatocellular or obstructive. That was confusing enough, but even more bemusing was his creatinine, which was also very high – about 0.65 mmol/l. His haemoglobin was normal, suggesting the renal failure was acute. He clearly didn't have liver failure and didn't seem nearly sick enough to have the hepato-renal syndrome. And I just couldn't think of any condition which could cause such deep jaundice and acute renal failure in an otherwise healthy young man.

I asked if the results were definitely from this patient, or could there have been a laboratory mistake. I was assured the results were probably correct, although the registrar tactfully asked if I would like them repeated. But the registrar clearly knew the likely diagnosis, and I realized there was no point in having the tests repeated.

So I fell back on the refuge of the diagnostically destitute – I asked the students what they thought. Their eyes immediately fell to the floor, and it quickly became clear they had no intention of venturing a suggestion when their consultant so obviously didn't know himself what was the diagnosis.

At last I was rescued by the registrar - she asked if I would like her to prepare the patient for acute peritoneal dialysis (PD), because the other consultants thought the patients with leptospirosis probably did better with early dialysis rather than waiting for their creatinine to get really high.

So that's how I diagnosed my first case of “lepto”. Unfortunately he did badly. We decided to commence PD, and the next morning

he seemed reasonably well, although perhaps a bit short of breath. I couldn't hear anything in his chest, and the chest Xray taken on admission only 24 hours previously was OK, so we decided to continue dialysis and watch and wait. The registrar rang me a couple of hours to say he was much more breathless, and she'd ordered another chest Xray. I went across to see him, and couldn't believe my eyes when I saw the Xray – there was almost a total white-out of both lungs. He was severely hypoxic, and was rapidly transferred to ICU for intubation. However over the next few hours he became more and more hypoxic, despite being respired with 100% oxygen, and he arrested in the afternoon, only about 6 hours after admission to the ICU and 36 hours after admission.

I was devastated, and went through the usual soul searching about whether or not we could have done more for him. However each of the other physicians said they had had similar cases, and I couldn't see what more we could have done. Thus I learned the hard way what a horrible disease it can be, particularly when it includes massive pulmonary haemorrhage, as with this patient.

Since then, I have had quite a few cases, and a couple more patients have died. However both of them had pulmonary haemorrhage on their initial chest Xray, so we knew they were likely to do badly. I'm not really convinced that early PD makes much difference – I have certainly had several cases where I have delayed PD, and they have turned the corner with creatinines at about 0.8mmol/L. Once they open up, their creatinines fall quickly, and it's amazing how quickly they get better. Except for the jaundice, which can take ages to go away - I had one chap who was still obviously jaundiced 3 months after he had gone back to work.

The Public Health people have frequent campaigns recommending that Fijians don't walk barefoot where any animals might have urinated, and the vets are continually trying to eradicate leptospirosis from the known animal reservoirs. No doubt we would see more cases without those campaigns. However the number of cases we see is still far too many for our liking.

The story with amoebic abscesses is much happier.

The typical patient is a middle aged Fijian male, who looks for all the world as though he has a terminal malignancy. Typical patients have loss of weight, vague ill health, and usually a large liver that feels firm and possibly malignant. However the liver ultrasound is usually very suggestive of an abscess rather than a malignancy, often showing a single lesion with a hypochoic centre. Sometimes we still can't be certain if it is an abscess or a hepatocellular carcinoma, and a CT can also be difficult to interpret. In that situation, we usually treat the patient as having an amoebic abscess, and within days it is usually clear whether or not the patient is responding. And it is very gratifying to see how quickly the patients recover, going from having a possible terminal malignancy to being virtually normal in a matter of days.

We have discussed with the surgeons whether or not they should be drained. Perhaps not surprisingly, if the patients are admitted under the surgeons, which they sometimes are, they tend to be drained, whereas if they are admitted under the physicians they tend just to get metronidazole. My reading of the literature is that there is no good evidence either way to guide us, but I am

influenced a bit by one patient I had with two big abscesses, one at the front, and one at the back, of the right lobe.

I asked the surgeons to see him and, not surprisingly, they recommended drainage. However they were only able to get into one of them, so they drained that one and left the other alone. A month after metronidazole therapy, repeat CT scan showed both abscesses had markedly reduced in size, and to about the same degree. So, for what it's worth, this $n = 1$ experiment of nature suggests drainage might not make much difference. Most patients do so well with metronidazole that it's also hard to see how they could do much better with drainage.

My most interesting case was only a few weeks ago. He was a middle aged Fijian man who had been a heavy smoker, and presented with a cough, fever, weight loss and haemoptysis. The initial diagnosis seemed to rest between TB and a carcinoma, but the reporting radiologist, who is reasonably experienced, said he was confident it was simple pneumonic consolidation at the right lung base.

I was not so sure and pressed hard for a CT scan, but I must admit I was suspecting a carcinoma, and only suggested making sure we saw the liver as well as the lung to see if he had liver metastases. The radiologist was very shamefaced when he rang and told me the patient had a huge abscess in the dome of the right lobe of the liver, right up under the diaphragm, which was almost certainly amoebic.

The next morning, after we had commenced the metronidazole, I asked the patient again what the haemoptysis was like. He said it was discrete pink "blobs", so I asked if he could produce some

for us to see. He obligingly coughed, and produced what for all the world looked like a squirt of anchovy paste. So it seems he was coughing up his liver!

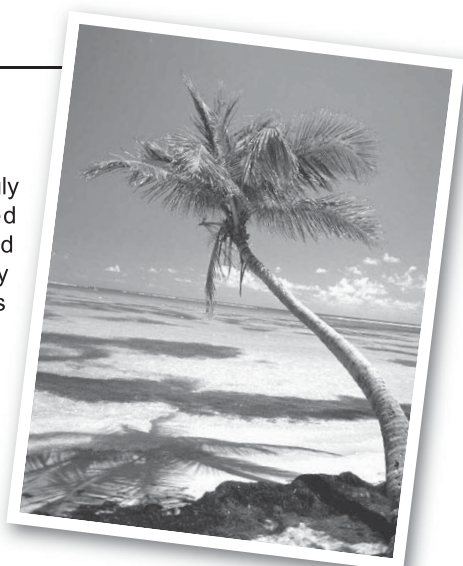
I didn't have the presence of mind to send the specimen to the laboratory, although I'm not sure what they could have looked for. And unfortunately when I brought my camera back some hours later to photograph the "haemoptysis", he could only produce a couple of small flecks of pink material.

He was so well after a couple of days of metronidazole therapy that we sent him home, and I'm looking forward to seeing the repeat Xray and CT scan in a month or so. Perhaps I should write him up as "An unusual case of haemoptysis"!

So that brings me to the end of my next letter. I hope I'm continuing to whet your appetites for something a bit different – we still need physicians up here, and I can assure you that any expressions of interest will be taken very seriously.

Vinaka vakalevu, and moce mada, from your Pacific correspondent,

ROB MOULDS



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2) Articles on Clinical Interpretation of the Literature

The EBMWG executive has commissioned a series of articles to be written on the clinical interpretation of published studies. Each article is entitled 'Cautionary tales in the clinical interpretation of: therapy trials/systematic reviews/ clinical practice guidelines/ studies of diagnostic tests/ prognostic studies/ observational studies. These are to be submitted to Internal Medicine Journal for publication and will also be posted in 'Resources section – Members only' of the IMSANZ website under 'Teaching EBP.' These articles are not simply another reincarnation of the many literature appraisal and validity guides that already exist (such as the McMaster 'Users' Guides'). Instead they focus on the pitfalls faced by practising physicians in transferring the results and conclusions of published studies to clinical practice. Each article that relates to a particular study type will illustrate a number of key concepts using recent examples from the literature. We hope that the first article that deals with therapy trials will be published in the August edition of IMJ. Stay tuned.

3) Resources for Teaching EBM

Many of us feel compelled to teach EBM to our trainees, medical students or other health professionals. But how many times have you wanted to give a lecture or workshop, or refer folk to key articles, but found it difficult to quickly put your hands on

the required material? This need is now met by the 'Teaching EBP' and 'Links to other CAT sites' sections of the 'Resources – Members only' page of the website, in which you will find a number of prepackaged powerpoint presentations, key articles (as pdf files), and links to teaching sites in EBM which will make putting a presentation or set of references together easy work. All we ask in return is that when using any of this material you acknowledge its source to your audience. We welcome contributions to this teaching resource from any member who has had positive experiences with novel ways of teaching EBM.

