IMSANZ
INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND

DECEMBER 2010

President
Nick Buckmaster, QLD

Vice President, NZ
John Gommans, NZ

Vice President, Aus
Don Campbell, VIC

Hon Secretary
Rob Pickles, NSW

Hon Treasurer
Tony Ryan, WA

Immediate Past President
Alasdair MacDonald, TAS

Councillors
Cameron Bennett, QLD
Robert Krones, VIC
Andrew Burns, NZ
Phillippa Poole, NZ
Nicole Hancock, TAS
Josephine Thomas, SA
Emma Spencer, NT
Jaye Martin, WA

Advanced Trainee Reps
Sara Barnes, Aus
Helen Kenealy, NZ

SAC Councillors
Adrianne Anderson, VIC
Andrew Bowers, NZ

Secretariat
145 Macquarie Street
Sydney NSW 2000
AUSTRALIA

Telephone
+ 61 2 9256 9630

Facsimile
+ 61 2 9247 7214

E-mail
imsanz@racp.edu.au

Website
www.imsanz.org.au

Copyright © 2010 IMSANZ

President's Report

IMSANZ has had a very busy few months recently. In early October we held the IMSANZ-RACPQ scientific meeting on the gold coast. We were delighted at the enormous turnout at the conference, with over 200 delegates spending the weekend catching up with colleagues and friends, enjoying the beautiful sights of Broadbeach, (though the weather was unseasonably wet), and listening to a smorgasbord of talks which were intentionally broadly aimed. We have had universal feedback that the meeting should become an annual event, so by the time you read this we will have already determined where next years meeting should be held. The organising committee has every reason to be proud of the outcome.

IMSANZ has also been heavily engaged in the planning of our future advanced training programs, for both those deciding to specialise in General Medicine alone, and also for those who intend embarking on a dual training program. We have developed new guidelines for advanced training which for the first time apply to trainees on both sides of the Tasman. The guidelines are designed to be practical and reasonably flexible, but at the same time provide strong support for a firm focus on appropriate training terms which will provide exposure to Acute care, chronic disease, and in-hospital general medicine. They are designed to allow dual training by recognising the necessity of minimum training in general medicine over 2 years when combined with a further 2 years of other specialty training.

We have also been engaging closely with the college and the general medicine SACs (New Zealand SAC called General and Acute medicine) in developing a comprehensive advanced training curriculum. By the time this newsletter goes out I expect both the guidelines and curriculum will be up on the IMSANZ website. I thank the many members of IMSANZ who put many hours of hard work into developing both these documents.

We continue to engage in many forums in putting forward the importance of general medicine in the health system. The issue of training and maintaining a generalist workforce is increasingly being recognised as critical for the viability of services in outer metropolitan, regional and rural centres, but the issue continues to be developing strategies that are likely to change current trends to increasing specialisation. I believe that there needs to be specific funding allocated for training, as well as greater status be given to recognising the particular skills of so-called general specialists (and I include nursing and allied health in this descriptor).

I am currently working here in Queensland with the health department workforce branch around more appropriately defining the advanced skills that all of us use in general medicine care settings, as a first step towards recognition, as well as discussing with NSW, possible strategies for them to make general medicine attractive to Trainees. Hopefully by the next newsletter I will have more to say on this.

I hope you all have a good Christmas and New Year. It is often a busy time for us in comparison to our procedural specialties. Make sure that you get some valuable time with your families especially if you do not get a formal break.

NICK BUCKMASTER FRACP
PRESIDENT, IMSANZ

In this issue...

NEW ZEALAND REPORT

It is particularly gratifying to see that Health Workforce New Zealand (HWFNZ) recognises the importance of general medicine and general physicians in NZ hospitals. The recently announced HWFNZ advanced trainee scheme will provide scholarships to assist advanced medical trainees to train or study overseas in shortage specialty areas; this includes general medicine, rheumatology and renal medicine. Scholarships are also targeted at those wishing to work in provincial hospitals that have a need for more generalist specialists (such as general physicians) and in geographic areas where there is maldistribution within specific specialties.

