IMSANZ
INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND

AUGUST 2009

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From the President...

As I am writing this in Exam week I am up to speed on all sorts of things even had a myotonic dystrophy to demonstrate the signs on during Sunday and plenty of good wholesome general medicine to establish that the candidates were ready to move on into sub specialist training. I hope, given the skills demonstrated by many, will include a good number undertaking dual training in general medicine or simply training in general medicine with or without an interest. As happens each year I resisted the unprofessional temptation of slipping a few of them my card in the hope of recruiting them to my hospital for their advance training, but certainly there are some impressive young doctors out there entering advanced training in 2010.

The world of general internal medicine still presents enormous challenges particularly in respect of workforce issues and the difficulty in establishing a mechanism to ensure the competencies and currency of skills within the trained and training community of physicians who practice in the broad area of general internal medicine, such that the systems of acute, chronic and peri-operative care across Australia and New Zealand are sustainable without loss of quality.

The leadership role that IMSANZ needs to take in this area must walk the tightrope that balances a refusal to compromise the quality of care that general physicians provide their patients, with a pragmatic understanding that departments of health and the public, demand a system of universal access that current trainee numbers and work force modelling indicates we cannot meet. We as a Society we need to look at mechanisms to fill this workforce shortfall with physicians and trainees whose competencies are brought to the level where they are able to participate in undifferentiated specialist care and to recognise that this may not be best done by lengthening the already long training scheme, such as the addition of extra years at the end of subspecialty training to allow trainees to participate in one of the less well remunerated specialties, is unlikely to be attractive to trainees nor the legislators who are already pushing for shorter training. Obviously there is an attraction to employers as a specialist, who is also an all-rounder, to be a more valuable asset than one with limited scope of practice. In addition, our allies in this area may come from outside our own college as the interventions required, particularly in the private sector are by our surgical colleagues, often best undertaken by the all-rounders of specialist medicine.

Moving away from such serious stuff and looking ahead as March 2010 approaches the World Congress in Internal Medicine is just around the corner and as the co-hosting Society with the RACP we have the opportunity to showcase our leadership in all areas of General Internal Medicine. The Society will hold its AGM as part of WCIM and will be responsible for a number of sessions. These include sessions on acute medicine, a free papers session, a rural and

Continued next page...

In this issue...

PRESIDENT'S REPORT

regional session, chronic disease and ambulatory care sessions, our young investigator award and a workforce session along with the opportunity to add an additional breakfast session, if we wish, as well as extra free paper sessions. The program is crammed full of subspecialty update presentations from the various societies along with contributions from the remainder of the college a well as the medical and research community beyond the RACP.

Opportunities are available to contribute and don't hesitate to contact me if you wish to help and registration is now open at www.wcim2010.com.au.

ALASDAIR MACDONALD
IMSANZ President

IMSANZ would like to welcome the following New Members:

- Dr Christopher Beare, Adelaide, SA
- Dr Suzanne Busch, Blenheim, NZ
- Dr Vernon Heazlewood, Morayfield QLD
- Dr Richard McLean, Wangaratta, VIC
- Dr Robert O'Sullivan, Brisbane, QLD
- Assoc Prof Ann Rudden, Gold Coast, QLD
- Dr Pravin Shetty, Kalgoorlie, WA
- Dr Campbell Thompson, Adelaide, SA
- Dr Julian Zurauskas, Adelaide, SA

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

- Dr Nizam Dastagir, Caboolture, QLD
- Dr Sergio Diez Alvarez, Armidale, NSW
- Dr Sam Kaldas, Melbourne, VIC
- Dr Sant-Rayn Pasricha, Melbourne, VIC
- Dr Edward Ritchie, Melbourne, VIC
- Dr Aye Nyein Tint, Melbourne VIC
- Dr Reon van Rensburg, Marlborough, NZ
- Dr K Manjula Vidyaratne, Melbourne VIC

INVITATION

A joint message from Napier Thomson (Chair of the WCIM 2010 Organising Committee and President of The International Society of Internal Medicine), John Kolbe (Chair of the WCIM 2010 Program Committee and President Elect of The Royal Australasian College of Physicians), Geoffrey Metz (President of The Royal Australasian College of Physician) and Alasdair MacDonald (President of The Internal Medicine Society of Australia and New Zealand).