We hope readers are excited by this new CPD initiative and take the opportunity to become involved.

IAN SCOTT
PETER GREENBERG
PADDY PHILLIPS

- *Appendix A.* General medical journals scanned for articles for inclusion in CATs Library
 Lancet, New England Journal of Medicine, British Medical Journal, Annals of Internal Medicine, Archives of Internal Medicine, Journal of American Medical Association, Journal of General Internal Medicine, Evidence-based Medicine, ACP Journal Club, Medical Care, Canadian Medical Association Journal, Medical Journal of Australia.
- *Appendix B.* Current subspecialty editors of the CATs Library
 Ian Scott (Cardiovascular), Peter Greenberg (Endocrinology), Paddy Phillips (Renal Medicine).

IMSANZ Support For A National Heart Failure Program

The National Heart Foundation of Australia (NHFA), National Prescribing Service (NPS) and National Institute of Clinical Studies (NICS) have joined forces to improve the management of heart failure with a new national program. This program is supported by the Internal Medicine Society of Australia and New Zealand as well as the Cardiac Society of Australia and New Zealand.

The Joint Heart Failure Program is being rolled out in 2005, providing up-to-date information on the diagnosis and pharmacological management of heart failure to general practitioners, pharmacists, practice nurses and other medical specialists.

Working in partnership with 42 Divisions of General Practice, the program is being rolled out through the network of local NPS facilitators. In participating Divisions the NPS facilitators will provide educational outreach visits and interactive small group meetings for local general practitioners. It is expected that about 8000 GPs will participate in the program.

NPS facilitators are currently inviting local cardiologists and general physicians to co-facilitate small group meetings for general practitioners. The meetings will cover two key aspects of heart failure management: the role of echocardiography in diagnosis and the optimal drug use in heart failure.

Engagement of general physicians is a key component of this program. If you wish to find out more about how you can assist, please contact Judith Mackson, Education and Quality Assurance Program Manager at NPS on Tel: 02 8217 8700 or email: jmackson@nps.org.au.

NPS has developed a number of publications to support this program: NPS News 35 and Prescribing Practice Review 26 published in October 2004. These materials are available on the NPS website at www.nps.org.au/healthpro.

For further details on the program visit www.nicsl.com.au (under Projects)

IMSANZ Council NZ Vacancies

New Zealand vacancies on IMSANZ Council and NZ executive

In May, there will be vacancies for NZ members on the greater IMSANZ Council and the IMSANZ New Zealand Executive. The work involved is not large – one annual face to face meeting and several teleconferences. It is however vital that we have a broad range of committed people involved, so that we may continue the traction being gained by IMSANZ and general medicine on both sides of the Tasman. If you are thinking about it, please don't hesitate to contact me to discuss further (without obligation). Otherwise the shoulder tapping will begin in earnest! Phillippa Poole p.poole@auckland.ac.nz.



INNOVATIONS IN MANAGING DEMAND

A Regional Hospital Responds To Workforce Crisis

Nestled on the edge of the eastern highlands at 850m above sea level is the temperate town of Toowoomba renowned for its Spring garden festivals and beautiful parks. Not far from Toowoomba on the southern escarpment, one can still view the original homestead of Arthur Hoey Davis, author and son of Dad of "Dad and Dave" notoriety. It would seem that the struggles of this pioneering family continue to be reflected in the health care institution of the Darling Downs where a small band of physicians continue to strive to provide quality care to a town that seems somewhat forgotten by the administrators of our State. Like Dad and Dave, our days are full of interesting escapades with a reasonable degree of joyful camaraderie. Mostly our exposure is one of a constant stream of general medical patients referred from surrounding districts with a skeleton staff of largely overseas trained medical registrars and recent graduates of the post-graduate medical course. Unlike Dad, we don't aspire to a bumper crop or a future career in Parliament and constantly find ourselves at the call of the "bank manager" to show cause for our inordinate overtime or burgeoning budget blow-out in chemotherapy or high cost drugs.

The Department of Internal Medicine of the Toowoomba General Hospital services 7,000 outpatients, 1,800 occasions of day chemotherapy and 4,500 inpatients per year. The Department is staffed by four full-time physicians, one 0.4 Visiting Oncologist and one 0.3 VMO. Our usual complement of seven medical registrars and five junior house officers or interns barely meets our needs for equitable rosters and a reasonable after-hours duty list. In August 2004, we encountered an unexpected crisis with a sudden fall in our registrar numbers from 7 to 3. This resulted from the sudden resignation of one mature-aged overseas graduate, the lack of arrival of a seconded registrar from a tertiary centre, the inability to recruit/replace one registrar moving interstate and the resignation within five days of an overseas trained registrar who decided that his overseas holiday in Australia was under threat because of the intense workload with which he was presented. Overnight a number of strategies were required in order to salvage the Department from apoplexy. Of course, our initial call was to our tertiary support centres to determine that there was no possibility of short-term relief from their registrar pools. Unfortunately, they appeared to be in a similar situation and were not forthcoming with any significant or tangible support. Our acting director of medical services worked through the night on the internet looking for appropriate overseas recruits but none were found that would suitably fill the vacancies but of course we were competing with other centres within the State with a higher profile.

Immediate strategies were put in place to ensure that inpatient care was not compromised and to ensure that some degree of external practitioner referral could be maintained.

The drastic modifications required led to a certain degree of disharmony among the residual physicians and ultimately led to the resignation of one of our full-time associates. The importance of communication, face-to-face negotiation, light-hearted frivolity and having a cup of tea together was very much highlighted during this crisis period and reinforced the destructive effects of public hospitals closing their medical staff tea-rooms and their Friday evening free kegs.

An impassioned plea to the District Executive in the form of an open letter failed to register any "shop floor" contact or support

of the junior staff and negotiations with nursing staff were left largely in the hands of the residual physician group.

The effective strategies that allowed the Department to continue included:

1. Cancellation of non-urgent public medical outpatients (all Category 2 and 3 patients).
2. Prioritisation of outpatient care to high risk patients including unstable diabetics, all oncology and renal patients, all unstable cardiac patients and all urgent general practitioner referrals.
3. The development of a Consultant supervised discharge clinic. Rather than deploying patients post-discharge to follow-up clinics run by the various services, Consultant run discharge clinics were initiated each week. The goal of these clinics was to complete the evaluation and management of the illness of patients recently hospitalised and to discharge them back to their general practitioner. Contrary to the usual 35% retention rate for revisits in our general medical clinics in the six months prior to this event, the subsequent retention rate from our Discharge clinic was less than 5%. This process has proved to be so effective that even when our Registrar complement was reinforced, we have elected to continue it as a structure within our Department.
4. Support of the residual registrars. Workloads were divided into one registrar supervised general medical inpatient service and rotating the other two on to night duty (7 days on / 7 days off). In addition, consultants, who were not further burdened with outpatient care, took up registrar roles with day-time admission rosters and day-time ward rounds with residents and interns.
5. Careful assessment of all phone referrals requiring aerial retrieval or prolonged travel to ensure that travel to our centre was necessary and to ensure that direct referral to our tertiary service was the best pathway for the patient.
6. Consultation with community general practitioners, explaining why Category 2 and 3 patients were not going to be serviced and soliciting their support in using the telephone to refer urgent cases that would be seen in a timely fashion.
7. A temporary closure of the Aged Care and Rehabilitation Service (10 beds) to facilitate those staff to be free for the management of inpatient acute general medicine.
8. Weekly interdisciplinary meetings with nursing staff, allied health staff, junior staff and consultants detailing the weekly roster changes, the weekly admission process and the weekly distribution of workload followed by morning coffee and patisseries. (These meetings seemed reminiscent of Winston Churchill's war office and his regular meetings with his military advisors.)
9. Complete closure of the Private Practice Medical clinic with rebooking of all elective patients to three months hence after review of patient notes and contact with the patient.
10. Cancellation of structured teaching sessions, e.g. Registrar Journal Club and weekly case presentations.
11. Weekly update with the hospital Executive in anticipation of expected Ministerial and patient or relative concerns. Inevitably, a media release was requested of the Hospital and both newspaper and television interviews were undertaken. Fortunately, the media dealt lightly with these interruptions



RECIPIENT OF THE 2005 IMSANZ RESEARCH FELLOWSHIP

Dr. Alison Mudge, MBBS(Hons), FRACP



Alison Mudge receiving her research scholarship from Ian Scott

Alison Mudge is a staff physician in general internal medicine at the Royal Brisbane and Women's Hospital (RBWH) in Queensland and a Research Fellow in its Internal Medicine Research Unit. In 2000, she was a Clinical Services Development Research Fellow in the hospital's Division of Medicine and was chief medical registrar in 1998.