The scholarship will provide approximately $20,000 to cover real and actual expenses of accommodation, airfares, training and courses that will contribute useful expertise to the trainee and prepare them for work in New Zealand. This may include management or leadership training in addition to clinical training. The aim is to ensure that trainees with excellent potential have the ability to benefit for overseas experience, while the NZ health sector has the opportunity to benefit from that experience.

To be eligible trainees require a career plan with a commitment from the college and District Health Board, a specified guaranteed job on return and be willing to work in an identified regional area of workforce need. Both the employer and the advanced trainee will be bonded for two years to ongoing employment on completion of their training and study.

Interested applicants should access HWFNZ via www.healthworkforce.govt.nz, but advanced trainees will also require assistance/support of the College and their future employer.

The NZ autumn scientific meetings will resume next year following the hiatus due to this years World Congress of Internal Medicine in Melbourne. The 2011 meeting has been confirmed for 2-4 March in Taranaki. Further details are available via www.imsanzconference.co.nz or the link on the IMSANZ website. A call for abstracts has opened and all advanced trainees and attending IMSANZ members are encouraged to submit. A draft programme is in preparation and will shortly be available. Confirmed speakers include Dr Richard Beasley on 'oxygen-a new look at an old therapy', Dr Sarah Aldington from Air New Zealand on 'medical fitness to fly', Assoc Prof. John Henley on 'acute demand in small hospitals' plus 'reflections on general medicine in New Zealand', Professor Des Gorman on 'health workforce issues' plus a separate discussion on 'medically unexplained diseases', Dr Andrew Bowers on both 'essential e-gadgets for the up-to-date physician' and 'national e-prescribing update', and Dr David Jardine from Christchurch on 'autonomic responses to stress (aka earthquakes)'

The conference theme 'Sea to Sky' reflects the breadth of expertise required of a modern specialist in general medicine as well as the geography that awaits those who attend the meeting in Taranaki next March. I look forward to seeing you there as this is an excellent time of year to visit New Plymouth and the usual accompanying social events will allow great networking opportunities in this relaxing, entertaining and artistic seaside environment.

I remind you once more that IMSANZ is here to serve you. If there are issues affecting general medicine in New Zealand then we need to know about them; contact one of your IMSANZ council members. Even better suggest a topic for the March meeting.

JOHN GOMMANS
NZ Vice President

IMSANZ would like to welcome the following New Members:

- Mr James Fink, Robina,QLD
- Dr Robert Krones, Wangaratta, VIC
- Dr Kugathasan Mutalithas, Brisbane, QLD
- Dr Grant Pickard, Kogarah, NSW
- Dr Nicolas Szecket, Auckland, NZ
- Dr Nathalie van Havre, Brisbane, QLD
- Dr Johan van Schalkwyk, Auckland, NZ

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

- Dr Justin Beardsley, Hamilton, NZ
- Dr Laird Cameron, Wellington, NZ
- Dr Debbie Chalmers, Napier, NZ
- Dr Andrew Davies, Hamilton, NZ
- Dr Elise Gilbertson, Brisbane, QLD
- Dr Karen Hitchcock, Newcastle, NSW
- Dr Hatish Jangwal, Sydney, NSW
- Dr Sam Marment, Brisbane, QLD
- Dr Mahesh Menon, Brisbane, QLD
- Dr Sara Mgaieth, Darwin, NT
- Dr Simon Quilty, Newcastle, NSW
- Dr A K M Nizam Uddin, Dandenong, VIC
- Dr Albert Nwaba, Perth, WA
- Dr Ayesha Saqib, Melbourne, VIC
- Dr David Tripp, Wellington, NZ
- Dr Natalie Yovenko-Lahovec, Brisbane, QLD
- Dr M Yousuf Zubair, Hobart, TAS

Also IMSANZ warmly welcomes Allied Health Associate Member:

- Ms Ashley Da Roza, Noosaville, QLD

IMSANZ AWARDS AND SCHOLARSHIPS 2011

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. This award can only be applied for once. *Applications Close 31 March 2011*

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 31 March 2011.*

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. This award can only be applied for once. *Applications Close 31 March 2011.*

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 31 March 2011.*

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 2011.*

IMSANZ-RACPQ GOLD COAST MEETING

– A New Zealand Perspective

The Gold Coast combined scientific meeting was certainly a great success. So much so it may turn out to be an annual event. There was a good NZ turnout and a pretty good advanced trainee showing too. The Measurement for Improvement workshop on the Friday was a very interesting walk through the field of quality and improvement led by true experts in the field. One of the highlights for me was the guide to drawing good graphs to display your stats in the most appropriate format, which was very enlightening.

The academic programme was a well thought out range of updates on very relevant areas to general physicians. The first morning programme included renal, heart failure, interventional cardiology and arrhythmia management updates. Among these it was confirmed that CTA and MRA are the best ways of investigating for renal artery stenosis; encouragement to titrate up cardiac meds to the optimum dose; if your patients with heart failure are hard to control consider using fish oil and checking their iron studies (if they are NYHA class III+); new high sensitive serum troponins can be used to rule out an MI at 4-6 hours; and as pulmonary veins are the most common source of paroxysmal atrial fibrillation they can be used for ablation therapy with subsequent pacing.

After morning tea, the scientific programme continued at full steam with updates in vascular medicine. The first presenter discussed the controversial issue of lifetime prophylaxis post the first unprovoked VTE, which is recommended in above knee DVT's as long as they are stable on anti-coagulation with a low risk. In the stroke update, cerebral microbleeds are present in 5% of healthy people, 34% in those with ischaemic CVA and 60% with an ICH so it is possible that their presence on T2 weighted MRI scans will predict future ICH. Carotid endarterectomy is still favoured over stenting in symptomatic patients.

The ID update post lunch showed us that >90% of *strep pneumoniae* are still sensitive to penicillin. There are not likely to be any new antibiotics for gram negative bacilli and ESBL's can now destroy even 3rd generation cephalosporins. We learnt about the new hypervirulent strain of *clostridium difficile* associated diarrhea – it's flouroquinolone resistant because of a genetic deletion leaning to increased production of toxins A&B among other reasons. It is also known as NAP1/REAB1/P027. Current hepatitis C treatment shows that rapid virological response can predict sustained virological response such that if they are negative at 4 weeks then 95% will achieve sustained virological response .

The Queensland Advanced trainees finished off the first day with a great range of papers. Dr Cho thoroughly deserved the award for her review of encapsulating peritoneal sclerosis. The next day kicked off with the IMSANZ advance trainee papers and it was lovely to see a NZ trainee Dr Laurence Teoh take out the prize for his use of a sticker to improve rates of resuscitation documentation and appropriate prescription of VTE prophylaxis.

The update in neurology that morning presented us with a number of uncommon causes of headache – very academically interesting. The update in epilepsy focussed on when it was appropriate to refer to neurosurgery to treat intractable seizures. The degenerative diseases talk focussed on the use of dopamine agonists for the treatment of Parkinson's.

The concurrent sessions discussed the future of general medicine training and the clinical application of population health data for clinicians – for both research and clinical purposes. The conference ended with a session on acute medicine session. The presenters discussed MAU's – the impact of the 4 hour rule and whether we can sustain the reduction in the average length of stay in MAU's.

It was an excellent conference with a wide array of thought provoking and practical presentations. Perhaps fortunately the weather was terrible – wet, wet, wet, so at least we didn't feel like we were missing out on time at the beach!

HELEN KENEALLY

– A Fijian Perspective

I was very privileged to be given the opportunity to attend the IMSANZ and the Royal Australian College of Physicians Queensland Combined Scientific Meeting on 1-3 October this year. This meeting was held at the Sofitel Hotel on the Gold Coast. It is the first time I've ever attended such an informative meeting and definitely it won't be the last.

