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INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND

APRIL 2008

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From the President...

Like the December Newsletter I find myself writing my report immediately after enjoying the hospitality of the New Zealand IMSANZ membership at the Tauranga meeting outside Auckland. The opportunity to get to know the New Zealand IMSANZ membership of this trans-Tasman society has been very valuable. At a specific level the meeting itself offered significant continuing professional development value to my personal practice and also allowed me to reflect on opportunities we have within the society as a whole to capture educational situations and see growth in the areas of trainee education and ongoing CPD. The meeting itself also offered many chances for social interaction and the cultural experience of poetry karaoke. A modest effusion, on my left knee, attests to the steepness and height of Mount Maunganui but the pre dawn and dawn light last Friday morning was worth the climb. The aircraft breakdown and bus trip back to Auckland added to the experience, not just in terms of an extra day but allowed me to fly on six differently badged aircraft in 4 days.

Since the last newsletter much has happened with respect to IMSANZ and college structural change. The new Adult Division Council has met for the first time and Society Presidents have been briefed on issues such as advanced trainee and CPD. The Adult Medicine Division Council Meeting outlined the new college structure and really constitutes a decision making body for Adult Medicine. It is made up of the Society Presidents along with four elected members including the additional IMSANZ members Lẽs Bolitho and Cameron Bennett, giving General Medicine a reasonably strong voice in this forum. However given the importance of General Medicine, and its development in the College, from the point of view of work force issues in the years to come and to make sure that the facility of quality training remains available to general trainees, I have nominated to become part of the executive of the Adult Medicine Division Council, although the election of these positions is somewhere down the track.

The forums I have attended on both advanced training and CPD during February outline the new educational structure of the College and the role the special societies will have with respect to their specialist training committees, formerly the SAC's, and the reporting of these committees to the Adult Medicine Division Council. The resources of these committees will be budgeted out of the College and the opportunity for these committees and the special societies to access educational expertise and administrative support from the College will be budgeted by submissions from the various specialty societies. So as a society we are now starting to put together work with regard to such submissions for approval by council and submission to the College in the next few weeks. Much of the discussion at these forums and some of the discussion at the Adult Medicine Division Council still centred around the issues of basic training and the ongoing concerns over

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the labour intensive nature of the mini-CEX as an assessment tool, although it remains part of formative rather than summative assessment at this time.

Hard work has been put in by a number of the society members serving on steering and program committees for the upcoming IMSANZ Annual Scientific Meeting which will be held as part of the college congress in Adelaide on May 13th and 14th. This promises to be an exciting program of topical issues in General Medicine supported by a program of clinical updates which have been organised in conjunction with the Adult Medicine Division. Jo Thomas and I continue to have an active involvement in the WCIM planning for 2010 and I hope to get to Buenos Aires later in the year to help with promotion of this meeting at the 2008 WCIM meeting. I also hope this may lead to an opportunity to continue to form close links with the Acute Medicine Society, based largely in the UK.

At a personal level I continue to enjoy the challenge of juggling private practice, a public appointment, medical education, administration and my IMSANZ and College roles with the challenges of family life. I look forward to renewing old friendships and, making new ones, in Adelaide in May and hopefully again in Shepparton in the spring.

ALASDAIR MACDONALD
IMSANZ President

IMSANZ would like to welcome the following New Members:

- Dr Nikolaus Hammerl, Noosa, QLD
- Dr Graham Hill, Hamilton, NZ
- Dr Kyle Perrin, Wellington, NZ
- Dr Bronwyn Sinclair, Auckland NZ
- Dr Tim Sole, Tauranga, NZ

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

- Dr Brendan Arnold, Napier, NZ
- Dr Robert Bevan, Auckland, NZ
- Dr Roy Chean, Singapore
- Dr Danielle Howe, Townsville, QLD
- Dr Carmel Jacobs, Auckland, NZ
- Dr Alan Lam, Brisbane, QLD
- Dr Kingsley Nirmalaraj, Tauranga, NZ
- Dr Gregory Plowman, Auckland, NZ
- Dr Andrew Sloss, Brisbane, QLD
- Dr Corrie Studd, Fremantle, WA
- Dr Lena Thin, Fremantle, WA
- Dr Zhi Hua (Michael) Zhang, Christchurch, NZ

MABEL – Improving your working life

MABEL (Medicine in Australia: Balancing Employment and Life) is a major new national longitudinal survey of doctors, funded by the NHMRC. Policies about the medical workforce and how to alleviate shortages of doctors need to be based on evidence about doctors' own views, preferences, and work and family circumstances. Without such evidence, policies may be insensitive to the realities of medical practice and less likely to be effective. MABEL is the first survey that will provide such rigorous evidence in Australia. The longitudinal nature of the survey will enable changes in doctors' views and circumstances to be followed up over time. The survey gives doctors the opportunity to provide information about what it is like working in medicine and how this interacts with their personal life. Invite letters for the first wave of the survey will be posted to a stratified random sample doctors in May 2008. Doctors can also register to take part in MABEL by going to www.mabel.org.au.

