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INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND

DECEMBER 2009

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From the President...

The year is drawing to an end, another successful one for IMSANZ as we pass through 520 members, perhaps not quite ready for world domination yet but an important voice in medicine in this country and particularly within the college. The increasing priority given to general medicine by legislators and health departments has added weight to the principles of the "Restoring the Balance" work of the society and particularly of Ian Scott. This ground swell of support for generalism needs to be ridden by us as a society and the RACP. The interest in the generalist in the acute sector is perhaps most pronounced within the acute medicine arena and I look forward to next week's acute medicine seminar in SA and the opportunity to network with many of our membership about this area. However, at that meeting will be other medical practitioners with interest in acute generalism and excitingly many nursing and allied health professionals with a similar acute generalism interests. We as a society should be excited by the chance this gives to broaden our membership base and be the one go to organisation for the acute medicine expertise. Many of our sister societies in the RACP in organ specific areas have engaged with their nursing, allied health and non- FRACP medical colleagues and in each case this has enriched their societies. So may I encourage all the membership to consider this issue and foreshadow that it will be brought to the AGM in Melbourne WCIM to change the constitution around the associate membership category to embrace these groups.

Integral to our role in acute medicine may be some compromises but the ability to be inclusive will be important where practitioners practising in this area need a group to network with and benchmark against. The risks in not being inclusive are a loss of relevance and the possibility of another group being formed perhaps in the image of the UK Society of Acute Medicine that would take leadership in this area. Although two organisations working in this area can be a successful model I believe we should take on this role as part of our portfolio of areas of interest. If as a society we chose to not move with this groundswell in acute medicine, although we could continue to participate as part of this process, we risk being not regarded as the leader in this area of medicine.

Whilst my time as president may be seen as a period when the area of acute medicine has been at the forefront of many of our discussions, we have, at the same time, led innovations in chronic disease management. Most of us, including myself, continue to largely practice in this area and predominantly in the ambulatory sector as part of multidisciplinary teams. So I am looking forward to welcoming Nick Buckmaster to the Presidency from March with his interest and expertise in chronic disease management. I wish to reassure those of you practicing like me in this area that IMSANZ remains very committed to chronic disease management as core business.

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My contribution to this newsletter would not be complete without promoting the upcoming WCIM in March where IMSANZ is co-hosting this meeting of the ISIM (International Society of Internal Medicine) with the RACP. I have been involved in this process since the Olympics style bidding for this meeting in Granada in 2004 and am very much looking forward to this educational opportunity and celebration of internal medicine in the Australian and New Zealand region.

May I finally offer all of you my greetings of the season and my best wishes for a safe, happy and successful 2010.

ALASDAIR MACDONALD
IMSANZ President

Acute Medicine 2-Day Conference

6-7 May 2010
Hutt Hospital, Lower Hutt

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IMSANZ would like to welcome the following New Members:

- Dr John Death, Central Coast, NSW
- Dr Lasantha Martinus, Greymouth, NZ
- Dr Kirsten Ramsay, Christchurch, NZ
- Dr Ric Reiner, Mackay, QLD

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

- Dr Chathurinie Aluthwala, Adelaide, SA
- Dr Tahir Chaudhry, Adelaide, SA
- Dr Erica Epstein, Wellington, NZ
- Dr Luke Gaffney, Brisbane, QLD
- Dr Krishan Gupta, Newcastle, NSW
- Dr Saurabh Gupta, Melbourne, VIC
- Dr Ramanamma Kalluru, Auckland, NZ
- Dr Tunde Maiyaki Ibrahim, Shepparton, VIC
- Dr Syed Hussain, Auckland, NZ
- Dr Hamish Jamieson, Christchurch, NZ
- Dr Yu-Min Lin, Auckland, NZ
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- Dr Nadarajah Mugunthan, Gold Coast, QLD
- Dr Adam Pastor, Melbourne, VIC
- Dr Madan Ravikumar, Melbourne, VIC
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- Dr Parind Vora, Adelaide, SA

SPECIALIST CARE FOR THE YOUNG INTELLECTUALLY DISABLED

Background

In 2005 a new clinic for young adults with motor and intellectual disabilities (ID) was incorporated into a well established tertiary ambulatory care healthcare service for adults with ID. The initiative grew from paediatric services of an adjacent hospital, where these young adult patients were no longer able to access their services, and the idea was strongly supported by the adult hospital health services. The larger pre-existing service for adult patients with ID, though within a generic Department of Internal Medicine, was somewhat specialised in that it was adapted to provide skilled health care to adults with ID using a highly organised infrastructure to optimise access and delivery of healthcare to adult population with ID. The clinical service was originally developed in order to address many of the disparities of healthcare identified in the adult population with ID[1], and is consistent with the published European Manifesto[2] on healthcare for people with ID. Details on the background, justification and the practicalities of running such a referral-based specialised service are provided elsewhere[3].

For the young adult clinic, referred patients were eligible if aged between 17.5 years and 20 years. New patients were given a set of three outpatient appointments: the first two one hour appointments for a complete biopsychosocial review including review of history, physical examination, investigations, diagnoses and assessments of current young adult health status leading to a baseline documentation letter, identification of need and referral to adult based hospital services, and a third shorter appointment specifically to discuss logistics of the adult hospitalisation processes. After the routine set of three for every referred patient, appointments were made as required, usually of at least a half hour duration.

The ID health service staff comprised an adult Physician, a part time clinical nurse, and a dedicated administrative person. Patients and their caregivers were able to contact staff by pager, email or hospital phones. The appointment system included appointment reminders, pre appointment preparation by caregivers, longer appointment times, no parallel bookings, distribution of letters to doctors and caregivers, and ID health resources which required only minor modification for the young adult clinic, but which differed somewhat to generic adult outpatients organisation. The ID clinics were held over two full days every week and the young adult clinic occupied one afternoon per week.

A startling vulnerability of this clinical service became apparent with notification of the physician leaving the state, and therefore the clinical service, in March 2008. The continuation of the service was threatened because of difficulty in finding an interested or experienced replacement and children's health services were not going to be able to "take back" these patients. Options considered to sustain the clinic included using the same infrastructure with recruitment of adult rehabilitation physicians or generic Internal Medicine units, incorporation of these patients into already existing generic general population outpatient sessions, or ceasing the service altogether.

The underlying aim of this retrospective observational study was to highlight to hospital executive the continued need for this specialised service within Internal Medicine. The anticipated findings were a group of young adults with ID who would have high medical needs which would not disappear during adulthood, who would develop some new health issues, who would benefit from a coordinated, organised system of care which would be logistically difficult to provide within generic adult outpatient or inpatient systems. The audit was performed to specifically depict -

(a) the health, social and environmental profile of the young adults attending the clinic,

(b) to support the hypothesis that many young adults with ID who have been accessing paediatric services also need specialist adult services,

(c) to provide adult hospital services a profile of this group of adult patients who will be accessing adult services and would find it hard to have their needs met within usual systems.

