IMSANZ

INTERNAL MEDICINE SOCIETY *of Australia & New Zealand*

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From the President...

Dear All,

Thank-you to all IMSANZ members who have supported the exciting and informative meetings held over the past few weeks, and to those who have been unable to attend but in contact lending support. A key role for IMSANZ has been to expand the in uence of General Medicine in all aspects of College activities

The New Zealand IMSANZ meeting at Akaroa in April 2002 was notable for the excellence of both scientific and and clinical update sessions,and a credit to David Jardine and John Thwaites for their organisational skills. The social events were indeed memorable.

The First World Rural Internal Medicine Specialists (RIMS) Conference in Shepparton in April 2002 presented the opportunity to explore Rural Workforce Issues in Australia and compare our situation to other countries particularly North America and Samoa. We are not alone in our difficulties in attempting to attract adequate, trained physicians to rural areas. The clinical sessions presented updates and newer techniques of management relevant to rural practice.

The RACP National Rural Summit on Sunday 28, 2002 held the day following RIMS allowed the College to focus attention on rural training and workforce issues for Australia and New Zealand. The aim of the meeting was achieved with the College acknowledging the needs of rural physician practice, the importance of rural training experience and the need to support trainees who are pursuing a career in rural General Medicine or Specialty Medicine with a view to rural practice. There is an impending crisis in providing adequate numbers of rural based physicians especially with, and exacerbated by, the advent of Rural Clinical Schools and Departments of Rural Health who require significant numbers of clinical teachers in addition to the clinical workforce. This is both a blessing and a challenge. We hope to attract more physicians to these positions from our urban colleagues who may desire a change to a rural lifestyle in the latter part of their practising lives. Please contact me if you would like to join us in rural physician practice - we can arrange reskilling and upskilling and are willing to retrain and entertain all applicants - including cardiologists, professors and retired presidents!!

The IMSANZ Day in Brisbane on May 5, 2002 was excellent and set new standards for our Annual Scientific Meeting. Congratulations to Ian Scott for his outstanding organisational abilities. Ian Scott has agreed to be President Elect for 2002, and will be the next IMSANZ President for 2003-4. I am sure the future of IMSANZ will be in good hands.

The RACP Annual Scientific Meeting(ASM) had several highlights and many interesting sessions. The College is still entertaining the idea of IMSANZ organizing the ASM Days 2 & 3 in Hobart 2003. This will be a challenge, and I am still awaiting an official letter from the Board of Continuing Education outlining our role and responsibilities, and explaining how much assistance and support will be offered by the College . This would/could replace the

As you turn the pages...

traditional IMSANZ Day and we will need to ensure IMANZ is not subsumed and lose its identity.

We may be able to focus the IMSANZ Day later in the year; for example we have had invitations to hold joint meetings in Samoa and Fiji.

Michael Kennedy represented IMSANZ at the April 2002 Specialties Board meeting whilst I was at the New Zealand IMSANZ meeting. There are interesting developments in Sydney with the reestablishment of a General Medical Unit at RNSH with Dr Rupert Edwards as the Director. The Greater Metropolitan Transitional Taskforce, overseeing medical services in Sydney, had not been aware of General Medicine as a Specialty until contacted by Michael recently! Clearly there is a significant workload to re-establish GIM in Sydney and NSW. There has been a proposal for GIM be a dual 'Ticket' - i.e.with another Specialty. However, I strongly support the notion that GIM is recognized as a Specialty in its own right, with our own training program and SAC. Core training for ATs in GIM should remain attainable with rotations through procedural and consultative Specialties. The non-core/elective year can include a Specialty or research or General or Rural year. (However, the converse is not necessarily acceptable for GIM ie 2 years in a selected Specialty and the elective year in GIM)

The Adult Medicine Division Committee teleconference is on Friday May 24, 2002 and the issue of GIM training in Sydney is listed for discussion. We need to encourage the establishment of active GIM units in all Sydney teaching hospitals. The future of GIM and Rural Medicine requires a strong tertiary training hospital commitment.

The next meeting associated with IMSANZ is in New Zealand in conjunction with the Cardiac Society (CSANZ) in Dunedin from August 4-6, 2002. There is a General Medicine Physician's Update organized in Queenstown, by the Dunedin Hospital Division of Medicine from September 5-8, 2002. Skiing should be great at Wanake! We hope to encourage more Australians to attend the New Zealand meetings and enjoy the hospitality and scenery.

I would like to welcome the new IMSANZ Council members David Russell, Melbourne, Thein Htut, Toowoomba, Emma Spencer, Cairns, Advanced Trainee member and Mary-Ann Ryall has 'volunteered' to be the ACT Council member, and willl be appointed formally in the near future. Please find attached a revised list of Council members. Please feel free to contact us and raise issues and problems so these can be addressed in a timely manner.

I will be attending the International Congress in Internal Medicine in Kyoto, Japan from May 26-31, 2002, with Dr Robin Mortimer and Geoff Metz. The RACP has suggested we assess the meeting and if suitable we will submit an expression of interest to hold the International Congress in Internal Medicine in Melbourne, Australia in 2010 (or 2008 if the current favoured city , Buenos Aires is deemed not suitable due to the current political and financial difficulties).

I will be taking holidays with my wife, Sally, and savouring the delights of Paris and the French countryside for the first 2 weeks in June. Please contact the IMSANZ Secretariat (Lyn Abery), Ian Scott or Bruce King in my absence.

The future of GIM and IMSANZ will require constant vigilance and enthusiasm from all our members. Thank you for your expressions of confidence and support in the directions IMSANZ is traveling. The future is both challenging and exciting.

Les Bolitho
lbolitho@netc.net.au

WATCH THIS SPACE

Letters to Editor

YOUR CONTRIBUTIONS WELCOME.

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AMENDED May 2002

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INTERNAL MEDICINE SOCIETY OF AUS & NZ

Annual Report 2002

This has been a challenging and invigorating year, with wide ranging activities involving significant time and energy. However, the outcome has been encouraging and I sincerely hope worth the effort in the longer term.

On behalf of IMSANZ, I have been involved in various College committees and activities, and also in the wider community and overseas.

The important role of the Consultant Physician in General Internal Medicine has been impressed on all contacts, particularly during meetings in related areas, such as Australian Association of Consultant Physicians, MOPS Review Committee, Rural Medicine Forums, and International delegations.

IMSANZ has been active in the Specialties Board Meetings addressing issues of training opportunities, and support for re-establishment/ continuation of General Medical Units in Sydney, and other regions.

The election of A/Prof John Kolbe and I to the Adult Medicine Division Committee of the College has provided valuable opportunities to in uence decisions and outcomes.

I have been involved with the RACP Victorian State Committee and the pilot scheme for selection of Advanced Trainees which will afford opportunities for advanced trainees in General Medicine to achieve training in selected specialty units.

The promotion of the important role of members of IMSANZ in the management of patients in hospital and community based medicine is an ongoing process. We have been working with the RACP Health Policy Unit to ensure IMSANZ is consulted in all areas affecting training, workforce and workplace issues.

The perception of General Medicine being "without a specialty" needs to be constantly resisted, with reinforcement of the holistic role of the management of the patient and involvement in the global issue affecting the often extended family unit. Expertise in multiple areas of is difficult to comprehend for some of our "organ specific" colleagues, who need education on the continuing existence, and re- emergence, of General Medicine as a 'Specialty'.