The survey is being led by Professor Anthony Scott at the Melbourne Institute of Applied Economic and Social Research (University of Melbourne) in collaboration with the Faculty of Medicine, Nursing and Health Sciences at Monash University, and is supported by a Policy Reference Group comprising professional organisations and governments.

CONFERENCE ROUNDS: NEW ZEALAND

IMSANZ Autumn Meeting at the Mount 13-15 March 2008

Tauranga served as a beautiful back drop for the 2008 IMSANZ New Zealand Autumn Scientific Meeting.The delegates rolled in on Thursday afternoon (like the waves on to Mt Maunganui's glorious beach) to the Twin Towers and Oceanside resort, and old friends were reunited, and some new faces lit up with the lively atmosphere. There was even a good turn out from "our old friends from over the sea", including our current President Alasdair MacDonald in tandem with Ian Scott and Caroline Brand. There was a bit of the inevitable "first night overshoot" as delegates enjoyed the fine food and changing light and colours of Mt Maunganui's stunning setting. This was quickly cured by a brisk 6.30 am walk and/or jog to the top of the Mount to watch the sunrise of this year's official St Patrick's Day, as decreed by the Catholic Church of Auckland. Whilst the sunrise was a mediocre spectacle on this occasion, the exercise and the stunning views more than compensated for the early start. A leisurely breakfast in one of the numerous cafes that surround the Conference venue prepared everyone adequately for the day's scientific sessions.

Caroline Brand gave two excellent talks on the important but potentially soporific topic of organisational reform, driven by the necessities of quality and safety, in the extremely complex environment of health care delivery, illustrating it well with her leading edge initiatives from her home town of Melbourne. Her stamina in delivering two substantial presentations for more than two hours in total was admired, and her presentations were illuminating and helpful.

The second part of the morning belonged to Cochrane culture zealots and cynics, with an immaculate presentation from Ian Scott, followed by (given that Easter was approaching), a pseudo-ecclesiastical sermon by David Spriggs, delivered in an entertaining and articulate style, and which teased and appeased both doubters and protagonists of EBM.

A hearty lunch was followed by the main competitive event of the Conference, the De Zoysa Young Investigator Award papers. There were six presentations ranging between audits, case presentations, and formal research. Topics included "Broken Heart" syndrome, not well known by its eponym "Takosubu's Cardiomyopathy" by many of the older members of the audience, and work from Christchurch which may become known in the future as "Coffee Heart".

The day's scientific sessions were completed by two crisp updates by Jeremy Krebs and Richard North, enlightening us on state of the art of Diabetes and Oncology respectively. Regular updates on the cricket score helped maintain focus on the science during the day.

Hot swims and beach strolls were some of the pre-dinner activities conference delegates were spotted indulging in before the drive to Somerset cottage, where the night's band "Five O'clock Shadow" was already warming up.

Poetry karaoke again proved to be a hit, with Ian Scott even offering prose unashamedly, in the afterglow of his recent trip to the great southern land of ice and penguins. John Henley stole the show with poems by his father, and there were many sensitive and articulate recitations by others, ranging from Yates to a rendition of Flight of the Concords (with a ukulele).

Fine wine and food was enjoyed before the band fired up, including a Van the Man bracket to acknowledge the Patron Saint

of the Emerald Isle. Rick, Anne, and their staff again certainly came up with the goods regarding the food for the evening.

The Neil De Zoysa prize was jointly awarded to a first year house physician from Wellington, Ryan Walkin, and Philip Robinson, an Advanced Trainee also from Wellington. Congratulations to them both.

Saturday morning dawned with a repeat of activities of the previous daybreak. The scientific programme for the morning began with two further high quality updates from colleagues Richard Frith and Kyle Perrin. Richard spoke on Neurological matters of seizures and muscle disease. Kyle's talk was in the category of "Idols assaulted", as he took on the panacea that was Oxygen. Watch this space.

The second session of the morning began with Ian Scott giving an outstanding EBM-based analysis of the utility of new screening tests and biomarkers in assessing cardiovascular risk. Four further presentations very suited to an IMSANZ audience by their quality scepticism were given by Michael Furlong, Brendon Arnold, Tim Sutherland, and Tony Neaverson. This session included a debate between the Devil and the Tooth Fairy, about whether centurions and their like deserve statins with their morning cup of tea.