Methods

Basic demographic and health information of all patients aged between 17.5 years and 20 years inclusive who were referred to the clinical services between 1st January 2005 and March 30th 2008 were collected from their medical records. The demographic data were recorded by the administrator of the clinic and the remaining social and health data were recorded by the clinician attending the clinic.

Results

A total of 73 patients aged between 17.5 years and 20 years were referred to the young adult clinic between January 2005 and March 2008, 33 (45%) by paediatricians, 38 (52%) by GPs, and 2 (3%) by Adult Specialists. The majority of the referral letters were less than half a page consistent with a transfer of care, rather than transition. Of these 73, 13 (17%) young adults had all appointments after March 2008 and 2 (3%) did not attend for two baseline appointments so these15 referred patients were not included in the subsequent audit. Of the remaining 58 patients, all underwent a biopsychosocial review including identification of appropriate and referral to other adult based specialist services. A routine third visit of half an hour was arranged to ensure that the patients and their caregivers received a copy the letter of the initial review, to ensure that the ball was rolling in terms of referrals to other specialists, and to discuss how to manage hospitalisation in the adult system should this be required. At the time of the audit, 13 of the 58 had not yet had their third visit.

In total, an amount of 2½ hours of face to face clinical time was dedicated and provided to each patient for the initial set of reviews and approximately 20 minutes per patient after the clinics for letters corrections, resource development, extra phone calls. For just over a third of the patients, a difficulty in the medical assessment process was reported due to either a requirement for a hoist, or behavioural issues in the rooms.

Table 1 shows the biopsychosocial profile of the group of 58. Most patients lived at home with their parents, and just over half had left school and were now attending a day program. Stressors at home either behavioural, health or disability related were reported by about half the caregivers. There was a wide range of causes of ID, many of which would be considered rare

by “generic” hospital specialists. More than half of the patients had at some physical disability and at least moderate levels of disability and even those with mild levels of ID could not contribute substantially to their medical history. The data show that most patients had a significant number of medical problems (on average 6 per patient), the majority of which required follow up at the hospital level. Interestingly all patients had at least one health promotion concern, a health domain usually considered to be part of primary care.

The common types of medical conditions were not rare and included epilepsy, nutritional concerns, musculoskeletal problems, polypharmacy, and vision and hearing problems.

Discussion

This biopsychosocial audit of 58 young adults with ID referred to a specialist clinic for young adults with ID within Internal Medicine of an adult hospital confirmed that patients in this group have high medical needs, many of which require ongoing specialist input; it confirmed that their assessments are time consuming, complex and associated with a much longer duration than the general population general medical adult patient. The patient typically lives at home and in many cases there are family stressors either with the disabilities per se, behavioural or health issues or combinations which may certainly impact on the provision of clinical care.

The audit data certainly support the notion that it would be logistically difficult to see such patients in a general population adult outpatient clinic setting, where times allocated to patients are often less than half an hour and double booked. Physicians in Internal Medicine would understandably be reluctant to see patients in these conditions. Nevertheless, if properly constructed, a department of internal medicine is well suited to managing arrays of chronic medical and social problems and facilitating assessments by sub specialist colleagues. Though the health profile differs to that of the usual older general population patient visiting a General Physician, the health conditions are not rare, and creating a dedicated clinic increases the experience and skill of the health professionals and clinic staff involved. The range of medical problems or approach required is not usually that faced by Rehabilitation physicians nor by GPs, though these health professionals certainly may have roles to play. Paediatricians could potentially contribute more to the handover processes by providing more comprehensive documentation for a transition rather than a transfer of care as seemed to occur in this setting[4].

These young adult patients are not going to go away. With children’s health services clamping down on cut off age limits of 18 years, it borders on unethical to send these patients with complex medical and social needs, previously requiring specialist services, for follow up to their GP or a “kind elderly physician”, as one paediatrician was quoted as suggesting at a recent RACP conference, just because they turn 18 years. Data suggest that poor hospital care contribute to preventive morbidity and mortality among this group of adults[5,6]. A designated hospital based service such as the one established which has been adapted in a logistically practical manner to provide the care should be developed, or maintained in this case, to cater for this population. The aims of the service are to assess the current young adult biopsychosocial health status, to facilitate referral to other appropriate adult specialist services, to provide backup to mainstream services, so that patients can be provided with the very best current healthcare has to offer. This implies establishment of a specialist regular clinic especially adapted and supported with nursing and administration staff, and senior hospital staff. Understandably, physicians may be at first intimidated by the range and depth of medical problems of these patients as well as their intellectual disability. A helpful infrastructure of clinical service and possibly more support from the paediatricians is speculated to ameliorate this stress.

In summary, the description of the biopsychosocial profile of young adults with ID attending a specialist hospital based healthcare service show a definite need for this service with its adapted infrastructure.

R A WALLACE

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Potential conflict of interest: None

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Table 1. The baseline biopsychosocial profile of young adults with intellectual disability attending an specialised clinic for adults with intellectual disability in the adult hospital setting for the first time.

CHARACTERISTIC	NUMBER	
Gender		
Male	34	(59%)
Female	24	(41%)
Average age in years (range)		
Male	18.3	(17-20)
Female	18.6	(17-20)
Residential type		
Family home	51	(88%)
Group home	7	(12%)
Residential > 9 residents	0	(0%)
Activity in day (≥ 3 days per week)		
School	13	(22%)
Day program	38	(66%)
Activities < 3 days per week	7	(12%)
Family involvement in care		
Yes	55	(95%)
No	3	(5%)
Reported stressors at home		
Yes	33	(57%)
Cause of intellectual disability		
Undifferentiated	18	(31%)
Down syndrome	11	(19%)
Other defined chromosomal disorder[1]	9	(16%)
Intracerebral malformation	6	(10%)
Spina bifida	2	(3%)
Metabolic/mitochondrial	7	(12%)
Infection	3	(5%)
Abuse/accident	2	(3%)
Additional autism	13	(22%)
"End of bed" assessment of level of intellectual disability		
Mild -moderate	7	(12%)
Moderate-severe	17	(29%)
Severe-profound	34	(59%)
Mobility		
Mostly normal gait	26	(45%)
Mostly abnormal gait	11	(19%)
Requiring wheelchair	21	(36%)
Number with difficulty in examination[2]		
Yes	21	(36%)

