IMSANZ
INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND

DECEMBER 2007

Secretariat
145 Macquarie Street
Sydney NSW 2000
AUSTRALIA

Telephone
+ 61 2 9256 9630

Facsimile
+ 61 2 9247 7214

Email
imsanz@racp.edu.au

Website
www.imsanz.org.au

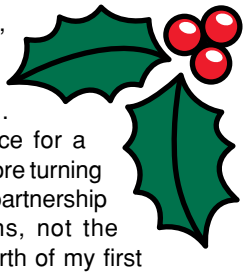
From the President...

Seasons Greetings

As we sit back to review the year, and continue to plan for the next year, it has certainly been no annus horribilis in General Medicine. The events in the last twelve months that impact on General Medicine in a positive sense have been many and there is a real feeling that the blueprint for the shape of General Medicine in the future "Restoring the Balance" is finally gaining some traction in both the College and in Government circles.

However the most important aspect of my first newsletter report as President is to recognise the enormous shoes I step into and to pay tribute to the work of Phillippa in her time as President. The successes of recent times are testament to her leadership. She continues as a tireless worker for IMSANZ and General Medicine, both on committees and behind the scenes. It is also important to note the major ongoing contributions of the other past presidents, office bearers and councillors. In my short time on the committee the work done by Phillippa, Ian Scott and Mary-Ann Ryall in all aspects of general medicine has provided me daunting role models, along with the IMSANZ and AACP work of Les Bolitho.

Perhaps it would also be sensible to tell you, in this newsletter, who I am and what I am passionate about with regard to General Medicine. I went to school in the 60 and 70's, completed Uni in the 80's and wished to pursue a career in general practice, preferably in a rural setting (already some generalism tendencies). I worked in a city practice for a reasonably short time before turning down an offer to buy into partnership for a number of reasons, not the least of which was the birth of my first child and the relevant real estate prices at the time.



I initially returned to the public sector as a medical registrar but after some time took up a position as Emergency registrar in this relatively fledgling training program. But within a year my supervisor was to move on to an alternative position interstate and I acted as the Director of Emergency medicine for approximately eighteen months before finding that without a supervisor my time was not accredited. This with the lack continuity and of follow up of patients was starting to frustrate me. From there I went to ICU and then had an epiphany and left the shores of Tasmania for Adelaide with two and a half children to undertake physician training with a desire to, in due course, practice General Medicine. I returned to Tasmania with my wife and 4 children in the late 1990's and have worked in General Medicine ever since. Along with this I have had the opportunity to be involved in the development of our stroke unit and am now a VMO practicing more than half my time outside the public sector. My public sector appointments, however, continue to include

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PRESIDENT'S REPORT

the Directorship of General Medicine and the Directorship of our Stroke Unit along with being the deputy department head and the Discipline Head for Medicine in our clinical school. So I believe that I bring some appreciation of the large role of General Medicine in our community, having practiced in many aspects of it, but also a passion that comes from a very deliberate decision about the type of medicine I wanted to practice following my moulding experiences in other disciplines.

From the perspective of looking at General Medicine in Australia and New Zealand we certainly are entering an exciting and challenging period. Increasingly government and educational institutions, including the colleges, are valuing generalism from not only the perspective of its benefits in patient care but also from the perspective of the economic benefits of a more rationalised health service. I certainly see IMSANZ's challenge, as a society, is to maintain and control this debate. We are the logical drivers of the process of General Medicine in Australia and New Zealand and whilst the legislators and the universities are obviously keen to introduce generalism into the acute and chronic health mix in urban, regional and rural centres, they aren't always focused on an appropriate time frame for this. We, as physicians, recognise that it takes more than the life of one government to train a General Physician, even at a post graduate level. Hence to sort out the manpower crisis in generalism, particularly in Australia, will take a commitment by government that will see the full term of more than three federal administrations. Thus our society must take control of the debate, protect the quality of the medicine practiced and hence protect the public from cheap alternatives whilst still being forward thinking and innovative in our training and the practice of our discipline.

Phillippa Poole handing over the reins to Alasdair MacDonald

This ground swell of change towards Generalism is not isolated in Australia and New Zealand but is a world wide phenomena as manifest by my recent experiences with the Society of Acute Medicine in the UK, which you will find elsewhere in the newsletter, and by the ongoing advocacy of the International Society of Internal Medicine, who we are lucky enough to be involved with and will be sharing their world congress in Melbourne in 2010. Similar changes are also being seen across the America's.

For this reason in concert with the RACP, and the hard work done by Phillippa, Ian, Mary-Ann and their colleagues, we are strongly placed to lead this process in Australia with well developed curricula, both at a basic and advanced training level, and strong advocates within our society, the RACP and the AACP. So after assuming the Presidency of the Society, at the recently successful combined meeting with the Australian and New Zealand Society of Geriatric Medicine in Adelaide, I look forward to pushing up my sleeves and playing a role in this important battle for the maintenance and expansion of all aspects of being a general physician.

ALASDAIR MACDONALD
IMSANZ President

IMSANZ would like to welcome the following New Members:

- Dr Bob Eason, Auckland, NZ
- Dr Mark Forbes, Robina, QLD
- Dr Ruth Hughes, Christchurch, NZ
- Dr Callum Pearce, Claremont, WA
- Dr Yogesh Sharma, Adelaide, SA
- Dr Catherine Yelland, Brisbane, QLD

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

- Dr Steven Chung, Newcastle, NSW
- Dr Matthew Kelly, Wellington, NZ
- Dr Bahija Khanom, Auckland, NZ
- Dr Jee Yuen Kong, East Perth, WA
- Dr Hui Yann Lee, Auckland, NZ
- Dr Christopher Leung, Box Hill, VIC
- Dr Oliver Menzies, Christchurch, NZ
- Dr Somanthra Munthree, Cambridge, NZ
- Dr Seshasayee Narasimhan, Newcastle, NSW
- Dr Lisa Claire Noonan, Auckland, NZ
- Dr Katherine Norton, Wellington, NZ
- Dr Ketna Parekh, Wellington, NZ
- Dr Richard Shepherd, Taumarunui, NZ
- Dr Ritva Vyas, Wellington, NZ
- Dr Jennifer Weil, Melbourne, VIC

NEW COUNCILLORS

Several Councillors retired from the IMSANZ Council at the recent AGM. Below are four new Councillors.