A lively IMSANZ business session, followed by lunch, ended the formal part of the conference, though some informal activities went on for at least another 24 hours.

Victoria Janke is gratefully thanked for her superb organisational skills - we are so lucky to have her reappear on the IMSANZ stage after a gap of about a decade. Sanofi-Aventis are also thanked for their generous sponsorship again, especially Barry Collecut, who had a lot to do with putting the Conference together. The

Twin Towers staff are thanked for their attentiveness which meant the Conference went extremely smoothly.

Everyone would love to see more Australians and more advanced trainees next time, but New Zealand was well represented. We look forward to seeing you all in Adelaide in May, and in the Wairarapa for next year's Autumn IMSANZ meeting.

NEIL GRAHAM
Tauranga

An Advanced Trainee's Experience

Tauranga served as a beautiful back drop for the 2008 Autumn Scientific Meeting. Set in a resort at the bottom of Mt Maunganui. The conference opened with a Quality in General Medicine forum. The two guest speakers, Caroline Brand and Ian Scott, are Australian based experts and provided very thought provoking presentations. In the afternoon 6 young investigators presented a great range of research from case reports to audits and a clinical study into the effects of caffeine – watch out for those results!!! The updates on both Thursday afternoon and Friday morning were half hour highlights of diabetes, oncology, neurology and oxygen.

Friday evening's dinner was a divine menu from Somerset Cottage in Bethlehem (just out of Tauranga). The evening kicked off with Poetry Karaoke. We heard a variety of heart felt poems recited by our colleagues – ranging from Yates to a rendition of Flight of the Concords (with a Ukulele). There was also some intense bogeying on the dance floor to the live band late into the night. The conference closed with an entertaining cardiovascular risk assessment forum including a debate between the devil and an angel about whether the very elderly should be treating with statins or not. All and all the conference was well enjoyed by all.

Everyone would love to see more Australians and more advanced trainees next time, but New Zealand was well represented. For a first timer it was an informative and varied conference – I will look forward to the next one.

HELEN KENEALY
NZ Advanced Trainee Representative

Reflections from a Fijian member

This was not only my first attendance to an IMSANZ conference, but also my first visit to New Zealand. The conference was well organised with excellent venue and catering. I found the topics discussed very interesting. The different perspectives of evidence based medicine and its application to clinical practice was very thought provoking. The sub-speciality updates of Diabetes, Oncology and Neurology, tailored for a generalist was very helpful. Most of the issues and updates discussed are relevant to my practice in Fiji. The evening functions were enjoyable and also gave an opportunity to meet and socialise with other colleagues. I feel conferences like this are helpful to us Pacific physicians and I look forward to the next such meeting of IMSANZ. I wish to thank IMSANZ council for giving me this wonderful and fruitful experience.

DR SHRISH ACHARYA
Suva, Fiji

Editor's note: Shrish was the inaugural winner of the IMSANZ Pacific Associate Membership Travel Grant.

Internal Medicine Research Review

subscribe at www.researchreview.co.nz

10,000 medical journals are published each month and for the medical community keeping up is hard. Research Review produces a series of local updates that make ongoing education easy, and most importantly - it's free!

The Review brings the 'must read' studies to you once every two months with commentary and advice from Internal Medicine expert Dr Sisira Jayathissa, a Consultant based in Wellington. Support funding for the initiative means there is no cost to recipients - the content remains completely independent of the sponsor.

Research is selected and included because of its potential to change local practice or significantly improve current understanding. The Reviews feature ten of the most significant studies and provide summaries and live links to full studies for more information. They help you stay up to date without having to trawl through all the international journals to find what really matters – we do that for you.

Research Review publications are a convenient, timesaving tool in today's demanding workplace. If you have additional medical interests, the organisation produces a series of 18 specialist focused updates you can enrol to receive. Each one takes about 15-20 minutes to digest and you're up to speed with the latest developments in any area.

New Zealand members can subscribe free at www.researchreview.co.nz and Australians at www.researchreview.com.au

CRY FOR HELP FROM RURAL EDUCATORS

This is a reproduction of a letter that IMSANZ member A/Prof Dawn DeWitt recently sent to Ms Lina Cachia, Assistant Director of Specialist Programs and Review Section, Workforce Infrastructure Branch, Mental Health and Workforce Division, Federal Department of Health and Ageing.