She graduated from the University of Tasmania medical school in 1989 with first class honours, completed a Certificate of Health Economics with high distinction at Monash University in 1999, and has been enrolled in a Master of Philosophy degree at the University of Queensland since her final year of advanced training in 2002. This degree will be upgraded to a part-time Doctorate of Philosophy this year.

(From Page 11)

and presented a more positive slant which is likely to have maintained some degree of public confidence.

We have moved through this "famine" but have grown in respect for our junior staff and the phenomenal amount of hard work that they undertake in their daily duties and our expectations on ward rounds have been significantly modified by our own personal experiences when trying to scratch together an effective patient summary and written record at 2 am after many hours of sleep deprivation. Having worked in this same institution as an intern, resident medical officer, senior medical registrar and now staff consultant, I have certainly witnessed a lot of the transitions in the hospital structure, the Health District structure and staff morale. The incredible transformations that have occurred in medicine over the last 22 years with increasing public accountability, the increasing actuality of legal retribution and the increasing complexity of diagnostic and management algorithms, we need to become more tolerant of the difficulty that our junior staff experience as they come to grips with day to day patient management while trying to deal with their own emotional issues on the background of increasingly needy and demanding patients and relatives.

Alison has received several awards in recent years: the IMSANZ/Roche Advanced Trainees Award for best paper presentation at the 2000 IMSANZ Annual Scientific Meeting, a best paper prize at the University of Queensland Postgraduate Student Conference in 2003, the Australian Resource Centre for Healthcare Innovation (ARCHI) Award for excellence in 2004, and best paper prize for health services research at the Queensland Health Annual Medical and Scientific Meeting in 2004.

Alison has wide research interests in health services analysis, health outcome measurement, economic evaluation of health care, quality improvement and the hospital-community interface. She has undertaken studies in appropriateness of pathology testing, use of clinical indicators, quality of life measurement, and practice improvement in cardiac care. She was a principal clinical investigator in the Brisbane Cardiac Consortium Clinical Support Systems Program and continues to undertake long-term outcome studies of patients enrolled in this program.

Alison's most recent research involves a controlled trial of a better resourced, better co-ordinated allied health service in the general medicine units at RBWH. The principal results of this study were presented at the RACP ASM last year as well as several other national meetings. During this study, an extensive dataset on almost 2000 consecutive general medical patients, including 6-month follow-up, was collected which will be further analysed in studies which focus on subgroup analysis, outcome modelling and a closer examination of the nature of service rationing.

In the last 5 years, Alison has authored 6 papers in peer-reviewed national and international journals, and has given presentations at more than 15 national conferences. She continues to provide clinical service in general internal medicine at RBWH while pursuing research studies as part of her PhD degree, in addition to her domestic responsibilities as a mother with three busy young daughters.

IMSANZ Council is very pleased to award the 2005 IMSANZ Research Fellowship to this outstanding young physician.

There is no doubt that this three month period would have contributed to adverse outcomes with patients deteriorating from chronic illness because of their inability to be reviewed or supported in their general practice care. The initiatives that were instituted to salvage the Unit are presented in no way to extract admiration or applause but rather to highlight the essential role of our junior staff and how important it is for both Departmental managers as well as District Executives to recruit, retain, support and even sometimes entertain them. In the Old Testament Book of Ecclesiastes, it says "My son if you desire to serve, prepare yourself for an ordeal, be strong and steadfast of heart for there are trials ahead of you." In making a commitment to serve the infirmed as a physician, there is no doubt that our privileged position will be associated with trials, many of which only we can understand and need to internalise as part of our journey with the sick.

PETER NOLAN

Acting Director of Internal Medicine
Toowoomba General Hospital

General Physician Outreach Clinics For Remote Communities

Background

Central Australia is a region of around 1.2 million square kilometres, encompassing two thirds of the Northern Territory. The residential population is 47,500 people, although numbers fluctuate according to population shift across three borders. The population of Alice Springs is 28,500 people and that of the surrounding region, including the Barkly is 18,900. Around 18,000 people (38% of the total) are Aboriginal and 70% reside outside the town in 30 remote communities.

A clinical challenge

People living in remote communities are the least able to access specialist and sub-specialist medical services which are generally centred in large towns and cities. Barriers are many and include large geographical distances, difficulties with travel, physical and cultural dangers associated with visiting Alice Springs, and the limited number of local specialists and visiting sub-specialists. On the other hand, indigenous communities have a disproportionately increased burden of chronic diseases, including type 2 diabetes, cardiovascular disease and renal disease, and show 2 to 3 times the mortality rate from these diseases compared to non-indigenous populations.

Alice Springs Hospital (ASH) is a modest 160 bed facility with 4.5 FTE general physician positions, although it has not been fully staffed for several years. The hospital has a visiting cardiology service from the Royal Adelaide Hospital, consisting of four visits of 3.0 – 3.5 clinic days per year. Patients requiring tertiary level investigations or interventions, including those of a cardiological nature, are generally referred to the Royal Adelaide Hospital (RAH).

Access to sub-specialist clinics at ASH was becoming more and more difficult, characterised by long waiting times for routine appointments. In 2003, the waiting time for a new referral to be seen by a visiting cardiologist at ASH had increased to well over twelve months. Managing such increasing demand required alternatives to traditional face-to-face clinic consultations.

A potential solution

In January 2002 a full time community general physician commenced regular outreach clinics to most of the remote communities. Patients undertaking a consultation in the community with the community physician receive a comprehensive assessment and care plan which addresses all medical problems. In cases where cardiological advice is required, it is obtained directly by email or telephone. Where an intervention is required, it is arranged directly with RAH (or the Royal Darwin Hospital if resident in the Barkly), bypassing the cardiology clinic. This is both convenient for patients and an efficient use of time and resources.

In addition, the federally funded Medical Specialists Outreach Assistance Program (MSOAP) began to provide an outreach echocardiography service to remote communities in 2002. A cardiologist and technician travelled with a portable Cyprus machine, purchased with MSOAP funding. This service further reduced the numbers of patients needing to travel to Alice Springs for medical assessment.

In evaluating the effects on waiting time, costs and quality of care of community outreach clinics compared to referral to the

hospital-based visiting cardiologist clinic, the authors undertook an audit of remote referrals still waiting for a first consultation at the visiting cardiologist clinic as of June 2003.

Methods

A list of 47 “new” referrals of remote dwelling patients to the visiting cardiology clinic was generated by the Out-patients Department clinical nurse consultant, and chart reviews were undertaken on 45 patients. Two patients had no chart as they had never visited ASH before. Measured variables included the date of the original referral, the initiator of the referral, number of non-attendances and appropriateness of the referral, and whether the patients had been seen by the community physician in outreach clinics and the outcome of those consultations.

Results

Timing of referrals

There were 47 new remote referrals to the cardiology clinic and these spanned 1998 – 2003. Of all new referrals, 23.4% (11) were from 2001, prior to physician outreach visits. However, 57.4% (27) were from 2002 and 17% (8) were from 2003. One recurrent non-attender had originally been referred in 1998! Eight patients had been offered clinic appointments but failed to attend (17%), six of whom failed to attend on two or more occasions. A total of 19 cardiology appointments were wasted as a result of non-attendance. One patient referred to the cardiology clinic in November 2002 died in February 2003, but her name was still on the waiting list at June 2003!

Source of referrals

Referrals from the primary care doctor accounted for about half of all new referrals (26 patients, 55.3%), with around 80% being made in 2002 when physician outreach services were just becoming established, 50% coming from short term or locum district medical officers (DMOs) who may not have been aware of the existence of community physician services. Referrals from hospital doctors accounted for 21 new referrals (44.7%), with one third made prior to 2002 before the existence of outreach physician services. Most of these referrals were associated with hospital admissions.