Robert Pickles – NSW Rural

Robert graduated from Newcastle Uni (NSW) 1988 and trained at Royal Newcastle Hospital, and completed advanced training in Infectious Diseases in the Hunter and at Alfred Hospital Melbourne. After returning to Newcastle, he spent 9 years in private practice in Taree on the NSW Mid-North Coast as a General Physician/Infectious Diseases Physician. He returned again to Newcastle in late 2004, working as senior staff specialist in General Medicine and Infectious Diseases, and is currently Director of General Medicine at John Hunter Hospital. When he's not at work, he's kept very busy with his 4 children!

Andrew Burns – NZ Metro Representative

I received my undergraduate training at the University of Cape Town and moved to New Zealand in 1994. Prior to training in General Medicine and Infectious Diseases in Auckland, I worked in a variety of hospital and other positions, including 2 years as a paediatric registrar and time in General Practice-writing my GP exams. Pursuing an interest in Public Health, I then completed my MPH at James Cook University, Townsville, followed by 2 years working for an International Medical Assistance company and a subsequent return to hospital medicine to specialise.

I moved from Auckland to Hawkes Bay Hospital in Hastings (on the east coast of NZ) early in 2007, with an eye on a provincial lifestyle, more trout-fishing and space for the growing family - as witnessed by the arrival of our 3rd child in early November. My current role is General Physician - with an Infectious Diseases interest - in an Acute Assessment Unit.

Don Campbell – Victorian Metro

Don Campbell is Professor of Medicine in the Department of Medicine, Monash University. He is also Head of the General Medicine Unit at the Monash Medical Centre Clayton, and has had a previous career as a Respiratory Physician.

Don has participated in several Breakthrough Collaboratives auspiced by the Department of Human Services in Victoria.

Don is:

- Medical Vice President of the Asthma Foundation Board of Victoria
- Member of the Australian Council of Healthcare Standards Research Committee
- Member of the Australian Kidney Trials Network

He has previously conducted several epidemiological studies of asthma including surveys of asthma mortality with particular emphasis on psychosocial features of near-fatal asthma. He completed his Masters degree in Clinical Epidemiology and Biostatistics from Newcastle University, undertaking a Case Control Study of Asthma Mortality in South Australia.

He has had a clinical career as a hospital based general and respiratory physician. His research career has taken him from the benchtop (Immunology) to the bedside and beyond through his interest in the continuum of care from community to hospital.

Don established the Clinical Epidemiology & Health Service Evaluation Unit at Melbourne Health in 1998, where his research interest in quality improvement has lead to an examination of systems where the emphasis is on seeking solutions to problems in delivery of high quality health care. He took on the role of Director of the Monash Institute of Health Services Research from 2003 until June 2007 when he was appointed to his current position.

In terms of teaching, Don has played a major role in implementing undergraduate teaching in evidence-based clinical practice at Monash University and University of Melbourne. He currently co-chairs the management committee of MBBS Theme II which covers "Population, Society, Health and Illness" for Years 1-5. He also conducts Health Promotion and Knowledge Management lectures at Monash University.

He has supervised Honours, Masters and PhD students. More recently his work examining factors associated with problems of access to hospital has led to an interest in applied simulation modeling.

He is currently a Chief Investigator on an ARC linkages grant working with University of Melbourne on Modelling patient flows through hospitals: optimising effective use of resources. He is also undertaking research on clinical audit with the Department of Human Services Victoria.

James Andrew Macdonald – Advanced Trainee Representative, Australia

I am an ex-patriot Kiwi, who has been based in Brisbane since 2001. My undergraduate medical training was at Otago University, from which I graduated in 1997. My early formative experiences at Southland Hospital kindled my passion for general medicine, which has remained with me ever since. After interrupting basic training for overseas travel, locum work and theological study, I finally sat the Part I exam in 2006. At present I am finishing my first year of advanced training, at the Princess Alexandra Hospital. I have an interest in health care in the Pacific, and will explore this further through a six month term at the start of 2008 with Prof Rob Moulds in Suva, and work in tropical Australia in 2009.

General medicine continues to have an essential role in contemporary medical practice, but as a professional society we must strive to protect our training programmes from subspecialty encroachment, and continue to promote and develop this as an attractive career option. I have sat in the past on local committees in various capacities (including a short-lived and inauspicious term as union representative) and am ready to bring my experience and enthusiasm to the service of IMSANZ.

The Internal Medical Society of Australia and New Zealand is pleased to welcome its members, and physicians in general, to its scientific meeting which is being held as a concurrent stream of the RACP congress in 2008 after a successful meeting with the Australasian Society of Geriatric Medicine in 2007. As a complement to the Adult Medicine Division stream and to the specialty updates, the Internal Medicine stream this year offers particular focus on the special skills of general physicians along with opportunities for trainees and fellows to present their own work.

The specific sessions will include a seminar and panel discussion on acute medical assessment and management, bringing together national and international specialists in this particular aspect of General Medicine, along with sessions focusing on chronic and ambulatory diseases, perioperative medicine and using evidence based decision making in complex cases with multiple comorbidities. We are delighted to have a former President of the Society of Acute Medicine in the United Kingdom, Professor Derek Bell, as our keynote speaker to speak on the UK and other international experience in acute medicine and to contribute to our seminar on Medical Assessment Units in Australia.

We look forward to a stimulating program for General Physicians and the physician within all our subspecialty colleagues.

Call for Abstracts

All delegates are invited to submit abstracts for consideration either as an oral or poster presentation - please visit the website for details relating to each specific program and the opportunities available. Various awards and prizes will also be offered. Please note: abstracts must be submitted via the online form, which can be found at www.racpcongress.com.