Dear Ms Cachia,

As the Chair of FRAME and the Head of the University of Melbourne School of Rural Health, my major concerns stem from the huge increase in medical students from ~1200 to over 3000. In turn, the number of post-graduate trainees will increase as well. In order to properly train these students and post-graduates we need infrastructure in new clinical teaching environments (e.g. Community Teaching Clinics/Superclinics that specifically include teaching as a major mission), more clinical teachers, and the resources to train and support/pay them.

With the current doctor shortage, the same stressed rural doctors are also being asked to teach. At our School of Rural Health (SRH) site in Shepparton, the GP:population ratio is 1:2000. Only 7% of specialists in Victoria live rurally and 71% of rural doctors (and therefore teachers of students) are Overseas Trained Doctors (OTDs). My biggest problems are hiring appropriate staff to teach and paying them appropriately when the city is so enticing.

Problems with which I have experience are as follows with recommendations discussed below:

Recruitment of appropriate, English-speaking doctors

Recruiting highly qualified teaching clinicians from English speaking countries (US, UK, Canada, NZ) takes forever and the hoops to jump through are enormous. I am fully in favour of quality, but we must make it easier for the good doctors to get in since bad doctors will do anything to get here but good doctors have choices.

Importantly, rural hospitals have relied heavily on overseas trained doctors as hospital medical officers. These doctors, despite having passed a written English exam, have poor oral communication skills for “medical language”. While they are expected to function “under supervision” more support for medical experience must be metro-based where work-force shortages are not as acute.

We have been recruiting senior residents in their final year of physician training for an “elective” training experience here at the Rural Clinical School. This benefits us greatly because they contribute to teaching and patient care, their training is top notch, The University of Washington is one of the top 5 training programs in this area and ranked #1 for rural health/primary care training in the U.S. (U.S. News and World report rankings), and their salary is paid by their US program. Thus, in the past 5 years we have attracted 8 months of “free” teaching and service and one of residents is coming back as a consultant for at least a year in July 2008.

Their training program only allows them to come to Australia for 1-2 months and they are closely supervised at all times. We make them file complete AMC and state paperwork, re-verify all their U.S. degrees, etc., which has already done by the Washington State Board and the training program. The fees for this assessment are now almost $600 AUD for a 4-week experience!

Recommendations:

- Please facilitate and expedite the planned streamlining of appropriate teacher-clinician applicants from these countries.
- Facilitate state registration that encourages short-term exchanges for trainees from English-speaking countries with good training. This will benefit them and us as we are recruiting and building our workforce.
- Doctors from non-English speaking backgrounds should have an assessment of a *medical* case presentation to a clinician to assess medical communication (not medical knowledge per se) either in person or via telephone or videoconference with an option to function for 1-3 months as a supernumerary doctor at the intern/basic trainee level in a metro setting. The Bogong Regional Training Provider has begun an excellent program in General Practice to assess and teach such skills, but the problem is much more acute in rural hospitals where these doctors are expected to teach/supervise our medical students and interns as part of their job.

Getting Doctors to Teach in Times of Workforce Shortage

Local rural specialists in Shepparton have 4-6 month waiting lists for public out-patients. Doctors say they do not have time or space to teach in private rooms without reimbursement. Visiting rural specialists often travel from the cities for a day-long clinic. They leave hours before their clinical day starts at 9 am and travel home after their “day” is over. They often see 30-40 patients a day. Asking them to teach other than to have a student “sit in” is like getting blood from a stone. They simply don’t have the time to do it well and they are trying to recoup their costs of travel, etc. (if ineligible for MSOAP). They usually have no extra teaching rooms in which students can take histories. In Shepparton, our visiting dermatologist has retired meaning that all patients wishing to see a dermatologist must travel 2+ hours to Melbourne and we have no specialist dermatology teaching available. Likewise, 2 visiting neurologists visit for 1 day fortnightly and one of them has just cut back to monthly.

Recommendations:

- Expand MSOAP and provide Teaching Incentive Payments “TIP” for doctors willing to come to Rural Clinical School sites. Recently we have lost our visiting dermatologist and one of our fort-nightly visiting neurologists (2) have decreased their visits. We need such specialists to see patients and teach but Shepparton is not eligible for MSOAP and although GPs receive PIP (Practice Incentive Payments @ $100/session) for having students, specialists do not.
- Review PIP incentive payments to be sure they cover the lost costs of practices (estimated by myself using RWAV data for then Minister Abbott in 2004 as $243/day or $122.50/session). Dr. Lucie Walters’ recent paper on student consultation times in General Practice in Medical Education

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IMPROVING OPPORTUNITIES FOR ADVANCED TRAINING IN GENERAL MEDICINE

Ed: This is the third article in a series authored by trainees describing some of their training experiences that have arisen as a result of advocacy on the part of IMSANZ.