Reason for referral to the visiting cardiologist clinic

The most common reason for referral related to patients with rheumatic heart disease (18 patients or 38.3% of the total), followed by chronic heart failure (9 patients or 19.1% of the total) and ischaemic heart disease (4 patients or 8.5% of the total). Other reasons for referral included follow up of congenital heart defects (6.4%), investigation of a murmur (4.2%) and dysrhythmias (4.2%). The reason for referral was not known in 8.5% of cases.

Referrals of patients already seen in community physician clinics

A total of 16 new remote referrals (34%) had already been seen by the community physician on outreach visits by the time of the audit. Looking through the clinic letters for these patients, 3 patients (18.8%) were sent directly to the RAH for cardiac investigations (including coronary angiography and angioplasty)



and were able to bypass the cardiology clinic waiting list. All patients received a detailed care plan encompassing their cardiac and other medical problems.

One third of new referrals to the visiting cardiologist clinic comprised patients who had recently undergone full assessment of their cardiac and other chronic health problems in outreach clinics and did not require a cardiology consultation. In addition, almost 20% had undergone definitive cardiac interventions through liaison between the community physician and cardiologists at a tertiary centre.

Appropriateness of new remote referrals

After undertaking a chart and clinic letters review, none of the 47 remote patients definitely required a routine cardiology outpatient consultation. Two patients (4.3%) had serious cardiac problems but should have been discussed directly with a cardiologist to obtain a care plan and arrangements made for tertiary level cardiac investigations. One of these patients had an atrial septal defect complicated by severe pulmonary hypertension and symptomatic right heart failure whilst the second had documented recurrent ventricular tachycardia with new onset syncopal episodes.

The other 45 remote patients on the waiting list did not require a cardiology consultation as they either had had significant but stable heart disease (e.g. rheumatic heart disease), heart disease which could be routinely managed by general physicians (e.g. secondary prevention of cardiovascular disease and atrial fibrillation) or "other" problems (e.g. investigation of a heart murmur or palpitations) which are well within the competency of an appropriately skilled community physician.

Finally, 7 patients (15%) were likely to gain little or no benefit from undertaking cardiology review. Five had no letter of referral. Chart review at ASH for one patient (the only chart available to the cardiologist) revealed no clues as to the reason for referral. Two patients were referred for investigation of heart murmurs without an echocardiogram; when they did eventually undertake the study only minor abnormalities were found.

Costs associated with remote referrals

In all, 45 patients referred to the visiting cardiologist clinic could reasonably have been seen by the community physician at their community of residence. Two patients should not have been placed on a routine waiting list because of the urgency of their problem. In assessing the net costs of referral to cardiologist clinic versus referral to community physician outreach clinics, it should be noted that ASH assumes the costs for visiting interstate specialists whilst the community physician is funded by a Commonwealth program. In estimating the costs/cost savings to the hospital budget of care in the community by an appropriately skilled visiting general physician, the following factors were considered:

EXPENSE	COST
Average cost for one remote patient to come to Alice Springs for a clinic appointment ¹	\$412.50
Average cost per day for a cardiologist to come from Adelaide and undertake clinics at ASH ²	\$1,509.80

Average cost per day of a community physician visit to a remote community ³	\$760.60
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¹ Figure provided by ASH Patient Travel Office (current in 2002).

² Costs per day are calculated as follows:

- \$445.80 (travel + accommodation + meals + taxi vouchers, divided by 3 days).
- \$1,064 (salary rate of \$114 per hour, based on an 8 hour day + 4 hours paid travel time, divided by 3 days) (current in 2002).
- the total cost of a cardiologist per day of clinics is \$1,509.80.
- the cardiologist sees an average of 12 patients per day in clinic. This gives a cost of \$125.80 per patient seen.

³ Costs per day are calculated as follows:

- \$406.45 (travel + T/A + incidental expenses).
- \$354.10 (based on annual salary + annual NT contribution to pension + annual professional training allowance, divided by 365 days) (current in 2002).
- the total cost of a community physician visit per day of clinics is \$760.60.
- the community physician sees an average of 8 patients per day in clinic. This gives a cost of \$95.10 per remote patient seen.

The cost / cost savings of 45 patients attending a cardiology clinic at ASH when they could have received appropriate care from a visiting community physician are as follows:

Cost for remote patients to see a cardiologist at ASH	
1 patient	\$538.30 ¹
45 patients	\$24,223.50

Cost for a remote patient to see a visiting community physician	
1 patient	\$95.10 ²
45 patients	\$4,279.50

¹ Costs are calculated as follows: cost of a patient to travel from a remote community to Alice Springs (\$412.50) + cost of a cardiologist consultation based on 12 consultations per day (\$125.80 per patient).

² Costs are calculated as follows: cost of a physician to undertake a remote clinic per day (\$760.60) divided by 8 consultations per day.

The total cost of sending 45 remote patients to Alice Springs for a non-essential cardiology consultation was \$24,223.50. The cost of care in the community by an appropriately skilled community physician would have been \$4,279.50. The cost saving for the hospital budget would have been \$19,944 for these patients.

Discussion

In Central Australia there is a high prevalence of third world diseases such as rheumatic heart disease concentrated in Aboriginal people. Heart failure is also common, with local figures suggesting idiopathic dilated cardiomyopathy occurring twice as often in Aboriginal people than in non-Aboriginal population. Clearly the need for cardiac care is substantial.

The results of this audit suggest that, in remote areas, only patients who really need to see a cardiologist should be referred

to the local hospital for a standard consultation. Appropriately skilled and supported general physicians providing community outreach are cost effective, efficient and can help manage hospital clinic waiting lists by reducing the number of patients referred to hospital-based subspecialists.

Care provided by general physicians meets evidence-based standards derived from national and international treatment guidelines e.g. American College of Cardiology /American Heart Association Guidelines (ACC/AHA) 1998 for rheumatic heart disease and the National Heart Foundation/Cardiac Society of Australia and New Zealand 2001, AHA/ACC and European Heart Association Guidelines for heart failure management.

Our study highlights three key themes:

1. *Supply and demand issues common to all medical systems* – how to use precious resources better, in this case how to free up cardiologist waiting lists by utilising a community physician to manage those patients in the community who do not need to come in and see a cardiologist.
2. *Innovation of general physicians in Alice Springs and Central Australia* – a preparedness to develop local systems not based on conventional city-based practice models. Given the sheer remoteness of our communities, the inherent difficulties associated with travel and the absolute shortage of medical specialists and sub-specialists, we must adopt more efficient and streamlined modes of accessing secondary and tertiary care. It is not practical for all patients requiring cardiological input to visit a cardiology clinic 3 to 4 times per year as might occur in urban settings (and we would contend this is not an efficient model of care either!).
3. *Efficiency, efficacy and excellence of general physicians who work in a supported framework.* In practice, booking a remote patient for a cardiologist appointment at ASH actually translates to no care whatsoever or excessive delays in care, due to the difficulties inherent in travel and missed appointments. Utilisation of a suitably skilled community physician with cardiology support, together with telemedicine, can substantially reduce cardiology clinic waiting times for these patients.

We suspect that the findings from this audit are applicable to all sub-speciality medical clinics at ASH. MSOAP-funded community general physicians are able to manage a broad range of medical conditions in the community and arrange for tertiary level care directly where appropriate. Therefore, careful consideration must be given before any patient from a remote community is referred to a sub-specialist medical clinic at ASH.

As patients are referred from a number of sources, including primary carers and DMOs as well as from hospital wards and the Emergency Department, there needs to be good communication between all stakeholders about the status of referral of individual patients to community physician outreach clinics if unnecessary referrals to hospital sub-specialist clinics are to be avoided. Information about outreach clinics need to be incorporated into the orientation packages of all hospital and remote health doctors.

All new cardiology referrals are now screened by the Director of Medicine at ASH, and those for remote dwelling patients are forwarded to the community physician. These referrals are discussed directly with primary care doctor for the community

(although the referral may have been initiated elsewhere), a care plan generated and review planned at the next physician visit.