Number of medical problems per person[3]		
Nil	2	(3%)
1-3	11	(19%)
4-5	9	(16%)
Over 6	36	(62%)
Average number per person	6	
Number of medications[4]		
Nil	7	(12%)
1-3	26	(45%)
4-5	13	(22%)
Over 6	12	(21%)
Average number per person	3.8	
Requiring health promotion[5]		
Yes	58	(100%)
Requiring ongoing hospital level specialist care[6]		
Yes	49	(84%)
Letter to GP and patient		
Yes	58	(100%)

[1]Defined chromosomal disorders or syndromes: Klinefelter 1, Rett 3, Angelman 1, Cri du Chat 1, CHARGE 1, Miller Dieker 2

[2] A patient was deemed to be “difficult to examine” if a hoist were required or if there were behavioural problems

[3] number of medical conditions included chronic medical or surgical problems, symptoms requiring investigations, polypharmacy of 3 or more drugs, but did not include unrelated remote history such as appendectomy

[4] The “medications” count included regular over the counter formulations

[5] Having “health promotional needs” was assessed as being present if the patient were due for young adult sensory assessments, hepatitis immunisations, exercise, dental review

[6] The patient was assessed as requiring “continued specialist input” if they had to re-attend the specialist clinic for follow up, or other subspecialists in the hospital for standard reasons.

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.

Applications Close 26 February 2010.

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.

Applications Close 26 February 2010.

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.

Applications Close 26 February 2010.

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

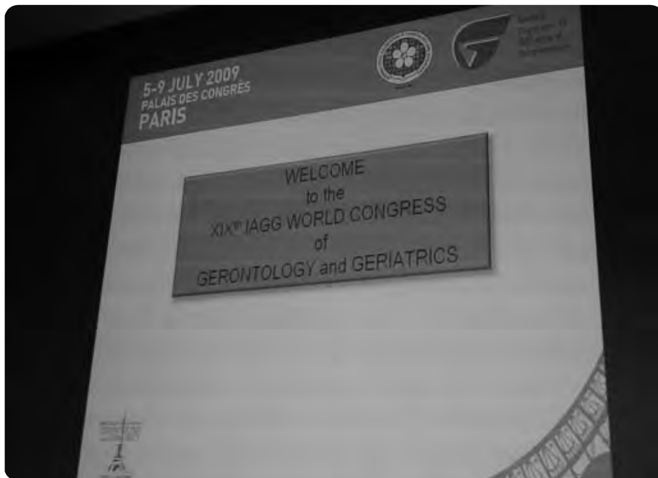
Purpose: To assist one IMSANZ Pacific Associate Member of IMSANZ to travel to any IMSANZ or RACP meeting in either Australia or New Zealand. This grant will contribute towards the cost of airfares, registration and expenses associated with attending the meeting.

Application Process

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

Applications close 15 January 2010.

TRAVEL SCHOLARSHIP - 19th I.A.G.G. WORLD CONGRESS PARIS, JULY 2009



Ahhhh, Paris in the summertime. Fabled in legend and song, and venue for the 19th International Association of Gerontology & Geriatrics (IAGG) World Congress in July 2009 (the Geriatrics equivalent of our Internal Medicine World Congress being held in Melbourne next year – just in case you'd forgotten). The conference itself was attended by over 6,000 participants from 90+ countries, and consisted of over 250 sessions (usually with 3 or 4 speakers per session) organised around 4 primary themes:

- Biological sciences (my focus for being there – why and how we go wrong and emerging work on how to slow it),
- Health sciences and Geriatric medicine (Alzheimer's and more Alzheimer's, but also fascinating work on sarcopenia, sleep and the new buzz-syndrome of dermatoporosis),
- Behavioral and Psychological Sciences (the aged and depression, loneliness, sexuality, etc), and
- Social Research, Policy and Practice (how are we ever going to cope with all these frail people? Its' interesting how Geriatric's is getting closer and closer to removing a specific age threshold as their defining domain and replacing it with frailty).

Being a primarily scientific meeting, it's difficult to say there was a lot of practice changing information imparted (apparently we should all eat right, get lots of exercise and sufficient sleep, and not smoke). But as a source of inspiration and excitement about the practice of medicine and likely developments in the next 5 to 15 years it's hard to imagine anything better. If only a quarter of some of the promising approaches translate to clinical practice, the scope and ability of clinical medicine is going to continue (and accelerate) the incremental wonders of the 20th century. The atmosphere was reminiscent of the rush of Brisbane's EXPO '88 – in a nerdy, medical kind of way.

Whilst we generally learn the cutting edge advances that are ready for implementation by reading and discussing the journals, it is another thing again to sit in a session and have those same famous ground-breaking lead authors talk about their lifelong topic of fascination and hear about what their labs are doing now. As a method of clarifying understanding of a topic, this approach has much to recommend it. And then you go to the next session for more of the same (at least if you chose your sessions carefully in advance). Speaking as someone feeling a bit worn and jaded after years on the exams and advanced training treadmill, to see and hear people so excited and passionate about their work and to be inspired by the promise of the future, things that will unfold through my early practice lifetime, was a much appreciated pick-me-up.

Then there're the posters. Row, after row, after row, of posters – all changed daily. Due to time limits (they went up as the first session of the day started and came down as the last session started), and as the lunch break was spent crossing town to hunt food, the traditional lunch time browse and chat wasn't really an option. I felt sorry for all those presenters hovering dutifully near their work as everyone rushed by. I do trust things will be better in Melbourne.

Palais des Congrès de Paris- Venue of the IAGG 2009

Which brings me to my Top Tips for Overseas Conference Attendee's:

1. European conferences do not serve food during the breaks, and the conference centre is not necessarily near sufficient restaurants. The queue for "New Novosource" samples got quite long at times (due here next year, the vanilla was remarkably like a rich Paul's custard),
2. Similarly, ATMs and rubbish bins are few and far between,
3. When you've travelled a goodly portion of the way around the world you probably want to hit the best sessions. Unfortunately with 8 simultaneous streams they may often compete with each other. So, plan your next day in advance (much as you may just want to curl up and sleep courtesy of jetlag and the need to try some Parisian restaurants), as there isn't a lot of time between sessions in which to work out which of the competing sessions you're headed to next. Let alone actually making your way to "Amphi Bleu" or Room 242B might be easier said than done,
4. The abstract book is going to be heavy (1.9kg with 70 pages of authors' index). Very heavy. Be prepared to ditch it. That said it can be very useful for determining in advance what sessions look the best.
5. Don't lose your pocket programme,
6. Most speakers are happy for you to take photos of their slides and often that's a most efficient way of getting the references. If they aren't happy they'll let you know. But make sure you're familiar with your camera, don't use a flash, and ideally have some zoom (or be prepared to be there early and sit up the front).