The John Hunter Hospital had its first intake of general medical advanced trainees in 2007. This was made possible by funding from the Hunter New England Area Health Service and NSW Health in response to recommendations made in *"Restoring the Balance"*. There were four of us in total, distributed between the John Hunter and Mater hospitals. Trainees came from Newcastle, Sydney and Launceston.

This was an exciting opportunity for us, as general medical training in NSW had been limited up until now. There is a strong general medicine department in the John Hunter and the consultants were extremely friendly and supportive. I worked mostly with a surfie, tea-drinking pharmacologist and a kindly, chocolate-fixated professor but I could sense there were quite a few other interesting chaps out there.

Our roles as senior registrars were very varied and quite flexible. We functioned as "junior consultants" under the supervision of a senior consultant who was always on hand if needed in more difficult cases. We looked after ward patients with our team, comprised of a registrar (BPT) and a junior medical officer. We were on the consultant roster for new admissions from the emergency department once or twice a week, but we did not have to take part in the usual registrar overtime roster.

Aside from ward responsibilities, we attended weekly clinics from three different sub-specialties. The medical sub-specialty clinics were of our choice, and limited mostly by the logistics of organizing times which did not clash with other responsibilities. I took part in respiratory and infectious diseases clinics, and a neurology outreach clinic, which offered a very interesting case load; ranging from mesotheliomas, to Hepatitis C, to strange neurological conditions associated with consanguineous relations.

Research interests were encouraged by our supervisors, and time was set aside for these to be pursued. Mine was an audit into the ordering patterns of Brain Natriuretic Peptide and whether use of this fairly new test altered patient management. Another trainee performed a meta-analysis on B12 levels and their relation to red cell macrocytosis while a trainee for next year has already begun designing a RCT involving severe Vitamin D deficiency comparing different regimes of replacement.

Newcastle itself is a great place to be. Being from Sydney, I was pretty chuffed to afford a beachfront apartment on my registrar salary. The beaches are good, the surf plentiful and the conveniences of a big city are there without all the hassles.

Up until now, I've probably made it out to be some sort of utopian paradise, but there were a few downsides. Occasionally there was a lack of professional recognition from sub-specialties; which is probably a culture not specific to Newcastle. At times, we had to fight to prevent general medicine from becoming a "dumping ground" for all unloved medical or surgical patients. Overall though, I don't feel these problems are insurmountable and they are problems which are perhaps faced by general medicine and geriatric departments in most large hospitals.

There were another four positions for 2008, which have been oversubscribed, and have now been filled with candidates of high caliber. If all goes well, the number of trainees will be increased over the next several years to be double or even triple the current numbers.

The future of general medicine in Newcastle is looking bright.

STEVEN CHUNG
Senior Registrar, General Internal Medicine
John Hunter Hospital

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(2008:42:69-73) and my work in medical education and clinical practice teaching (e.g. DeWitt, Working Smarter, Australian Family Physician, January 2007) show that using a two-room model can greatly increase productivity when doctors are teaching. Thus, while experienced teachers can lose few patient visits, Walters' paper does not account for time spent on out-of-consultation orientation, teaching, de-briefing, documentation review, etc.

- Provide funding for "Clinical Education Facilitators" in rural and regional hospital settings (see attached abstract).

Infrastructure

Rural hospitals were not built as teaching hospitals and have woeful living accommodation. While the RCS program success has created a core of infrastructure around which post-graduate programs might be centred, what exists will not cope with a 30-50% increase in trainees.

Recommendations:

- Build on Rural Clinical School sites as "hubs" for post-graduate teaching as well as undergraduate teaching by providing infrastructure for "University Teaching Clinics" (a la "Superclinics" at RCS sites.
- Quality accommodation will also be needed for the increases in interns and post-graduates. Most hospital accommodation in the rural sector is woefully inadequate or absent, even if post-grads were able to pay for accommodation much of it is poor and short-term (3-6 month rotations) make leases impossible.

I hope this information is helpful in your deliberations. Please do not hesitate to contact me regarding this information or for further discussion.

DAWN E DEWITT
MD, MSc, FACP, FRACP
Professor of Rural Medical Education
Head of School of Rural Health
Dean Rural Clinical School
University of Melbourne

THE BEGINNINGS OF AN INTERNAL MEDICINE RESEARCH NETWORK

On Friday March 28, a number of IMSANZ members with an interest and involvement in clinical and health services research converged on the Qantas lounge at Adelaide airport to discuss the formation of a trans-Tasman Internal Medicine Research Network. The meeting was the brainchild of Paddy Phillips from Flinders Medical Centre who also kindly paid for the airfares of interstate participants who included Cameron Bennett and Ian Scott (Brisbane), Peter Greenberg, Don Campbell and Caroline Brand (Melbourne), and Simon Dimmitt (Perth). Also present were Adelaide folk Campbell Thompson, Michael Ahern and Bill Jefferies, with Phillippa Poole on telephone hook-up from Auckland. Lorraine Condon, Paddy's secretary, kindly took minutes of the meeting.