Conclusions

We must expand visiting physician services in order to improve access to care in remote communities. Outreach specialist physicians can manage the majority of patients with chronic heart disease (as well as their other chronic medical problems) and can also act as a “bridge” with tertiary level services. In 2005, accessing cardiology or other sub-specialist medical expertise should no longer necessitate remote patients undertaking a face to face cardiology consultation in Alice Springs. The value of the visiting cardiologists is in supporting and up-skilling remote general physicians and being readily accessible by telephone or email to consult on unusual or difficult problems. “Follow-up” cohorts of patients should be reviewed to verify the need for further attendances and to ensure they are not displacing new referrals from being seen in a reasonable time period.

The problems identified by this audit of remote referrals to a cardiologist clinic are likely to exist for other sub-specialist medical clinics. We suggest that a review of these clinics would be useful, and strategies to reduce the number of unnecessary or inappropriate referrals, as demonstrated here, be implemented.

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Draft Curriculum For Physicians Specialising In General Internal Medicine

A draft of the general internal medicine (GIM) advanced training curriculum can be found on the IMSANZ website the address is:

<http://www.racp.edu.au/imsanz/newsTrainees/curriculum.htm>

Please forward any comments on this document to: imsanz@racp.edu.au
OR fax to +61 2 9247 7214



General Internal Medicine Advanced Training Curriculum

Most of you will have by now received an email copy of the draft general internal medicine (GIM) advanced training curriculum developed through 2004 and early 2005 on your behalf by a very enthusiastic working group. Please have a look at it and provide any feedback to Mary at imsanz@racp.edu.au. Thanks to those of you who have already taken the time to do so.

IMSANZ believes this is a sentinel document as it has several purposes - facilitating the development of a physician able to function as an independent consultant physician in general internal medicine and defining for stakeholders the outcomes expected at the end of advanced training in general medicine. By doing these, it defines the particular strengths and standards of the discipline of general internal medicine. Stakeholders include health professionals (including other subspecialists), medical boards, health authorities, government, potential trainees, members of the public etc. It also outlines the standards required for consultants in general internal medicine throughout their life in clinical practice. This is a very important consideration for us all, as for example, in New Zealand the new health practitioners' competency assurance act (HPCAA) requires demonstration of maintenance of competence. Provided that the RACP keeps the role of setting professional standards for physicians in the longer term, this curriculum will inform the development of the standards of practice required.

The document has been circulated to the Chairs of the Adult Division and the Specialties Board who have both given very positive, and as yet unqualified feedback. It has also been forwarded to the RACP Trainees Committee.

RACP Education Strategy Implementation

The GIM curriculum is being developed within a much larger project-the implementation of the RACP Education strategy. The next steps with the GIM curriculum will be determined by the feedback received as well as what transpires during the next phase of the RACP deliberations. Issues that need working through are - what constitutes basic training, selection into basic and advanced training, moderation between the various subspecialty curricula, determination of the skills generic to all physicians, methods of assessment, training experiences, supervision, the list goes on! We have taken a very large first step and now stand on the high ground ready to move.

RACP AMC Accreditation

In order to continue as the physician training body, the RACP must be accredited to do so. To this end the RACP had an accreditation visit by an AMC panel in August 2004. While this is reported extensively on the RACP website some of the key findings relevant to those of us in GIM are repeated here. The following were reported as areas of strength:

- The quality of the graduates of College training programs;
- The effective application of the apprenticeship model in postgraduate medical training;
- The committed contribution of College Fellows to training and assessment activities;
- The flexibility provided by a number of routes of entry to training and within the training programs;
- The RACP's commitment to research support;

- The comprehensive review of strengths, weaknesses and challenges facing the College in its education and training roles, as presented in the Education Strategy 2004-2007, and the clear commitment to addressing the challenges facing the College;
- The developing structures for trainee input to College decision-making processes, such as the Trainees' Committees.

The report identified several major areas requiring further development including:

- Detailed curriculum documentation associated with the College's training programs;
- The development and implementation of a diverse range of assessment instruments that covers the full range of educational objectives relating to knowledge, skills and attitudes;
- Communicating to Fellows the case for major change outlined in the College's Education Strategy, and finding ways of engaging already busy clinicians in the activities necessary to implement the Strategy;
- Selection policy and processes;
- Processes for communicating with College trainees and for supporting trainees;
- Support for Fellows who undertake training and assessment activities on the College's behalf, particularly the Directors of Physician/Paediatric Physician Training;
- The further specification of criteria for the accreditation of hospitals and training sites, and the coordination of accreditation processes both within the College and between the College and other bodies;
- Information sharing between the Divisions, Faculties and Chapters;
- Further development of a continuing professional development (CPD) program where participating in and recording of CPD is relevant to a particular physician's practice and is part of that physician's everyday life.

The AMC granted accreditation to the RACP to continue its roles until June 2008 but this is subject to a review by the Specialist Education Accreditation Committee by December 2005 of a report outlining the detailed and prioritised plans of the RACP to develop its proposals concerning trainee selection, training environment and experience, partnerships with Specialty Societies and universities, and professional development, among other things.

It also needs to describe in detail curriculum developments, including the RACP's planned wide-ranging review of assessment, including the review of best practice in assessment, and evaluation of current College assessment processes in the light of this review. There needs to be a report on the first draft of the basic training curricula for adult medicine by the end of this year.

As may be seen from this there is a mammoth amount of work going on right now. Your Council representatives in this process are Leonie Callaway (Aust), Phillippa Poole (NZ), and Ian Scott (Aust). Andrew Bowers (NZ) is also heavily involved. There will be another round of RACP education meetings in mid March in Sydney, at which stage we hope to have a better sense of how all the educational activities are likely to integrate, as well as the next steps to be taken.

PHILLIPPA POOLE

NZ Vice President

LEONIE CALLAWAY

Advanced Trainee Representative

The limited efficacy of antidepressants at standard doses in chronic depression may be considerably enhanced at lower doses

A number of benefits have been ascribed to pharmacologic antidepressant compounds based on quite modest clinical trials evidence, beginning with tricyclics and mono-amine oxidase inhibitors in the 1960's. Antidepressants have typically been used in acute or recalcitrant ('major') depression, particularly when stress management, lifestyle changes, counselling and psychotherapy had proven insufficient. Increasing use of antidepressants in general practice, often in low to modest dose, has seen benefits in a broader range of chronic disorders, including milder grades of depression, anxiety disorders, insomnia and in a range of chronic vexing physical symptoms, including headache, musculoskeletal pain, irritable bowel and bladder instability. The advent of the better tolerated selective serotonin reuptake inhibitors in the last 15 years has seen ever increasing antidepressant usage, mainly based on clinical trials using the old antidepressants as comparators, in doses applicable to 'major' depression.

Published clinical trials have mainly addressed 'major' depression, with which significant improvements are typically seen in around 45-60% of actively treated patients, compared to around 30% taking placebo. However, this evidence base has had significant limitations. Most clinical trials have been of less than 6 weeks duration and data demonstrating sustained longer term benefits is extremely limited. More than half of antidepressant clinical trials have not been analysed by "intention to treat" and, related to considerable drop out rates due to toxicity and comorbidity, reported benefits are likely to have been exaggerated.¹ Without placebo treatment groups in most studies, the best conclusion that might be made is 'non-inferiority' but it is accepted now that this trial design may fail to distinguish comparable from no efficacy!

Of concern, the levels of statistical significance in earlier clinical antidepressant trials are usually around 0.05 and rarely <0.01, compared with the level of evidence ($p < 0.001$) usually required by trial steering committees and regulatory bodies with drug treatments for cardiovascular and many other diseases.

There is virtually no clinical trials evidence relating to use of antidepressants in community settings where more than 90% of antidepressants are prescribed, often in lower doses, in chronic mild mood, anxiety and related disorders.

The "SADHART" study published in 2002² was a 6 month clinical trial conducted by psychiatrists and cardiologists, analysed by intention to treat, addressing major depression in 369 coronary patients randomised to sertraline or placebo. It appears to be one of the highest quality and robust antidepressant clinical trials ever undertaken. This study raises major concerns about relatively limited efficacy of standard dose sertraline. At a mean prescribed dose of 70mg daily, sertraline failed to have a clear impact on the commonly used Hamilton Depression (HAM-D) score (from a mean of 20 at baseline, falling to a mean of 11.2 in sertraline treated participants by 16 weeks, only 0.8 better than those on placebo, not statistically different, $p = 0.14$). A statistically significant but only very modest benefit emerged based on Clinical Global Impression Improvement score, by

which 67% of treated patients "responded" compared to 53% in the placebo group ($p = 0.01$). Thus, as encountered in most trials, there was substantial improvement unrelated to drug therapy but clinicians ascertained more 'improvement' in those treated with sertraline than those on placebo. Both measures improved in individuals with more serious depression in sub-group analysis, but even in these very ill patients, the HAM-D score improved only by 2.2 ($p=0.01$).