It is with great pleasure that we invite you to attend the World Congress of Internal Medicine 2010 to be held in Melbourne in conjunction with Physicians Week at the new Melbourne Convention Centre 20-25 March 2010. This is the first time the Congress will be held in Australia and we are very excited to be co-hosting this biennial international event.

The Congress will explore current and future global health issues through various keynote plenary and concurrent sessions. Several themes will run throughout the Congress that will showcase excellence in Australasian medicine and medical sciences, including science research and innovation, health policy, clinical medicine, young people and health, medical science, and healthcare technology. In addition, we want the Congress to celebrate the diversity of the College, its Adult and Paediatric Divisions, Faculties, Chapters and its associated Specialty Societies.

We hope that you will take this opportunity to network with your national and international peers and keep abreast of the latest development in general internal and in specialised internal medicine. The Congress will offer a superb opportunity for physicians and medical specialists to attend expert update sessions on specialty areas outside their own specialty.

We invite you to come and experience Melbourne's brand new convention and exhibition facility; the largest of its kind in Australia.

For registration, program and general information visit www.wcim2010.com.au

CALL FOR ABSTRACTS NOW OPEN
Closing Date: 18 September, 2009

THIRD INTERNATIONAL CLINICAL SKILLS CONFERENCE

As a recipient of an IMSANZ travel scholarship, in 2007, I was very fortunate to have the opportunity to attend the 3rd International Clinical Skills Conference, held in Prato, Italy in July 2009. Medical education is a topic that is close to my heart and one that is becoming increasingly important in general medicine. As medical student numbers increase and bed-stays shorten, teaching by traditional methods is becoming difficult. I wanted to learn more about new and innovative ways to train our medical students, junior doctors and ourselves.

The conference was organised by the Monash University's Centre for Medical & Health Sciences Education and was held at their Italian satellite campus. I don't want to offend anyone from Melbourne but the students at the Prato campus are onto a good thing. Prato is a gorgeous Tuscan town, 25 minutes from Florence. It is known throughout Italy for its textile industry which may explain why the cobbled streets are lined with boutique fashion houses as well as the usual Italian cafes and delis. The Monash centre is situated in the heart of Prato's *Centro Storico* (historical centre) in a beautiful elegant 18th century building (how many lecture theatres have gilt mirrors and chandeliers!) The adjacent courtyard and rooftop terrace was a perfect place for the welcoming cocktail party.

This was the third time this conference has been held. Its aim was to bring together experts in the fields of medical education, simulation and clinical skills training. Key-note speakers included Professor Sari Ponzer (an orthopaedic surgeon from Sweden who spoke about inter-professional education), Professor Pat Croskerry (a Canadian ED specialist who discussed clinical decision-making, diagnostic error and patient safety) and Professor Tara Kennedy (a developmental paediatrician from Canada who led a workshop on assessing trainee competence).

In some ways, the discussions and networking done over coffee and pastries were just as valuable as the timetabled lectures and workshops. I had a chance to meet health educators from all over the world and discuss different teaching techniques. In particular I was interested to hear about how centres in the UK have been using trained patients and simulated ward rounds to get round the problems of unequal clinical exposure (not all students get to see all types of patient during their clinical attachments) and interrupted teaching sessions (apparently lunch, patient relatives and orderlies from x-ray interrupts history-taking teaching sessions the world over!)