The aim of the meeting was to assess the potential for a network of researchers to instigate original clinical studies in topics relevant to internal medicine that might prove attractive to funding agencies such as the NHMRC, NICS, state or federal health departments, and other bodies. It was acknowledged that there was growing interest in investigator-led trials of diagnostic, therapeutic and prognostic topics which have traditionally been of little or no interest to commercial sponsors. The past and current research activities and available infrastructure support of participants were canvassed and several topics worthy of study were discussed. It was envisaged that certain individuals within the network would act as lead investigators on specific studies with other members joining in and apportioning time and resources according to their level of interest in the topic in question.

It was felt important that trials be appropriately scoped to render the best chances of success so as to get some runs on the board, and a template was suggested by which draft study protocols could be circulated and appraised by all those who may be interested in participating. A list of cautions was also developed to ensure enthusiastic investigators were not biting off more than they could chew in the first instance, especially as the network itself would not (and could not) be seen as a potential source of funds. Governance arrangements for the new network were also considered and it was decided that those at the inaugural meeting, together with a few notable absentees who would be invited to join, would serve as the steering group, supported by an Adelaide secretariat, for what is envisaged would be a broader network of co-investigators linked to specific studies.

The network steering group will next meet at the Adelaide RACP Congress in May after having undertaken further developmental work on logistics, governance, and objectives. All participants were excited by the prospects of building a structure that encouraged interstate collaboration in research projects that would feature large representative samples sizes and multi-site involvement. It was considered important however, in terms of attracting funds and professional support, that the network not be seen as an entity owned or governed by IMSANZ or its council but stand as an independent body which IMSANZ would be happy to endorse and support. Another issue was to ensure national representation on the steering group and for that reason nominations are being sought from folk from NSW, Tasmania, Northern Territory and the ACT. We also welcome ideas from our readers about topics relating to everyday practice that they consider are calling out for a proper trial. Watch this space for further news on this exciting initiative.

PADDY PHILLIPS, IAN SCOTT

DUCK INTO SHEPPARTON IN OCTOBER

16-18th October 2008

School of Rural Health
Faculty of Medicine, Dentistry and Health Sciences
The University of Melbourne
Graham Street, Shepparton Victoria

IMSANZ Conference

"Duckgone" updates in:

- Diabetes
- New Cardiology guidelines
- Rheumatological management with new agents
- Simulation workshops
- SPSS workshops, statistics for the everyday researcher

THE UNIVERSITY OF MELBOURNE

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www.imsanz.org.au/events

Notice of

ANNUAL GENERAL MEETING

of the

Internal Medicine Society of Australia & New Zealand

To be held in
Riverbank 3 Room
Adelaide Convention Centre, Adelaide
Wednesday, 14 May, 2008 at 12.30 pm

AGENDA

1. Apologies
2. Minutes of the AGM held on 7 September 2007
3. President's Report
4. Honorary Treasurer's Report
5. Other matters

Alasdair MacDonald
President

Nick Buckmaster
Honorary Secretary

Please note that the Minutes from the last Annual General Meeting and signed Financial Report are posted on the website in the Members Only Section - www.imsanz.org.au/members/AGM.cfm.

VALE DAVID TAVERNER

Consultant physician and teacher of medical students and specialist trainees.

Born: October 12, 1951; Cornwall, England

Died: February 11, 2008; Adelaide

Dr David Taverner, who has died at the age of 56, was a consultant physician and IMSANZ member with broad-ranging interests. His major goal in his professional life was to improve the health of the community, both by providing services to individuals, and by improving public health systems in several ways, including better prescribing and information management. He was also a very committed teacher of medical students and trainee specialists. He will be long remembered within the Royal Adelaide Hospital and the University of Adelaide for his acute intelligence, his broad-ranging medical knowledge, his enthusiasm for all things intellectual, and his quiet determination to get things done in the most rational manner possible.

David Taverner grew up and was educated in the UK, where he did his medical training at Cambridge University, and his specialist training in general and renal medicine, and clinical pharmacology. He completed an MD, also at Cambridge and worked as a research fellow in the UK. In 1990, he was invited to the University of Adelaide to take up an academic position in Clinical Pharmacology. David's lectures were models of clarity and logic, and his tutorials were marked by a gentle, encouraging approach but an expectation of high standards. He tutored senior students in therapeutics, and, more importantly, demonstrated excellence in therapeutics during his ward rounds in the hospital. David was a committed teacher and mentor to hundreds of medical students and dozens of physician trainees over his 17 years associated with the University of Adelaide Medical School and the Royal Adelaide Hospital.

