IMSANZ
INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND

AUGUST 2010

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President's Report

The last few months seem to have passed in a blur. In that time we have started to get increased detail on the models for the new Australian networks for primary care (Medicare Locals), as well as some further details regarding the shape of the new Hospital Networks. It is disappointing to me that there appears to be little recognition of the current importance of General Physicians and General Medicine services in the documents to date, let alone an understanding of the role that we could play in improving the capacity and efficiency of acute and chronic care. There appears to be an overestimation of the capacity of General Practice in particular to provide integrated care for patients with chronic disease, and while I do not doubt that many of our General Practice colleagues are very well trained in the care of patients with common chronic diseases, they struggle with the patients with multiple co-morbidities and the more complex complications that are our "bread and butter".

Our New Zealand colleagues appear to have been better able to convince government of their crucial role, especially regarding the importance of planning for a workforce to ensure that there are appropriate physicians providing generalist care in rural hospitals. The Health Department recently sponsored a roundtable discussion on the requirements for maintenance of acute services at their ten smaller hospitals, and we were given the opportunity to provide our perspective as a critical component of these services.

While on the topic of things New Zealand, John Gommans has agreed to take on the role of New Zealand Vice president. As a result he will take over the role of President of the society in 2 years time. John is a general physician practicing in Hawkes Bay.

We also welcome a new Australian Trainee representative to the Council in Sara Barnes. She has challenged us to demonstrate that we can better mentor our advanced trainees and organize at least one informal event in each state where trainees and consultants can get together. I think this an excellent idea as it will help to produce a sense of identity and esprit de corps for our younger colleagues. I will ask each of our state representatives on the IMSANZ council to work with their colleagues and take this forward.

I am pleased to inform members that we have managed to make some significant ground in ensuring that we are able to have clear training guidelines which are consistent across the Tasman. A working party consisting of Andrew Bowers, Nicole Hancock and myself have produced a draft of the guidelines which we believe will more clearly align with the skills required of General Physicians to practice in the multiple settings where we are needed. The major components of the guidelines reflect the training necessary for Acute medicine, inpatient medicine and the longitudinal care of chronic diseases. We also believe the guidelines will clarify the way in which trainees can embark

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on dual training pathways if they desire. The drafts are currently being circulated to the SACs and to the IMSANZ council, prior to going out for general comment. The framework of the guidelines was also used in drafting the next stage of the General medicine curriculum. I hope that by the next newsletter the updated curriculum will be also ready for comment.

The planning for the meeting at the Gold Coast in the first weekend of October is well advanced. Most of the speakers are now locked in, with a program that looks exciting and informative. The website will be open for bookings at the time of publication, so please have a look and book it in your diaries.

Finally, I am pleased to see that the new Associate membership category for allied health and Nursing clinicians is starting to be used. We welcome the new members to our Society. We would be pleased if Members working with eligible people encouraged them to consider joining.

NICK BUCKMASTER FRACP
PRESIDENT, IMSANZ

A trainee plea for more mentoring and networking

Currently General Medicine has 150 Advanced Trainees registered within Australia. Despite this there are negligible numbers becoming fellows of the College. Why do we lose so many of our trainees to other specialities? I argue that other speciality groups foster and mentor their trainees to a much greater degree. We need to start fostering an environment of mentoring and networking. This needs to occur not only within, but also outside the hospital environment. It has been well researched that a mentoring environment not only encourages learning but also creates a supportive environment[1,2] A simple but effective way to encourage this to occur would be informal dinners as used by other specialities. This would allow Trainees within General Medicine to network and debrief amongst themselves. In addition it would encourage those interested in undertaking General Medical Training Programme to be immersed within our culture to encourage participation.

I raise the challenge to all Fellows within General Medicine in Australia to come together in a proactive manner to organise one informal dinner with their State's General Medical trainees by the end of this year.

SARA BARNES
Advanced Trainee Rep, Aus

IMSANZ would like to welcome the following New Members:

- Dr Mohammad Ahmedullah, Adelaide, SA
- Dr Michael Boyle, Newcastle, NSW
- Dr Iain Bruce, Coffs Harbour, NSW
- Dr Louise Cing Ciin, Darwin, NT
- Dr Christopher Fong, Melbourne, VIC
- Dr Terence Glynn, Campbelltown, SA
- Dr Mohammed Khateeb, Gold Coast, QLD
- Dr Tim Lightfoot, Melbourne, VIC
- Dr Kingsley Logan, Whakatne, NZ
- Dr Colin MacArthur, Liverpool, NSW
- Dr Gabrielle O'Kane, Newcastle, NSW

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

- Dr Chris Cederwall, Wellington, NZ
- Dr Ben Griffiths, Wellington, NZ
- Dr Alex Lampen-Smith, Wellington, NZ
- Dr Timothy Ryder, Brisbane, QLD
- Dr Laurence Teoh, Auckland, NZ
- Dr Ben Vogler, Townsville, QLD

Also IMSANZ warmly welcomes Allied Health Associate Member:

- Ms Liz Sellers, Upper Hutt, NZ

IMSANZ NZ Autumn Conference

2-4 March 2011

Copthorne Hotel
New Plymouth, Tarankai, NZ

MARKETING GENERAL MEDICINE IN ATTRACTING PHYSICIAN TRAINEES

In Australia the numbers of Advanced trainees in General Medicine have been declining steadily until the last few years when there has been something of a resurgence in numbers. This has occurred despite the clear need for an increase in the General Physician workforce. The reasons for the decline in popularity of General Medicine are numerous, including the relatively low profile of General Medicine training in many hospitals, and the perception amongst trainees that General Medicine is very challenging specialty to master.

At a recent meeting of the Queensland Statewide General Medicine Clinical Network (SGMCN) Executive Committee, IMSANZ member Dr Charles Denaro (Director of Internal Medicine and Aged Care at Royal Brisbane and Women's Hospital and Associate Professor of Medicine at the University of Queensland) briefed the committee on his thoughts of how departments of internal medicine around the state and the SGMCN could better market general medicine in attracting physician trainees into our specialty. The following strategies arose out of discussions involving other members of the committee and may be of interest to colleagues across Australia and New Zealand. While our perspective is that of public hospital departments, especially those who train many basic physician trainees, many of the strategies could equally apply to private hospitals and group practices.

1. Profiling the diverse and interesting casemix of patients admitted to general medicine units

Our units span the spectrum of internal medicine with particular focus on older patients with complex problems and multiple co-morbidities. This diversified casemix of patients provides a source of professional interest to attract basic trainees into advanced training in general medicine and keep them there. As a 'prized asset,' this casemix needs to be maintained and, where necessary, reclaimed from other specialties. Close relationships with emergency medicine departments and the advent of medical assessment and planning units, coupled with liberal, no-restriction admission policies underpin our being perceived as the specialty of least resistance on the part of pressured emergency physicians. This is particularly evident after-hours when the bulk of medical admissions occur and emergency units are seeking a receptive first point of contact for new admissions. We need to be seen as the physicians who welcome the challenge of diagnostic and management problem-solving and caring for patients with undifferentiated presentations. We also need to advertise the niche areas that many general physicians occupy in regards to acute and chronic care of the elderly, peri-operative medicine, post-ICU care, obstetric medicine, palliative care, acute stroke medicine, acute medicine units, and clinical pharmacology.