I was also interested to hear about how simulated wards (including text-paging, nurses interrupting because of deteriorating patients and phone-messages from radiology / pathology) were being used to make clinical assessments more realistic. Unlike the highly unrealistic and essentially ritualistic short-case exam, this type of assessment is much closer to real-life and would require trainees to display good judgement, time-management and communication skills as well as skills in resuscitation and observed history-taking and examination. Potentially this has a place in either formative or summative assessment of house-surgeons or international medical graduates.

Overall I am very grateful to IMSANZ for the opportunity to have such an enjoyable and educational experience. I had a chance to meet some very interesting and knowledgeable people from around the world and learn some fantastic new educational techniques. I am now brimming with enthusiasm and look forward to sharing what I have learned ... with anyone who will sit still and listen to me!

INGRID HUTTON

For more information visit:
www.InternationalClinicalSkillsConference.com

IMSANZ YOUNG INVESTIGATOR AWARD

The IMSANZ Young Investigator Award was once again held at the Physicians Week Congress in Sydney in May 2009.

The quality of presentations for this year's award were very high and it was difficult to select an outright winner. The prize was jointly awarded to Dr Paul Lee, Sydney and Dr Sant-Rayn Pasricha, Melbourne.

Paul's paper was titled ***"Chronic beta-blocker therapy is associated with lower physical activity and obesity"***.

Sant-Rayn's paper was titled ***"Understanding anaemia amongst young children living in rural Karnataka, India"***.

Congratulations to both Paul and Sant-Rayn.

CONDUCTING A COMMUNITY RESEARCH PROJECT IN RURAL INDIA

Through the window of our laboratory, the muddy field outside was being ploughed by water buffalo driven along by a thin, loin clothed farmer. As it was afternoon, the electricity was off, and so we were running our little centrifuge off a small diesel generator; the malaria slides were being examined by illuminating the microscope's mirror with a fluorescent emergency lamp. Outside, our field workers were ensuring the day's questionnaires had been completed correctly, while the lab technicians were pipetting the day's prize, the valuable serum, into Eppendorf tubes, to be stored in the clinic's vaccine fridge until the following morning, when a villager would retrieve them before dawn and take them on a hair raising bus trip along two hundred kilometres of disintegrating highway, north to Bangalore, to be deposited with the reference lab. As I fixed the day's other prize, the dozen or so stool samples, in 10% formalin, I wondered, not for the first time during the year, what I was doing here, how far away I had come from my haematology unit and the diagnostic haematology lab my colleagues were now working in. But there was little time for musing: we had to finish before dusk, when the road between the health centre and the village where we were sleeping would be closed due to the risk to our vehicle from roaming bison and elephants.

Apart from being the world's capital of cricket, masala, musical cinema and yoga, India is also the world's capital of childhood malnutrition. Almost half of Indian children are undernourished; four in five 1 year old children are anaemic. India comprises about a third of the world's total burden of anaemia. However, there is surprisingly little research exploring childhood anaemia in India, especially in rural areas, and anaemia control policies are probably poorly implemented. Most Indians live in villages, outside the major cities, and beneath the radar for most foreign tourists, investors and researchers. Conditions in the slums of the Indian mega-metropoli are well known; life in the villages is often even harder. Most Indian data on anaemia is derived from urban environments, a stone's throw from researching institutes, or hospital outpatient studies. However, epidemiologic data, especially related to nutrition and burden of disease, is unlikely to translate well from urban to rural regions, given the differences in diet, activity, access to health care and wealth. National survey data have suggested that levels of anaemia are actually increasing in rural areas, even though the Indian economy (until recently) was booming.