There have been numerous committees, meetings and conferences, which have been attended by IMSANZ members. Ian Scott, and others, are involved with the Healthcare Collaborative initiatives. Michael Kennedy has established contact with the Greater Metropolitan Transition Taskforce in Sydney. I am sure there are other members involved with Federal and State Health authorities and it is important we continue to support their endeavours as a society. Consultation by the NSW Medical Board and other government bodies continues to enhance the role of IMSANZ in Australia and New Zealand

Neil Graham and I represented IMSANZ as members of the international delegation assessing the Health Care System in the Lao PDR. A visit to Nauru to provide physician services to the 32nd Pacific Island Forum allowed a unique insight to some of the extensive medical problems of our Pacific Island neighbours. Contact has been established with the International Society of Internal Medicine and I will attend the International Congress of Internal Medicine in Kyoto in May 2002 as the IMSANZ representative on the RACP delegation. Continuing liaison with the European School of Internal Medicine and EFIM has provided invaluable opportunities to promote IMSANZ on the international medical scene.

I would like to welcome the new members on Council - A/Prof David Russell from Melbourne and A/Prof Thein Htut from Toowoomba. Dr. Emma Spencer is the advanced trainee representative on council and I look forward to her advice and perspectives. My thanks are extended to Dr Bob Lodge for his support and enthusiasm.

Ms Lyn Abery, IMSANZ Secretariat, has provided valuable assistance during the year. She has been very tolerant of several moves within the RACP building and is now located in the Kent Street premises.

The increasing activities of IMSANZ have involved increased expenditure and the Council will need to ensure the finances of the society remain satisfactory. This may require an increase the modest subscription rates.

The upgrade in the IMSANZ Newsletter, the outsourcing for printing and the increased distribution has incurred additional expenses, but this is offset by the increase in recognition by our colleagues and outside agencies.

I would like to thank the Executive and Council of IMSANZ on both sides of the Tasman for their support and tolerance of change and new ideas, which will hopefully ensure the long-term viability, vibrancy, and vitality of IMSANZ

Please don't forget *to contribute letters, articles, reviews, CATs and cases to the IMSANZ Newsletter which is now well received by all our specialty colleagues and provides a visible presence for IMSANZ within the College.*

Day Report 2002

Another enormously successful IMSANZ day was held on Sunday 5th May 2002 at the Brisbane Convention Centre. As is usual, it was held the day before the RACP Annual Scientific meeting.

The day commenced for the enthusiasts with the AGM at 7:15am. The scientific sessions began at 9am with two workshops of 90 minutes each, one on renal disease and the other on psychiatry for the physician.

Dr. David Johnson, Deputy Director of Renal Medicine, Princess Alexandra Hospital, Brisbane presented a case of a 60 y.o female post office worker with hypertension and renal impairment. This formed the basis for a detailed discussion of the assessment and management of renovascular disease.

He emphasised that renal function could be overestimated by the use of the serum creatinine alone if muscle mass was low. The Cockcroft-Gault equation to calculate GFR better estimated renal function.

Control of blood pressure , hyperglycaemia, hypercholesterolaemia, ACE inhibitors, angiotensin II receptor antagonists and smoking cessation were all important to retard the decline in renal function. Although dietary protein restriction has been demonstrated to retard progression, it is associated with other undesirable outcomes related to malnutrition. Use of ACE inhibitors is sometimes associated with a rise in plasma creatinine but this is reversible once the ACE is ceased (PARADE study). A rise in creatinine of less than 30% compared to baseline, and serum potassium up to 6mmol/L is acceptable. A lack of initial fall in GFR following ACE inhibitor commencement is predictive of poor long-term renoprotective effect. Features of mild renal impairment (GFR 50-80 ml/min) include osteodystrophy, cardiovascular disease, malnutrition, sleep apnoea and nocturia. Anaemia, hyperkalaemia and acidosis are usually seen in moderate to severe renal impairment. There is no data to support reduction in cardiovascular mortality in chronic renal failure with the use of ACE inhibitors, EPO, Vitamin E, HMG CoA reductase inhibitors, calcium channel blockers or aspirin.

The second workshop was presented by Associate Professor Gerard Byrne, Psychiatrist, Royal Brisbane Hospital, Brisbane. He presented an update on medication for depression, delirium and dementia. His indications for the use of anti-depressant medication were major depressive disorders, dysthymia and minor depressive states, severe anxiety attacks (especially with panic attacks) and depressive states due to general medical conditions. Evidence for the use of antidepressants for the medically ill can be found in Cochrane review by Gill D, Hatcher S (2000). Of the SSRI medications available, he felt that sertraline and citalopram had the best side effect profile and least drug interaction. Venlafaxine was a reasonable choice for a second line agent. Paroxetine had troublesome muscarinic side effects that increased the risk of urinary retention; uoxetine had a long half life necessitating a two week wait before commencement of an alternative agent. Hyponatraemia is a well recognised class effect of the SSRI's and serum sodium concentration should be checked in the elderly with cerebrovascular disease or those on diuretics. If there is no response to treatment, consider a trial of an alternative agent.

Medical patients with delirium and dementia may benefit from antipsychotic drugs. Of the drugs available haloperidol is very useful as it may be given IV, IM or oral and is cheap. However it has significant extrapyramidal side effects. Risperidone, one of the newer agents is an alternative which has the best side effect profile. Antipsychotic drugs have the side effects of postural hypotension, sedation, extrapyramidal side effects and neurolept malignant syndrome. The lowest effective dose should be used and the drug ceased after several weeks of treatment.

Cholinesterase inhibitors for the treatment of dementia were discussed. The general principles were that treatment should be commenced at the lowest recommended dose for the drug and at least one month of treatment should elapse before considering a dose increment. Anticholinergic drugs should be ceased; asthma, cardiac conduction abnormalities and gastrointestinal disease diagnosed and treated. Efficacy of cholinesterase inhibitors is usually modest.

The last topic for this workshop was delirium (acute brain syndrome), a common condition with a high mortality. Important diagnostic features are acute onset with clouding of consciousness, fluctuating memory, very poor attention, psychomotor agitation and behavioural disturbance. Symptoms are often worse at night and disordered sleep-wake cycle is common. Management includes correction of underlying aetiological factors, cessation of anti-cholinergic medication, ensuring the safety of the patient and others, and low dose anti-psychotic drugs.

The next session of the day featured the Trainee Award Presentations. Dr. Callaway presented "Very advanced maternal age-outcomes for pregnancies progressing beyond 20 weeks gestation in women over the age of 45". This was a retrospective chart audit from the Royal Women's Hospital, Herston,

INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND

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"All Systems Go"

UPCOMING CONFERENCES

ALLICANTE, SPAIN, 22-27 September 2002.

There are two sponsored positions for Advanced Trainees for 2002 for attendance at this conference. Dr Neil Graham & Dr Michael Kennedy will be participating as tutors. This is the first time Australasian fellows have participated in this event.
Enquiries, contact the IMSANZ Secretariat on imsanz@racp.edu.au

HAWKES BAY, NEW ZEALAND, 28-30 March 2003

Hawkes Bay is central to two cities, Napier which is the Art Deco of the world and Hastings which is the centre of a major wine growing area. The area is beautiful and the weather is excellent. The professional content is always first class. The Venue is the War Memorial Conference Centre Napier. Plan your holidays so you can attend and stay on to enjoy the surrounds. More details later. Convenor is - Dr Rob Armstrong, Villa 2, Respiratory Department, Hawkes Bay District Health Board, Private Bag 9014, Hastings NZ.
E-mail: lungs@hawkesbaydhb.govt.nz Ph: 64 6 878 8109. If you make your enqiries to Rob and not the sponsors (GlasoSmithKline) it would help.

IMSANZ diners enjoying themselves.