2. Profiling our departments as having equal standing with other specialties in the areas of clinical service, education and training, research, clinical governance, and quality and safety improvement

Clinical service: Departmental reports, letterheads, websites and other 'public domain' documents should list and publicise the various clinical services and areas of special interest offered by the department and, where appropriate, profile the clinical achievements and standing of departmental members.

Education and training: Departments should develop and promote education and training programs that indicate the capacity and willingness of general physicians to cater to the needs of a wide spectrum of novices, from medical students to interns to basic and advanced physician trainees. For this reason, internal medicine departments should take the lead in hospital-level medical education programs. Programs based on explicit learning objectives and which provide hands-on, practical tuition using case scenarios and simulations attract great interest and satisfy real-world learner needs. Programs need to cover both core content areas and essential attributes of professionalism such as clinical reasoning, interdisciplinary teamwork, effective prescribing, ethics and quality and safety improvement. An example of a comprehensive training program for interns is discussed elsewhere in this newsletter. Any symposia, workshops or courses provided by internal medicine units should be promoted on websites and in other media, and individual physicians should apply for academic teaching titles wherever possible. Active involvement in the training programs of postgraduate years 1 and 2 as well as college PREP programs, which include tutorial and viva preparation for written and clinical examinations, should be regarded as mandatory for every general physician. Where possible, a general physician should occupy the position of Director of Physician Training (DPT) or, at the very least, have very close liaison with the DPT as well as the senior medical registrar who, in turn, should ideally be an advanced trainee in general medicine.

Research: The undertaking of original research is a key activity that marks a specialty as deserving such a title and is one that has been an Achilles' heel for many internal medicine departments, particularly when surrounded by high-profile specialties within tertiary hospitals. Compared to other societies, including those such as the geriatricians who have some commonalities with, and a similar membership count to, IMSANZ, internal medicine has a relatively low per capita research output. This is reflected not only in numbers of research publications in peer-reviewed journals but also in numbers of conference abstracts and presentations at scientific meetings. One key obstacle may be the lower numbers of full-time general physicians able to devote time to research compared to other specialties. Nevertheless, strategies for enhancing research output have been articulated elsewhere, IMSANZ members are involved in government and NHMRC funded research, advanced trainees are expected to undertake research projects, and the recently inaugurated national Internal Medicine Research Network provides a forum for supporting general physician-led studies. We would suggest that every internal medicine department aim to submit one paper to a conference or to a journal each year, and that these be showcased on departmental portals and registered with a centrally collated IMSANZ registry. Affiliations with research agencies and universities should be promoted and advertised.

Clinical governance: Internal medicine is very much a discipline interested in the 'big picture', system-level perspective of ensuring safe and effective healthcare. In demonstrating this interest and commitment, departments should actively involve themselves in the organs of clinical governance by seeking and securing membership (and indeed chairmanship) of committees or bodies, at hospital or district level, that deal with service capability

and performance frameworks, credentialing and scope of practice, patient quality and safety, clinical education and training, drugs and therapeutics, information technology, hospital-community liaison and division-wide clinical service activities. In this manner, general medicine departments become increasingly 'indispensable' and are provided with more opportunity to expand its numbers and create more full-time appointments.

Quality and safety improvement: In keeping with our identity as innovators, departments should be receptive to experimenting with, and evaluating, new technologies and models of service delivery aimed at improving quality and safety of care. The results and learnings from such projects should be documented and shared with others and indeed this is one of the future objectives of the SGMCN. In areas of clinical practice directly relevant to our discipline, general physicians should participate in panels tasked with developing clinical practice guidelines, protocols and pathways. This serves two purposes in addition to improving care: it indicates general physicians can lead in providing evidence-based guidance, and it provides the opportunity to build collaborations with other specialties which reassure them that general physicians are capable of demonstrating best practice and ensure general medicine is not excluded from the care of particular patient groups, thus helping again to maintain the diversified casemix. Each department should have orientation and handover procedures for trainees, sets of clinical guidelines and performance indicators for commonly encountered conditions, assessment and performance reviews for all clinical staff, regular mortality and morbidity reviews and clinical audits, and reports on activity and budget statistics. Discussed elsewhere in this newsletter is a service principles and practice grid for general medicine units proposed as a set of auditable operating standards by members of the Models of Care Working Group of the SGMCN.

3. Promoting good role models, mentoring, teamwork and morale

The senior members of every department must demonstrate the professional attributes that endear themselves to trainees and invoke a desire on the part of the trainee to emulate them and join the community of general physicians. This means acting as good role models and communicators, mentoring trainees, fostering teamwork, demonstrating openness, showing leadership, engendering trust and building morale. In another article in this newsletter, one of our trainees asks for more mentoring and suggests greater use of informal dinners as one way of consultants getting to know and understand the needs and aspirations of trainees. Consultants must be perceived as 'walking the walk' as well as 'talking the talk,' being visible on the wards and in clinics, providing close supervision and guidance to trainees, regularly attending Grand Rounds, journal clubs and other educational forums, and offering genuine help to those with problems or special needs. Being a source of constructive criticism, while avoiding harsh judgments, and congratulating folk on their achievements are important skills which strengthen morale and aspirations towards excellence. In some hospitals which rely on visiting medical officers as the predominant physician workforce, fulfilling all these requirements may be difficult in the absence of a critical mass of full-time physicians who have the time and 'on-site' presence to devote to these activities.

4. Enhancing training infrastructure for advanced trainees in general medicine

There are several ways general physician can assist individual advanced trainees (ATs) in customizing training programs that meet their specific needs.

- Brocker rotations and other clinical exposures in other specialties with the relevant departmental directors at either hospital or district level.
- Occupy the position of DPT or build a strong working relationship with the DPT (and Senior Medical Registrars in those hospitals that have such a position) and lobby for a minimum number of trainee positions within a range of specialties to be reserved for ATs in general medicine.
- Develop 2 to 3 year career pathways for trainees which include rotations through different units and hospitals (both metropolitan and regional) in providing security of tenure and an enriched training experience.
- Grow the number of training positions for ATs in general medicine by lobbying government and hospital executives for more training positions (in both public and private hospitals and community settings), scholarships and research posts.
- Advocate for minimum standards in regards to the required inpatient and outpatient caseload, ratio of consultants to trainees, after-hour on-call, protected time for education activities and core rotations required for trainees to acquire the core competencies of a general physician.
- Ensure that all departments of general medicine have updated and comprehensive advanced training profiles on the IMSANZ website and within departmental orientation manuals and websites - http://www.imsanz.org.au/training/sites/index.cfm

5. Adopting an active advocacy role for the discipline of general medicine

Finally, general physicians should take every opportunity to adopt an active advocacy role for our discipline within any body or forum of influence. This includes actively contributing to the activities of IMSANZ, SGMCN, and other similar bodies, and advocating for general medicine within the affairs of RACP, health departments, hospital committees, civic and community groups. The more folk engaged in such activities, the less the burden on a small number of individuals and the greater the perceptions of strength and representativeness on the part of those outside our discipline.