In 2000, David Taverner moved to a position as a full-time senior specialist in the hospital. David was a widely read, knowledgeable physician, who took great satisfaction in the diagnosis of difficult conditions, and particularly in designing the most appropriate therapeutic plan for individual patients. He was approachable and was able to explain complicated situations to his patients in order to reassure and give confidence. Over the next few years he rose to the position of Head of General Medicine. In this position, he worked tirelessly towards the improvement of hospital systems that would lead to improvements in patient care. David was driven always by his vision of a sensible solution for every problem, even if it sometimes challenged the status quo. He was committed to the public health system, and remained within it for his whole career. David was a rare example of what a senior public hospital doctor can be, focused completely on high quality care for patients and rational approaches to problems.

David Taverner played important roles in the regulation of drug availability in Australia and also chaired the committee that reviews drug-related research studies at the RAH from 1995 to 2006, maintaining a watching brief on the safety of participants.

David was a true academic and was involved in research throughout his career, initially in renal medicine and hypertension and, from the late 1990s, in an area that was both a great challenge and also relevant to just about everyone - treatment of the common cold. David set up one of the best-equipped laboratories in the world for carrying out measurements of nasal responses to drug treatments, and carried out investigations of several remedies for nasal symptoms, using gold standard methodology and research design. He published several important publications about treatment for the common cold.

David Taverner's unexpected death represents a great loss to the medical community in Australia. His keen intelligence, quiet enthusiasm, respect for others and engaging humour made him a delightful colleague and friend.

He is survived by his devoted wife of 35 years, Jacky, and his three sons, Thomas, Richard and John. All of his sons are following in David's intellectual footsteps in one way or another, Tom in biochemical research, and Richard and John in medicine.

Prepared by **DR ANNE TONKIN**

WHAT'S NEW ON THE WEBSITE

The latest critically appraised articles to be added to the CAT library are as follows:

- Predicting long-term survival in patients with suspected coronary artery disease and normal ECG undergoing stress ECG
- Adjustable gastric banding more effective than dietary/ lifestyle measures in inducing remission of diabetes in obsess patients
- Hydrocortisone does not improve survival or shock reversal in septic shock
- Intensive insulin therapy in septic patients increases risk of serious hypoglycaemia
- Statins improve cardiovascular outcomes in chronic kidney disease
- Long-term risk for fatal pulmonary embolism after treatment of venous thromboembolism
- Cholinesterase inhibitors and memantine have marginal clinical effects in patients with dementia
- BNP assessment provides incremental prognostic information in patients with acute coronary syndromes and normal troponin
- Vitamin K supplementation can help achieve control of anticoagulation in adults with unexplained instability of response to warfarin
- Salmeterol + fluticasone more effective than single agent tiotropium in decreasing mortality in COPD
- Varenicline triples the chances of successful long-term smoking cessation compared with pharmacologically unassisted quit attempts

FORTHCOMING MEETINGS

Year	Month	Meeting
2008	MAY	**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 is the IMSANZ Keynote Speaker. IMSANZ Program: www.racpcongress.com/program_imsanz.asp Website: www.racpcongress.com/ On-line registration: www.racpcongress.com/registration.asp
	AUGUST	**XXII International Congress of The Transplantation Society, Sydney** **10 - 14 August 2008** Sydney Convention Centre, Darling Harbour and approximately 3,500 registrants are expected from around the world. Early Bird Registration Closing Date - 26 May 2008 Phone: +61 (0) 2 8221 8814 E-mail: tts2008@meetingplanners.com.au Website: www.transplantation2008.org
		European School of Internal Medicine (ESIM-11) - Estoril, Portugal **31 August - 7 September 2008** The European School of Internal Medicine post-graduate course (ESIM-11) will be held 1- 6 September 2008 at the Seminário Torre de Aguilha, Estoril, Portugal. Residents Arrive: 31 August; Depart 7 September 2008. The format will be the same as previous ESIM courses, details can be found at the Website: http://esim.spmi.pt/ Location Information: www.portugalvirtual.pt/_tourism/costadelisboa/estoril/index.html
	SEPTEMBER	**29th World Congress of Internal Medicine** **16 - 20 September 2008** 29th World Congress of Internal Medicine, Buenos Aires, Early registration closes 30th April, 2008. For more details go to: www.isim2008buenosaires.com.ar
		2nd International Conference of the Society for Acute Medicine **29 - 30 September 2008** The International Conference of the Society for Acute Medicine will be held in London, UK at the South Kensington Campus. IMSANZ members are invited to attend the conference. Website: www.acutemedicine.org.uk On-line Registration: www.regonline.com/SAMLondon
	OCTOBER	**IMSANZ and Victorian School of Rural Health, Faculty of Medicine** **16 - 18 October 2008** There will be a joint meeting in Shepparton, Victoria. E-mail: johc@unimelb.edu.au Further details on the IMSANZ website go to: www.imsanz.org.au/events/
		Canadian Society of Internal Medicine **15 - 18 October 2008** Annual Scientific Meeting of the Canadian Society of Internal Medicine will be held in Montreal, Quebec More info can be found at: www.csimonline.com/