QLD which showed good maternal and pregnancy outcomes in this group of patients. The second presentation by Dr. Elston from Tauranga Hospital, NZ was "Screening for diabetes using glycated haemoglobin in a Maori population at risk of type 2 diabetes mellitus - clinical assessment and glucose tolerance test follow up." As part of Hepatitis screening program, opportunistic screening using HbA1c for undiagnosed type 2 diabetes was performed to assess the incidence of this condition. Difficulties with this type of screening were discussed including difficulty with follow up, lack of resources and benefit of screening. Dr. Brett from the Royal Melbourne Hospital presented "Morbidity and mortality complicating hip fracture surgery at a Melbourne teaching hospital." This was a retrospective chart review of 200 randomly selected patients. Using multivariate analysis, it demonstrated that the major risk factors for increased length of stay in hospital were an abnormal cardiac rhythm, heart failure and general anaesthesia. Predictors for 28 day mortality were COAD, pre- and/or post-operative heart failure and post-operative renal impairment. The session was completed by a case presentation by Dr. Bolitho.

After lunch, the plenary session 'Vascular homeostasis- new insights and implications for clinical practice' was presented by Prof. B. McGrath, Vascular Medicine, Monash Medical Centre, Melbourne. He discussed common carotid artery intimal-medial thickness measurement by ultrasound and its relationship to risk of ischaemic heart disease and cerebrovascular disease; endothelial dysfunction; and the utility of pulse pressure, pulse wave velocity and the augmentation index (the increase in systolic pressure as a result of re ected waves from the periphery) as predictors for vascular disease and its assessment.

The afternoon continued with a "Hypothetical" and panel discussion. Two cardiologists and an endocrinologist were asked to discuss the case of a 68 yo male with a past history of IHD, 40 pack year history of smoking (now ceased), 3 year history of type 2 diabetes mellitus who

IMSANZ diners enjoying themselves.

presents to a large rural hospital with 45 minutes of typical ischaemic pain and troponin of 1.9 ng/l. The burning question was "evacuate to a major interventional cardiac centre or not?" There was considerable discussion!

The afternoon workshops were 'Update in infectious diseases' and 'Modern management of asthma.' Prof. J McCormack, (Infectious diseases physician, Mater Adult Hospital, Brisbane) used a case of Strep. pneumoniae pneumonia to open the discussion of penicillin resistance. 8.6% of Strep pneumoniae isolates in Australia are reported to be fully resistant. Use of uoroquinolones as single therapy was not encouraged due to the increased risk of the development of quinolone resistance in Streptococci. He further discussed the problem of VRE and fungal infections.

Assoc. Prof. C. Mitchell in his workshop on asthma raised a number of important issues. In one case of "acute asthma", he illustrated the issue of being sure of the diagnosis - is the presentation due to glottic closure? He discussed the importance of inhaler technique and that improved delivery of an inhaled asthma medication is achieved with quiet respiration rather than forced inspiration from residual volume. Another important point for the assessment of acute severe asthma is that a 'quiet chest' is alarming as it implies little movement of air and increased risk of ventilatory failure.

The last event of the day was 'Re ections', a review of General Medicine in Australia and New Zealand from the formation of the specific societies by Neil Graham and Peter Greenberg, their amalgamation and the current state of IMSANZ presented by Neil Graham, Peter Greenberg and the president of IMSANZ, Les Bolitho. Cameron Bennettt gave an amusing view of life as a trainee in General Medicine.

The day closed with a feeling of satisfaction and well-earned thanks to the principal organiser of an excellent meeting, Dr. Ian Scott.

M.R. Levinson

RACP Ceremony

There were a number of members of IMSANZ involved in the College ceremony on Monday May 6, 2002 in Brisbane at the RACP ASM. ***Congratulations are extended to all new Fellows and recipients of Awards and Medals.***

Presentation of Fellows

Congratulations to Theresa Thompson on her achieving Fellowship.

College Medals

Dr John Sands bequeathed to the College funds for the purpose of presenting medals to Fellows of the College who in the opinion of the Council have particularly contributed to the welfare of the college. Council resolved that medals for outstanding service be awarded to Fellows who have contributed significantly to the College but have not attained the office of President. There following IMSANZ members were awarded College Medals.

Alexandra Jane Caroline Bune

Alexandra Bune graduated from the University of Sydney in 1970 and undertook her postgraduate training at the Royal Prince Alfred Hospital. She gained Membership of the College in 1973 and Fellowship in 1977. In 1975 she was appointed Senior Staff Specialist (Medicine) at the Repatriation General Hospital and the Flinders Medical Centre and Senior Lecturer at the Flinders University of South Australia. From 1980 to 1996 she was Director of Cardiovascular Medicine and Hypertension at the Repatriation General Hospital and during that period served as Chair of the Division of Medicine. In 1996 Dr Bune moved to the Royal North Shore Hospital in Sydney where she was appointed Coordinator of Medical Education for the Northern Clinical School of the University of Sydney and Convenor and Chair of the Hypertension Group and north Shore Hypertension Service. She has been active in clinical research in hypertension as well as collaborative research in pulmonary hypertension in early obstructive sleep apnoea and in chronic obstructive airways disease.

Throughout her career, Alex Bune has been a leader in medical training and curriculum development at undergraduate and postgraduate level. At FMC she chaired the committee for (continuing from p.?) planning and supervision of the final year of the undergraduate medical course. This included the introduction of core terms in rural hospitals in South Australia and the Northern Territory, leading to the establishment of a full clinical school at Darwin. She also chaired the working party for the planning of the third and fourth years of the graduate entry program & was involved *(cont. on p.10)*

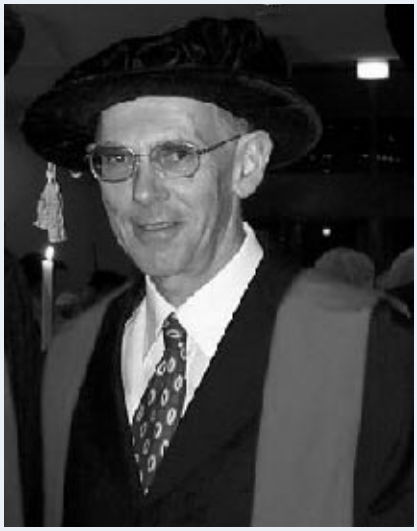
in the consortium of three Australian medical schools, which developed problem-based programs and new selection procedures. At the University of Sydney Alex chaired the committee for overall planning and implementing the third year of the new graduate medical program, as well as coordinating the program at the Northern Clinical School. Most recently, she has been Interim Dean of the new Medical School at the Australian National University leading negotiations between the University, the Government and external bodies in order to establish the necessary structures, relationships and funding.

For the College, Alex Bune has provided outstanding leadership and service over 23 years. She was a member of the SA State Committee from 1978 to 1994 and during that time was a member and then convenor of the Scientific Program Committee for the College's Annual Scientific Meeting. She was a Regional Examiner from 1984 to 1990 and a National Examiner from 1991 to 1997. She served as Director of Physician Training at the Repatriation Hospital, Daw Park from 1980 to 1996 and as a member of the Specialist Advisory Committees in each of General Medicine, Rehabilitation Medicine and Genetics.

Jonathan Brookes Douglas

Jon Douglas graduated in medicine from the University of Queensland in 1964 and undertook his early post-graduate and research training at the Princess Alexandra Hospital in Brisbane. He was admitted to Membership of the College in 1970 and Fellowship in 1975. Jon worked in private practice in Cairns from 1971 to 1978 and then returned to Brisbane as a Consultant Physician in private practice and Visiting Physician to the Royal Brisbane Hospital.