Abstract Submissions Close: 24 January 2008

IMSANZ 2007 Awards

Travel Scholarship 2007

Dr Ingrid Hutton from Auckland, NZ is the winner of the 2007 Travel Scholarship. Ingrid intended to travel to the 10th European School of Internal Medicine in August, but unfortunately she has had to defer her travel until 2008.
Ingrid currently works at North Shore Hospital in Auckland. Congratulations Ingrid.

Advanced Trainee Award 2007

Our congratulations go to Dr Christopher Leung from Box Hill Hospital who was the recipient of the IMSANZ Advanced Trainee Award for 2007.
Chris presented a paper titled "*Audit of Lumbar Spine Radiographs in an Emergency Department*" at the Medicine, Ageing and Nutrition Conference in Adelaide in September.

New IMSANZ Travel Scholarship for Pacific Associate Members

At a recent Council Meeting the IMSANZ Council decided to create a new Scholarship from 2008. The Scholarship will be for AUD1,500 and will be awarded to an IMSANZ Pacific Associate Member, situated in the Pacific Islands, for assistance in travelling to an IMSANZ Conference or RACP Congress in either Australia or New Zealand.

All IMSANZ Pacific Associate Members are eligible to apply for this scholarship.

To apply please complete the Scholarship Form which is on the website http://www.imsanz.org.au/resources/awards.cfm#Pacific or email the Secretariat imsanz@racp.edu.au for a copy to be sent to you.

Closing date for the Scholarship is 31 January 2008

CHRISTCHURCH MEETING

November 2007

I'm sitting waiting for my flight home after three good days mixing with the NZ membership in Christchurch. Being from a sometimes forgotten island myself I felt at home over here as long as we kept away from such subjects as netball and didn't remind them about the rugby, despite our own poor performance. The weather was great and the company matched it, the NZ program committee had put together excellent sessions that kept me at the convention centre rather than wagging the meeting and seeing the sites in the sun.

The highlights included the standard and particularly the number of the papers presented by trainees and certainly the Australian membership and trainees come a distant second in this rivalry (just as well we won the netball). Combining a meeting with the Gastroenterologists and their nurses did rather swamp us and certainly their trade display has far more interesting toys than are generally available to consulting specialist.

Alasdair MacDonald, Andrew Bowers and John Doran

The GI topics were interesting and I took the opportunity to attend a motility workshop that was quite enlightening. It is, however, easy to get lost in the crowd when there is such a large discrepancy between delegate numbers and this will remain a concern for combined meetings where the need to be identified as a lead character not just an extra needs to be matched against the economies of size that a big and in this case multidisciplinary society brings. Obviously the ideal solution is to get big ourselves and we continue on the way with Mary informing during the meeting that our numbers are now 318 Australians, 127 New Zealanders and 17 Pacific Associate members for a grand total of 462.

The other program highlights included sessions on stroke imaging and obesity. The social program was a mixed bag I enjoyed an excellent night out with IMSANZ members, RACP fellows and many of the trainees at the Mexican Café then on with a few stayers for a couple of post dinner drinks. But the dinner itself although spent with the pleasant company of David Spriggs from Auckland, some gastroenterology nurses and industry reps was an event where IMSANZ was badly overwhelmed.

Christchurch Cathederal

The gap between general medicine and procedural resources was apparent in the number and value of awards handed out by the NZ gastroenterologists including fellowships that are available annually in NZ and if awarded by all of IMSANZ would send us into receivership with just one granting and such diversity of awards to include such things as a "lumenal" prize. I cannot finish without thanking for their hard work all involved in the various committees and behind the scenes. Finally the meeting and the collegiate group were missing some key players and none more than Phillippa who was unable to attend because of her father's ill heath and I would like pass on my own and the Societies condolences for his passing during this week.

ALASDAIR MACDONALD
Launceston, TAS

Medicine Ageing and Nutrition 2007 Conference

From the 5th to the 8th of September medicine's experts in complex comorbidity, the general physicians and geriatricians, joined with the International Academy of Nutrition and Aging, in Adelaide, for our respective annual scientific meetings. For me, the trip to Adelaide was an opportunity to rekindle old friendships, catch up with former colleagues and revisit familiar places, having spent the 1990's in Adelaide doing physician training. I had, through much of July and August, been a little nervous about my responsibilities in assuming the IMSANZ Presidency in Adelaide and presenting some data on our local stroke unit, but the week before travelling to Adelaide political turmoil locally saw me addressing a 7,000 strong public crowd at a save our hospital rally and the idea of talking to a few hundred physicians seemed almost welcoming. The combined meeting, particularly with the geriatricians was an excellent opportunity to build more links between ourselves and the group of physicians with whom we have the most in common. The backdrop of the Torrens River and the beautiful rim of gardens around the CBD presented a relaxed environment to recharge intellectually and physically.

The program itself was, as always, an excellent balance of original work, invited speakers, clinical updates and workshops. Presentations by the key note speakers were particular highlights including Chris Mathias' two presentations and Shaun O'Keefe's insights into the ethics and otherwise of tube feeding. As I always do I particularly enjoyed the keypad sessions with the highlight of Sepehr Shakib and Robert Adams session on evidence based medicine. Though perhaps the most exciting part of the meeting for me was the prevalence of people that I'd trained with presenting on the program and the opportunity to catch up with their lives. The social program, which I enjoyed with a backdrop of rich South Australian reds, offered the opportunity to kick back and mingle with our colleagues, along with a chance to discuss shared ground with the incoming president of the Australian New Zealand Society of Geriatric Medicine, Catherine Yelland.

All in all, for me, it was a very pleasant week and wet my appetite for a return to Adelaide for our annual scientific meeting in May, in combination with the RACP. My thanks must go to all the hard work of the organising committee in total with particular mention to Justin La Brooy, Mark Morton and Jo Thomas.