Curiously, The "SADHART" study is best known for showing the safety of SSRI in patients with significant underlying heart disease and there has been interest in the apparent reduced cardiovascular events in the sertraline treated group (not statistically significant) - the limited efficacy of sertraline appears to have largely escaped comment.

Furthermore, there is no convincing evidence that increasing dose of antidepressants is associated with increased benefit. A flat dose response appears to apply to most antidepressants according to recent meta-analyses of trials employing tricyclics,³ a wide range of commonly used antidepressants,¹ and sertraline in the range of 50-150mg.⁴ In these analyses, increased dose was associated as expected with increasing toxicity, potentially significantly curtailing clinical utility.

Much concern has previously been expressed about the limited evidence for the efficacy of antidepressants at usual doses, particularly well articulated in a recent editorial in the British Journal of Psychiatry.⁵ More than one third of published clinical trials addressing antidepressants have failed to demonstrate significant benefits. The true experience is likely to be less convincing given that negative studies may not be submitted and there is a well known bias by journals towards publishing positive studies.

In practice, toxicity is common even with SSRI's and many clinicians have resorted to dose reduction,⁶ hoping to minimise adverse effects without compromising treatment benefits. Common concerning side effects include increased agitation, insomnia, fatigue and flat mood, all of which are common features of depressive illness. Indeed, there is increasing concern with evidence that several classes of antidepressants at conventional doses are associated with increased suicide risk, especially soon after their initiation.⁷

Interestingly, dose reduction has evolved in clinical practice in many areas of medicine, such as antihypertensive agents, cardiac failure regimens, bronchodilators and disease modifying agents in rheumatoid arthritis. For example, many cardiovascular agents, which are the most commonly prescribed drugs in general practice, are contemporarily commonly prescribed at doses of 1/4 (eg ACE-inhibitors, β blockers, calcium channel blockers), 1/6 (thiazide diuretics, α blockers, perhexiline) to 1/10 (amiodarone) and even 1/30 (aspirin) of those originally recommended.

What has surprised clinicians has been the substantial preservation of clinically useful efficacy, eg aspirin, at such low doses, with relative freedom from toxicity. The prevalence of such lower doses in practice reflects endeavour by clinicians and patients to find the optimal "window" between pharmacologic efficacy and toxicities, as depicted in Figure 1 below. This clearly been imperative with cytotoxic agents in oncology. Similar

findings have emerged in analysis of dose response and toxicity with inhaled corticosteroids in asthma.⁸

Indeed, in almost all areas of therapeutics, clinicians in practice commonly employ drugs in the lower part of recommended dose ranges in the treatment of chronic diseases, interestingly even with major tranquilisers in psychoses. In fact, aside from antibiotics, antidepressants appear to be one of the few groups of drugs still usually employed near the top of the dose response curve.

In this context, it is a concern that psychiatrists often increase antidepressant doses in acutely ill patients, quite often above formulary recommended ranges, where there is a dearth of clinical trial data.

Our unit now has an extensive experience with very low doses of a variety of antidepressants (eg Venlafaxine ½ x 37.5mg, Doxepin 10mg, Mirtazapine 5mg, using compounding pharmacy for smaller dosing) in patients with mild to moderate depression, anxiety, stress and fatigue, often associated with chronic medical illness. We frequently see encouraging improvements in a wide range of physical and psychological symptoms, with relative freedom from side effects. The frequent side effects seen with standard doses probably cloud these benefits and make them less sustainable.

Further improvement can be seen with strategic combinations of low doses of antidepressants, probably in a manner similar to that recently reported with a 'polypill' approach to hypertension management.⁹

Recruitment is underway in 'proof of concept' clinical trials at the Mood Research Foundation at St John of God Healthcare, to

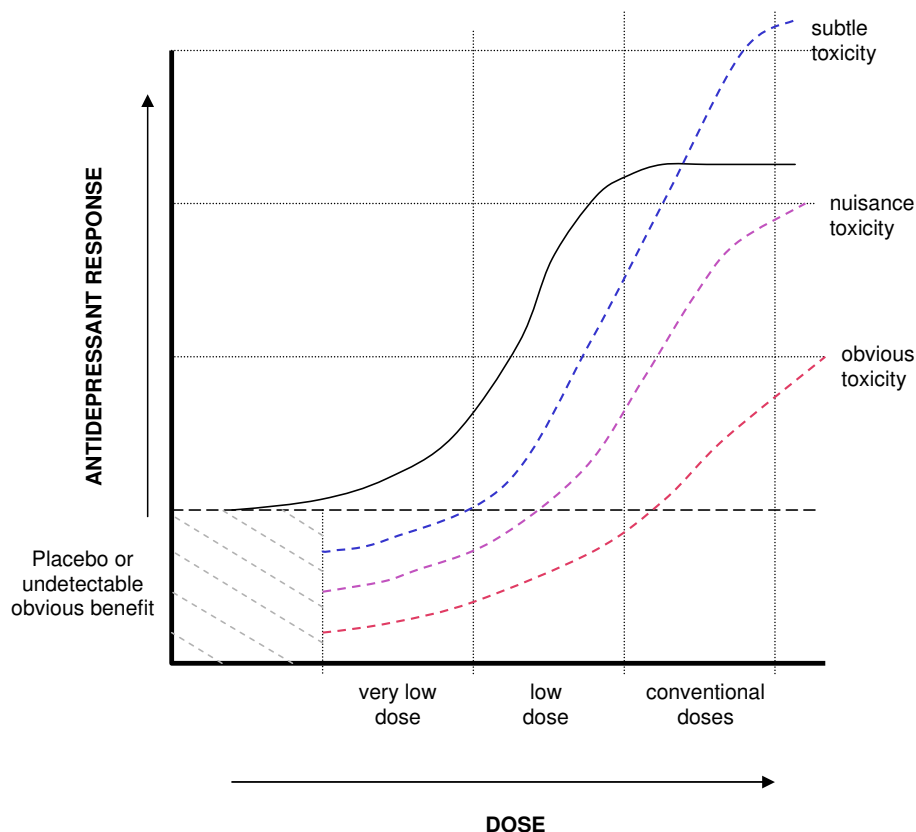
formally evaluate the efficacy and tolerability of very low doses of SSRI's, compared to placebo, in chronic illnesses like heart disease and chronic fatigue.

SIMON DIMMITT

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Figure 1.
Dose response of antidepressant pharmacologic agents efficacy plotted as continuous line toxicity (different grades) plotted as broken lines.





Urgent action is needed to address critical issues pertaining to the practice of general internal medicine in remote Australia. Issues such as workforce (retention, training, support), delivery of community-outreach services, and the role of specialist services in developing and sustaining primary health care must be addressed urgently to ensure future access to adult specialist services in remote Australia. While bodies such as RACP and IMSANZ are broadly representative to groups in this area these are issues which many specialists and health planners, even those living and working outside major urban centres, do not necessarily see as relevant.

Specialists in regional Australia can be a potent force in health service development but only if there is an appropriately qualified and sustained workforce. Without this we run the risk of health service delivery in remote Australia being delivered (or not delivered) and directed by tertiary level sub-specialists and becoming increasingly hospital-centred in capital cities. Such a centralised sub-specialty model of health care clearly does not reflect the practicalities and needs of our most disadvantaged and isolated communities. It is not one which is efficient nor which sustains and supports the key component of isolated, non-urban health service delivery, namely the primary health care system.

It may be burn-out or pragmatism but many specialists working in remote Australia are increasingly concerned that existing regional services, both specialist inpatient services and community out-reach, in 'truly' remote and regional Australia is reaching the stage where it may die out as a viable model of care. This may be due to the benign neglect or ineffective response of jurisdictions, clinicians on the ground (i.e. us), tertiary referral centres and the RACP. Or maybe it's the inability of our specialist colleagues to see life as being possible more than a few hours from Melbourne or Sydney? Whatever the cause we run the risk of denying some of the most disadvantaged and isolated Australians access to a minimum level of specialist care which those living in or near our capital cities take for granted.