I had long been keen to gain field research experience, and this problem appeared an excellent fit for a haematology registrar with an interest in international health. My literature search could not find any comprehensive study of anaemia among children in rural India – and hence, that became our study goal. With the support of the Nossal Institute for Global Health at the University of Melbourne, we developed a collaboration between an Indian research institute (St John's Research Institute in Bangalore, Karnataka), and an Indian non-governmental organisation which had been providing primary health care in the villages for many years (the Karuna Trust). I took a year off from my haematology training to live in Bangalore, Karnataka, a state in Southern India of about 55 million, of whom about 5 million live in the capital famous for its information technology industry, while most of the remainder live in rural regions, where the electricity runs at most a few hours a day. We identified two districts: Chamarajnagar, about 200km south of Bangalore, and Ramnagara, about 90km north of Bangalore, where the Karuna Trust was operating their Primary Health Centres (PHCs), and based our project in the villages served by these centres. The first few months of the year were spent building relationships with the leaders and administrators of the Karuna Trust and the PHCs, visiting the involved villages and meeting villagers to determine what would be acceptable, and negotiating with high quality biochemistry laboratories in Bangalore. Ethics submissions were prepared, study protocols developed, and agreements signed.

The plan was to comprehensively evaluate the contribution of factors associated with haemoglobin levels to anaemia in children aged 12 to 23 months. We would perform a full blood count, serum ferritin, B12, folate, and retinol binding protein (vitamin A), thalassaemia screen, c-reactive protein and malaria test for each child. This would require collection of venous blood from little children in the villages, a fact received dubiously by many of our local collaborators, whom suspected mothers in the villages would refuse to allow their children to undergo venipuncture. We also planned to collect blood from the mothers for haemoglobin, and stool from each child to identify hookworm infection.

We spent considerable time prior to commencement of the study and finalisation of the protocol, travelling through the villages, discussing our plans, and in particular the explaining to local mothers, fathers, community leaders and health workers the requirement for blood collection. The most important aspect to the success of the project was our excellent field leader and the team of local village women we recruited to work as our field workers. Each was a former health or community worker, still living in the village. Over several sessions, the team was trained about the theme of the study, the design of the project, the administration of the questionnaire, and the importance of an ethical approach to research. We also recruited a laboratory technician who had been born and raised in a village and could collect blood from the children and process the samples, and who would fit well with the team and be comfortable in a village environment.

The field project work was conducted from early August to late October. Each day, we would travel to a different village, set up a clinic in the local Anganwadi (village maternal-child health care) centre, and liaise with local health workers and school teachers to recruit as many children as possible in the village. After an interview, children entered the Anganwadi centre for measurement of height and weight and collection of blood. Enrolment of children was compared with lists of children in the village compiled by the local health workers and house to house surveys.

Following collection of samples, we would return to the primary health centre, where the serum would be processed, malaria slides and hookworm samples examined, and questionnaires checked. In the afternoon, we would travel to the next village, walk through the area guided by the Anganwadi workers, speak to the mothers and remind them to attend the following morning. We did not pay any incentive to the mothers for participation, although each child was given a packet of biscuits, toy ball, small bed sheet and bottle of iron/ folic acid/ B12 solution following collection. All mothers signed (or thumb-printed) a consent form and were provided with a plain language document to keep.

The villages were poor – the chief livelihoods were farming and manual labour; most households earned around less than A$1.50 per day, about a third of mothers were illiterate, and practically none of the households had a toilet, table or bed. Where we had feared mothers would avoid presenting their children for venipuncture, we found that they would often bring all their children, even those older or younger than the designated age range, seeking a 'health check'. We found that like parents anywhere, mothers and fathers were genuinely interested in the health of their child and, as long as we discussed the risks openly and offered to provide copies of the results, rarely had opposition to the concept of blood collection.

It took considerable time to build the trust and personal relationships required to conduct the study. Perhaps the most difficult aspect of the year was to live with the constant sense of dread that the project would fail: the collaborations would fall, the villagers would reject the study, a child would get hurt, my field workers would invent the data, a petty official would shut down the project, the team would get bored and abandon me, the laboratory would ruin our samples. Like any researcher, I had invested so much energy and emotional capital. Careful training of the field team, rigorous preparation of our field equipment, and constant vigilance over the data prevented most of disasters, but I learned that field research requires a capacity for problem solving and creativity – getting the samples to the lab even if the bus breaks down, finding extra diesel when the generator unexpectedly collapses, resolving conflicts within the team, negotiating optimal prices for medical equipment – perhaps outside the strict role of the 'scientist' but within the role of the 'researcher'.