ALASDAIR MACDONALD
Launceston, TAS

Enjoying the Conference Dinner at the National Wine Centre

Mary-Ann Ryall handing over the Treasury to Tony Ryan

Alasdair MacDonald, Chris Mathias (UK) and Mary-Ann Ryall. Chris Mathias was the IMSANZ Key Note Speaker at the conference

My personal highlight for the ANZSGM / IMSANZ / IANA combined meeting in Adelaide in September, was the presentation by Shaun O'Keeffe on artificial nutrition and hydration in the elderly. Dr O'Keeffe's workshop presentation on delirium was also well worthwhile, unclouding for a while at least that nebulous clinical entity. While most IMSANZ members talk to their geriatric colleagues in the tearoom on a regular basis, I suspect that few of us often have the opportunity to hear from nutritionists. It happens that many of the most interesting speakers of this conference came to us by way of IANA (International Academy of Nutrition in Aging). None of us will forget the discussion of blue berries and aging, memory testing of rats, nor John Morley's animated contribution to the cause.

The presentations on sarcopenia, and on weight loss on the elderly, were so compelling they cut into Jo Thomas' prepared session for IMSANZ trainees. We all finally did meet up though for the combined trainees dinner (courtesy of Servier). Jolley's boathouse is a great venue, and the geriatrics trainees were mostly well behaved.

Trainees enjoying their dinner at Jolley's Boathouse

The IMSANZ free paper session saw some fine presentations from fellow trainees, but there was also plenty of space for a few more (hint hint…). It was heartening to hear from the West Australian delegates about improved training opportunities for general medicine. Training for general medicine in Queensland and in Newcastle has also been recently strengthened, with the creation of funded general medicine positions within the subspecialties. Queensland Health was not shy, and had a recruitment booth open in the trade display for the entire conference (replete with tropical landscapes and beaches). There are now over 80 advanced trainees registered by the Australian SAC. While not discussed specifically at the trainee meeting, one would think this number is enough to justify a separate trainee event, much like the geriatric, nephrology or infectious disease trainee weekends organised by the respective specialist societies.

Jo Thomas enjoying a quiet moment after all her hard work in organising AT dinner and sessions for Trainees

The conference dinner at the National Wine Centre was a fine occasion, and a fitting and dignified gathering. Some of the trans-Tasman IMSANZ delegation were by all accounts disappointed by finishing before midnight and the lack of dancing, but ultimately were very understanding about the need to make allowances for the geriatricians. Breakfast sessions on rheumatology, sleep disorders and the aging liver followed the conference dinner.

JAMES ANDREW MACDONALD
AT General Medicine, QLD

INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND

Annual Report

IMSANZ Annual Report

At a recent Council Meeting Council elected to post the Society's Annual Reports on the website for 2006 and future years.

The IMSANZ 2006 Annual Report has now been posted on the website in the Members Only Section.

To view the Annual Report please go to the link below: http://www.imsanz.org.au/members/annual

The 2007 Annual Report will issue after the Annual General Meeting in May 2008.

METHANOL TOXICITY AND 100% BLINDNESS

Four Indo Fijian males aged 20, 22, 26 and 28 years drank methanol, mixed with orange juice, pineapple juice, coke and beer. Three of them had no past history of any sickness while one of them aged 26, is a known case of inflammatory bowel disease, under weight and malnourished.

They took methanol on Thursday evening, Friday morning went to work, and Friday evening they drank again. Two of them got sedated and slept at the friend's home where they were drinking on Saturday evening. A boy aged 22 took some amount of methanol without mixing it with juice. He was brought to the emergency room with CNS and respiratory complications and he died after a few hours. Another boy aged 20 was brought to the emergency department and admitted with total loss of vision on Monday. I started Injection Hydrocortisone 100mg TDS, tab Thiamine 50 mg BD and Tab Folic acid 5mg OD. I referred the patient to an ophthalmologist and he reported that the patient had developed 100% blindness due to methanol toxicity and that it was an irreversible condition. The situation looked hopeless for this young boy: he was completely blind, even with loss of light perception, but I didn't lose hope. On the internet I searched for methanol toxicity and downloaded one study reference: Rotenstreich Y, Assia E, Kesler A. Late treatment of methanol blindness. Br J Opthalmol 1997; 81: 416-7.

So on Tuesday I decided to change from Inj. Hydrocortisone to Tablet Prednisolone 60 mg OD for 21 days, Thiamin tabs to Injection Thiamin 100 mg for 3 days and then orally and continued tablet Folate 5 mg. When two other boys heard that one of their companions had died and another had become 100% blind, they were also brought by the police for assessment with complaints of blurred vision since the second day of their drinking party. One of them, aged 26, was a known case of inflammatory bowel disease (IBD) and malnutrition but he had complained of episodes of bloody diarrhea as well, once or twice a day, after the ingestion of methanol. I commenced the same treatment for these two and after a week the ophthalmologist reported their vision was perfect and they were discharged.

But the boy with 100% blindness didn't show any improvement for 8 days. However, on the ninth day on morning round, he told me that he had light perception when he was brought back from the bathroom. His vision started improving gradually and by the fourth week he was able to recognize fingers and could walk without support. He made about 25% to 30 % improvement with above treatment. I stopped prednisolone after tapering doses and now he is on no medication.

Finding this study on the internet helped me to restore sufficient vision to this previously 100 % blind young boy such that he can now undertake purposeful activity and live independently.

DR. OMAR.H.K.NIAZI
Consultant Physician
Labasa Divisional Hospital.
Labasa. Fiji Islands

(Editor: nice example of how searching for evidence-based answers to clinical problems using electronic databases [and not just accepting the opinion of a single 'expert.'] can make a real difference to patient outcomes).

ANZSGM / IMSANZ / IANA
TRAINEE SESSION IN ADELAIDE, SEPTEMBER 2007

Following the cutting of IMSANZ 10th birthday cake and a speech from Phillipa Poole, as outgoing president, an informal trainee information session was held at the IMSANZ/ANZSGM meeting in Adelaide in September.

Phillippa holding the greeting from the 10th Anniversary Cake

Advanced trainees in general medicine gathered with members of the Australian Specialist Advisory Committee for General Medicine (past and present), Trainee Supervisors and IMSANZ members (from both sides of the Tasman). A lively exchange of ideas ensued.