Throughout his career Jon Douglas has been an outstanding teacher and mentor of medical students, nurses, physiotherapists, physician trainees and general practitioners. At Cairns Base Hospital he was Coordinator of the Registrar Training Program and a lecturer to student nurses. On returning to Brisbane he was appointed a Clinical Tutor to medical students at Princess Alexandra Hospital and then at Royal Brisbane Hospital and continued to serve in that capacity for over 21 years. He has also lectured in the Family Medicine Training Program, in Sports Medicine and in the Master of Physiotherapy course at the University of Queensland.



Since 1980, Jon has coordinated a weekly clinical teaching session at Royal Brisbane Hospital for medical students, Resident Medical Officers and Medical Registrars and since 1994 has been the organiser of the College's Lecture Series conducted by the Queensland State Committee, a role which he relinquished last year. His commitment to education through the College is re ected in his membership of the Committee for Examinations from 1993 to 2000, membership of the Board of Censors from 1998 to 2000 and his appointment as a senior examiner for the Australian Medical Council.

Jon has also served as a leader in the profession, within and outside the College. He has been a member of the College's Social Issues Committee, the Working Party on Recertification, the Organising Committee for the Annual Scientific Meeting, the Specialties Board and the Relative Value Study Joint Working Party with the Australian Association of Consultant Physicians. Amongst his many appointments he has been President of the Cairns Local Medical Association, the Cairns Hospital Board, Chairman of the Wesley Hospital Board, Chairman of the Uniting Health Care Board and Chairman of the Medical Assessment Tribunals for Q-Comp. He has been a member, Vice-President and President of the Australian Association of the Consultant Physicians in General Medicine (now the Internal Medicine Society of Australia and New Zealand).

Jon Douglas has provided outstanding service to the College and is a worthy recipient of the College Medal.

Please note change to Michele's Levinsons email (refer to back page)

michelel@bigpond.net.au

RACP Medal for Clinical Service in Rural & Remote Areas

The Council in 1997 established a College Medal to recognise those Fellows who have provided outstanding clinical service in rural and remote areas...

Clive David Hadfield

Clive Hadfield graduated with the degree of Bachelor of Medical Science with first class honours from the University of Sydney in 1975 and with the degrees of Bachelor of Medicine and Bachelor of Surgery with second class honours in 1978. He undertook his early training at the Royal North Shore Hospital and Royal Prince Alfred Hospital in Sydney with rural secondments to Kempsey, Gosford and Orange Hospitals in New South Wales. He gained Fellowship of the Royal Australasian College of Physicians in General Medicine in 1986.

In 1988, Clive took up an appointment as Director of Medicine at Cairns Hospital in North Queensland and in 1996 was appointed to his current position of Staff Physician at Cairns Hospital.

In addition to providing outstanding service in Cairns in 1990 Clive was concerned to establish Australian Standards of care in rural and provincial

areas by improving local access. He developed a major outreach service by establishing General Medicine clinics in isolated towns and indigenous communities in Cape York Peninsula and the Torres Strait. These clinics delivered clinical services in internal medicine and investigations such as echocardiography and endoscopy at a local level. They also provided communication about patients between outlying areas and the referral hospital in Cairns. With the help of many colleagues, Clive was involved in establishing a nearly full range of subspecialty services in Cairns and has aided in making Cairns and North Queensland an attractive location for training in General Internal Medicine.

Clive has been a major contributor to the work of the Queensland State Committee of the College and the Physicians' network in North Queensland. His Queensland Workforce Survey conducted on behalf of the State Committee and the Internal Medicine Society of Australia and New Zealand, remains unsurpassed and has provided an invaluable framework for discussions with government and hospital managements.

He is a most worthy recipient of the College's Medal for Clinical Service in Rural and Remote Areas.

Arthur E Mills Memorial Oration

The late Arthur E Mills of New South Wales was a Foundation Fellow of the College and an outstanding physician, medical administrator and teacher. The Arthur E Mills Oration was endowed in 1950 by his widow and established within the College for the promotion and encouragement of medical education and general culture.

The 2002 Arthur E Mills Memorial Oration was delivered by
Khun Mechai Viravaidya, AO, FAFPHM (Hon)
Chairman, Population and Community Development Association, Thailand

His presentation on the program in Thailand to introduce birth control measures and limit the spread of HIV and AIDS was memorable and well received by all present.

IMSANZ MEETING REPORT

April, 2002 - Akaroa

"Our accommodation at Alicante."

The beautiful and serene setting of Akaroa was the site for another very successful IMSANZ meeting. The hour-long winding bus ride from Christchurch airport was well worth the effort. The picturesque harbour was resplendent in the evening light, with verdant hills emerging from the calm harbour. An ideal conference venue, the boatshed sitting above the water was surprisingly well equipped for 50-odd keen attendees.

The opening dinner at Harbour 71 restaurant was a good chance to relax and meet up again with colleagues before the mandatory business meeting.

The next morning kicked off with a session entitled 'Non-Boring Diabetes' by David Cole, which certainly lived up to its name, and covered pancreatic transplantation, the new insulins, and glitazones. Alan Pithie gave a particularly pithy update on infectious diseases, including the worrying increasing incidence of penicillin resistance in pneumococcal disease. Chris Collins, a psychogeriatrician from Christchurch, spoke on the broad area of dementia, and provided an overview of various aspects of Alzheimer's aetiology and some of the treatment options for the cognitive and behavioural/psychiatric aspects of dementia, both Alzheimer's and other dementias.

After lunch we heard a panel of experts talk about various aspects of syncope. Ivana Stolarek, David Jardine, Matt Hills, John Thwaites, and Ian Crozier presented a broad range of cases followed by a panel discussion. Matt Hills delved into ancient literature to look at the aetiology of cough syncope - perhaps cerebral concussion has a role in some cases?

The advanced trainee presentations were, as usual, of a high standard. Marianne Elston of Tauranga is to be congratulated for her winning presentation on screening a high-risk Maori population for type II diabetes with HbA1c. As part of her prize, she will be presenting again at an upcoming college meeting in Australia. Sarah Lynn presented an audit of the North Canterbury experience of in ammatory myopathy. Matt Doogue showed great facility with PowerPoint in his talk on the impact of the Digital Age on the practice of medicine, and the alternative therapy of caesium chloride for cancer as a cause of torsades was outlined by Terry Mitchell.

The conference dinner at the French Farm Winery was a most enjoyable evening - good food, good wine, good spirits, and a good time was had by all. Great entertainment was provided, both by the resident duo who were versatile with any number of instruments, but also by the guitar skills of John Henley and the singing talents of numerous attendees who shall remain nameless. The IMSANZ dinners continue to live up to their reputation as a chance to relax with friends and colleagues in convivial surroundings, let one's hair down, and temporarily forget the pressures of the daily medical grind.

The next morning fortunately started a little later. Peter George from Christchurch gave a very useful presentation on laboratory medicine. He outlined, amongst other things, the potential utility of genetic testing for personalised drug prescribing, a technique likely to become more relevant and available in the future. Les Bolitho told of an interesting case of post-transfusion purpura. Bruce King discussed the results of his audit of risk factor intervention for secondary prevention of cardiac disease in the Nelson area - generally successful, and would be worth comparing with results from other regions.

The 'Controversies in Medicine' session was ably presented by Briar Peat and Kirsten Holst, who discussed the role of the Mantoux test in TB diagnosis, and the justification for CT head scanning prior to LP in suspected meningococcal meningitis, respectively. These sessions have been very popular at previous meetings. The presenters are asked to provide a succinct account of the evidence for and against a particular proposition, before taking a stand. Vigorous discussion follows. It is certainly hoped that these sessions will continue at future meetings.