We welcome feedback from readers about any additional strategies that may further enhance the profile and drawing power of general medicine to physician trainees.

CHARLES DENARO, IAN SCOTT & NICK BUCKMASTER
for the Queensland Statewide General Medicine Clinical Network

IMSANZ – RACP (QLD) SCIENTIFIC MEETING

Sofitel Hotel, Broadbeach October 1-3, 2010

The 2010 trans-Tasman IMSANZ annual scientific meeting is being held in conjunction with the RACP (Qld) annual meeting in beautiful, sub-tropical Gold Coast in spring. There is something for everyone in the program as well as all the social and recreational delights of one of the best known seaside playgrounds in Australia. So come and join us. The event kicks off with a workshop on clinical performance measurement and improvement sponsored by the RACP, and featuring concise, practical case studies and evidence reviews delivered by clinician experts in the field who will both educate and challenge us in how we reflect on our own practice. We suspect the discussions and debates arising from the workshop will continue (and perhaps intensify) with the aid of drinks at the evening reception. On day 2, the scientific program begins in earnest with updates across several topics of importance to general physicians within the specialties of cardiology, renal medicine, vascular medicine, infectious diseases, and neurology. The afternoon of day 2 will also feature the Queensland advanced trainees presentations, followed by an open meeting of IMSANZ members to discuss new developments in IMSANZ policy, including revised guidelines on advanced training in general medicine and credentialing and scope of practice. The conference dinner later that evening will hopefully feature college president-elect, Dr Les Bolitho as guest speaker who will share his insights (and a few humorous anecdotes) on the many challenges facing the college and its fellows and trainees. Day 3 will commence with the IMSANZ free papers session (so be ready for the 8am start and support our trainees and colleagues who have put effort into these presentations). With more than 30 abstracts received to date, our judges are finding it hard to select between those suitable for either oral or poster presentations - we may need to add another session as well as expand the poster displays. After morning tea, there will be two concurrent sessions for delegates to choose from: one sponsored by IMSANZ which focuses on new directions in internal medicine, and the other, sponsored by the Public Health faculty of the college, on Local Hospital Networks. After lunch, for those hardy souls who still want more, an informal workshop on acute medicine will be convened to discuss latest advances in this changing field including the possible impacts of a 4-hour rule for access block in emergency departments. So much to see and hear in very stylish surroundings and with convivial company. We look forward to seeing you there. The website for registrations and accommodation bookings, with early bird discounts, is now open at: www.imsanz-racpq.org.au.

NICK BUCKMASTER
IAN SCOTT
On behalf of the 2010 IMSANZ-RACP(Qld) ASM Steering Committee

PRELIMINARY PROGRAM

As of 4/8/10

TIME	TOPIC	SPEAKER
Friday October 1		
1400-1730	**Measuring for Improvement Workshop** This workshop aims to provide attendees with a practical framework for measuring and improving clinical performance in daily routine clinical practice. Presentations will focus on clinical indicators, individual physician performance measures, and change management and feature several case studies and evidence reviews. **Registration fee: $75.00** **Includes afternoon tea**	RACP Quality Expert Advisory Group and associated speakers including: Prof Clifford Hughes, NSW Health A/Prof Caroline Brand, Damien Jolly, David Russell, Royal Melbourne Hospital A/Prof Ian Scott, Princess Alexandra Hospital A/Prof George Rubin, University of Sydney **For more information please email: quality@racp.edu.au**
1800-1930	**Welcome Reception**	
Saturday October 2		
0820-0830	**Welcome and Opening**	Nick Buckmaster
0830-1030 *Chair: Ian Scott*	**Update in Cardiology and Renal Medicine**	

0830-0900	**Update in renal Medicine** • Renovascular hypertension: How to diagnose and when is procedural intervention useful • What is the Hb to aim for in chronic renal failure and what is the best way to achieve this • What is the best strategy for preventing contrast induced nephropathy • What is the best treatment for proteinuric renal failure	**Prof Rob Fassett** Director of Renal Research Royal Brisbane and Women's Hospital, Brisbane
0900-0930	**Advances in heart failure** • BNP-guided therapy • Iron therapy • Low dose vs high dose ARB/ACE-inhibitors • CRT in CHF – who will benefit most?	**A/Prof John Atherton** Director of Cardiology Royal Brisbane and Women's Hospital, Brisbane
0930-1000	**Interventional cardiology** • Ultra-sensitive troponin assays-how to interpret? • Current role and timing of PCI in ACS • Percutaneous AV implantation: eligibility and timing	**A/Prof Con Aroney** Holy Spirit Hospital Northside, Brisbane
1000-1030	**Arrhythmia management** • Atrial fibrillation – antiarrhythmic drugs vs ablative therapy • Preventing sudden cardiac: who's at risk and how to prevent it? • Older patient with syncope – who needs further cardiac investigation and who needs pacing?	**Dr Wayne Stafford** Qld Cardiovascular Group, Brisbane
1030-1100	***Morning Tea***	
1100-1230 *Chair: TBC*	**Update in Vascular Medicine**	
1100-1130	**Venous thromboembolism** • Who should get life-long anticoagulation after unprovoked first VTE • VTE prophylaxis in medical and surgical patients – who is at highest risk; how long to treat • Current role of vena caval filters	**Dr Andrew McCann** Acting Director of Vascular Medicine Princess Alexandra Hospital, Brisbane
1130-1200	**Preventing cardiogenic thromboembolism** • Has dabigatran replaced warfarin as drug of first choice? • Intensity of anticoagulation in patients with mechanical heart valves – moving target?	**Dr Bev Rowbotham** Haematologist Sullivan and Nicolaides Pathologists, Brisbane

1200-1230	**Preventing and treating acute stroke** • Role of CEA vs carotid stenting • When and who should be lysed in acute stroke? • Risk stratification following acute stroke & TIA	**Dr Graham Hall** Director of Acute Stroke Unit Princess Alexandra Hospital, Brisbane
1230-1330	***Lunch***	
1330-1500 *Chair: TBC*	**Update in Infectious Disease**	
1330-1400	**Antibiotic resistance** • Penicillin-resistant community-acquired gram (+) infections • Multi-drug resistant TB • New antibiotics for multi-drug resistant infections in hospital practice	**A/Prof David Paterson** Infectious Diseases Physician Royal Brisbane and Women's Hospital, Brisbane
1400-1430	**Changing disease patterns** • Dengue fever – how low can it go (geographically) and how to diagnose it early • Clostridium difficile – extended disease spectrum and new treatments • Malaria – resistant strains, vaccination, new antibiotics	**Dr Claire Heney** Infectious Diseases Physician Princess Alexandra Hospital, Brisbane
1430-1500	**Viral hepatitis** • What are new advances in patients with chronic active hepatitis? • Who should receive these treatments, when and for how long? • How do we evaluate cure vs remission? • What impact does treatment have on long-term sequelae such as cirrhosis and HCC?	**Prof Darrell Crawford** Professor of Hepatology Greenslopes Private Hospital and University of Queensland
1500-1530	***Afternoon Tea***	
1530-1700	**Queensland Advanced Trainees presentations**	*Chair: TBC*
1700-1800	**IMSANZ meeting**	*Chair: Nick Buckmaster*
1900	**Conference dinner**	*Guest speaker: Dr Les Bolitho* *President-Elect, RACP (TBC)*
Sunday October 3		
0800-0900	**IMSANZ Free Papers**	*Chair: Nick Buckmaster*
0900-1030 *Chair: TBC*	**Update in Neurology**	
0900-0930	**Headache** • Common diagnostic conundrums in acute and chronic headache • New drugs for migraine prophylaxis	**Dr Max Williams** Neurologist, Brisbane