Topics covered included recent changes to requirements for training in Australia; enlightened models of funding for general medicine trainees in some hospitals which allow good quality subspecialty experience; tips for research projects; differences between NZ and AUS training- just to name a few. I am sure SAC members were also educated about some of the difficulties faced by trainees.

Opportunities for Supervisors and Trainees to interact are valuable and need to be a regular component of all IMSANZ meetings.

Jo Thomas
Adelaide

LETTER FROM THE PACIFIC

Your Pacific Correspondent

If I had to nominate the single most serious and depressing health problem here in Fiji, it would have to be type 2 diabetes.

The scale of the problem is horrific, and its complications span major specialities. The ophthalmologists have to deal with the retinal and other eye complications, the surgeons have to deal with the sepsis and foot complications, and we physicians have to deal with the macrovascular and renal complications.

Just to give an idea of the scale of the problem, a recent population survey showed that approximately 15% of the adult population in Fiji has type 2 diabetes - and we have wards full of patients with complications of diabetes of one sort or another. Interestingly, type 1 diabetes is very rare, affecting only a relative handful of Indians and virtually no Fijians.

The prevalence of type 2 diabetes is a little higher in the Indian than the Fijian community, and the patterns of complications are a little different – the Indians tend to get more coronary artery and renal disease, and the Fijians tend to get more septic and foot complications. However these are gross generalisations, and all the major communities, both urban and rural, are devastated by diabetes.

As can be imagined for such a complex problem, nearly everybody has their own pet hobby horse about causation and treatment. However a few facts are obvious. First, the problem is certainly not just due to obesity (and thus it won't go away if we can just persuade people to shed a few extra kilograms). There may well be a relationship with obesity – indeed there almost certainly is – but we see plenty of thin people with severe and complicated diabetes. Similarly bad diet, at least at the time of diagnosis, is not the only culprit, as we see plenty of diabetic Indians who are vegetarians and have a diet normally considered exactly what is required in diabetes.

There clearly is a strong genetic component, as most patients have a strong family history of diabetes. Indeed it is very common for a patient to request to have their sugar measured because they are worried about diabetes as it affected their mother or father or other close family members. So the community is reasonably well educated about "the sugar", and they know the devastation it can cause.

Probably the most depressing aspect about the whole problem is our clear inability to greatly influence either the prevalence or the complications of diabetes. We are continuously bombarded by undoubtedly well meaning "experts" who lecture us on the importance of diet, of exercise, of early detection, of meticulous glucose control, of meticulous blood pressure control, and of close monitoring for complications, with the clear implication (although seldom overtly stated) that if only we did better in these areas the problem will go away. This approach also leads to a "blame culture", where it is assumed that if a patient has complicated diabetes then someone is to blame – either the patient for not being compliant, or the doctor for not looking after the patient well enough.

However it seems clear to me that none of these (either individually or together) provides a real solution. For instance, one of the most depressing graphs I ever show in lectures is the graph from the UKPDS showing the effect on the development of complications of "tight" glucose control compared to "usual" glucose control in previously uncomplicated type 2 diabetics. The two lines are statistically significantly different, but they are depressingly close together, and after 5 years over a third of the patients with "tight" control (ie the best we can do) have still developed a complication.

Nor does the answer lie in prevention. It is obvious that prevention is better than cure, but do we really have the ability to prevent diabetes? Here, the data again seem to me depressingly poor. The results of prevention trials are nearly always projected as being positive, and the conclusion trumpeted that diabetes is preventable. But many of the people in the prevention trials still developed diabetes, and most of those in the intervention groups who didn't develop diabetes were not going to develop diabetes anyway (as judged by the development rates in the control groups). So the hype about prevention seems excessive, to say the least – realistically the cup is nearly empty, not a little bit full.

It is interesting to compare the treatment of diabetes with that of hypertension. The latter is a major success story, and if patients comply with antihypertensive treatment, usually their blood pressures are well controlled and they do not have a complication attributable to hypertension such as a cerebral haemorrhage. In other words, we are good at treating hypertension, and our current therapeutic armamentarium includes a good range of safe, effective and cheap medications. In contrast, antidiabetic medications seem remarkably ineffective, and we repeatedly see patients who are almost certainly compliant, yet have very poorly controlled sugars. We don't have access here to glitazones or other newer agents, but my reading of the literature suggests they only provide incremental rather than quantum leap improvement. Conversion to insulin can help, but even then many patients remain poorly controlled on the only sort of insulin regimen which they can realistically manage in Fiji.

I'm all for prevention, and I try to be as enthusiastic as I can about the "run for health", and "good diet pyramid" campaigns. However in my heart of hearts I wonder how much they are really achieving. Equally, I try to be as enthusiastic as I can in the outpatient clinic as I see my tenth patient for the afternoon with amputated toes, retinopathy and heavy proteinuria, and whose HbA1c is 10.5% and creatinine 250. So I dutifully increase the doses of enalapril and glipizide, and think about commencing insulin. But most patients can't afford to monitor their own glucose (the glucometer is not a problem – it's the sticks that break the bank), and there is no way that the 30,000 diabetics just in the Suva area can be closely monitored in the already grossly overcrowded health centres, let alone in specialist diabetic clinics.

So what is the answer, and how do we stop ourselves from becoming therapeutic nihilists? What we desperately need is an artificial pancreas, or some other mechanism of better duplicating the way the pancreas adjusts our blood glucose on a minute by minute basis. However as far as I know, no such drug or device is even on the horizon, and even if it was, it would undoubtedly have a price tag which makes it completely unaffordable in a country like Fiji. In the meantime we have to maintain enthusiasm, try to prevent the development of diabetes with public health campaigns, detect it early when it does occur (as it will), and do our best to treat the patients who have already developed diabetes as well as we can within the limitations of our resources and with the rather poor tools at our disposal. But it is all very depressing.