Of the many ways physicians can work for the poor in developing countries, perhaps research is simultaneously the most potent and least effective. I have previously volunteered in East Timor as a doctor; conducting clinical work was certainly more 'satisfying' on a daily basis – each day, each hour, there is an opportunity to help someone, and achieve a sense of success, whereas I spent the whole year constantly fearing the whole expedition would be futile. There are no marks for effort! Understandably, although surprisingly for a haematology registrar more familiar with the rigorous academic culture of major tertiary hospitals, the value of research was discounted by many of those practicing on the ground. Constantly, local doctors remarked that we were not actually 'helping' anyone, and that clinical work was the most important contribution a doctor could make. Sometimes, doctors even regarded us as mercenaries, seeking publications without a commitment to improving conditions for the people on the ground. These perceptions were overcome as we spent lengthy periods in the villages, provided real-time feedback of the clinical results, and provided guidelines and supplied iron-folic acid for treatment.

We are now home in Melbourne, working with my supervisors to assemble our analyses whilst learning the ropes in the diagnostic haematology laboratory at the Royal Melbourne Hospital. Learning to use the statistical software to ask the questions of the data myself has been really valuable. Although operating Stata is a relatively dry exercise and very different to leading a team through the villages, it is remarkable how clearly the data speaks to me, when the context from which they were derived is understood – most of the children and their mothers were anaemic, half were experiencing food shortages, and not even one of the children received adequate iron in their diet.

In the end, we recruited 415 children, of a total of 470 believed to be living in the selected regions. It remains to be seen if our data changes the way people think about anaemia in rural India. Regardless, I have learned so much about the challenges and opportunities of working in research in the developing world. There are so many haematology themes – anaemia, thalassaemia, transfusion medicine, laboratory practice - which have ample scope for research and programmatic activities. With help and support, I look forward to building on this experience and developing my contribution to this field.

DR SANT-RAYN PASRICHA
Victoria

Queen's Birthday Honours

Congratulations go to A/Prof John Henley who was awarded an Officer of the New Zealand Order of Merit (ONZM), for his services to Medicine, in the New Zealand Queen's Birthday honours list in June.

2009 IMSANZ Travel Scholarships

The 2009 IMSANZ Travel Scholarship was won jointly by Dr Brendan Hanrahan from Queensland and Dr Simon Dalton from Christchurch.

Brendan has chosen to go to the 19th IAGG World Congress of Gerontology and Geriatrics in Paris in July. Simon has chosen to go to the European School of Internal Medicine–12 which is being held in London in September.

Articles on both of these meetings will be published in the December Newsletter.

2009 Best Internal Medicine Paper

The 2009 Best Internal Medicine Paper has been given to A Prof Ian Scott for his clinical review paper titled "*Evaluating cardiovascular risk assessment for asymptomatic people*", which was published in BMJ 17 January 2009, Volume 338.

PROGRESS REPORT FROM THE INTERNAL MEDICINE RESEARCH NETWORK

The IMRN has progressed several research projects over the last 6 months as described below. Any reader who would like more information on these projects and/or would like to participate in a project as a co-investigator are asked to contact the Network secretary, Lorraine Condon: Lorraine.Condon@fmc.sa.gov.au.