TIME TO WALK THE WALK IN EXPANDING IMSANZ MEMBERSHIP?

General Physicians have traditionally prided ourselves as being inclusive, open to new ideas and looking forward. We have embraced changes in models of care and have ridden the waves of alterations in health funding and government policy. IMSANZ has taken the lead in working on behalf of General Internal Medicine, espousing the virtues of our profession as a critical part of our health system because of our unique broad but balanced perspective of patient care to ensure best possible outcomes for our patients. Amongst the characteristics which define our unique place within the health system has been our recognition of the importance of a team-based approach to the management of our patients, whether they be in the community or in hospital. Governments increasingly are recognising our abilities to lead multidisciplinary teams and increasingly are willing to put funding into well developed and effective team care models. I think, therefore, it is time for us to look at expanding the membership, and the political credibility of IMSANZ by exploring the possibility of extending some form of membership to other health professionals working in the provision of General Internal Medicine services.

In making our society more inclusive we will not be unique. Many of the other societies already have opened their membership to other health professionals taking leading roles in furthering research or practice within their relevant fields. By offering (usually associate) membership to these professionals, these societies have increased their credibility and relevance to their non-medical colleagues, and have increased their strength in guiding change towards what they perceive as being optimal models of care. They have been able to give their non-medical colleagues a real sense of identity and pride. When I talk to my allied health and nursing staff working in General Medicine in Queensland, this sense of pride and identity is sorely lacking.

Having non-medical members has also been a powerful lever to nurture research activities for many of the other societies at both the basic science and health system research level. We already struggle to engage in research within our community. By opening up our membership to researchers engaged particularly in health system research, we will increase our credibility in progressing General Medical models of care.

Our non-medical colleagues are crying out for an organised platform to engage with in improving general medical services around our countries. In the recently established Queensland Statewide General Medicine Network I have been overwhelmed by the enthusiasm with which nurses and allied health professionals have greeted its creation. They almost universally have been looking for a platform by which they can express their pride in their services and better define their roles in an optimal system of healthcare delivery. Doesn't this sound the same as our reasons for establishing IMSANZ? And aren't the threats that our profession faces the same as theirs, as we ride the winds of health system change?

I think therefore that the time has come to engage in a debate within our society regarding opening our books to non-medical associate membership. We talk the talk about our place as leaders of multidisciplinary teams, of our holistic approach to patient care, and our integrative skills. Isn't it time we walked the walk!

NICK BUCKMASTER
Queensland

From page 8

Superb buskers practicing in the street, Musée du Louvre in the far background

As to Paris itself, everyone who was new to the city commented on how rude and difficult the people were and how dirty and cigarette smoke filled the streets. Whilst those who hadn't been back for years commented on just how much better all those things were compared to previously. Unfortunately food is no cheaper, and I'll still take an Australian Red over a French one any day – even with a French sommelier's aid.

The greatest downside was the sheer distance involved in getting there, and whilst Australian's seemed second in numbers only to geriatricians from the UK (even more than the French, although there may have been some language-based bias as some "French-speaking only" sessions were run), most were there with their families (intending to travel and holiday a bit before heading back home), and so headed back to their hotels to be with them in the evenings. So my final tip: If you're going to an overseas conference, try to take a familiar face with you, as it's all too easy for the nights to be long and lonely – particularly during the Parisian summer.

In summary, World Congresses are really something extraordinary and I deeply appreciate both IMSANZ and the travel scholarship for both the opportunity and the positive effects it will no doubt have on my practice into the future. Finally, I'm looking forward to seeing everyone in Melbourne next year for a World Congress of our very own.

BRENDAN HANRAHAN
Queensland

EVERY CLOUD HAS A SILVER LINING:

A new virtual resource in evidence-based practice

"Knowledge is the enemy of disease. That is a powerful metaphor. Applying what we know already will have a bigger impact on health and disease than any drug or technology likely to be introduced in the next decade… There are huge gaps in knowledge application, and a link is needed between knowledge and effective decision-making..."

Tikki Pang, Muir Gray, Tim Evans, Lancet, January 28, 2006

www.cebpa.info

The (virtual) Centre for Evidence Based Practice Australasia (CEBPA) is not a typical website but an evolving 'cloud' (or collection) of EBP resources from across Australia and New Zealand, with particular emphasis on Australasian content. CEBPA possibly differs from similar centres elsewhere in that those involved are not based in one location or within one institution: 'ownership' is dispersed, resources are pooled and collaboration is all-inclusive. It is hoped, over time that more organisations and individuals will collaborate in this co-operative venture.

The main focus of CEBPA is knowledge convergence and the provision of communication mechanisms, connecting stakeholders within the EBP community, as well as the infrastructure to source, store, and share and update clinical knowledge.

A/Prof. Sharon Straus of the Department of Medicine, University of Toronto, and Director of the Knowledge Translation Program (a joint initiative of the Li Ka Shing Knowledge Institute at St. Michael's Hospital and the University of Toronto) launched the CEBPA 'cloud' on October 19 while visiting Australia as Royal Melbourne Hospital's International Visitor. During her stay, A/Prof Straus led workshops, lectured and facilitated forums. Her presentations are now on the CEBPA site (on the Home page).

Built using open-source Joomla and Moodle platforms, the CEBPA 'cloud' provides a Content Management System infrastructure and in accordance with the philosophy of 'cloud computing', the aim is to ensure minimal maintenance while providing the facility for registered members to easily update/improve the content, as with a wiki. Although there is no organisational structure for CEBPA, it does make sense to have an Advisory Group to provide an ongoing exchange of views on the content and structure of the 'cloud': consequently, all endorsers are automatically considered members of this Group and an Advisory Group online forum has been created for this purpose.

As the CEBPA cloud is a collective resource, if gaps in resources are identified or areas found requiring improvement, endorsers and registered users are encouraged to contribute resources accordingly. (Note: author rights are automatically provided to all endorsers.)

For a complete list of endorsements to the CEBPA cloud, see Endorsements on the Home page.

Important: to see all the CEBPA cloud's resources users will first need to register on the CEBPA site: go Login, then Register and follow the prompts.