ROBERT MOULDS FRACP
Suva, Fiji

IMSANZ AWARDS & SCHOLARSHIPS 2008

IMSANZ Travelling Scholarship

Purpose: To contribute towards the cost of airfares, registration and expenses to attend a major international meeting relevant to the discipline of Internal Medicine. Examples include 1) annual scientific meetings of the European Society of Internal Medicine, Canadian Society of Internal Medicine, Society of General Internal Medicine (US); 2) Asia-Pacific or European Forum on Quality Improvement in Healthcare; 3) Scientific Basis of Health Services Meeting or Cochrane Colloquium; 4) annual meetings of the International Society of Heath Technology Assessment or Association of Health Services Research.

Value: $A5,000

Eligibility: Advanced trainee or fellow of less than 5 years duration of the Royal Australasian College of Physicians, and who is a member of the Internal Medicine Society of Australia and New Zealand. Successful applicants will be required to explain how attendance at this meeting will be used to enhance the practice of Internal Medicine and to provide a 1000 word summary of the meeting attended for publication in the IMSANZ newsletter.

IMSANZ Research Fellowship

Purpose: To provide support for an advanced trainee or younger fellow to undertake a higher research degree (Masters MD or PhD) in clinical epidemiology, health services research, quality improvement science, or a related field.

Value: $A10,000. The fellowship is a total amount that is paid on a pro rata basis for the duration of enrolment in the research degree.

Eligibility: Advanced trainee or fellow of less than 5 years duration of the Royal Australasian College of Physicians; membership of the Internal Medicine Society of Australia and New Zealand; and enrolment in a higher research degree at a University in Australia or New Zealand.

IMSANZ Award for Best Scientific Publication in Internal Medicine

Purpose: To recognise and promote the undertaking and publication in peer-reviewed journal of original research relevant to the practice of Internal Medicine.

Value: $A2,000

Eligibility: Advanced trainee or fellow of the Royal Australasian College of Physicians; membership of the Internal Medicine Society of Australia and New Zealand; publication of research in one of a list of peer-reviewed clinical journals.

IMSANZ Excellence in Clinical Education Award

Purpose: To recognise and promote excellence in clinical teaching and education.

Value: $A1,000

Eligibility: Advanced trainee or fellow of the Royal Australasian College of Physicians; membership of the Internal Medicine Society of Australia and New Zealand; nominated by peers to receive award.

Application Process: Applications or nominations for these various awards will be sought 6 months prior to the annual general meeting of the Internal Medicine Society of Australia and New Zealand in the year the awards are to be granted. Whether any particular award will be offered in any particular year will be at the discretion of IMSANZ Council in terms of quality of applications and/or availability of funds. Guidelines for applications will be available from the IMSANZ secretary and will be in accordance with those issued by the RACP Research Advisory Committee. All applicants will be required to: have IMSANZ membership; provide referee contact details; be available for interview if required; and list relevant past academic record, publications and appointments.

IMSANZ Pacific Associate Member Travel Grant

Value: $A1,500

Purpose: To assist one IMSANZ Pacific Associate Member of IMSANZ to travel to any IMSANZ or RACP meeting in either Australia or New Zealand. This grant will contribute towards the cost of airfares, registration and expenses associated with attending the meeting.

Application Process: Applications for this grant will be sought at the beginning of each calendar year.

More details and scholarship application forms can be found at www.imsanz.org.au/resources/awards.cfm.

Applications for the 2008 Travel Scholarship should be sent to the IMSANZ Secretariat by 31 March 2008.

Applications for the 2008 Pacific Associate Member Travel Scholarship should be sent to the IMSANZ Secretariat by 31 January 2008.

Details of closing dates for the other scholarships can be found on the website above.

SAM CONFERENCE GLASGOW

At the beginning of October I had the opportunity to travel to Glasgow for the 1st international meeting of the Society for Acute Medicine. The Society for Acute Medicine is a multidisciplinary society supported by the Royal College of Physicians and they are largely driven medically by physicians with a strong general medicine interest and the desire to provide optimal management for acute hospital patients often with undifferentiated diagnoses and multiple comorbidities.

I got away from Launceston in the early hours of a clear cold Thursday morning and took the opportunity to stop off in the big smoke and catch up with Mary at the office. Where I signed some papers and reviewed some issues at the nerve centre of the Internal Medical Society of Australia and New Zealand. Then I was shattered by the discovery that my aircraft was fully booked and that, despite my enormous number of frequent flyer points, I was not going to achieve a business class upgrade. I travelled to the airport where, whilst waiting for my delayed departure due to air conditioning failure, I consoled myself with several glasses of red wine.

Edinburgh Castle

A little over 24 hours later, and feeling somewhat worse for wear, I found a new connecting flight to Glasgow from Heathrow and spent the majority of the day exploring Glasgow in an attempt to turn my clock around. Glasgow is a delightful, although somewhat grey city, with friendly people still largely dressed in blue Rangers shirts or green and white Celtic shirts. Its diverse shops allowed me to explore my Scottish heritage in a retail sense and find appropriate items of memorabilia for the kids. The next day, with my first official commitment late in the day I caught the train up to Edinburgh, only 37 miles and less than an hour, and visited the bustling tourist hub of Edinburgh, walking the royal mile, visiting the castle and enjoying a pub lunch over a drink. Edinburgh didn't seem to have changed much in the 25 or so years since my last visit.

That evening, following the start of the congress, I waited in the hotel lobby with another delegate for the bus to the civic reception at St Mungo's museum which is a fascinating museum including medical and religion related exhibits. We got chatting and the smallness of the world became clearly apparent. She was a general physician with an interest in respiratory, general and acute medicine from London and she was married to a emergency specialist from Launceston in Tasmania and would be visiting my home town in the coming weeks to catch up with his relatives. I also found myself attending a health planning session from a Welshman who is advising the Tasmanian State Government on health reform.