While the Northern Territory (NT) earned considerable kudos for its models of remote outreach in the 3 major outreach surveys done in 2003-4, all the reports warned that the models were vulnerable and likely to be non sustainable, because they ran on physician goodwill and minimal or nonexistent funding. It is not surprising therefore that the bubble is about to burst as predicted. In the Top End, physician goodwill is gone, due to serious self doubt about the effectiveness of the services provided, being tired of having to do everything for nothing (in one instance being docked salary by the NT Department of Health and Community Services [DHCS] for being out of the office while on outreach!), and sheer work overload. General outreach services are on hold for the moment. In the centre, it looks as though the previous meagre DHCS funding (as distinct from Commonwealth funding) has been reduced further, and it is unclear just what service can be continued. In Western Australia adult specialist services outside Perth and major centres continue to develop and then collapse as specialists working in isolation become burnt out, disillusioned or move on to more lucrative or satisfying positions.

The word crisis can be overused but in this case we can say that:
ADULT SPECIALIST SERVICES IN REMOTE AUSTRALIA ARE

IN CRISIS. We have a moral imperative to ensure the current inadequate level of service does not persist whilst advocating for change to ensure sustainable and quality adult specialist services for ALL Australians, not just those 'fortunate' enough to live within a few hours drive of a capital city. To do this we must seize the initiative, define appropriate models of sustainable remote specialist services, and then utilise the College and relevant specialist societies to fulfil their charter of advocating for all specialists. Many of us cannot publicly advocate because we are employed by the systems we are challenging. Nevertheless specialists working in remote Australia believe we can play a key role in improving the health of local residents. Only by working together with provider organisations, health planners and jurisdictions can we ensure that this is possible today and in the future.

Announcement

The RACP and IMSANZ will co-host a half-day satellite meeting titled "Saving Medical Specialist Services for Remote Communities in Australia" just prior to the IMSANZ Annual Scientific Meeting in Alice Springs on the afternoon of Thursday, September 1, 2005. This will be a symposium dedicated to: 1) scoping the issues of specialist workforce, outreach services, community and primary health care planning, program funding, and regionalised networks involving tertiary hospitals; 2) discussing and sharing practical models of care and other initiatives; and 3) formulating an action plan for improving the current situation.

Specific invitations will be forwarded to: community physicians, paediatricians, and other specialists who reside/work in remote or regional areas throughout NT, WA, and far north Queensland; public health fellows involved in remote clinical services; members of the RACP Rural Taskforce; and representatives of the Rural Specialists Support Scheme. All IMSANZ members who have an active interest in this subject are also welcome to attend and can register at no cost for this meeting. It is to be hoped that getting policy and health service planning people involved from these jurisdictions and the RACP may assist greatly in helping move things forward.

Professor Rick McLean who chairs the RACP Rural Taskforce and who will be attending this satellite meeting has kindly accepted an invitation from IMSANZ to summarise the outcomes of this meeting and to present the college perspective on these issues at a 'Red hot debate' session at the IMSANZ Annual Scientific Meeting on Sunday, September 4, 2005. All delegates attending the satellite meeting on Thursday are welcome to attend the IMSANZ ASM for which day registration as well as full conference registration is available.

GRAEME MAGUIRE

Broome, WA

DIANE HOWARD

Darwin, NT

STEPHEN BRADY

Alice Springs, NT



WHAT'S IN THE JOURNALS?

Outlined below are recent publications of relevance to General Internal Medicine. Please send along additional publications and/or comments.

Impact of specialist follow-up in outpatients with congestive heart failure. Ezekowitz JA et al. CMAJ 2005;172:189-94.

This is a population based retrospective cohort study of 3136 patients discharged from hospital in Alberta (Canada) between 1998 and 2000 with a new diagnosis of congestive heart failure. They were followed for 12 months. Patients followed by **both** specialists (cardiology or internal medicine) and family physicians (42%) has significantly better survival over 12 months than those followed by family physicians alone (24%), or those who had no follow up visits for a cardiovascular diagnosis (34%). In an accompanying editorial, **Patients with treatable malignant diseases – including heart failure – are entitled to specialist care. Cleland JGF. CMAJ 2005;172:207-209**, the limitations of a study based on hospital discharges with a primary diagnosis of heart failure are noted, as well as the problem of not considering all follow ups by considering only cardiovascular follow ups. Cleland emphasises the desirability of instituting chronic disease management for cardiac failure patients.

Association between physician specialty and volumes of treated patients and mortality among patients hospitalized for newly diagnosed heart failure. Cujec B et al. Am J Med 2005;118:35-44.

This study is based on 16,162 discharges from hospital in Alberta (Canada) between 1994 and 2000. Treatment by “high-volume” physicians during hospitalisation for newly diagnosed heart failure was associated with a reduction in in hospital mortality, but this effect was not apparent at 12 months.

Remoteness of residence and survival from cancer in New South Wales. Jong KE et al. MJA 2004;180:618-622.

The survival of patients diagnosed with cancer in New South Wales between 1992 and 1996 up to December 1999 was analysed. The relative excess risk (RER) of death over 5 years was estimated for 20 cancer types across geographical remoteness categories, with adjustments for age, gender, years since diagnosis and cancer stage. There were significant differences in RER for “all cancer” and for cervical and prostate cancer, before and after adjustment for the stage of cancer at diagnosis. There were also significant variations in RER for death by remoteness, for head and neck, lung and colon cancers and for cutaneous melanoma. In a subsequent editorial, **Rural inequalities in cancer care and outcome. Jong KE et al. MJA 2005;182:13**, the solution to rural inequalities in cancer care and outcome, by better primary care and access to multidisciplinary services is proposed.

What effect does inpatient physician specialty and experience have on clinical outcomes and resource utilization on a general medical service? Parekh V et al. J Gen Intern Med 2004;19:395-401.

Resource utilisation, hospital mortality and 30 day readmission rates were considered retrospectively for 12 months, for 2617 admissions to the general medical service at the University of Michigan Hospital (USA). The hospital had reorganised general medical services by eliminating rheumatology and

nephrology inpatient services, so that patients seen previously in these clinics are now assigned to general medicine. General internists had shorter lengths of stay and lower costs compared to subspecialists. Hospitalists (defined as those “attending” admitted patients for 3 or more months) showed a trend towards reduced length of stay. Resource utilisation was less for attending physicians with greater inpatient experience in the past 2 years.

Relation between renal dysfunction and cardiovascular outcomes after myocardial infarction. Anavekar NS et al. New Engl J Med 2004;351:1285-95.

General physicians learn quickly how comorbidities contributes to poor outcomes and greater costs. This study shows that even mild impairment of renal function contributes to the risk of cardiovascular complications after acute myocardial infarction.

Sub-version or sub-specialty? Coffin C. The General Internist 2004;Fall:14.

In the “Resident’s Corner” of the newsletter of the Canadian Society of Internal Medicine, changes proposed for general internal medicine training are discussed. After 3 core years of internal medicine training, trainees in general internal medicine would have an exit examination after 2 years additional training. This period would include 8 months of “fixed” training in a variety of general internal medicine settings, as well as 16 months of “flexible” training tailored to suit individual trainees’ needs.

General Physicians of the 21st Century. Batey R. RACP News 2004;September:30-31.

Bob Batey’s letter comments on efforts being made in the Hunter Area Health Service (NSW) to improve training programs in general medicine.

What is IMSANZ? Scott I. RACP News 2004;April:9 and introducing the ‘General Physician’ of the 21st Century. Scott I. RACP News 2004;April:10-11.

Ian Scott, IMSANZ President, updates the RACP Fellowship on the reform of, and the future for general internal medicine.

101 ways to be stimulated (and simultaneously make a difference). McLean R. RACP News 2004;September:10-11.

Rick McLean outlines his career change from nuclear medicine in suburban Sydney to the University of Sydney’s Rural Clinical School in Dubbo (NSW). “UpToDate” became his bible. He discusses the clinical support needed by rural specialists and how the RACP should face its social responsibility to provide a workforce that most optimally meets the health care needs of Australians.