Below is a summary of the cloud's current features:

- **ERA** (Evidence Repository Australasia): a 'warehouse' for evidence summaries generated within Australasia. Currently, this is a pilot for a collection that includes evidence summaries from the Centre for Clinical Effectiveness, Evidence Direct (Melbourne Health) and the Northern Territory Health Libraries. If you have evidence summaries you would like to contribute, please do so by either adding them direct as links to pdf files or by uploading pdfs in bulk to era@cebpa.info. Once more summaries are included, a dedicated search facility will be added. (Note: the responsibility for accuracy and efficacy of the evidence summaries will remain with the source.)
- **Clinical ANZwers**: a tool to convert evidence summaries into clinical questions & answers. This has kindly be arranged by TRIP (Turning Research Into Practice) and will be searchable globally via TRIP Answers, with each ES tagged by its source and with the facility to add comments dynamically. Full instructions on how to access and use this tool are given on the 'cloud'. It's been tested out and it works fine. (Note: in time we plan to have our own branded service, which will additionally include the facility for anyone to upload a question.)
- **Evidence Australasia**: a dedicated search engine that searches guidelines and similar sites across Australasia. You can forward URLs on for inclusion.
- **Converge**: a communities of practice communications hub, linking clinicians, health policy-makers, academics, researchers and health consumers across Australasia on issues relating to EBP.
- Critical appraisal and clinical audit resources (including **AuditMaker**, CAT check lists and **GateLite**)
- an **EBM Toolbox**
- dynamic **EBP news** feeds/mashups/alerts
- A dedicated **Virtual Learning Centre** that can provide online classrooms and the facilities for developing online EBP courses, etc, has also been constructed. Currently the VLC is an infrastructure only – please advise of any EBP training resources you have to offer

PETER GREENBERG
RUSSELL GRUEN
TERRY HARRISON
PETER MORLEY
on behalf of CEBPA

IMSANZ/ANZSGM/ANZSPM/RACP

Annual Scientific Meeting & RACP Trainees Day 3-6 Nov 2009

Michele Levinson, Phillippa Poole, Andrew Bowers, Ian Scott, and Nick Buckmaster.

The trainees day was well attended, with 82 adult medicine and paediatrics trainees from all over New Zealand, as well as a couple from Australia. There were three streams – for basic trainees, paediatrics and advanced trainees. It was very helpful to hear about topics of common interest – such as preparing abstracts and research presentations, approaching employment interviews, and the value of overseas fellowships. The day closed with some reflection on personal self-care – timely for all of us, regardless of our level of training – and part of the new RACP professional qualities curriculum (7.1) that many of us might find difficult to find time for in our home institutions.

The spring IMSANZ meeting was a lively and energetic affair. The conference organisers are to be commended on the choice of conference partners – the NZ branches of the Geriatric Medicine and Palliative Medicine societies. 228 delegates were listed, with 52 of us making it from across the Tasman (2 from Darwin!). The Hyatt-Kingsgate in Auckland is only a shuttle-ride from the airport, and close to downtown shopping for anyone needing to escape during meal breaks.

A high quality and large number of free papers and research results were presented. The winner of the IMSANZ and RACP young investigator award was Australian Nelson Loh from Perth, presenting on High sensitivity troponin-T as a marker of myocardial ischaemia during myocardial stress testing. The New Zealand winner was Stephanie Cox from Rotorua Hospital, who presented an exciting investigation into an outbreak of viral meningitis in the Rotorua region. Look out for Stephanie's presentation next year at the WCIM in Melbourne in the trainee presentation show-down.

The IMSANZ dinner took place at Mecca restaurant in former America's cup village. The conference dinner was lively; following established tradition it was IMSANZ members ('The Shallows') who provided the music to which others danced (palliative medicine showed us all up in this regard – apparently palliative medicine meetings have even better dancing than even IMSANZ).

While all societies contributed to the programme, for me it was our palliative medicine colleagues who made the greatest impact. While generalists normally manage patients with end stage disease, and the care of the dying patient is clearly part of our scope of practice, we can learn a great deal from palliative medicine in advances and new approaches to symptom relief, as well as considering greater palliative input in management of advanced non-malignant disease.

The March meeting will of course be at WCIM in Melbourne. I look forward to the combined Spring meeting 1-3 October 2010, in that Kiwi enclave known as the Gold Coast.

JAMES MACDONALD
Advanced Trainee Representative (Australia)

Specialist generalism firmly on the agenda at the Australasian MedEd 2009 conference, but still work to do

Over 150 delegates from a range of educational jurisdictions in Australia and NZ attended meeting sponsored by the Medical Deans of Australia and New Zealand in Sydney from October 30-31 2009. The three themes were: flexibility of workforce, vertical integration of training, and training capacity. I attended in my university capacity.

Through the conference there was a recurrent and strong commitment to 'specialist generalism' as a way of maintaining a flexible workforce equipped for purpose. There were discussions on how to promote generalism and to better maintain a generalism vs. sub-specialism balance, however as with so many of these discussions, until the fee-for-service and private systems change and/or generalist work conditions match those of subspecialists (including trainees), not much will change in my view. Even GPs are sub specialising into low utility activities. Interestingly, support for generalism within their own discipline came from the colleges of GP, surgery, anaesthesia, O and G, ED and orthopaedics. Strong support for general physicians came from GPs and surgeons, including the private sector.

In many specialties, vocational training places are opportunistic and decided by health services in consultation with their own specialists and Colleges. Generalist trainees are the 'last cab off the rank' and increasingly lack generalist role models. In the closing session, the great majority of delegates "agreed or strongly agreed" that a lack of generalists was compromising health care in Australia. As a result one of the recommendations was that the Colleges work with governments to develop policy and strategy for expanded generalist training by the end of 2010.

It was a privilege to hear the considered presentations of Prof Sir John Tooke who led the review of the Modernising Medical Careers initiative in the UK and produced the report "Aspiring to Excellence" (1). Sir John emphasised the importance of reconfirming the essential role of the doctor, especially as much health care occurred unpredictably as a result of patients already on a protocol having a sudden deterioration. **Generic** skills for all health professionals included good communication, being a team worker and non judgemental as well as having empathy and integrity. **Obligatory** skills for doctors are *a capability to clinically reason and to make diagnoses*. In the end, the public wants doctors primarily to be able to give an *accurate assessment* as to what is wrong. The doctor has to manage risk and uncertainty and be capable of leading teams – making sure responsibility is taken for clinical decisions. The doctor is a synthesiser, integrator, interpreter and supporter. Doctors also must have roles in improving health outcomes of populations and in managing scarce resources.

While we might believe General Physicians are in the perfect position to claim the mantle of 'specialist generalists', it was obvious that 'general medicine' means different things to different people. It should be matter of urgency for IMSANZ and the RACP to provide governments and health services with a succinct and contemporary description of general medicine and what general physicians can bring to the health services in 2009 and beyond.

A/PROF PHILLIPPA POOLE
NZ VP IMSANZ

1 Tooke J. The Final Report of the Independent Inquiry into Modernising Medical Careers. Available from www.mmcinquiry.org.uk/draft.htm

PACIFIC ASSOCIATE MEMBERS

Pacific Associate Members are reminded that the closing date for the Pacific Travel Grant is 15 January 2010.