There were two of us from Fiji who were represented at the meeting and we were honoured to be welcomed from day one. It was a relief to learn that we were heading to the sunshine state to experience the warm weather similar to home. To be greeted by rain from day one was the beginning of surprises that continued to unfold as events progressed.

Renal medicine took over centre stage after the warm welcome with an given by Professor Robert Fasset. The best treatment for proteinuric renal failure was very interesting. The use of ACE inhibitors and when to stop them were discussed. Likewise the haemoglobin target for chronic renal failure I thought was a very practical one for us coming from the Pacific.

ARB and ACE inhibitors in heart failure was revised in the cardiology update. Iron therapy I suppose is something that we had not often thought about in our setting. In the Pacific. Device therapy for heart failure is unlikely to be an option in the near future.

The update on DVT was interesting. There was a recommendation for continuation for heparin prophylaxis at least one month after discharge in high risk patients. This is impractical in our setting where low molecular weight heparin is not available at the public hospitals. However, patients have the option of securing supply from private retail pharmacies.

The intensity of anticoagulation in patients with mechanical heart valves was very well discussed. In our country this is applicable given the rising number of rheumatic heart patients with mechanical valve replacements.

The infectious disease update by Professor Darrell Crawford was comprehensively covered. It was interesting to learn of the current areas of research in hepatitis although in our practice, hepatitis B is not treated with drugs as in Australia and NZ. The use of transient elastography for quantifying liver fibrosis and stiffness was an excellent non-invasive tool for assessment of the liver, particularly when it is painless. This is a better tool than our usual ultrasound scan.

On the last day I entered the room with a lot of expectations on neurology update by Dr Max Williams. Students often say that neurology becomes an interesting subject only if taught by the right people. The speaker of the day was definitely one of those. We were reminded that migraine is a disease and not just a headache. I was thrilled by the range of headache causes such as CADASIL which stands for cerebral autosomal dominant arteriopathy with subcortical infarctions and leucoencephalopathy. Another new cause of headache I learnt was HaNDL which is headache and neurological deficit with CSF lymphocytosis. Here in the Pacific we would be careful to exclude TB before attributing a headache to HaNDL.

The interesting "saw tooth" type of headache (analogous to atrial flutter on ECG) was an eye opener. This was SUNCT-short lasting unilateral neuralgiform headache with conjunctival injection and tearing. The case discussed demonstrated a saw tooth pattern type of headache lasting for an hour. The patient had 20 seconds of headache and pain subsides in 20 seconds.

Overall the meeting was filled with relevant updates on common clinical conditions that we as general physicians face daily in our practice. The contents of the presentations were absolutely superb particularly with updates of evidence presented by each speaker on their various subjects.

I would like to thank the organisers and sponsors for a job well done.

DR WILLIAM MAY
Fiji School of Medicine
Pacific Associate Member, Fiji

MEDICAL AID AND CAPACITY BUILDING IN TIMOR-LESTE

Timor-Leste is known to most Australians for its recent history of social and political turmoil, pre-dating and since the withdrawal of Indonesian occupation forces in 1999. It remains in the public eye through the Labour government's offshore detention centre aspirations for this tiny nation and the ongoing commitment of Australian troops in the International Stabilisation Force.

It is hard to fathom that a country geographically so close to Australia could have such limited access to decent medical facilities. I spent the first six months of 2010 to see if I could help develop medical capacity in the major hospital of Dili. This was primarily to set up a fibreoptic bronchoscopy service but many other tasks needed doing along the way. My mission was made possible through the generosity of the Department of General Medicine at the John Hunter Hospital and Olympus Australia.

I arrived in Dili in January - within three days of arriving, I was involved in a motorcycle accident and fractured my left clavicle. Following this inauspicious and painful start, I spent one month attending meetings with hospital doctors and administrators. The Timorese, I soon realised, were extra-ordinarily fond of meetings; but it all paid off when I was eventually assigned a room to set up the bronchoscopy suite and two Timorese general physicians who were interested in learning the technique. Drs. Lena and Edgar had plans to train in dermatology and ENT respectively; none of the local physicians were interested in pulmonology as there was a prevailing belief that these misguided physicians would eventually succumb to tuberculosis themselves.