The conference finished with a session from Paul Reeve regarding questions for the Part I FRACP exam. Paul is representing the subspecialty of Internal Medicine on the RACP Written Exam Committee. The difficulties of writing a good question were readily apparent after a few sample questions were discussed amongst us. Paul welcomes suggestions for questions.

The conference was once again an out-standing success - well attended but small enough to provide stimulating discussion and interaction in a relaxed atmosphere. The chance to meet up with colleagues from around the country (and the odd Australian) was especially valuable. Many thanks are due to the organisers

John Thwaites and David Jardine. Thanks also to GlaxoSmithKline for their generous sponsorship.

We look forward to the next meeting in August in Dunedin (in conjunction with the Cardiac Society), at which safari suits and Hawaiian shirts will (hopefully) be replaced with something more appropriate to the locale.

Alan Jenner
Dunedin

Dr Ian Lyall retiring...

Dr Ian G Lyall is considering retirement in 2002 and would be pleased to hear from any Physician interested in his practice in Geelong. He also has medical rooms in Ryrie St Geelong available for lease.

He may be contacted on 0407 342 332

February, 2002

There has been great concern in IMSANZ circles lately about the closure of the General Medicine unit at Concord. This has raised all the familiar anxieties about General Medicine in Teaching Hospitals, but we need to move beyond the usual handwringing

to a workable strategy for the establishment of General Medicine as a discipline within Australia's major centres of medical excellence.

We have a clear duty to develop General Medicine as a discipline, because of its importance in meeting the needs of patients presenting with complex multisystem disease; and because any effective delivery of secondary care in Internal Medicine outside the metropolitan centres will rely on well trained General Physicians. This challenge is also an opportunity for us because there is now substantial political interest both in developing alternative models of care and in providing good quality care in Regional, Rural and Remote communities. We must pursue these opportunities and bypass the conservative thinking of some Capital City institutions.

What follows are some personal re ections on the problem, an account of our experiences in Newcastle, and finally, some suggestions.

I believe that in Teaching Hospitals where the subspecialties admit directly, General Medicine Units will always struggle for a role other than that of default admitting unit. This can be addressed by identifying specific roles within the institution for the General Medicine Unit, but that may or may not be successful.

It may be possible, for example, for the General Medicine Unit to operate an Acute Admission Unit managing the first 24 - 48 hrs of the hospital stay, but that needs careful separation from the role of the Emergency Department. Alternatively, the General Medicine Unit could run a special unit for patients with multiple complex problems, but this could easily metamorphose into an acute Geriatrics unit, which might upset the Geriatricians. In spite of the difficulties, both these things have been done at different times and places successfully, and I am sure there are other options.

Here in Newcastle we have had some successes and some failures in developing Teaching Hospital General Medicine and I would like to review these brie y. This is not intended to be an exercise in self promotion, but our experiences may be instructive.

By an accident of history, the Newcastle Mater Misericordiae Hospital (MMH) has retained a full General Medicine Service. We are a Teaching Hospital of the University of Newcastle and have tertiary services in Oncology, Haematology, Palliative Care, Clinical Toxicology, and Addiction Medicine. However, except for Toxicology, the tertiary units only admit directly patients they already know, and the toxicology service is partly integrated so all acute Medicine is under our care. This has allowed us to maintain our skills in all the facets of General Medicine and to provide training in them also. The consultants in the unit have a variety of subspecialty skills as well; most notably Gastroenterology, Respiratory Medicine, Immunology, Infectious Diseases, and Clinical Pharmacology and we can provide specialist training in these where appropriate.

In addition, we have established a good working relationship with the physicians at Tamworth and we have a very successful rotation there suitable for both Basic and Advanced training. I go to Tamworth every six weeks and conduct a Hepatitis C clinic there as well as some supervision and support of our registrar. We attempted to set up a remote area and Indigenous Health program in partnership with Alice Springs Hospital and the Nganampa Health Council in Northern South Australia which worked well for the first year but now, unfortunately has come to a halt.

Thus, we have some strengths, some potential strengths and some failures.

Our colleagues at John Hunter Hospital are in a different situation. At JHH the subspecialties admit directly, but expect the General Medicine Unit to take the patients who do not fall neatly into one of their disciplines. This makes the General Medicine Unit a "default" unit which some would support, but I do not think is satisfactory. It is interesting that the Division of Medicine at JHH is strongly supportive of this arrangement.

The John Hunter unit, however, has some advantages we do not have. Because JHH has the Obstetric Unit, they run the Medicine of Pregnancy service which is an important area for young physicians to have experience in. They are also all part of the Area Diabetes Service, which is even more important, particularly since it provides opportunity for experience with high risk groups such as adolescents and Indigenous people. They enjoy a good relationship with the Infectious Diseases Unit, the Cardiology and Intensive Care Units, and can arrange for Advanced Trainees to have attachments in these.

As would be obvious from the above, we have seen that there are great advantages in combining the two units for the purposes of training.

Between us we have the opportunity to practice and to teach:

1. The management of acute multisystem failure. Most of the time we have 3 or 4 of the beds in the ICU at the Mater.
2. The in hospital care of the full range of conditions in Internal Medicine.
3. The organisation and delivery of care of chronic diseases such as CAL or CCF.
4. Innovative forms of care delivery such as hospital in the home.
5. General Medicine in a major regional centre.
6. Remote Area and Indigenous Health.
7. Subspecialty skills such as endoscopy and echocardiography.
8. Expertise in other common areas in which General Physicians are consulted such as Medicine of Pregnancy, Diabetes in high risk groups and Addiction Medicine.

We have therefore agreed to combine our resources to provide 1-3 years of Advanced Training in General Medicine and also to run the Basic Training program in Medicine for the Hunter Area.

In case that all sounds too good to be true, we have had some major problems, disappointments and failures.

1. The position of the unit at JHH continues to be precarious. Even though the consultants all have a strong commitment to General Medicine, all have subspecialty responsibilities also, and none are full time General Physicians. The Area Health Service also, seems to think that General Medicine is not a suitable activity for JHH and is planning to move some of their beds.
2. In spite of very active promotion, including sending a flyer to all the Advanced Trainees on the IMSANZ mailing list, we have failed to attract Advanced Trainees in the numbers needed to maintain the training program. We are not sure whether this is because we are outside the Capital Cities or because General Medicine itself is not seen as attractive or both. Perhaps people are also reluctant to commit themselves to an area of Medicine which is seen as being practised away from the big cities.
3. We began very well with our Nganampa attachment, but it lapsed after one year because of difficulties in recruitment and logistic problems. This was a severe blow, because we felt it had enormous potential both to deliver secondary care to people who have difficulty gaining access to it and to provide a unique training opportunity. We failed because we were unable to recruit enough registrars from JHH and MMH, and we did not foresee the problems the scheme would pose for Alice Springs Hospital. Ultimately, however, we failed because we failed to recruit enough allies from the Commonwealth, the College or the other Teaching Hospitals all of whom were lukewarm at best in their support. We simply didn't put in the necessary groundwork and bridge building.

The above then, represents my credentials to have an opinion about Teaching Hospital units in General Medicine. A successful unit needs to cover all of acute Medicine, to have strategic alliances with enough organisations to provide training in a variety of settings and to have adequate resources. It also needs to be run by people who know what they are doing and can give it their full time attention.