The application form can be found on the IMSANZ website - www.imsanz.org.au/resources/awards.cfm

FRIENDLY REMINDER

Members are advised that the 2010 Subscription Invoices will be e-mailed to you shortly.

If you have a new e-mail address please ensure that you have provided it to the Secretariat - imsanz@racp.edu.au

RACP(NZ)/IMSANZ/ANZSGM/ANZSPM
MEETING REPORT *"Intersections and Transitions"*

Over 200 members from the general, geriatric and palliative medicine societies attended this meeting at the Hyatt in Auckland from 4-6 Nov 2009. Delegates were welcomed into meeting by the local tangata whenua and then heard the NZ Minister of Health, Hon Tony Ryall, describe how the government was meeting the challenges of providing quality health care to an ageing population. Prof Martin Connelly followed with an entertaining overview of aging and trends in residential care, finishing with information from a recent survey that shows that NZ DHBSs are not doing well in meeting the chronic disease burden. Dr Sinéad Donnelly, a palliative care physician from Wellington, presented her recent documentary on 'Dying at Home.' There were few dry eyes as we headed to lunch.

The final guest speaker on Day 1 was Dr John Bourke from the UK who kindly agreed to share the stage with two locals (Warren Smith and Nigel Lever) to address controversies in AF. John has a particular interest in electrophysiological approaches to AF management. The session was a fascinating revision of basic science, new approaches to management and The Seven Deadly Sins of AF management.

Dr & Mrs De Zoysa, Jega Pasupati

The generalist nature of the three societies allowed a ready focus on the themes of older peoples' health and end-of-life care. There was an emphasis throughout the meeting on professional issues including communication skills. A keynote address and workshops were provided by Dr Tony Back an oncologist from Seattle with specific skills in communication near the end of life. The keynote offerings were complemented by a range of other invited lectures, workshops and 35 free paper or trainee presentations. A Trainees Day held on the Tuesday prior was attended by over 80 trainees, many of whom stayed on for the main meeting. The IMSANZ De Zoysa Trainee Prize went to Dr Nelson Loh for his presentation 'High Sensitivity Troponin-T (nsTnT) as a Marker of Myocardial Ischaemia During Myocardial Stress Testing'.

Most importantly for IMSANZ, the social programme fostered conviviality and mutual support. Around 25 made it to a dinner in The Viaduct on Wednesday. This was followed by the Conference Dinner at the Fale of the University on Thursday. The evening highlight was undoubtedly the guest appearance of 'The Shallows' (aka John Thwaites and David Jardine, with Geoff Green on bass), aptly dressed for a couple of brackets of island-style music.

Thanks to all the IMSANZ councillors and members who contributed to making the meeting such a success. Thanks are also due to the main sponsors, Auckland General Medicine Trust Fund and Mundipharma, and to Lynda Booth from Workz4U who was a superb conference organiser. While most speakers have agreed to make their talks available on the IMSANZ website, I can assure you it is more fun to come to the real thing.

PHILLIPPA POOLE
NZ VP IMSANZ, November 2009

IMSANZ Dinner Attendees

Full marks to an excellent Combined Annual Scientific Meeting in Auckland in November, as well as being very well organised and running to schedule the content was both relevant and well presented.

Following the Powhiri the meeting commenced with a sobering talk from the NZ Health Minister who talked of tight pockets and thrifty planning (again) but generally got the approval of the crowd. It turned out that 'Intersections and Transitions' really meant that the lectures had a lean toward the topics of palliative care and chronic illness. The highlight for me being Dr Sinéad Donnelly, Palliative Care Specialist's lecture which provoked and moved everyone there and the clear and stimulating update in cardiology. There's just so many ways to skin that AF cat.

Meanwhile, next door there was a wide range of excellent talks from the Young Investigator Awards, of particular note Drs Nelson Loh and Stephanie Cox with their excellent and original presentations which deservedly won Nelson a prize from IMSANZ, but all the presentations were good, and it was really a shame they ran separate to the other lectures! Ditto the communication skills workshops which were appropriately practical, friendly and informal.

ANTHONY SPENCER
Christchurch, NZ

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Mildura Base Hospital, VIC
Staff Specialist or VMO

Mildura Base Hospital (MBH) is seeking a General Physician (RACP or equivalent) to provide high quality medical services to the Sunraysia community.

The successful applicant will become part of a team made up of 4 physicians, both hospital-based and VMOs, working collaboratively to cater for the catchment population of approximately 80,000. The position can be entirely hospital based with right of private practice, or can be a mixture of private and public work.

MBH is a near-new modern facility with 146 beds comprising surgery, medicine, paediatrics, obstetrics and gynaecology, emergency, intensive care, psychiatry and rehabilitation. Mildura Base Hospital is a unique facility to the extent that it is a public hospital contracted to Ramsay Health Care to provide services to the community by the Victorian Department of Human Services.

The successful applicant will be supported by registrars and interns.

MBH is affiliated with the Monash Rural Clinical School of Medicine and La Trobe University and participates in the provision of medical, nursing and allied health education. The opportunity exists for an honorary teaching appointment with the Monash University for a candidate with appropriate skills.

Mildura is a vibrant rural centre and offers a friendly, relaxed lifestyle, access to Australia's mighty Murray and Darling Rivers and a wide variety of sporting and leisure activities, sensational places to eat, and a rich Arts culture.

To find out more, please contact:
Trevor Matheson, Mildura Base Hospital
on (03) 5022 3215 or email to mathesont@
ramsayhealth.com.au

MOMENTUM GROWS FOR NEW MODELS OF HOSPITAL CARE

Acute Medical Assessment and Planning Units

There in growing interest, both in Australasia and internationally, for the establishment of Acute Medical Assessment and Planning Units (MAPUs) in medium to large hospitals. Several workshops have been held over the last year and more are planned over the coming months (see IMSANZ website for more details), aimed at sharing people's experience of such units and how this new model of care can be made more effective in improving efficiency and quality of care to acutely ill medical patients presenting to hospital.

For those not yet familiar with the concept, MAPUs can be defined as designated hospital wards specifically staffed and equipped to receive medical inpatients presenting with acute medical illness from emergency departments and/or the community for expedited multidisciplinary and medical specialist assessment, care and treatment for up to a designated period (typically between 24 and 72 hours) prior to discharge or transfer to medical wards. In some hospitals, synonymous names have been applied including acute medical assessment unit (AMAU), acute medical unit (AMU), acute assessment unit (AAU), acute medical wards (AMW), acute planning units (APU), rapid assessment medical units (RAMU) and early assessment medical units (EMU). These units are supervised by consultants with an interest in acute general medicine, feature multidisciplinary teams which comprehensively assess and manage both medical illness and functional disability, and, in many instances, are geographically co-located with emergency departments and key diagnostic services such as pathology and radiology.