The training involved lessons in pulmonary anatomy, computer simulations of navigating the endobronchial tree and finally hands-on exercises. Drs. Lena and Edgar practiced bronchoscopy on a crude model fashioned from a cardboard box + plastic tube (as pictured), removed green peas from aforementioned crude model and progressed to biopsying raisins from raisin bread. After basic technical competency had been achieved, we began to perform procedures on real patients.

The three biggest challenges were; establishing a reliable power source, safely sedating patients and disinfecting equipment. The power source issue was addressed when I found an Australian biomedical engineer squirreled away in the bowels of the hospital. Mr Bruce Morrison was a saviour who introduced me to a "voltage regulator" and an "uninterruptible power source" (UPS). The Rotary Club of Timor-Leste was kind enough to sponsor the purchase of some of this equipment.

Sedation was problematic in that resuscitation facilities were limited and drugs came in batches which could vary in potency. For instance, our first batch of fentanyl was manufactured in the UK and seemed to follow the familiar rules of dosage. Our next batch came from Indonesia; within minutes of administering a standard dose, our patient had respiratory depression and transiently required bag and mask ventilation! Fortunately no adverse consequences resulted as oxygen saturations had been maintained, but it was certainly a hairy experience and an adverse event. Subsequently all sedation was performed at extremely low increments of dosage to guard against variation in potency of drugs. No further adverse events occurred.

Disinfecting the bronchoscopes required Cidex OPA in large quantities as the substance has a two-week shelf life from opening. Air cargo restrictions meant it could not be flown on a commercial flight and courier transportation costs were prohibitive. My first shipment from Australia lasted one month and cost several hundred dollars. Fortunately, the logistics company PDL Toll were kind enough to sponsor my second (and far larger) shipment free of charge; this shipment is anticipated to be adequate for a year.

Those difficulties aside, we successfully performed about forty bronchoscopies over the six month period. Most cases were diagnostic, although removal of foreign bodies and suctioning of bronchial secretions did have good outcomes in several cases. In terms of diagnostics, pathology services were somewhat hit and miss, positive AFB results were the most reliable, histopathology the least. The bronchoscopy service was officially opened in July 2010 and President Ramos-Horta was kind enough to attend the opening ceremony. The photo shows him presenting Drs. Lena and Edgar with certificates at the completion of their bronchoscopic training.

I experienced many other interesting things while in Timor-Leste. A week was spent as the physician to the President, I was employed as a World Health Organisation advisor on multi-drug resistant TB, I provided training to ICU doctors on the use of their newly purchased Draeger ventilator, and most satisfyingly, I practised general medicine in a small hospital known as the Bairo Pite clinic where the lack of diagnostics meant clinical acumen was once again foremost.

My time in Timor-Leste was unforgettable and I would certainly recommend a trip up there to help out our close neighbours. I would be happy to be contacted if anyone requires any specific information on Timor-Leste. Thanks again to those who provided assistance and sponsorship for my trip.

DR STEVEN CHUNG
General Medicine Fellow (Cardiac Ultrasound)
MBBS, FRACP
stev78@optusnet.com.au