I would like to suggest the following:

1. A meeting be arranged as soon as possible between the existing Teaching Hospital Units and the College of Physicians to share experiences, exchange information, and develop a common national strategy for the development of General Medicine.
2. All Metropolitan teaching units should have a partnership agreement with at least one regional or rural centre concerning joint development of clinical, teaching and training programs. This would not just mean having a rural attachment but a real partnership involving actual contact between the consultants.
3. Consideration should be given to a Statewide or even Nation wide allocation system for Advanced Trainees as is done in some other disciplines.
4. IMSANZ and the RACP in consultation with the teaching hospital units, develop a set of criteria to define a Teaching Unit in General Medicine. I would suggest:
    a. The unit Director should be a full time specialist or clinical academic whose primary appointment is in General Medicine. There should also be at least one other full time consultant.
    b. The unit must undertake the acute admission and in hospital care of the full range of conditions in Internal Medicine in a Teaching Hospital.
    c. They should have skill in the management of acute multi-system failure.
    d. Expertise in the organisation and delivery of care in chronic diseases.
    e. Provision of services in non conventional settings such as hospital in the home schemes etc.
    f. Expertise in one or more of the "consulting" disciplines such as Diabetes, Pregnancy, Addiction etc.(others will be able to think of other examples)
    g. A working relationship with one or more rural or regional centres covering clinical services and teaching which allows for the provision of supervised training in a non metropolitan setting.
    h. An appropriate research program.
    i. Involvement in national programs to improve the standard of patient care such as the National Demonstration Hospital Program or equivalent.

The above may seem like a fairly daunting "wish list", and in most places that I can think of, could only be achieved by combining activities at two or more sites. Nonetheless, the range of activities and personnel suggested is modest compared to what one would expect in, for example, a teaching hospital Renal or Gastroenterology unit.

Not all Teaching Hospitals will be able or willing to operate a General Medicine unit of this standard, and frankly, I'm not sure that they all should. What we need is a national system of training underpinned by a national network of Teaching Hospital units of a universally high standard. That network can then, by forming another network of partnerships with facilities in regional and rural areas, deliver clinical expertise, training and a regular supply of new General Physicians to Regional and Rural Australia.

To do this successfully we will need a coalition between IMSANZ, the RACP, the Commonwealth Government, and the Faculties of Medicine.

The above are my views and my suggestions. Others may have better ideas about how to achieve an effective delivery of services and of training. What is clear however, is that we do have the skills and expertise, the resources required are not great in the overall scheme of things, and we can do much better than we are doing.

There is quite simply no excuse for failing to take advantage of the present circumstances to establish General Medicine as a discipline and to use it to make a major improvement in the standard of care of our fellow Australians regardless of where they live or who they are.

Aidan Foy

CRITICALLY APPRAISED TOPICS (CATs)

Glucosamine for knee osteoarthritis

Oral Glucosamine sulphate improves symptoms and arrests progression of joint space narrowing in knee osteoarthritis (OA).

Citation: Reginster JY et al. Long-term effects of glucosamine sulphate on osteoarthritis progression: a randomised, placebo-controlled clinical trial. Lancet 2001;357:251-6.

Clinical Question: For patients with osteoarthritis of the knee, does oral glucosamine alter pain, function, or disease progression? (Glucosamine is a normal constituent of glycosaminoglycans in cartilage and synovial uid. It is postulated to have pharmacological effects at these sites).

The Study: Double-blinded concealed randomised controlled trial with intention-to-treat (ITT) analysis.

Patients: Recruited from University Hospital rheumatology research clinic in Belgium. Age>50 years. Primary OA in medial compartment of knee.

Exclusions: intra-articular or systemic steroids in the 3 months before study, BMI>30, ESR>40, Rheumatoid Factor>=1:40. Abnormal haematology, renal or liver function.

Control group (N = 106; 106 analysed): Placebo for 3 years. 'Rescue' analgesia (paracetamol, NSAID) allowed and use recorded.

Experimental group (N = 106; 106 analysed): 1500mg glucosamine (pure!) taken for 3 years. 'Rescue' analgesia recorded as above.

Outcomes:

Self-rated symptoms. The WOMAC (Western Ontario and McMaster Universities osteoarthritis index) score has 24 questions: 5 concern pain, 2 stiffness and 17 concern physical function. Each question is self?administered by marking a 100mm visual analogue scale. The total score is out of 2400mm and higher scores are worse. This measure has been shown to correlate well with trained interviewer-based assessments (Bellamy et al, J. Rheumatol. 1988;15:1833-40). The score has been shown to have high reliability and validity, although there is no definite "gold standard". One third of patients used to establish the WOMAC score had hip OA, otherwise the patients in this study were similarly selected. Baseline WOMAC scores in this study were 940 and 1030 for placebo and glucosamine groups respectively.

Radiological measures. Standardised weight-bearing radiographs were taken at baseline, 1, and 3 years. Images were digitised and analysed automatically using a previously validated system. The films were also assessed manually.

The Evidence:

Outcome	Time to Outcome	CER	EER	RRR	ARR	NNT*
Mean joint space narrowing of > 0.5mm	3 years	0.30	0.15	50%	0.15	7
	95% Confidence Intervals:			13% to 87%	0.04 to 0.262	4 to 25
Mean decrease in joint space (mm)	3 years	0.31	0.06	p = 0.04		
Decrease in minimum joint space (mm)	3 years	0.40	0.07	p < 0.01		
Average % change in WOMAC score	3 years	+10%	-12%	p = 0.02		

**CER = Control Event Rate, EER = Experimental Event Rate, ARR = Absolute Risk Reduction, NNT = Number Needed to Treat*

Comments:

- No side effects compared to placebo.
- The "intention to treat" analysis may have underestimated the true effect of medication, as one third of patients dropped out of the study in both groups.
- No difference in "rescue" drug use between the groups argues against a substantial effect of glucosamine.
- Although joint space narrowing is a marker of osteoarthritis, there is poor correlation between symptoms and degree of narrowing. This study showed that the correlation between improvement in joint?space narrowing and improvements in symptoms was poor.
- Glucosamine should be considered in all patients with symptoms of knee OA.
- Glucosamine costs between A$66- and A$558- per year.
- Trials of glucosamine in hip and hand OA and additional trials in knee OA are needed.
- Also see commentary. McAlindon T. Lancet 2001;357:247

Appraised by: Dr Lynden Roberts (17 January 2002)
E-mail: lyndenroberts@hotmail.com
Kill or Update By: February 2003

CRITICALLY APPRAISED TOPICS (CATs)

...Prognosis in heart failure

Assessment of physical signs such as the jugular venous pressure and a third heart sound are clinically meaningful markers of prognostic significance in patients with heart failure

Citation: Prognostic importance of elevated jugular venous pressure and a third heart sound in patients with heart failure. Drazner et al, NEJM 2001;345:574 - 81.

Three-part Clinical Question: Does an elevated jugular venous pressure and a third heart sound have prognostic importance in patients with heart failure?

Search Terms: SOLVD (Studies of Left Ventricular Dysfunction), heart failure, left ventricular ejection fraction, physical signs, jugular venous pressure, third heart sound, adverse outcomes.

The Study: Retrospective analysis of the (SOLVD) treatment trial (Am J Cardiol 1990;66:315-22).

The Study Patients: 2539 patients enrolled on the basis of: 1) age between 21 and 80 (mean 62 ± 10) and 2) left ventricular EF £0.35. Follow up was for an average (±SD) of 32±15 months. At time of enrolment and review, the presence or absence of elevated JVP and a third heart sound was assessed.

Exclusion criteria: Haemodynamically significant valvular obstruction, complex congenital heart disease, patient intolerant to ACEI (enalapril), cor pulmonale, significant renal or hepatic disease.