Glasgow Convention Centre

The meeting itself was a fascinating mix of clinical presentations by dynamic speakers, procedural technique learning labs and other parallel sessions in organisation and in all aspects of a physician practice. There were also parallel sessions applicable to nursing and allied health delegates. Contributing to sessions, including the main plenaries, were Australians such as Ken Hillman, a Professor of Intensive Care, from NSW and our own former SAC chair James Williamson. Over the next two and a half days I was able to interact with a very dynamic group of physicians, focused on generalism particularly in the acute setting, and this was invaluable. The hospitality of the group was exceptional and this was certainly a terrific experience. The opportunities for links and professional interaction with this group are endless from micro management issues to clinical interaction and research. I also took the opportunity to invite one of the charismatic speakers and former society President, Derek Bell, as plenary session speaker for next year's IMSANZ annual scientific meeting as part of the RACP congress.

As I settled in to, yet again, my economy class seat consoled, once again, with several red wines I returned to Australia with reinvigorated enthusiasm for the opportunities ahead of general physicians throughout Australia and the globe.

ALASDAIR MACDONALD
Launceston TAS

WHAT'S NEW ON THE WEBSITE

New CATs that have recently been posted on the website are as follows. Please note that due to excessive workload imposed on the editor in writing the CATs, I have decided to simplify the task by making some amendments to the PubMed abstract for the cited articles and adding a commentary where relevant.

- Thyroid hormone replacement not necessary for subclinical hypothyroidism
- SSRI use may predispose to osteoporosis in elderly patients
- Perindopril plus indapamide in patients with type 2 diabetes marginally improves cardiovascular outcomes (ADVANCE)
- Decompressive surgery improves outcomes in malignant middle cerebral artery infarction
- Adverse effects of combination angiotension-II receptor blockers plus angiotensin-converting enzyme inhibitors for left ventricular dysfunction
- Early treatment of transient ischaemic attacks and minor stroke substantially reduces risk of early recurrent stroke (EXPRESS)
- Initiation of insulin in type 2 diabetes already receiving oral hypoglycaemic therapy – biphasic or prandial insulin provides better control than basal insulin (4-T Study)
- Prolonged proton-pump inhibitor therapy may predispose to hip fractures
- Warfarin > aspirin in preventing strokes in pts older than 75 with A fib (BAFTA)
- Pantoprozole more effective than somatostatin for peptic ulcer rebleeding
- Capsule endoscopy more sensitive than push enteroscopy in patients with undiagnosed GI bleeding
- Apolipoprotein levels no better than standard methods to evaluate cardiovascular disease risk
- Bleeding risk with warfarin is high among elderly, especially those older than 80 years

REPORT FROM SOUTHERN TASMANIA

Improving Opportunities for Advanced Training in General Medicine

As a result of "Better Hospitals" funding package provided by the Tasmanian state government in September 2004, Clinical Services Medicine at the Royal Hobart Hospital were able to establish a Senior Registrar role in Medicine.

This role is super-numery to existing registrar positions. The successful applicants have the opportunity to take on a greater mentoring, supervising, training, research, quality activities and administrative role within the Department of Medicine, whilst being able to engage in clinical activities within their chosen specialty. The role goes to the specialty with the most suitable candidate. Applications were invited from registrars within the final 12 months of fellowship being conferred or from recent fellows who wish to have a gentler step into consultant practice.

In the first two years, we had very few applicants and the position ended up going to first year advanced trainees initially in Oncology and then Endocrinology. 2007 has seen this position "turn the corner"- we are now attracting superb applicants and in 2007 we had a nephrologist from Sydney join us to undertake a fellow year in GIM and in 2008 we have a 4th year dual Geris/GIM trainee joining us from New Zealand. The selection process was very competitive and the position highly sought.

It has been fantastic that this position has fallen to GIM in 2007 and 2008. We do not believe this has just been good fortune. Our Department of GIM has been working hard to raise the awareness of training in GIM. Each possible candidate who contacts us is quickly answered (usually via e-mail), details of possible future applicants are kept and are contacted around recruitment time and ex-locals are told about the post by yearly "newsletter". We are finding that the candidates largely contact us through word of mouth and thus we have minimised expenditure on expensive advertising. We utilise our hospital web site to provide updated information about the position.

Our 2007 SR is continuing as a staff specialist in a dual role across renal and GIM in 2008- this is an additional bonus to our Department of GIM at the Royal Hobart Hospital.

What do I think have been the factors in making this position successful?

- Super-numery- not allowing the role to be overwhelmed by usual service delivery tasks. This allows for tailoring of the trainees year to match training needs.
- Close liaison between DGIM and other specialties to facilitate training opportunities.
- Competitive and well coordinated selection process adding prestige
- Base salary- significantly higher than other registrars and not far from a first year consultant salary.
- Significant supervision and guidance whilst encouraging autonomy

DR NICOLE HANCOCK
Head of Department
General Internal Medicine
Royal Hobart Hospital

(Editor: This is the first of a series of articles describing innovative ways in which folk in different states and territories and in New Zealand are expanding the opportunities for advanced training in general medicine. If you have something to 'show and tell' then please send in a letter (a few paragraphs will do) so that we can all share in it).

WHAT'S IN THE JOURNALS

December 2007

The impending disappearance of the general surgeon.

Fischer JE. JAMA 2007; 298:2191-2193

It's not only general physicians! This US study shows 50% fewer general surgeons, as a fraction of the medical workforce, over the last 30 years, while the fraction of subspecialty surgeons has remained fairly constant. One contributory factor is re-distribution of reimbursements following analyses of 'relative value' scales, including a policy decision in 1993 to redistribute resources from proceduralists to primary care physicians. This decline in the general surgical workforce threatens the survival of rural and relatively smaller hospitals.

Medical residents' understanding of the biostatistics and results in the medical literature.

Windish DM, Huot SJ, Green ML. JAMA. 2007; 298:1010-1022

A survey across US hospitals shows surprisingly poor levels of the basic knowledge required to understand and appraise published clinical and epidemiological data. Included a 20 question self-administered score across relevant domains. You can determine how you would have fared in the survey!

Dignity and the essence of medicine: the A,B,C, and D of dignity conserving care.

