Update ME

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A brief update from the
Civil Aviation Authority
Central Medical Unit

15 March 2005

Welcome to another *update* newsletter. A comprehensive *Medical Examiner* newsletter is planned for next month. Ideas, comments, and contributions are invited.

New Rule Part 67 on the horizon.

Civil Aviation Rule Part 67, Medical Standards and Certification, is being rewritten by the Ministry of Transport (MoT). MoT has recently advised that they anticipate the new rule coming into force on 01 July 2005.

Most of the contents, including the medical standards, of the current Rule Part 67 were first published in 1992.

A detailed analysis of the new rule is planned for our next *Medical Examiner* newsletter.

Exercise Stress Electrocardiography

The Stress ECG is an important, and relatively non-invasive cardiovascular investigation that is used in the *front-line* of workups where ischaemic heart disease is a concern.

The utility of a stress ECG is improved if a maximal exertion (c.f. sub-maximal exertion) endpoint is used and if a significant period of the recovery phase is recorded. It is also important to obtain a copy of the full tracing of the stress ECG, not just the report.

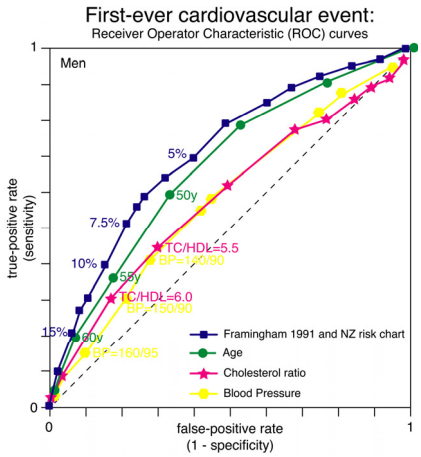
Stress ECG: Request the recording to continue for 5 minutes into the recovery phase; Obtain a copy of the full tracing as well as the report.

CVS risk prediction

In a pair of papers in the NZ Medical Journal Milne et al (2003) analyse the NZ Heart Foundation CVS risk assessment tool[1]. The areas under the ROC (Receiver Operator Characteristic) curves illustrate the utility of the multi-factorial method recommended by the NZ Guidelines Group[2]. It will also be no surprise that the multi-factorial method is superior and that, of the factors analysed, age is the most powerful single predictor.

The use of multiple risk factors is the superior method of assessing 10-year cardiovascular risk.

Below is a simplified version of the (men only) ROC curves from the *discrimination* paper.



For argument's sake

Debate and argument takes many forms. Another of the recognised argument forms is called *argumentum ad hominem*. The phrase derives from the Latin for "argument to the man".

An ad hominem argument is: 1) a logical fallacy that involves replying to an argument or assertion by addressing the person presenting the argument or assertion rather than the argument itself; 2) an argument pointing out an inconsistency between a view expressed by an individual and the remainder of their beliefs[3].

In his book on logical fallacies Dr M Pirie comments "If you cannot attack the argument, attack the arguer. While an insult itself is not fallacious, it is if made in a way calculated to undermine an opponent's argument, and to encourage an audience to give it less weight than it merits. When this is done, the famous *argumentum ad hominem* abusive is committed."[4]

[1] Milne R et al, Discriminative ability of a risk-prediction tool derived from the Framingham Heart Study compared with single risk factors, NZ Medical Journal 2003, 116(1185).

Milne R et al, Framingham Heart Study risk equation predicts first cardiovascular event rates in New Zealanders at the population level, NZ Medical Journal 2003, 116(1185).

Williams M (Editorial), Risk assessment and management of cardiovascular disease in New Zealand, NZ Medical Journal 2003, 116(1185).

[2] The assessment and management of cardiovascular risk: Evidence-based best practice guideline, New Zealand Guidelines Group 2003.

[3] http://en.wikipedia.org/wiki/Ad_hominem

[4] Pirie, M. Book of the Fallacy: A Training Manual for Intellectual Subversives. Routledge & Kegan Paul Books Ltd (1985).

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