0930-1000	**Epilepsy** • New drugs and their relative advantages and disadvantages • When and in whom should neurosurgical ablation be considered? • Structural brain disease – who needs anti-epileptic prophylaxis?	**Prof David Reutens** Director Centre for Advanced Imaging, Professor of Experimental Neurology, University of Queensland
1000-1030	**Degenerative disease** • New dopamine agonists in Parkinson's disease • Advances in multiple sclerosis	**Dr John O'Sullivan** Neurologist, Brisbane
1030-1100	***Morning Tea***	
11-00-1230 *Chair: TBC*	**Concurrent Session** **Public Health: Local Hospital Networks**	
1100-1130	Parallels between the UK and Australia	**Prof Steve Kisely** Health LinQ University of Queensland
1130-1200	Using differences in health service organisation in Scotland & England to evaluate effectiveness	**Dr Elizabeth Crowe** Health LinQ University of Queensland
1200-1230	What are the options for assessing outcomes in Australia?	**TBA**
1100-1230 *Chair: John Gommans*	**Concurrent session** **Setting New Directions in Internal Medicine**	
1100-1130	Redefining the role and functions of general physicians in times of great change	**A/Prof Ian Scott** Princess Alexandra Hospital, Brisbane
1130-1145	The Queensland State-wide General Medicine Clinical Services Network	**Nick Buckmaster** Gold Coast Hospital
1145-1230	Attracting basic trainees into internal medicine (Panel Discussion)	**Dr Charles Denaro**, Brisbane **Dr Peter Boyd**, Cairns **Dr Andrew Bowers**, Dunedin
1230-1245	Revised guidelines for advanced training in general medicine	**Nick Buckmaster**
1245-1250	**Close**	
1250-1330	***Lunch***	
1330-1500	**Acute Medicine**	**Kevin Clarke**

The following articles published so far this year have been selected as being of interest to general physicians.

Rifaximin reduces the risk of recurrent hepatic encephalopathy in patients with chronic liver disease.

Bass NM, Mullen KD, Sanyal A, et al. **Rifaximin treatment in hepatic encephalopathy.** N Engl J Med. 2010 Mar 25;362(12):1071-81. *(Original)* PMID: 20335583

Long-acting beta-agonists, even if used with long-acting inhaled corticosteroids, increase the risk of asthma-related deaths and intubations.

Salpeter SR, Wall AJ, Buckley NS. **Long-acting beta-agonists with and without inhaled corticosteroids and catastrophic asthma events.** Am J Med. 2010 Apr;123(4):322-8.e2. Epub 2010 Feb 20. *(Review)* PMID: 20176343

Administration of a Lactobacillus single-agent regimen as a prophylactic agent during antibiotic treatment reduced the risk of developing antibiotic-associated diarrhoea compared with placebo in adults but not pediatric patients.

Kale-Pradhan PB, Jassal HK, Wilhelm SM. **Role of Lactobacillus in the prevention of antibiotic-associated diarrhoea: a meta-analysis.** Pharmacotherapy. 2010 Feb;30(2):119-26. *(Review)* PMID: 20099986

Valsartan in combination with lifestyle modification reduces risk of diabetes but has no effect on cardiovascular events in patients with impaired glucose tolerance.

McMurray JJ, Holman RR, Haffner SM, et al. **Effect of valsartan on the incidence of diabetes and cardiovascular events.** N Engl J Med. 2010 Apr 22;362(16):1477-90. Epub 2010 Mar 14. *(Original)* PMID: 20228403

In type 2 diabetes at high risk of cardiovascular events, aiming for a systolic blood pressure <120 mm Hg, as compared with <140 mm Hg, did not reduce the rate of major cardiovascular events.

Cushman WC, Evans GW, Byington RP, et al. **Effects of intensive blood-pressure control in type 2 diabetes mellitus.** N Engl J Med. 2010 Apr 29;362(17):1575-85. Epub 2010 Mar 14. *(Original)* PMID: 20228401

Continuing dual antiplatelet therapy beyond 12 months in patients who have received drug eluting stents does not improve outcomes and may worsen them.

Park SJ, Park DW, Kim YH, et al. **Duration of dual antiplatelet therapy after implantation of drug-eluting stents.** N Engl J Med 2010;362(10):1374-1382.

Use of extended-duration enoxaparin may reduce VTE more than it increases major bleeding events in acutely ill medical patients with level 1 immobility, or who are older than 75 years or of female sex. (This RCT was heavily sponsored by a drug company, changed patient eligibility criteria during the trial, and undertook multiple post-hoc analyses without statistical correction – so be wary of its conclusions)

Hull RD, Schellong SM, Tapson VF, et al. **Extended-Duration Venous Thromboembolism Prophylaxis in Acutely Ill Medical Patients With Recently Reduced Mobility: A Randomized Trial.** Ann Intern Med. 2010 Jul 6;153(1):8-18. *(Original)* PMID: 20621900

In patients with cirrhosis hospitalized for acute variceal bleeding and at high risk for treatment failure, early use of a transjugular intrahepatic portosystemic shunt (TIPS) is associated with significant reductions in treatment failure and in mortality.

Garcia-Pagan JC, Caca K, Bureau C, et al. **Early use of TIPS in patients with cirrhosis and variceal bleeding.** N Engl J Med. 2010 Jun 24;362(25):2370-9. *(Original)* PMID: 20573925

According to prospective comparative trials or observational cohort studies, metformin is not associated with an increased risk of lactic acidosis, or with increased levels of lactate, compared to other anti-hyperglycemic treatments. (The real message is that for patients who are eligible to be included in a metformin clinical trial, there is no increase risk for lactic acidosis. The review, which used data gained from 70,490 patient-years of metformin use compared to 55,451 patients-years in the non-metformin group, does not address the risk in patients who have substantial co-morbidity [which could increase lactate] as they would not be enrolled in clinical trials. However this review suggests the risk of lactic acidosis in many diabetic patients with mild heart, liver or renal failure may have been over-emphasised given its usefulness in controlling diabetes and preventing weight gain).

Salpeter SR, Greyber E, Pasternak GA, et al. **Risk of fatal and nonfatal lactic acidosis with metformin use in type 2 diabetes mellitus.** Cochrane Database Syst Rev. 2010 Jan 20;(1):CD002967. *(Review)* PMID: 20091535

Once weekly exenatide injection appears to be a therapeutic option for patients for whom risk of hypoglycaemia, weight loss, and convenience are particular concerns compared to receiving once daily insulin glargine.