Prognostic Factors of Interest:

- Death from all causes
- Hospitalisation for heart failure
- Death or hospitalisation for heart failure
- Death from pump failure
- Death from arrhythmia

The Study Outcome

Study Feature	Yes	No
Well-defined sample at uniform (early) stage of illness?	X	
Follow-up long enough?	X	
Follow-up complete?	X	
Blind and objective outcome criteria?		X
Adjustment for other prognostic factors?	X	
Validation in an independent "test-set" of patients?	X	

The Evidence: *CI = Confidence Interval, PPV = Positive Predictive Value, NPV = Negative Predictive Value, RR = Relative Risk*

End Point	Incidence (per 100 person-yr) according to the presence of		RR			CI	PPV		NPV	
	Elevated JVP (N=280)	Elevated (N=597)	Elevated JVP	S3	Elevated JVP, S3, or both		Elevated JVP	S3	Elevated JVP	S3
Death from all causes	20.3	17.5	1.15	1.15	1.17	95%	0.49	0.44	0.64	0.65
Hospitalisation for heart failure	23.8	20.9	1.32	1.42	1.43	95%	0.43	0.41	0.70	0.72
Death or hospitalisation for heart failure	38.1	30.9	1.30	1.22	1.28	95%	0.69	0.61	0.49	0.50
Death from pump failure	12.4	10.4	1.37	1.40	1.47	95%	0.30	0.26	0.83	0.84
Death from arrhythmia	3.6	3.8	0.96	1.13	1.08	95%	0.09	0.10	0.91	0.92

Comments:

The presence of an elevated JVP and a third heart sound are independently associated with adverse outcomes including progression of heart failure. The more infrequent the event, the higher the negative predictive value. The physical examination should be integrated with laboratory investigations and imaging studies (eg echocardiography) to better predict prognosis in individual patients with complex illnesses such as heart failure.

Appraised by: Dr Peter Barlis, Elizabeth Austin Professorial Registrar, Department of General Medicine, Austin & Repatriation Medical Centre (Tuesday, 28 May 2002)

E-mail: peter.barlis@armc.org.au

The publication of the *Clinical Workforce Surveys 2001*[1], by Owen Dent, which report on the current workforce of Fellows of the College who are clinically active, provides some interesting insights.

The comments in italics are my observations on - Australia: Clinical Workforce in Internal Medicine and Paediatrics 2001.

In the report, Consultants in Adult general medicine (with or without a specialty interest) and Specialist Physicians are grouped under the rubric General Consultant, consultants in a specialty field in adult medicine (with or without general responsibilities) are grouped under the rubric Specialist Consultant.

Key Points

In Australia there are 474 General Consultants in adult medicine, with an additional 2913 Specialist Consultants in adult medicine *(i.e. General Consultants were 13.99% of total adult physician pool of 3387 clinically active physicians)*.

The workforce in adult medicine grew by 3.15% compared to an Australian growth rate of 1.3% per annum.

The ratio of the total population of Australia to all clinically active Fellows was 4.490:1 in 2001 compared with 7,410:1 in 1981.

In adult medicine, the ratio of the population aged 15 years and older to General Consultants ranged from 22,540:1 in South Australia up to 50,120:1 in the Australian Capital Territory whereas for Specialist Consultants the ratio ranged from 4040:1 in the ACT to 11,380:1 in Northern Territory.

Women formed 19% of the workforce as compared with 16% in 1999. Forty -five percent of the age group 30-34 yrs are women compared with 11% or less in the age groups over 50 years. Women are most strongly represented among Specialist Paediatricians (32%) and least among General Consultants (13%).

The age distribution ranged from 30-75 years with a mean of 48 years and 42% aged 50 or older. General Consultants, with a mean age of 53 years, were distinctly older as a group then Specialist Consultants or paediatricians.

Owen Dent reports that for Specialist Consultants, cardiology *(435 specialist consultants + 52 specialist consultants with general responsibilities)* and gastroenterology *(267+81)* were the two most prominent specialty fields, followed by neurology *(236+14)*, thoracic medicine *(177+66)* and endocrinology *(160+60)*. *Geriatric Medicine (115+60) presents an interesting comparative specialty*.

Overall, there are an additional 513 Specialist Consultants with General Responsibilities. However, once again the report seems to dismiss General Consultants as not having a "specialty"- 474 general consultants with possibly an additional 513 physicians ie 987/3387 or up to 29.14% of Fellows practice General Internal Medicine!

He has not been collecting statistics on the role and function of Generalists and we are not included in further analyses.

The average working week over all types of professional activity was 53 hours.

The average time spent in clinical practice was 40 hours per week.

Fellows in State capitals had the lowest average (39 hours) while those in regional centres had the highest (46 hours).

In the Northern Territory there are only 13 Consultants all told, with no consultants in 11 of the 18 fields tabulated.

The 60% of the Australian population living in New South Wales, Victoria and the Australian Capital Territory were served by physicians and paediatricians at the ratio of 4,170:1.

Intensive Care fellows include 73 Specialist Consultants, and 11 with General Responsibilities (NSW 27, VIC 27, QLD 8, SA 7, WA 7, TAS 6, NT 0, ACT 2). These figures are relevant when considering eligibility for the Joint Faculty of Intensive Care Medicine).

Ambulatory Care is not accorded the credit deserved

Hospital and University appointments are recorded. 26% of Fellows had a full-time public hospital appointment, with 58% part-time, 4% full-time University and 16% part-time.

84% of Fellows held paid public hospital, and 20% paid university appointments, 17% held both, 14% of Fellows held neither.

Location & demographics of practice

Fellows grouped by postcode of mailing address into three categories:

(a) State Capitals -80% of workforce

(b) Other Large Cities (population > 100,000) Newcastle, Wollongong, Geelong, Gold Coast

[1] Clinical Workforce Surveys 2001. Dent OF. Nov 2001. RACP News. RACP.

(c) Regional Centres (incl. Darwin) -13% *(5.3% of physicians in VIC practise in rural setting for 29% of VIC population)*
(d) The average clinical workload in regional centres was greater than in the State capitals, and often much greater
(e) By State, the percentage of Fellows in capitals were:
NSW 78%, VIC 88%, QLD 67%,
SA 98%, WA 96%, TAS 61%
(f) Proportions in Regional Centres:
NSW 13%, VIC 9%, QLD 24%,
SA 2%, WA 4%, TAS 39%
(g) 24% of workforce was female in State capitals, 13% in large cities, and 14% in regional centres
(h) In regional centres 87% Fellows engage in private practice, with only 29% in regional centres being involved with research
(i) Fellows in State capitals spent below the overall mean time in clinical practice (39 hrs), large cities (45 hrs), and regional centres (46 hrs)
(j) The mean time in clinical practice for males was 42 hrs, and for female 30 hrs

This will become increasingly relevant with the increasing numbers of females Fellows in the workforce. It is estimated that 60% of medical graduates will be female by 2005, and this will in uence practice patterns in the next decades

In Summary

There is a significant body of Fellows who are engaged primarily in clinical activity as General Consultants (474 physicians) or are engaged as Specialist Consultants with General Responsibilities (513 physicians) who are not adequately represented by this bi-annual Clinical Workforce survey. We need to continue to make representations to the College, the School of Social Sciences, Australian National University and Owen Dent to include the role of General Physicians within the survey.

Les Bolitho
April 2002
lbolitho@netc.net.au

New Zealand

The publication of the *Clinical Workforce Surveys 2001*[1], by Owen Dent, which report on the current workforce of Fellows of the College who are clinically active, provides some interesting insights.

The comments in italics are my observations on - New Zealand: Clinical Workforce in Internal Medicine & Paediatrics 2001.

In the report, Consultants in Adult general medicine (with or without a specialty interest) and Specialist Physicians are grouped under the rubric General Consultant, consultants in a specialty field in adult medicine (with or without general responsibilities) are grouped under the rubric Specialist Consultant.