1. **AMAU survey:** A questionnaire survey of all acute medical assessment units (AMAUs) in Australia and New Zealand nears completion with 60% response rate and recent analysis of preliminary results. Lead investigator Gregor McNeil will be presenting his work at the Society for Acute Medicine conference in Birmingham in October. Units are mostly of recent origin and arose as assessment and discharge planning units rather than a facility that was designed primarily to decongest emergency departments. The survey is seen as a precursor to more focussed audits on such topics as utility of referral pathways and impact of the AMAU on relevant key performance indicators. Of interest, 90% of AMAUs expressed interest in conducting multi-site research with other units, with 37% of units currently involved in research studies.
2. **Quality of hospital prescribing:** At Flinders Medical Centre (FMC) A/Prof Campbell Thompson is lead investigator of a project aimed at assessing effectiveness of prescribing improving interventions in hospital practice. An audit of script-writing performance within 200 hospital medical records has been completed which will serve as a baseline against which results of a second audit will be compared in evaluating effectiveness of interventions. A multi-site collaboration is planned which would enable testing of the generalisability and sustainability of the interventions. Published literature (J R Coll Physicians Edin 2007:37:305-8) suggest error rates in prescribing as high as 40-50%. Co-investigator Jordan Li will prepare a protocol for distribution to interested parties and a teleconference will then be organised.
3. **Validation of eGFR in older general medical in-patients:** Jenny Martin from Royal Brisbane and Women's Hospital is leading a project aimed at validating automated estimated GFR (eGFR) based on the Modification of Diet in Renal Disease formula with the more traditional estimates based on the Cockcroft-Gault formula. For a variety of reasons eGFR and CG-GFR can differ markedly in their estimation of GFR and this may be more of a problem in older patients with multi-system disease. This potentially affects drug dosing and access to radiological procedures. Jenny and her colleagues recently wrote of their concerns in the MJA (2009; 190: 197-199) which attracted a response article from Prof David Johnson and his team who were responsible for the national roll-out of eGFR (MJA 2009; 190: 200-203). The project aims in the first instance to determine if there are clinically significant differences between the two estimates in a representative sample of acutely unwell general medical inpatients, and to assess the magnitude and potential effect of such differences on drug dosing. The study may also look at gentamicin clearance and include Cystatin C estimations as another marker of renal dysfunction. A multi-centre study is planned in order to adequately power the study within a short time-frame and to assess generalisability. A detailed protocol will be circulated to interested parties specifying aims and methods followed by a planning teleconference.
4. **Complication code (C-code) credibility project:** Lead investigator Caroline Brand reported that ethics and Victorian health department approvals are in place for this project to proceed, with contractual arrangements between the database holders now to be finalised. This project will assess the face validity and feasibility of using C-codes within administrative hospital data as automated adverse event screening tools in patients admitted with chronic heart failure and pneumonia to Victorian hospitals over 3 years. Several IMSANZ members will participate on an expert panel which will use modified Delphi consensus processes to identify C-codes that are most likely to be predictive of adverse events related to quality and safety issues.
5. **Simple clinical risk prediction score:** This project centres on the development of a simple scoring tool that could be used to estimate risk of in-patient mortality, extended LOS and discharge destination of patients shortly after admission to AMAUs. A scoring tool developed and validated in an Irish community hospital is being looked as a prototype for adaptation and validation in the Australasian context, including tertiary hospitals. A protocol is being developed and it is hoped that several AMAUs will then join in a multi-centre study to gather a large representative dataset for testing the predictive accuracy of the model and refining it as necessary. Data on more than 800 patients admitted to the AMAU at FMC has already been collected. Auckland City Hospital already has ethical approval to proceed. A teleconference will shortly be convened to discuss the project and all interested parties are invited to participate.
6. **Other developments:** The Network is hoping to sponsor presentations at the forthcoming WCIM in Melbourne 2010 around the recent AMAU survey and other projects if preliminary data are available. The Network is also considering inclusion in its ranks of new non-medical members who are active in research and who have a strong affiliation with general medicine units and specialty practice.

Current members of the Network comprise: Diana McNeill (NZ), Gregor McNeill (Qld), Campbell Thompson (SA), Phillippa Poole (NZ), Caroline Brand (Vic), Harvey Newnham (Vic), Ian Scott (Qld), Jenny Martin (Qld), Paul Jenkins (WA), Jordan Li (SA) and Cam Bennett (Qld).