Diamant M, Van Gaal L, Stranks S, et al. **Once weekly exenatide compared with insulin glargine titrated to target in patients with type 2 diabetes (DURATION-3): an open-label randomised trial.** Lancet. 2010 Jun 26;375(9733):2234-43. *(Original)* PMID: 20609969

Compared with non-high-dose proton pump inhibitors (PPIs), high-dose PPIs (80-mg bolus, followed by 8-mg/h continuous infusion for 72 hours) do not further reduce the rates of rebleeding, surgical intervention, or mortality after endoscopic treatment in patients with bleeding peptic ulcer.

Wang CH, Ma MH, Chou HC, et al. **High-dose vs non-high-dose proton pump inhibitors after endoscopic treatment in patients with bleeding peptic ulcer: a systematic review and meta-analysis of randomized controlled trials.** Arch Intern Med. 2010 May 10;170(9):751-8. *(Review)* PMID: 20458081

The Royal Australasian College of Physicians

Queensland State Committee

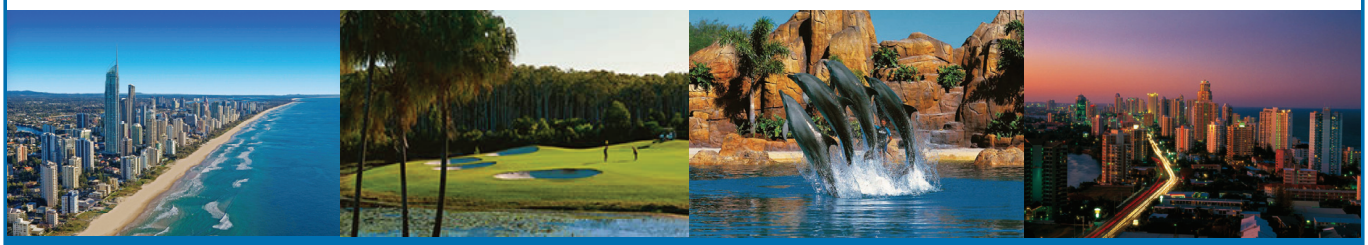
Internal Medicine Society of Australia & New Zealand and The Royal Australasian College of Physicians, Queensland

Combined Scientific Meeting 2010

1-3 October 2010

Sofitel Broadbeach, Gold Coast

www.imsanz-racpq.org.au



Positions for Advanced Training in General Medicine

There are up to four positions for advanced trainees in general medicine available at Princess Alexandra Hospital (PAH), Brisbane in 2011. PAH is a 600 bed tertiary teaching hospital in southern Brisbane incorporating University of Queensland Southern Clinical School with Southbank Parklands, Convention Centre and Performing Arts complex and other recreational and entertainment facilities of South Brisbane nearby. The department of Internal Medicine and Clinical Epidemiology has a full-time director, another full-time specialist, three part-time specialists, one visiting medical officer and one shared specialist (with Clinical Pharmacology). The department has 8 medical units of 8 -15 beds each staffed by consultant, registrar and resident. A Medical Assessment and Planning Unit will commence operation early January 2011 and this will be staffed by a full-time director and have 2 senior medical registrar positions assigned to it. The department has 80 beds representing 24% of all acute beds within the Division of Medicine, admits approximately 4000 patients a year and has more than 5000 outpatient occasions of service. The specialty interests within the department, in addition to general medicine, include geriatric medicine, acute stroke medicine, perioperative medicine, palliative care, endocrinology, non-invasive cardiology, clinical epidemiology and clinical pharmacology. The department has extensive programs in clinical education, research and quality improvement and plays an active role in clinical governance at both hospital and state level.

More information can be obtained at: **www.health.qld.gov.au/pahospital/**

Trainees interested in applying for these positions should contact the director, A/Prof Ian Scott at **07-31767355** or by E-mail: **ian_scott@health.qld.gov.au**

NEW ZEALAND REPORT

This is my first report since taking over the role of the New Zealand Vice-President of IMSANZ following our AGM at the Melbourne meeting of the World Congress of Internal Medicine in March.

My first duty is to acknowledge the sterling work of Professor Phillippa Poole who has been a stalwart on the IMSANZ Council representing New Zealand interests for many years. She has served as Vice-President - NZ, the IMSANZ President (notably as the first woman President in IMSANZ's brief history and only the second Kiwi in this role after Neil Graham) and has just finished her two years as immediate Past President. She still remains on the Council as the NZ representative for the larger metropolitan centres and continues her strong focus on curriculum and advanced training matters, and scientific meetings involving IMSANZ.

It was good to see such a strong Kiwi contingent at the recent World Congress of Internal Medicine especially as we cancelled our usual NZ Autumn meeting to ensure excellent IMSANZ member participation at the congress. For those of you who missed the informality and collegiality of our local meetings, never fear, plans are well in hand for our 2011 meeting in Taranaki next March. Details will follow once the venue and dates are confirmed. Those keen to participate in developing the programme are invited to contact me or any other NZ IMSANZ council members; Andrew Bowers, Andrew Burns and Phillippa Poole. Please ensure that those of you responsible for Advanced Trainees give them ample notice of this opportunity to present their projects.

General medicine in New Zealand remains in superb health. A recent NZ wide survey confirms that General Physicians (with varying specialty interests) participate in the acute care of unselected medical admissions in 20 of the 21 District Health Boards (DHBs) surveyed with three-quarters of these having at least one Physician with a declared specific interest in acute medicine. The survey also identified that in the six years since Auckland City Hospital opened NZ's first medical assessment and planning unit (MAPU) a further six units have been established. Another MAPU has since opened and a further six DHBs plan to open units over the next three years, potentially expanding MAPU provision to cover three-quarters of the NZ population.

Recognition that General Physicians continue to play a pivotal role in the provision of acute medical services in New Zealand is reflected in the fact that 71% of the 238 advanced trainees supervised by the RACP in New Zealand (prior to the latest exam results) have elected to train in General Medicine, with 79% of these undergoing dual training in both General Medicine and another speciality.

The NZ Specialist Advisory Committee (SAC) supervising general medical advanced training has changed its name to the SAC in general and acute medicine to reflect the evolving nature of specialist general medical practice including the recent emphasis on training in acute medicine, the need to prepare future physicians for roles in medical assessment and planning units and the importance of retaining acute medicine within the scope of practice of general physicians.

This was also reflected in a review of the proposed new advanced training curriculum in general medicine that was held by the college in Sydney on 16 July. Andrew Bowers, as Chair of the NZ SAC and myself represented New Zealand. Initial discussion centred on the definition of a General Physician and what makes us different to other specialist physicians, and you will hear more about this in the future. A clear message is that General Medicine should now be considered as a separate specialty alongside the others within the College. In future, general medical experience during basic training will not be accepted as sufficient to equip other specialists for participation in on-call rosters and care of undifferentiated acute medical admissions. With the majority of NZ advanced trainees undergoing dual training with General Medicine, this is unlikely to be an issue for NZ. It is important that physicians currently involved in acute care recognise that the planned curriculum changes will only apply to those entering advanced training as of 2011.