General medicine in Launceston. Bollipo S, Fassett R. RACP News 2004;Nov:15.

Problems arose from the resignation of 2 of the 8 physicians in general medical units. The solution included adding a renal physician, an intensivist and an oncologist to the general roster, with reorganisation into 3 teams, each with senior staff, registrar.

PETER GREENBERG

Low dose aspirin plus esomeprazole less likely than clopidogrel alone to cause recurrent ulcer bleeding

Clinical question:

In patients taking low-dose aspirin as prophylaxis against cardiovascular ischaemic events and who present with acute upper gastrointestinal bleeding secondary to peptic ulcer, does substituting clopidogrel for aspirin result in lower rates of recurrent ulcer bleeding compared to treating patients with aspirin combined with a proton-pump inhibitor?

Bottom line:

Low-dose aspirin combined with esomeprazole is superior to clopidogrel alone in preventing recurrent ulcer bleeding in patients with a history of aspirin-induced ulcer bleeding whose ulcers have healed and *Helicobacter* eradication treatment has been provided when indicated. Current guideline recommendations for coronary patients with major gastrointestinal intolerance to aspirin to be given clopidogrel are not supported by results of this trial.

Reference:

Chan FL, Ching JL, Hung LC, et al. Clopidogrel versus aspirin and esomeprazole to prevent recurrent ulcer bleeding. *N Engl J Med* 2005; 352: 238-244.

Study design:

Single-site RCT involving 320 patients using low-dose (325mg/day or less) aspirin who presented with acute upper gastrointestinal (GI) bleeding and who underwent endoscopy within 24 hours after presentation to identify site of bleeding and which included biopsy specimens from antrum and body for rapid urease test and for histologic examination for *Helicobacter pylori*. Aspirin was withheld and proton-pump inhibitor (PPI) therapy prescribed (although exact duration not stated). Patients with *H. pylori* infection were treated for one week with triple-drug eradication therapy which included PPI. Follow-up endoscopy with repeat testing for *H. pylori* was performed 8 weeks after eradication therapy completed, with acid-suppressing drugs withheld; it is presumed (although not stated) that patients who were negative on testing for *H. pylori* at initial endoscopy also underwent follow-up endoscopy.

Inclusion criteria were: endoscopically confirmed ulcer healing, negative results in initial testing for *H. pylori* or successful eradication, and anticipated regular use of aspirin for the duration of the trial. Exclusion criteria were: concomitant NSAIDs, COX-2 inhibitors, anticoagulant drugs, other antiplatelet drugs, or corticosteroids; history of gastric surgery other than a patch repair; allergy to aspirin or clopidogrel; presence of erosive oesophagitis, gastric-outlet obstruction, renal failure requiring dialysis, terminal illness, or cancer.

Patients were randomly assigned (allocation concealed) to receive 75mg clopidogrel daily plus esomeprazole placebo twice daily or 80mg aspirin daily plus 20mg esomeprazole twice daily for 12 months. Aspirin and clopidogrel were identical blue capsules; esomeprazole and its placebo were identical red

capsules. Drugs listed in exclusion criteria as well as over-the-counter analgesics (including herbal medicines), misoprostol, histamine H2 receptor antagonists, sulcralfate, and PPI drugs were prohibited. Drug compliance and use of concomitant therapies that may have contained NSAID or aspirin were assessed with pill counts, checking of area-wide electronic prescription database, and retrieval from patients, families and family doctors of all over-the-counter and formal prescriptions. Follow-up was undertaken at end of month 1, month 3 and every 3 months thereafter. Median follow-up was 12 months (range 0.3-12) in both groups. Follow-up was complete for 100% of clopidogrel group; 98% for aspirin+esomeprazole group.

Primary end-point analysed by intention-to-treat was recurrent ulcer bleeding defined as haematemesis or malaena documented by admitting physician, or decrease in haemoglobin level $\geq 2\text{g/dL}$, in the presence of endoscopically proven ulcers (defined as circumscribed mucosal break at least 0.5 cm in diameter and with perceptible depth) or bleeding erosions (defined as flat mucosal breaks of any size associated with visible blood in the stomach). Endoscopy was performed in a treatment-blinded fashion and bleeding events were adjudicated by an independent, blind committee. Only events occurring during treatment or within 28 days after treatment discontinuation were included in the analysis. Secondary end-point was lower GI bleeding defined by either malaena or rectal bleeding requiring hospitalisation or transfusion, or decrease in haemoglobin level $\geq 2\text{g/dL}$ in association with positive faecal occult blood test, both with negative results on upper GI endoscopy. Eligible patients underwent colonoscopy to locate the source of bleeding; those with negative results were deemed to have GI bleeding of unknown origin. Extra-GI bleeding included other bleeding disorders such as haematuria leading to hospitalisation, hypotension, any need for transfusion, or need to discontinue study medication.

Results:

429 consecutive patients taking aspirin and presenting with upper GI bleeding were screened and 320 (75%) were enrolled. At least 80% of assigned study drugs were taken by 94% of patients in each group. Rates of discontinuation, excluding primary end-point, were similar in the two groups (11.8% clopidogrel vs 8.8% aspirin+esomeprazole). No patient who discontinued medication early had recurrent ulcer bleeding or anaemia within study period.

Cumulative incidence over 12 months of recurrent ulcer bleeding was 8.6% in clopidogrel group vs 0.7% in aspirin+esomeprazole group (ARR=7.9% 95%CI 3.4-12.4%; NNT=13). The incidence of lower GI bleeding was the same (4.6%) for both groups. Extra-GI bleeding occurred in 1.9% of clopidogrel group vs 0% for aspirin+esomeprazole; corresponding figures for all other adverse events were 9.4% vs 4.4%, and for recurrent ischaemic events were 5.6% vs 6.9% (p=NS). All-cause mortality was 5.0% vs 2.5% (p=NS).

Commentary:

This is an important study as it deals with a common clinical problem about what to do when a patient with proven vascular disease who is taking aspirin presents with upper GI bleeding.



FORTHCOMING MEETINGS

2005	April	Evidence Based Workshop 30th April ~ Douglas, Queensland For more information email: jwasiak@ranzcog.edu.au
	August	Evidence Based Workshop 28th August ~ Bond University, Queensland For more information email: ssweet@bond.edu.au European Federation of Internal Medicine - 5th Congress 31st August - 3rd September ~ Paris, France www.efim2005.com
	September	IMSANZ Annual Scientific Meeting 2005 1st - 4th September ~ Alice Springs, Northern Territory Email: imsanz@racp.edu.au
	October	European School of Internal Medicine (ESIM-8) 22nd - 28th October ~ Alicante, Spain Email: jmerino@umh.es
	November	Annual Scientific Meeting of the Canadian Society of Internal Medicine 2nd - 6th November ~ Marriott Eaton Centre, Toronto, Canada 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 Australian Association of Neurologists World Congress of Neurology 5th - 11th November ~ Sydney Enquiries can be made to Shonna Peasley at Event Planners: shonnap@eventplanners.com.au Website: www.wcn2005.com

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In the CAPRIE trial (Lancet 1996; 348: 1329-1339) clopidogrel alone was shown to be marginally more effective than aspirin alone in reducing ischaemic events and was associated with a slightly lower bleeding rate (0.5% vs 0.7%). The AHA/ACC guidelines for patients with coronary disease recommend that, in those who require antiplatelet therapy and who show aspirin GI intolerance, clopidogrel should be substituted. This trial suggests that risk of recurrent bleeding is substantially less if combination aspirin-esomeprazole is used instead.

The limitations of this trial is that it was conducted at one site only, a daily dose of aspirin (80mg) lower than conventional

doses (100mg-150mg) was used which may favour the aspirin+esomeprazole group, and a number of exclusion criteria were applied. Its strengths are the 75% patient enrolment which strengthens generalisability, the rigorous follow-up to 12 months, adequate blinding, and sufficient study power as a non-inferiority trial with an equivalence boundary of 4% difference in bleeding rates. Its results underscore the importance of testing assumptions about relative safety of alternative therapies in proper head-to-head trials. The next trial which may be of interest is whether clopidogrel plus PPI is better than clopidogrel or aspirin alone in preventing recurrent ulcer bleeding.



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
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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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