IAN SCOTT FRACP
Queensland

IMSANZ Trans Tasman Meeting
1 - 3 October 2010

IMSANZ will be holding an Australian and New Zealand combined ASM at the

Sofitel Gold Coast in Broadbeach, Queensland.

Please watch website for further details.

There will be no Spring Meeting in New Zealand in 2010.

Website: www.imsanz.org.au/events/

Please diarise for next year.

MONASH University

TheAlfred

GENERAL MEDICAL CLINICAL WEEKEND

CLINICAL INTERNAL MEDICINE FOR ADVANCED TRAINEES & CONSULTANTS
Peppers Moonah Links Mornington Peninsula, Victoria

9 - 10 October 2009

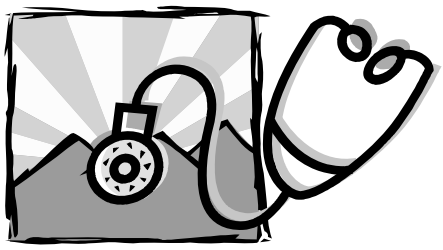
Preparation of Abstract for Clinical Case Presentations by Trainees

Abstracts should be of interesting clinical cases suitable for a General Medical audience that illustrate practical/contentious management points. Desired discussion points should be listed in order of priority. Presentations will be given by the trainees with a consultant chairing each session. Presenters will present the case, take questions regarding the case and lead discussion with supporting documentation from references/guidelines in the form of a brief literature review to illustrate each point. Ample time within the 30mins total should be allowed for audience participation in the discussion (eg <10mins case presentation, 10mins literature review and 10mins discussion). Clinical photos, imaging, pathology etc., should be included where relevant. Please note that cases do not necessarily need to fit in with topics for the plenary sessions but can cover any aspect of Internal Medicine.

There will be a certificate and prize for the best presentation by an Advanced Trainee

Please follow these guidelines:

- Abstracts to include; title, author names, institutional address(es) and sub headings
- Presenting author to be underlined
- Be no more than one A4 page
- Microsoft Word format, Arial font, 12pt, 2.5cm margins
- Saved in the following format: surname.doc



Abstract Deadline: FRIDAY 28th AUGUST 2009

SAMPLE ABSTRACT

Abstract title:

Surname and given names of Advanced Trainee and Supervisor/s and name of Department and Institution:

Case synopsis: *(Insert text up to 350 words)*

Discussion points: *(3-6 main issues to prompt discussion)*

Key references (<5): ……..…….

Email completed abstract to: c.curcio@alfred.org.au
Include "General Medicine Conference Abstract" and your Surname in message title.

THE PHYSICIANS WEEK

Sydney 2009

It was a great pleasure to attend Physicians Week in Sydney this year, not least because I believe that our Society helped to contribute to a very comprehensive, and most interesting program for Adult Physicians. Topics ranged from information and update sessions on Chronic Diseases through to further sessions on the directions for organising care in the private sector and in Acute Medicine, as well as a number of different sessions around e-health and the likely effects that this will have on Physician practice. These sessions were interspersed with excellent case presentations and free papers from our members and from our trainees. Once again the standard of competition of the Papers from our trainees continued to climb, setting new heights for trainees next year.

It is fitting that the IMSANZ stream of the congress covers such an eclectic group of topics, reflecting our interest in the broad continuum of general internal medicine, and the framework in which we work, as well as the effects that the organisation of medical services has on the quality of patient care. The common theme is that General Medicine needs to be considered front and foremost when changes are being planned in the management of the common diseases of our community.

The week also provided a great opportunity for catching up with friends and colleagues. It is always very pleasant to see old friends from around the country, and from New Zealand. Hearing their news about their lives, hearing their views on the issues facing General Medicine, and hearing their ideas as to the ways in which we can improve our care is always very satisfying and exciting. The particular wisdom that is available from senior members of our organisation, including especially luminaries such as John Henley, is a real highlight for me.