Provision of sustainable 'Acute Care in Provincial Hospitals' was the focus of a roundtable discussion organised by the Ministry of Health in Wellington in March. This dealt with the common challenges for our smaller hospitals in providing acute services including general medicine. IMSANZ was well represented with members John Henley from Auckland chairing the meeting and Tom Thompson from Wanganui representing the RACP (NZ). Ten provincial hospitals ranging from Greymouth and Ashburton (serving approximately 30,000 people each) up to Rotorua and Invercargill (serving 100-110,000 people each) were represented. The report identified several problems relevant to general medicine including:

- recruitment and retention of senior medical officers, and reliance on locums
- registration difficulties and supervision requirements for international medical graduates particularly in the smallest hospitals
- quality/volume relationships i.e. ensuring sufficient critical mass of SMOs to provide a viable 24/7 roster while providing each with sufficient elective and acute volumes to maintain competence and quality
- reduction in generalist skills amongst new specialists and training of sufficient specialists with general skills
- absence of Registrar training posts in provincial hospitals (particularly in medicine)
- inadequate provision of after hours general practice care
- low priority being given to investment in communication technology.

The report identifies several potential solutions with work ongoing to address these. The report should be available to each of the 10 hospitals involved or you can contact us.

Finally – IMSANZ is here to serve you. If there are issues affecting General Medicine in NZ then we need to know; contact one of your IMSANZ council members.

JOHN GOMMANS
NZ Vice President

COCHRANE COLLABORATION MEETING

New Zealand

Earlier this year I had the pleasure of attending a one day Cochrane Collaboration Symposium in Auckland. It was part of the collaborations mid year meeting in conjunction with the New Zealand Guidelines Group. It's title was Evidence on Trial: Has it made an impact on health? It was an action packed day with 4 sessions, every one led by world class experts in their field. The day also showcased some of our own local talent.

You can go to www.cochrane.org to learn more – in essence the Cochrane Collaboration, established in 1993, is an "international network of people helping healthcare providers, policy makers, patients, their advocates and carers, make well-informed decisions about human health care by preparing, updating and promoting the accessibility of Cochrane Reviews – over 4,000 so far, published online in *The Cochrane Library."* Cochrane believes in equal partnerships, remaining independent and ignoring geographical boundaries. They make sure there are plain language summaries on all reviews. New Zealand is the only country in the world that has free access to the Cochrane Library for all citizens.

The first session gave an introduction to evidence and the Cochrane Collaboration, aimed at people like me who knew very little about Cochrane before the symposium. They highlighted New Zealand's involvement in the Cochrane Collaboration. The other 3 talks were very interesting and discussed topics such as globalising evidence, responding to world information needs rapidly (such as in times of pandemics) and whether evidence made a difference in developing countries. One of the key themes was the need to globalise the evidence but localise the decisions. This approach acknowledges that even when evidence is clear the local circumstances will impact on its translation.

The second session started by discussing 'Evidence Beyond RCT's' as there are many different types of study designs so it's important to not confine evidence to the RCT. Also they highlighted that policy makers use a lot of different evidence and not just what medics would consider evidence. They have a different focus and for that reason they want to know what works for who, at what cost, in what setting, and in what time frame. Cochrane has identified ways that systematic reviews can contribute to implementation eg by including cost breakdowns. The next presentation 'Evidence: do we trust it?' and the last conflict of interest highlighted the importance of being aware of funding sources when reading papers. It was interesting to see the breakdown of how many areas there are where bias can be bought in to research. There was also a breath of fresh air with a consumer presentation entitled 'Evidence: do patients trust it?'

The third session was a workshop which was a small group interactive session. I attended the one entitled 'Case studies on evidence of impact' and 'The use of research on clinical guidelines in hospitals.' We had a wide range of people in the group and talked about clinical guidelines. We want them to be evidence based, concise and clinically focused, credible, multidisciplinary and up to date. The barriers for all of this include: time, resources (skills and access to evidence), lack of buy in/ engagement, systematic approach, unclear goals and difficulty getting consensus.

The fourth and final session focused on changing practice. Professor Bruce Arroll presented: 'Primary Care PEARLS (Practical evidence about real life situations),' which are a minimalist approach with a maximum of 200 words for the busy GP and can be found at www.cochraneprimarycare.org. The other presentations were focused on secondary care and changing practice - what works what doesn't. It seemed like a good idea at the time which is all too often how decisions get made. Professor Rod Jackson presented his GATE template in 'Evidence: can we teach it?' and to finish off we heard about the future of the Cochrane Library: What will it look like? www.thecochranelibrary.com - watch out for podcasts!

Overall this was an outstanding day with excellent and enthusiastic speakers. I would highly recommend a future such event to anyone interested in Cochrane and evidence.

HELEN KENEALY
NZ Advanced Trainee Rep

VOLUNTEERS REQUIRED

The Overseas Trained Physician (OTP) Unit at the Royal Australasian College of Physicians is currently looking for volunteers who may be able to assist in conducting interviews.

The interviews are an integral part of the OTP assessment process, designed to clarify matters of training and experience before an application is sent to the OTP Sub-Committee. Currently, we are working with a large number of applicants in General Medicine and we are looking for General Physicians who are willing to represent the General Medicine SAC at interview.

Interviews are generally of one hour duration and are organised at times and in locations which are convenient to both interviewer and interviewee – this can sometimes include videoconference. As such, we welcome volunteers from all around Australia who have held Fellowship for 5 years or more.

Interviewers are reimbursed for their time and assistance.

To express your interest or obtain more information, please contact: Lucinda Wallbank, Case Officer (Adult Medicine

Telephone: **02 8247 6206**

E-mail: **lucinda.wallbank@racp.edu.au**

A PROPOSED SERVICE PRINCIPLES AND PRACTICE GRID FOR GENERAL MEDICINE UNITS

Recently IMSANZ members Alison Mudge and Ian Scott, working within the Models of Care Working Group (MoCWG) of the Queensland Statewide General Medicine Clinical Network (SGMCN), drafted a service principles and practices grid that might serve as an auditable set of operating standards for in-patient general medicine units. At the time of writing, the care grid has been reviewed by other members of the MoCWG as well as multidisciplinary panels from two tertiary hospitals. It is to be distributed to all members of the SGMCN and all Directors of Medicine of Queensland public hospitals as part of an electronic survey asking respondents to rate the extent to which their units currently meet the proposed standards, to state enablers and barriers to their adherence to the standards, and to feedback any comments or suggestions for improving the standards. The results of this survey will be reported in future newsletters. However, we would like to give colleagues in other jurisdictions the opportunity to peruse the standards and provide additional feedback in the anticipation that the standards may serve, at some future date, as a template for a position statement on national standards endorsed by IMSANZ.

The standards are intended to be generic, aimed at the general medicine service as a whole as well as to particular sub-services. In the grid, the service principles are defined from a patient perspective, and corresponding care practices supporting each of these principles are listed in the adjacent column. The extent to which each practice is implemented will depend on local resourcing and organisational factors.