Key Points

The NZ survey included data on 590 of 617 Fellows apparently practising internal medicine or paediatrics in NZ.

The workforce had increased from 570 in 1999 to 590 in 2001, with an average growth rate of 1.7% compared with an annual population growth rate of 0.6%

The types of practice categories are similar to Australia and the number of CPs in each are:

> Consultant Physician in General Medicine n=31, 6%
> CP in adult general medicine with specialty interest n=51, 9%
> CP in specialty field in adult medicine n= 283, 48%
> CP in specialty field in adult medicine but with general responsibilities n=77, 13%

In a total of 450 adult physicians there are 89 General Consultants and 361 Specialist Consultants - NZ population > 15yo = 2,983,000 (VIC population > 15yo = 3,880,100 with 928 adult physicians - with only 52 in rural VIC).

Table 1. Ratios of populations aged 15yrs and older per consultant in adult medicine in New Zealand and Australia - Number (Population per physician).

There are 32 General Consultants 65% of General Consultants without a specialty were aged 50 years or older

In the specialty areas Cardiology has 67 Specialist Consultants and 7 with General Responsibilities, Geriatric Medicine 48 + 6, Gastroenterology 37 +6, Endocrinology 23 + 13, Thoracic Medicine 27 + 7, Neurology 29 + 4, Rheumatology 31 + 2, and among the other specialties there is Intensive Care 4 + 1 (see previous comments on JFICM)

General Consultants spent the highest average time in clinical practice (mean 38 hours). The mean for women (32 hours) was distinctly lower than for men (39 hours) and women tended to work below the mean (positive skewness) whereas men tended to work above the mean.

This is an important consideration with the increasing numbers of female medical graduates and the expected increase in female physicians

In Summary

In New Zealand there is a dedicated and relatively small number of General Consultants - 32- with an additional 57 Specialist Consultants with General responsibilities

IMSANZ needs to continue to strongly support the role of General Internal Medicine physicians and to encourage increased training opportunities in New Zealand and Australia

Les Bolitho
April 2002
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Table 1.

	General Consultant	Specialist
2001 resident population > 15 yrs		
NZ 2, 983,000	89 (33,500)	361 (8,260)
Australia 15,497,900	474 (32,700)	2913 (5,320)

[1] Clinical Workforce Surveys 2001. Dent OF. Nov 2001. RACP News. RACP.

WHAT'S IN THE JOURNALS?

General Internal Medicine

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

Advanced Training Programme for Rural Physicians

Simmonds D, Phelps G, Ziffer R, Bolitho L, Knight B, Disher G. RACP News; July 2001: 23. This describes the establishment and first year of an innovative programme in Victoria, Australia. Six advanced training positions have been funded for 2002.

Opportunities in Rural Medicine

Bolitho LE. RACP News; November 2001:7-8. Les Bolitho, on behalf of the Victorian Rural Physicians Network comments on the looming crisis in the delivery of specialist services in many rural and regional areas.

Remote Service Delivery - Still much work to be done

Larkins R. RACP News; November 2001:11-12. Richard Larkins comments on problems for overseas-trained physicians trying to practice in Australia, on incentive programmes to induce practitioners to work in rural and remote areas and on the role of the RACP in these matters.

Here life is stimulating, never boring

Semmonds A. RACP News: March 2001, 17-18. Dr Semmonds comments enthusiastically on her experiences during training at Tamworth Base Hospital, New South Wales, Australia.

General Internal Medicine at the crossroads of posterity & despair:

Caring for patients with chronic diseases in an aging society

Larsen EB. Ann Intern Med 2001; 134:997-1000. Eric Larsen is a former president of USA Society of General Internal Medicine. He discusses the evolution of general internal medicine in the USA since the 1970s, in terms of patient care, research and teaching, and outlines opportunities for general internal medicine particularly in the areas of systems thinking and quality improvement.

President's Message:

Canadian Society of Internal Medicine

The General Internist: Fall 2001. Dr Akbar Panju, retiring as President of the Canadian Society of Internal Medicine, comments on his term and outlines the strengths and problems for general internal medicine in Canada, many of which are similar to those in Australia. The Canadian Society of Internal Medicine website (http://csim.medical.org) contains programmes of meetings and relevant links. The website includes several of the past issues of "The General Internalist" which contain useful material for continuing education and other articles about general medicine in Canada of interest to IMSANZ members.

Surveying the Specialist Silos

Chew M, Van Der Weyden MB. Med J Aust 2002;176:2. In introduction to a series of updates on advances in Medicine, the Editor and Deputy Editor state. "...That medicine is increasingly isolated into the specialist silos is clearly visible in these Updates. Yet, it is equally clear that innovation is not dead unless these silos become even more airtight..."

General Internal Medicine

Scott IA, Greenberg PB. Med J Aust 2002; 176:16. A brief account of views pioneered by generalists which have become common to many clinical disciplines: eg evidence based medicine (EBM), quality improvement, outcomes management, interdisciplinary care and "hospitalism".

Update in General Internal Medicine

Sheffield JVL, Larson EB. Ann Intern Med 2001; 135:269-278. This includes a review of and comments on 17 selected papers published since 2000, of relevance to general physicians. Headings include hypertension, hormone replacement therapy, atrial fibrillation, anticoagulation, chronic infectious diseases, hospital medicine and prevention.

50 Years of Medical Specialisation:

From Foundation to Fragmentation

Hickie JB, Hickie IB. Med J Aust 2001; 174:45-47. An outline of the development of specialisation in Australia between 1950-1980 and the rationalisation of specialist health services between 1980 & 2000. "...There is a very real danger that, in seeking out the very best in specialised care for each of their major medical problems, patients will lose the continuity of care offered by general medical staff..."

The Hospitalist movement 5 years later

Wachter RM Goldman L. JAMA 2002; 287:487- 494. This reviews the development and uptake of "hospitalism" within the USA health system.

Prognostic Importance of Elevated Jugular Venous Pressure & a Third Heart Sound in Patients with Heart Failure

Drazner Mark H, Rame EJ, Stevenson LW, Dries DL. New Eng J Med 2001; 345:574-581. A retrospective analysis of the SOLVD data, which included patients with symptomatic heart failure or a history of it, showed that elevated JVP and a 3rd heart sound were independently associated with adverse outcomes, including progression of heart failure. See also accompanying editorial by Perloff JK. N Eng J Med 2001; 345:612-614.

Hepatic Fremitus:

'Monash sign'

Nagappan R, Parkin G, Tsui A, Sievert W. Intern Med Journal 2001; 31:567-668. Ramesh Nagappan and his colleagues describe palpable hepatic fremitus as a new physical sign in a pregnant woman with hepatic failure associated with herpes simplex.

Lowering Cardiac Risk in Non-cardiac Surgery

Fleisher LA, Eagle KA. N Eng J Med 2001; 345:1677-1682. In the "Clinical Practice" section, the authors present a case of a 60 year old man who requires resection of an abdominal aortic aneurysm. He has a past history of coronary heart disease. Steps that can be taken to minimise this patient's risk of peri?operative cardiac complications and discussed and an algorithm, guidelines, and other references provided.

Dispelling the myths about rural specialist practice; The Victorian Physicians Survey

Simmons D, Bolitho L, Phelps G, Ziffer R, DisherG. MJA 2002; 176:477-481.
A survey of more than 600 rural and metropolitan practising Victorian physicians evaluating obstacles to rural practice.

Peter Greenberg
Melbourne

FROM THE EDITORS

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

We are most grateful for contributions received from members.

The IMSANZ Newsletter will now be published three times a year: in October, February and June. 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 Lyn Abery, IMSANZ secretary.

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

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