On this note, John's speech for the Priscilla Kincaid-Smith oration was a superb dissection of the issues surrounding the Future for General Medicine. His description of General Medical services within many of our so-called teaching hospitals as "the Department of Residual Care" struck a strong chord in many of us. John's passion for our role and our expertise was plain for all to see. His speech was a call to arms for us to ensure that we provide the Models of care and the advice to Policy makers and politicians, that General Medicine must not be thrown out in the race to provide excellent highly specialised services which benefit relatively small proportions of our community.

Michael Hooper presenting John Henley, ONZM, with the PKS Oration Medal

I am looking forward to the next years meeting at The WICM Congress in Melbourne, and also to catching up, once again with friends at the November Meeting in Auckland.

NICK BUCKMASTER
Queensland

Private Practice opportunities for Physicians

Ramsay Health Care, Australia's biggest & best operator of private hospitals currently has a number of opportunities throughout Australia for Physicians interested in partnering with us to establish their private practice.

Interested Physicians must:

• Have primary medical qualification; • Be registered or registrable with the relevant State Medical Board; • Have Fellowship of the Royal Australasian College of Physicians &/or other specialist recognition as a Physician provided for under the Health Insurance Act, 1973

QUEENSLAND

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Contact: Mr Chris Murphy, CEO on (07) 3816 9901
or email: murphych@ramsayhealth.com.au

Caloundra Private Hospital, Sunshine Coast
Contact: Ms Louisa Marshall, CEO on (07) 5491 1522
or email: marshallL@ramsayhealth.com.au

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Albury-Wodonga Private Hospital
Contact Chief Executive Officer on:
(02) 6022 4105

Port Macquarie Private Hospital
Contact: Mr Paul Geddes, CEO on (02) 6582 9862
or email: geddesp@ramsayhealth.com.au

WESTERN AUSTRALIA

Hollywood Private Hospital
Contact: Dr Margaret Sturdy,
Director of Medical Services on (08) 9346 6249
or email: sturdym@ramsayhealth.com.au

VICTORIA

Beleura Private Hospital, Mornington
Contact: Mr Greg Hall, CEO on (03) 9788 3601
or email: hallgr@ramsayhealth.com.au

Peninsula Private Hospital, Frankston
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or email: hallgr@ramsayhealth.com.au

Shepparton Private Hospital
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or email: mellinod@ramsayhealth.com.au

Wangaratta Private Hospital
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FORTHCOMING MEETINGS

2009	**OCTOBER**	**Canadian Society of Internal Medicine** **21 - 24 October 2009** The Canadian Society of General Medicine will celebrate their 25th anniversary with their Annual Scientific Meeting to be held in Ottawa. More details are available on their website - www.csimonline.com Key Presentations from this year's conference can also be found on their website.
		General Medical Clinical Weekend **9 - 10 October, 2009** A Clinical Peppers Moonah Links Resort, Mornington Peninsula. More information - www.alfred.org.au/generalmedicine (click on General Medical Clinical Weekend).
	NOVEMBER	**RACP / IMSANZ / ANZ Society of Geriatric Medicine / Chapter of Palliative Care** **4 - 6 November 2009** A conjoint RACP/IMSANZ/ANZ Society of Geriatric Medicine / Chapter of Palliative Care meeting to be held in Auckland. For further details visit www.workz4uconferences.co.nz/racp
2010	**MARCH**	**World Congress of Internal Medicine** **20 - 25 March 2010** Melbourne Exhibition and Convention Centre, Melbourne, Victoria. Online registration now open - www.wcim2010.com.au Contact: wcim2010@tourhosts.com.au
	OCTOBER	**IMSANZ Trans Tasman ASM** **1 - 3 October 2010** IMSANZ will be holding a combined Australian and New Zealand ASM at the Sofitel Gold Coast in Broadbeach, Queensland. Please watch website for further details - www.imsanz.org.au/events/ There will be no Spring Meeting in New Zealand in 2010.

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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