2ND INTERNATIONAL CONFERENCE

Society for Acute Medicine Imperial College, London, 29-30 Sept 2008

I am really looking forward to the 2008 RACP Congress in Adelaide and hope to build on the synergies already established between Australia and the UK at the 1st International Conference of the Society for Acute Medicine held in 2007.

In the UK, Acute Medicine has grown exponentially and is the fastest growing specialty in the UK with its own recognised training programme. Acute Medicine is endorsed by all three Royal Colleges in the UK and has achieved a high profile cultivating in the comprehensive report, "**Acute Medical Care, The right person, in the right setting – first time**," with its clear set of recommendations to improve patient care.

Imperial College and the Society for Acute Medicine are co-hosts for the **2nd International Conference** being held in London from the 29th to the 30th September 2008. Imperial College took a bold step and founded the 1st Chair in Acute Medicine, based at the Chelsea and Westminster Hospital, London. Dr Louella Vaughan has been recently appointed as a Senior Lecturer in this department. Many of you will know Louella, who is from Brisbane. It is very refreshing to have an Aussie perspective on the team!

If we are to meet the demands of a 24/7 service, we believe acute medicine is an essential component in the delivery and improvement of patient care. There is increasing interest in the development of acute medicine and the central role it is playing in the redesign of hospital services ensuring they are *fit for purpose* for the 21st century.

The Society for Acute Medicine is keen to move this agenda forward, both clinically and academically and to embrace the multi-professional nature of acute care. We would like to invite you attend the London conference and contribute to the Australian experience. We greatly appreciated Dr Alastair MacDonald's input to the 2007 Conference along with key note lectures from Professor Ken Hillman and Dr James Williamson. For this year's Conference, we are delighted that Dr Ian Scott from Brisbane and Dr Michael Reade from Melbourne have accepted our invitation to join the faculty. The 2008 has a strong international element with European and American contributors as well. We'd love to see you there too!

Full details of the 2008 Conference including the Programme and call for Poster Abstracts can be found on the Society for Acute Medicine website – http://www.acutemedicine.org.uk

Derek Bell

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A NEW OPPORTUNITY IN GENERAL MEDICINE

Calvary Mater Newcastle

The Department of General Internal Medicine at Calvary Mater Hospital Newcastle is the only department of General Medicine in a Teaching Hospital in New South Wales which takes all the acute admissions in Medicine except for Acute Coronary Syndromes. We also operate an active outpatient service and have a particular commitment to practice in non-conventional settings. We have a busy hospital in the home program and operate an active outreach service to rural and remote areas servicing the needs of Indigenous and non-Indigenous people.

Within the hospital, we are concerned with continual improvement in the organisation and delivery of care; and in other settings, with the development of effective models for the provision of specialist services where they had not previously been available.

We are also committed to providing a work environment which is appropriate for the 21st century, with flexibility and part time arrangements which will allow physicians to combine an active family life with their career. We also have a collegiate approach to clinical care which maximises the level of mutual support. We are keen to recruit women into the department as they are currently underrepresented.

The department is presently looking for up to another three physicians to join us.

If you are interested in practice in a challenging setting, with supportive colleagues, and the chance to make a difference; contact us.

We are also keen to hear from Advanced Trainees who are nearing the end of their training in General Medicine.

Contact:

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FROM THE EDITORS

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

We are most grateful for contributions received from members.

The IMSANZ Newsletter is now published three times a year - in April, August and December.

We welcome contributions from physicians and advanced trainees.

Job vacancies and advertisements for locums can be published.

Please feel free to contact us with your thoughts and comments and give us some feedback concerning the contents and style of the newsletter.

Tell us what you want!!

The editors gratefully acknowledge the enthusiastic and creative input of Mary Fitzgerald, IMSANZ secretary.

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

Submissions should be sent to: ian_scott@health.qld.gov.au

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

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