In general, MAPU admission policies grant entry to any patient referred from emergency departments or directly from primary care practitioners with an acute medical condition who, in most cases, exhibit none of the following contra-indications to entry: 1) haemodynamic instability requiring invasive monitoring and/or critical care facilities; 2) special need patients (eg acute stroke, dialysis, oncology, endoscopy); 3) presentations for respite or residential care; 4) geriatric syndrome presentations best suited for admission to geriatric rehabilitation or dedicated elderly care units; and 5) severely behaviourally disturbed patients best suited for mental health care.

While MAPUs both within and between different countries have local peculiarities in organisation and operation, all share several common objectives and patient flow characteristics which confer potential flow-on benefits for patients, clinicians and health services as a whole. These include: more appropriate and timely assessment, diagnosis and treatment of patients leading to reduced length of stay; more organised work environment with standardised admission and discharge processes; reduced overcrowding in emergency departments and avoidance of unnecessary admissions; improved bed management and smoother patient flows; increased staff job satisfaction and more effective use of resources for the hospital as a whole.

A recent systematic review of both peer-reviewed and 'grey' literature suggests that MAPUs can reduce in-patient mortality, length of stay and emergency department access block without increasing readmission rates, and improve patient and staff satisfaction.[1] An opinion piece in the MJA extols the potential value of MAPUs as one vital component of whole-of-hospital clinical process redesign that can reduce access block in EDs and optimise patient flow.[2] Preliminary results of a recent questionnaire survey of existing MAPUs in Australia and New Zealand have been presented at the 2009 Society of Acute Medicine conference in Birmingham[3] (which included a number of presentations on this topic) and a paper has been submitted for publication. This survey compared current operations of responding units with standards developed by IMSANZ in 2006. It revealed that, while the majority of units in the most part matched the standards, some problems were noted with respects to average bed size, extent of geographic integration with ED, delays in transfer of patients from the ED to MAPU, and extent of consultant cover on weekends. Presentations from workshops conducted in various sites are available at the following websites for those who would like to delve further into the nuts and bolts. One thing is certain: MAPUs have come of age, more will be established over coming years (including I suspect private hospitals), and all general physicians will eventually need to engage in the workings of such units and understand their objectives and functions. It is vital that the supervision and ownership of MAPUs stay with general physicians who are the medical specialists best trained and equipped to provide this sort of service for a wide spectrum of acutely ill patients who are increasingly older and more complex.

Quick diagnosis units

Not infrequently patients are referred to hospital by GPs for further investigation of acute medical events that have clinically resolved by the time of presentation to the GP, or have had investigations done which suggest possible cancer or some other potentially sinister condition whose nature and extent has yet to be defined. Many of these patients are admitted, if only because patients have been made to feel that admission will occur so that they can be worked up quickly and their anxieties allayed. However a recent article in the MJA describes Spanish experience with 'quick diagnosis units' which constitute a potential ambulatory alternative to hospitalisation,[4] and where again the role of a generalist is paramount if such units are to function effectively.

Day units for investigation and therapy

A number of hospitals have established dedicated day therapy and procedure units for medical patients who require transfusions or infusions of various sorts, simple procedures such as joint aspiration, pleural taps or paracentesis, or desensitisation injections and skin testing. Such units close by the day's end and act to avoid placing patients in in-patient beds. If located closed to radiology departments they may also serve as an area for housing ambulatory medical patients requiring interventional procedures, including inter-hospital transfers where the aim is to transfer patients back to referring hospitals. Again, given the diverse nature of patients, generalists are required to oversee care in these units and ensure their efficient functioning.

Readers are invited to submit articles which describe other new models of care that they are aware of or have been associated with. The current climate of healthcare reform is ripe for general physicians to become proactive in promoting new models of care that may provide some solutions to our existing problems of hospital overcrowding and access block.

IAN SCOTT

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3 McNeill G, Brand C, Clark K, et al. Results of the Australasian Acute Medical Assessment Unit Survey. Presented in part by Paul Jenkins under the title: Contrasts in acute care: A comparison of the UK and Australian systems with thoughts for future. 3rd International Meeting of the Society of Acute Medicine, Birmingham, UK, Oct 1-2, 2009. Available at: http://www.acutemedicine.org.uk/ under 'Past Conferences' link

4 Bosch X, Aibar J, Capell S, et al. Quicki diagnosis units: a potentially useful alternative to conventional hospitalisation. Med J Aust 2009; 191: 496-498.

ACM 2010

Clinical Course in Acute Care Medicine and a special focus symposium on Acid Base and Clinical Disorders of Electrolyte and Fluid

BOOK WITHOUT DELAY - places strictly limited!

When: 21 to 24 January 2010
Where: Eastern Health & Monash University, Box Hill, Melbourne

The Department of Medicine in Eastern Clinical School, Monash University and Eastern Health is pleased to announce the 5th Annual ACM Course – Clinical Course in Acute Care Medicine and the Special Focus Symposium to be held in Eastern Health, Melbourne from 21 to 24 January 2010.

This is a course specially designed to upskill HMOs, Registrars, Fellows and Consultant Physicians in the Pre-ICU Clinical Management of the Acutely Ill.

The ACM course attracts about 150 HMOs, registrars and consultant physicians from Australia, New Zealand and the Pacific area. It runs for 2.5 days and includes lectures on topics of practical relevance and the hands-on ACES - Acute Critical Event Simulation skill stations - on the vital aspects of caring for an acutely ill patient. ACM 2010 will run from 22 to 24 January 2010.

On Thursday, 21 January 2010 there will be the 2010 special focus symposium on ABCDEF – Acid Base and Clinical Disorders of Fluid and Electrolyte.

For information about this course, FAQs, venue details, maps and the previous year's program, please go to www.easternhealth.org.au.

Course Conveners: A/Professor Ramesh Nagappan / Professor Peter Gibson

Contact: A/Professor Ramesh Nagappan, Director of Internal Medicine, Maroondah Hospital & Intensivist, Box Hill Hospital, Melbourne VIC 3128 Australia:

Tel. +61 3 9387 1000 or Fax +61 3 9871 3798 or by e-mail at ramesh.nagappan@easternhealth.org.au

TRAVEL SCHOLARSHIP REPORT: ESIM12 – 2009

Chakradhar Molugu (UK), Simon Dalton, Chris Davidson (ESIM Director)

In September I was fortunate to attend the 12th annual European School of Internal Medicine (ESIM) in London, thanks to the support of the IMSANZ Travelling Scholarship. ESIM was founded in 1997 in Alicante, Spain, and was the brainchild of Professor Jaime Merino, then President of the European Federation of Internal Medicine (EFIM). His purpose was twofold: to provide an exciting scientific programme on advances in Internal Medicine, and to develop links between young residents in training from all over Europe. The School was an immediate success, both scientifically and socially, and was held annually in Spain until 2006. For the last three years it has been in Lisbon, under the successful direction of Antonio Martins Baptista, who joined Chris Davidson as Co-Director of this year's school in London, where we were hosted by the Royal College of Physicians. The venue for the school was the historic surroundings of Sir Christopher Wren's Naval College in Greenwich. The campus boasts some of London's finest Grade 1 listed buildings, and forms part of the Maritime Greenwich World Heritage Site.