Patient perspective		**Principles**	**Practices**	**Rating of practice achievement (1 to 5)** 1 = do not achieve this at all 3 = achieve this 50% of the time 5 = achieve this nearly always	**Barriers/ Enablers** *(please specify)*
1	**What is wrong with me?**	Prompt evaluation and diagnosis *(early senior review)*	• Consultant physician review within 24 hours of admission • Formal risk screening (eg falls, delirium, malnutrition, VTE) within 24 hours of admissions • Formal interdisciplinary communication within 24 hours of admission		
2	**Who is looking after me?**	Continuity of care *(consistent teams, systems for managing staff turnover)*	• Consistent interdisciplinary team throughout acute admission • 'Old case" rule for readmitted patients • Daily weekday team meetings including medical, nursing and allied health • Minimum periods for staff rotation through general medical wards • Patient care plan in bedside chart • Standardised formal clinical handover processes between shifts		

3	**Can you make me better? (Am I in good hands??)**	Effective management of symptoms, primary pathology and co-morbidities impacting on health *(senior staff, systems for continuing education, systems for audit of performance)*	• Consultant physician review within 24 hours of admission • Orientation for all disciplines rotating into service • Systems of regular performance appraisal for all staff • Education sessions at least weekly • Interdisciplinary education sessions • Monthly morbidity and mortality meeting • Measurement and feedback of clinical outcomes to clinicians • Systems for consumer feedback		
4	**Will it hurt?**	Minimising adverse effects of hospitalisation *(early risk assessment, regular interdisciplinary communication, safe medication practice, systems to reduce functional and cognitive decline)*	• Comprehensive medical assessment and medication history including known allergies • Comprehensive admission assessment of premorbid function, current living arrangements, carer support, info relating to enduring power of attorney, advanced health directive, existing community support • Assessment of additional needs including indigenous status, language needs, hearing and sight impairment • Structured systematic risk assessment for pressure injury, falls, malnutrition, cognition, delirium, function/mobility, VTE, infection status, dysphagia, depression available to all team members • Individualised care plan linked to needs assessment and involving all team members • Daily multidisciplinary team meetings • Medication reconciliation on admission • Systems for identifying drug errors/ missed doses • Systems to encourage early mobility • Systems to provide orientation and cognitive stimulation		
5	**Will I get back on my feet?**	Early functional rehabilitation	• Functional improvement program for all older patients • Documentation of premorbid and admission functional status • Documentation of admission cognitive status		

6	**What are my (our) options?**	Involve patients (and family/ carers) in decision making	• Individualised care plan informed by comprehensive patient assessment • Bedside nursing handover • Documentation of patient goals • Expected date of discharge communicated to patient/carer within 24 hours of admission		
7	**When will I be able to go home?**	Define discharge expectations as early as possible	• Expected date of discharge estimated within 24 hours of admission and shared with multidisciplinary team • Comprehensive admission assessment of premorbid function, current living arrangements, carer support, info relating to enduring power of attorney, advanced health directive, existing community support • Daily multidisciplinary team meeting		
8	**What should I do now? What will I do if things go wrong again?**	Effective handover of clinical care (*discharge communication, patient education, follow-up)*	• Electronic standardised medical discharge summary sent within 24 hours • Standardised medical, nursing and allied health summary for all patients using community providers • Copy of discharge summary sent to residential aged care facility for RACF patients • Consumer medication information for all new medications • Discharge medication reconciliation • Patient held information about admission • Patient held information about current drugs • Patient held information about "red flags" and action plan • Systems for referral for intensive follow-up of high risk patients eg heart failure, COPD, complex care needs		

Comments and feedback from readers are most welcome.

ALISON MUDGE
IAN SCOTT
on behalf of the Models of Care Working Group,
Queensland Statewide General Medicine Clinical Network

GEM COLLECTING & CHERRY PICKING IN SCOTLAND

With 3 months to go before the Society of Acute Medicine in the UK holds its annual international meeting, this year in Edinburgh, I am starting to prepare to once again visit the home of my ancestors. What a great excuse to visit such a lovely city. Acknowledging that the UK is not Australia and that workforce demographics are different, there is still a lot to learn from the physicians in the UK practicing acute medicine along with their professional colleagues in nursing and allied health. After all, most of the diseases are the same and they still present to the hospital system acutely.

The meeting may provide other value as we progress towards IMSANZ becoming a fully multidisciplinary society. The SAM UK meeting is an environment where delegates participate in an interprofessional learning environment, the meeting has streams of interest to the broad church of acute medicine particularly in the plenaries, but also multiple streams where the emphasis may have stronger impact on specific professional groups, and these streams run concurrently throughout the program. This model in many respects is new to general medicine. We have had a number of very successful seminars in acute medicine involving a cross discipline audience of professionals, but IMSANZ has not looked at this over the whole spectrum of general medicine. A number of our specialist colleagues in other areas of medicine have already taken the chance to combine with health care professionals in their own specialty, but we perhaps have the most exciting prospects in this area because in many ways we have the strongest links with a whole multidisciplinary team.

This year, from an acute medicine perspective, the decision of the new conservative government in the UK to back away a little from the 4 hour rule in emergency departments will add an extra degree of interest to the meeting. Although the rule was not instrumental to the establishment of the models of care, it has had a role in embedding them in the UK health system and, as a result, the new political direction does leave the society with some issues in respect of health policy and I am particularly keen to get the local perspective on this when I visit.

Aspects of the acute medicine training program in the UK give us models that can perhaps inform some of our processes. Interestingly, whilst I believe we will need more flexible options in future training in Australia, with additional training allowing sideways career trajectories, some trends move us further away from flexibility. Current aspects of training in both Australia and the UK, as opposed to New Zealand (where dual training remains prevalent), are potentially making for less flexibility in career paths. These include the shift towards 3 core training years in some specialties reducing opportunities for dual training in Australia and, in the UK, the reducing of scope of practice that acute medicine training may allow. So I am keen to be better informed around this questionable direction. However, the only way to fully appreciate the health environment that these changes are occurring in is to go there and listen and question.

I am excited to be going to SAM UK, honoured to be contributing, and sure that I will return to Australia with gems that I will use in my every day clinical practice as well as in my other health care roles. Along with this I will have the opportunity to cherry pick the synergies of care provision that fit our work force demographic and patient population. I hope to see others from Australia and New Zealand enjoying this beautiful city and the Scottish hospitality.

ALASDAIR MACDONALD
Past President

August 2010

AACP – Your Advocate

It is important to have an organisation that exclusively advocates for all consultant physicians and paediatricians (CPPs) at Government level – The Australian Association of Consultant Physicians (AACP) is this organisation.

The AACP's work benefits all Internal Medicine physicians and their patients. To ensure the AACP remains a strong, influential and viable organisation, we need the support of many more of the Internal Medicine physicians that we represent.

Reasons to join the AACP

- The AACP successfully negotiated Items 132 and 133 - the first items for CPPs in 20 years - Imagine what the AACP could achieve with stronger membership support,
- The AACP has a united approach, representing the workforce and economic interests of all CPPs,
- The AACP is working to ensure that the MBS acknowledges the complexity of care required by your patients and the value of your consulting time,
- The AACP develops a range of submissions to improve the level of Medicare benefits available to your patients for your services, and
- The AACP is lobbying for a 60-minute plus consultation item and a prolonged follow up item for all CPPs.