Chochinov HM. BMJ 2007; 335:184-187

In these days of ever-shortening length-of stays for admitted patients, which is not only driven by 'casemix' funding, this thoughtful paper is a timely reminder of the necessity of 'dignity' in patient care. **A**ttitude, **B**ehaviour, **C**ompassion and **D**ialogue are discussed.

What does it mean to be a physician?

Whitcomb ME. Acad Med 2007; 82:917-918

The desirable personal characteristics of physicians are considered here. It is asserted that *caring*, even for patients for whom specific treatment or cure is not possible, *inquisitiveness* and *social responsibility* are critical qualities needed to distinguish physicians from highly skilled technicians.

The annual physical examination: important or time to abandon?

Chacko KM, Anderson RJ. Am J Med 2007; 120:581-583

This traditional service, so popular amongst both consumers and providers, has come under attack yet again. These visits account for about 4% of all health care visits in the US; in more than 25% of these, test or procedures of unproven value are undertaken. A more targeted approach, based on age, gender and risk-factor analysis is recommended instead. Guidelines, based on the evidence supporting this alternative approach, have been have been developed in the US, Canada and Australia. See http://www.ahrq.gov/clinic/pocketgd/ , http://www.ctfphc.org/ and http://www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/TheRedBook/2005Redbook_6th_ed.pdf

Free internal medicine case-based education through the World Wide Web: how, where, and with what?

Pappas G, Falagas ME. Mayo Clin Proc 2007; 82:203-207

Are you interested in web, case-based continuing professional development? A web search was undertaken of major academic schools of medicine and other institutions, medical journals and other possible sources of free, case-based educational resources in 2006. Criteria for selection included journal impact rates, English language and content. 47 sites are published with comments on each regarding content and update rates

Frailty: an emerging geriatric syndrome.

Ahmed N, Mandel R, Fain MJ. Am J Med 2007; 120:748-753

We all recognise frailty but would probably find it difficult to define. An attempt is made here to define and to consider relevant epidemiological and pathophysiological characteristics.

Updates

The following updates, of interest to general physicians, were published in the Annals of Internal Medicine during 2007. Selected ('influential') and structured abstracts are presented, along with commentaries.

General Internal Medicine. **Harrington DW, Munekata MT. Ann Int Med 2006; 147:104-116**

Hospital Medicine. **Amin AN, Pistoria MJ. Ann Int Med 2007; 147:628-632**

Neurology. **Samuels MA. Ann Int Med 2007; 146:128-132**

Cardiology. **Frye RL. Ann Int Med 2007; 147:180-186**

Geriatric Medicine. **Reuben DB. Ann Int Med 2007; 147:470-477**

Hematology. **DeLoughery TG. Ann Int Med 2007; 147:717-724**

PETER GREENBERG
Melbourne

GENERAL MEDICINE TRAINEE NUMBERS INCREASING SLOWLY

The number of General Medicine trainees in Australia is 48, with another 38 training in General Medicine as a secondary subspecialty. This is an increase on 38 in 2006, but still far short of health system requirements.

The current number of General Medicine trainees in New Zealand is 152.

(Data supplied by Fairlie Clifton, RACP Office, Oct 2007)

IMSANZ (NZ) Conference
Bay of Plenty, New Zealand

IMSANZ (NZ) will be holding their next meeting from March 13-15 2008 at the Oceanside Resort and Twin Towers in the Bay of Plenty, directly across the road from the beach at Mt Maunganui. Being in this stunning location the meeting is shaping up to be very exciting!

The key feature of the meeting will be a Quality in General Medicine forum to kick off the meeting. The keynote speaker for this is Assoc Prof Caroline Brand who is Director of the Clinical Epidemiology and Health Services Evaluation Unit at Melbourne Health. She is also a rheumatologist. Caroline has a particular interest in clinician engagement in a systems approach to patient safety, models of care management of chronic rheumatic disease and implementation of evidence into practice.

Those IMSANZ members who attended the recent Optimising Quality of Care seminar in Auckland at the end of August will have heard Caroline speak there. The rest of the meeting will be made up of specialty updates, the De Zoysa young investigator award and free papers.

Call for Abstracts

General physicians and trainees are invited to submit abstracts to be considered for presentation at this meeting.

The scientific committee will consider all submitted abstracts for presentation. Depending on the numbers of acceptable offerings, you may be asked to make an oral or a poster presentation.

Closing date for abstract submissions is 5.00pm Friday, 25 January 2008

Further details can be found on the IMSANZ website http://www.imsanz.org.au/events/

FORTHCOMING MEETINGS

2008	**JANUARY**	**ACM 2008** **18-21 January 2008** (Clinical Course in Acute Care Medicine) and Symposium on Transfusion in Acute Care Medicine at Box Hill Hospital, Melbourne Website: www.easternhealth.org.au/acm
	MARCH	**IMSANZ (NZ) Autumn Meeting** **13-15 March 2008** Mount Maunganui Program information is posted on the IMSANZ website Website: http://www.imsanz.org.au/events/index.cfm *Call for Abstracts* Abstracts Deadline is 5.00pm, Friday, 25 January 2008
		RACP Congress **11-15 May 2008** Adelaide Convention Centre – Adelaide IMSANZ have created a stream of sessions over two days 13 and 14 May. Professor Derek Bell from the UK has agreed to be our Keynote Speaker. *Call for Abstracts* Online abstract submissions is now open. Abstract details can be found at http://www.racpcongress.com/Abstracts.asp The closing date for abstract submissions is Thursday, 24 January 2008 More information can be found on the RACP Website: http://www.racpcongress.com/
2010	**MARCH**	**World Congress of Internal Medicine** **20-25 March 2010** Melbourne Exhibition and Convention Centre, Melbourne, VIC Website: http://www.imsanz.org.au/events/ Contact: wcim2010@tourhosts.com.au

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: ian_scott@health.qld.gov.au

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

A/Prof Ian Scott
Director of Internal Medicine

Level 5B, Medical Specialties
Princess Alexandra Hospital
Ipswich Road, Brisbane
Queensland 4102

Phone: +61 7 3240 7355
Fax: +61 7 3240 7131
Email: ian_scott@health.qld.gov.au