The 2009 school attracted 73 delegates from 29 countries. Only 2 delegates were from outside Europe; a visiting Canadian and myself. We were made very welcome as additional members of a greatly expanded "European Union".

Lectures covered a wide range of topics. There were many excellent discussions including for example; obstetric medicine, the meaning of a positive ANA, and acute pancreatitis. I was surprised to learn that this condition is usually managed by general physicians, as everywhere I have worked in Australasia it is regarded as a surgical problem and managed by the general surgeons. Each represented country also presented a short case. There were some fascinating (although largely rare) cases. Clinico-pathological conferences and small group workshops led to lively discussion and debate. A highlight of the teaching was one of the few non-clinical lectures, presented by Prof Linda Snell, on issues in medical education and the use of effective presentation techniques.

To balance the academic side was a well organised social programme. We spent some time exploring Greenwich Naval College, and the Royal Observatory. Later in the week we enjoyed a cruise down the Thames which provides a wonderfully different vantage point to some of London's famous sights. These social occasions afford an opportunity to discuss our various backgrounds, experiences, and medical training with each other. Essentially it illustrated to me how medicine is the same the world over, although there may be minor differences around the edges. I was somewhat surprised that most of my Eastern European colleagues (for example Estonia) have ready access to PET-CT scans and 24 hour cath-labs. They were even more surprised that we in New Zealand do not.

At the end of the week a celebratory gala dinner was held at the Royal College of Physicians following a study day. This was an immensely enjoyable event, although tinged with the sadness of knowing our time at ESIM was almost up.

In conclusion, I wish to thank IMSANZ for their generous sponsorship, and commend all advanced trainees in General Medicine to consider attending ESIM in the future.

SIMON DALTON, NZ
dalton@ihug.co1.nz

FORTHCOMING MEETINGS

Year	Month	Meeting
2010	JANUARY	**ACM 2010** **21-24 January 2010** **Eastern Health & Monash University, Box Hill, Melbourne** **BOOK WITHOUT DELAY - places strictly limited!** Contact: A/Professor Ramesh Nagappan, Director of Internal Medicine Tel: +61 3 9387 1000 Fax: +61 3 9871 3798 E-mail: ramesh.nagappan@easternhealth.org.au
2010	MARCH	**World Congress of Internal Medicine** **20-25 March 2010** **Melbourne Exhibition and Convention Centre, Melbourne VIC** Online Registration: www.wcim2010.com.au *Early bird registration close 15 January 2010* Contact: wcim2010@tourhosts.com.au Website: www.imsanz.org.au/events/
2010	MAY	**Acute Medicine 2-Day Conference** **6-7 May 2010** **Hutt Hospital, Lower Hutt NZ** • Are you responsible for Acute Medical takes? • How secure do you feel about running an acute take? • Practical talks from Consultants involved in frontline medicine. • If you are a Registrar about to take full consultant responsibility or a Consultant and want an update. • Don't delay register your interest now, places are limited For details and a programme e-mail wendy.holmes@huttvalleydhb.org.nz Tel: +64 4 587 2519 Fax: +64 4 570 9254
2010	OCTOBER	**IMSANZ Trans Tasman Meeting** **1-3 October 2010** **Sofitel Gold Coast in Broadbeach, Queensland** IMSANZ will be holding an Australian and New Zealand combined ASM. There will be no Spring Meeting in New Zealand in 2010. Please watch website for further details. Website: www.imsanz.org.au/events/
2010		**Canadian Society of Internal Medicine (SCIM) Annual Scientific Meeting** **27-30 October 2010** **Hyatt Regency in Vancouver, BC**
2012	NOVEMBER	**XXI World Congress of Internal Medicine** **11-15 November 2012** **Santiago, Chile** Please make a note in your diary. Website: www2.kenes.com/wcim/Pages/Home.aspx

VALE THE CATS LIBRARY

It is with a sense of regret that I have to announce the end of the CATs library in its current form. Put simply, I no longer have the time to write the summaries and maintain the archives. It is also a recognition of the many alternative secondary sources of summary data now available and which I know many of my colleagues use. Such sources scan general medical journals and, at regular intervals (which may be as frequently as every few days), provide summaries of articles thought to be relevant to Internal Medicine or direct links to their PubMed abstracts. These resources, some of which are free, include:

- Internal Medicine Research Review available at **www.researchreview.co.nz**. This same resource also provides summaries of articles across a broad range of subspecialties.
- Evidence Updates available from BMJ group at: **http://plus.mcmaster.ca/EvidenceUpdates**
- Essential Evidence Plus supplied by InfoPOEMs at: **www.essentialevidenceplus.com**
- Medscape available at: **www.medscape.com**

These are but a few and there are probably many more some of you have found useful in your clinical practice. These services are timely with turnaround times between article publication (which may be at the on-line, pre-print stage) and release of the summary much shorter than the 4 month intervals at which the CATs are currently posted on our website. They also cover a greater number of articles within a set period of time, and many include commentaries or ratings which give the reader some idea of their validity and applicability to routine practice.

Thus I have come to sense the increasing redundancy of the library, although I appreciate that many of our members, particularly trainees, use the library to update themselves on sentinel articles, as evidenced by the rise in website hits following publication of the new CATs titles in each issue of the newsletter. Still, the effort to produce these CATs cannot be sustained indefinitely. Another consideration has been the advent of myCPD and other initiatives which are putting more responsibility on individuals to undertake their own self-directed learning which involves the active seeking out of evidence to inform clinical decision-making. Push strategies, focussed on dissemination of information to end-users, while useful, are probably less important than pull strategies by which individual clinicians retrieve information in real time when needed in response to specific clinical questions.

However, not to disappoint folk totally, a replacement for CATs will be New Evidence: a listing of recent key article titles with a short outline of the topic, to which an electronic link to the PubMed abstract will be attached. As this will take considerably less time to compile, the result will be an increased capacity to list more topics. In the meantime the current CATs archive will remain accessible to all members, and from the start of the new year, an e-mail will be periodically forwarded to all members notifying them of new article listings. Anyone who would like to assist as a sub-editor in this activity please feel free to contact me.

IAN SCOTT

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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