How to Join

For further information on the AACP, and to download your membership application form, visit the AACP website today at **www.consultantphysicians.com.au**. Alternatively, contact the secretariat to request your membership application form by email at secretariat@consultantphysicians.com.au or by phone on **02 9810 0061**.

PAPUA NEW GUINEA PHYSICIANS' ASSOCIATION

This letter has been edited by A/Prof Ian Scott to better meet requirements of the IMSANZ newsletter.

Papua New Guinea Reflections following WCIM 2010

From the outset I would like to thank AusAID to assist making it possible for me to attend the 2010 World Congress Internal Medicine in Melbourne. Please note that I have been the President of PNG Physicians'' Association for 12 years now and have not had the opportunity to attend the previous WCIM.

My visit to the Congress caused me to reflect on a few areas that may be of interest to my internal medicine colleagues in Australasia.

Internal Medicine Specialists like PNG Physicians from developing countries have different challenges ranging from human resources to monitoring to updating on current knowledge in Internal Medicine and Medicine in general.

Internal Medicine in PNG has had some strong relationships with the Royal Australian College of Physicians in Australia but recently the relationship has become rather loose. (By relationships I am referring to Associations to Associations / Associations to Colleges/Colleges to Colleges relationships in a formal way). There is no formal training mentoring and working relationship with the Internal Medicine Colleges in the Asian region and others for this matter with the PNG Physicians Association. Recently Aus Aid has commenced the Health Education Committee program in association with the School of Medicine and Health Sciences UPNG.

In further promoting closer relationships I would like to make the following suggestions:

1. Papua New Guinea Physician Association and the Chief Physician or nominee from the National Government Health Department to attend future WCIM meetings. For support services in terms of financial assistance the Australian Department of Health could support the Chief Physician and AusAID to support the President of the PNG Physicians' Association.
2. There should be a slot in the program of the next WCIM for Internal Medicine Specialists from developing countries so that they may be given an opportunity to make presentations to the conference.
3. RACP and other Colleges to consider being a mentor or partner to our Papua New Guinean Physicians' Association to help develop our college in various areas e.g.:- further basic physicians, advanced training, researches and other collaborative activities.

My best wishes to my Australian and New Zealand colleagues.

DR. GOA TAU
PRESIDENT
PNG PHYSICIANS' ASSOCIATION
21/05/2010

COORDINATED ADVANCED TRAINING PROGRAM IN GENERAL MEDICINE

Alfred Health, Southern Health and Western Health Supported by Victorian Department of Health

August 2010

Applications are invited for 6 positions for 1-3 years of advanced training in General Medicine, to be provided across 3 health care networks: Southern Health, Alfred Health and Western Health.

Successful applicants will be provided with experience necessary to satisfy RACP advanced training requirements in General Medicine with opportunities for rotations which may include:

- Acute Medicine Unit
- Respiratory Medicine
- Cardiology (Metro)
- Cardiology (Rural)
- Trauma Medicine
- Perioperative Medicine
- Emergency Department Acute Medicine
- Intensive Care

Applicants for >1 year of training will have the opportunity to arrange rotations in their 2nd/3rd year of training that compliment those already gained. Applicants who have completed core training in another subspecialty will be provided with 12 months of General Medical Training with the possibility of an additional 12 months as a junior consultant post-fellowship in order to achieve the highly regarded dual training in General Medicine and another subspecialty.

Applications should be made to the desired hospital website by Friday 20th August with inclusion in the application of your intention to enrol in the coordinated training program.

Contact details:

ALFRED HEALTH
A/Prof Harvey Newnham
Tel: 03 9903 0198
E-mail: h.newnham@alfred.org.au

SOUTHERN HEALTH
Prof Donald Campbell
Tel: 03 9594 1311
E-mail: donald.campbell@monash.edu

WESTERN HEALTH
Prof Peter Ebling
Tel: 03 8345 6429
E-mail: peterre@unimelb.edu.au
- or -
Prof Edward Janus
Tel: 03 8345 6666
E-mail: edwarddj@unimelb.edu.au

FORTHCOMING MEETINGS

2010	**OCTOBER**	**IMSANZ Trans Tasman Meeting** **1st - 3rd October 2010** IMSANZ will be holding an Australian and New Zealand combined ASM at the Sofitel Gold Coast in Broadbeach, Queensland. There will be no Spring Meeting in New Zealand in 2010. IMSANZ Website: http://www.imsanz.org.au/events/
		General Medical Clinical Weekend **15th - 16th October 2010** Peppers The Sands Resort, Torquay, Victoria Clinical Internal Medicine for Advanced Trainees and Consultants Further Details: http://www.imsanz.org.au/events/index.cfm
		International Conference on Residency Education **23rd - 25th September 2010** Ottawa, Canada **"Duty hours across borders"** hosted by the Royal College of Physicians and Surgeons of Canada. Info: http://icreblog.royalcollege.ca/2010/04/30/duty_hours_symposium/ Registration: https://www.multisoftevents.com/ICRE10Reg/
		Canadian Society of Internal Medicine (SCIM) Annual Scientific Meeting **27th - 30th October 2010** The CSIM Annual Scientific Meeting in Vancouver is just over two months away! Many great topics will be presented and the speakers are high-calibre. To ensure that you receive your first choices in workshops and to take advantage of the early registration discount, please submit your registration form as soon as possible. Preliminary Program: http://www.csimonline.com/content/meetings/annual/2010/pdf/2010-ASM_PRELIM_PROGRAM.pdf CSIM Website: http://www.csimonline.com/
2011	**JANUARY**	**European School of Internal Medicine** The European School of Internal Medicine will be held in Saas-Fee, Switzerland. Arrival date is Sunday 16th January, Departure date Saturday 22 January 2011. For more information please go to the IMSANZ website.
	MARCH	**IMSANZ NZ Autumn Meeting** **2th - 4th March 2011** The 2011 meeting will be held at the Copthorne Hotel, New Plymouth Taranaki NZ Wednesday evening 2 March to Friday 4 March 2011 inclusive. Further details can be found on the IMSANZ Website.
2012	**NOVEMBER**	**XXXI World Congress of Internal Medicine** **11th - 15th November 2012** The XXX1 World Congres s of Internal Medicine will be held in Santiago, Chile Please make a note in your diary. Website: http://www2.kenes.com/wcim/Pages/Home.aspx

NOTICE TO MEMBERS

Could you please ensure that your contact details, including email, are up-to-date.

If your details have changed, please complete this form and return to:

145 Macquarie Street
SYDNEY NSW 2000
Fax: +61 2 9247 7214
Or e-mail your details to imsanz@racp.edu.au

PLEASE PRINT.

Full Name: _____

Old Address: _____

_____

New Address: _____

_____

Tel: ( ) _____

Fax: ( ) _____

E-mail Address: _____

Specialty Interests: _____

FROM THE EDITORS

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

We are most grateful for contributions received from members.

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

We welcome contributions from physicians and advanced trainees.

Job vacancies and advertisements for locums can be published.

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

Tell us what you want!!

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

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

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

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

A/Prof Ian Scott
Director of Internal Medicine

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