FORTHCOMING MEETINGS

2011	**JANUARY**	**ACM Course – Clinical Course in Acute Care Medicine** **20-23 January 2011** Special focus symposium on Infections in Acute Care Medicine. The Department of Medicine in Eastern Clinical School, Monash University and Eastern Health, Melbourne, is pleased to announce the 6th Annual ACM Course *Clinical Course in Acute Care Medicine* & the Special Focus Symposium to be held in Eastern Health, Melbourne. Further information visit: www.easternhealth.org.au/media/events/acm.aspx
		Mayo Clinic Meeting, Kauai, Hawaii, USA **24-28 January 2011** The Mayo Clinic's 23rd Annual Selected Topics in Internal Medicine CME course, January 24-28, 2011 on the beautiful island of Kauai, Hawaii. For more information visit: http://www.mayo.edu/cme/family-medicine-2011r962
	MARCH	**IMSANZ NZ Autumn Meeting** **2-4 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.
	MAY	**RACP Congress, Darwin** **22-25 May 2011** The 2011 RACP Congress will be held in the Darwin Convention Centre from 22 to 25 May 2011 at the Darwin Convention Centre. The theme for the Congress will be Chronic Disease. *Abstracts close 25 February 2011* Website: http://www.racpcongress2011.com.au/
	OCTOBER	**Canadian Society of Internal Medicine** **12-15 October 2011** The CSIM meeting will be held in Halifax, Nova Scotia Website: http://www.csimonline.com/
		IMSANZ Joint Meeting **14-16 October 2011** A joint meeting between IMSANZ and the Victorian RACP is being planned for 14-16 October. Victorian venue to be decided
2012	**OCTOBER**	**Canadian Society of Internal Medicine** **17-20 October 2012** The CSIM meeting will be held in Quebec City, Quebec Website:http://www.csimonline.com/
	NOVEMBER	**XXXI World Congress of Internal Medicine** **11-15 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

THE SOCIETY FOR ACUTE MEDICINE

4th International Conference, Edinburgh, October 2010

I am in my third year of dual advanced training in General Medicine and Endocrinology. As a recipient of an IMSANZ travel award for 2010, I was very fortunate to attend the 4th international conference in Acute Medicine, held in Edinburgh in Scotland in October 2010.

I was fascinated by Edinburgh city owing to its spectacular, rugged setting and vast collection of Medieval and Georgian architecture, including numerous stone buildings. It is often considered one of the most picturesque cities in Europe and the Old Town of Edinburgh is a UNESCO world heritage site. The city attracts 1 million overseas visitors a year, making it the second most visited tourist destination in the United Kingdom, after London. Edinburgh Castle, Scotland's top paid tourist attraction is at the heart of the city. An ancient stronghold situated on top the craggy remains of an extinct volcano; it was probably an important fortification since the Iron Age or earlier. It is visible from miles around from the city. Edinburgh is also a centre of excellence in the fields of medicine, research and science and head office for one of the oldest medical professional bodies, The Royal College of Physicians of Edinburgh (RCPE), which was established in the 17th century. I appreciated the organisers for choosing this lovely city for the conference.

The conference was organised by the Society for Acute Medicine, UK. The Society is virtually a new addition to the medical world, started ten years ago. The pressure on hospitals from emergency medical admissions has risen inexorably over recent years, resulting in overcrowded emergency departments and associated adverse effects on efficiency, safety and quality of care. To overcome this, a new medical specialty of acute medicine has been developed and acute medical units (AMUs) have been established in the UK. Virtually all acute hospitals in the UK now have an AMU, and more than 80% of patients admitted to emergencies require initial treatment by a multidisciplinary team on the AMU. Acute Medicine in the UK was approved as a separate specialty in 2009; previously it had been a subspecialty of General Medicine from 2003.

The conference was inaugurated with awarding Acute Medicine Honorary fellowships to two eminent personalities who have contributed to acute medicine management. One of them was Professor Sir George Alberti, Endocrinologist whose pioneer work in diabetic ketoacidosis led to the present management of diabetic ketoacidosis. I was fascinated to hear his speech that earlier (before the 1970's) diabetic ketoacidosis had been treated with massive doses of insulin and how he had proved the effectiveness of low dose insulin therapy in diabetic ketoacidosis. I was even more fascinated when he admitted that a few years after publishing his work he found similar work on the effectiveness of low dose insulin therapy in diabetic ketoacidosis had already been published in one of the German medical journals in the late 1940's and had not been recognised by the wider medical world. Thanks to information technology, we are fortunate to be able to search things in Pub Med and other data bases in seconds and also to report our new findings in an effective way to the contemporary medical community.

The conference continued with parallel sessions and leading experts shared their innovative ideas and techniques in acute topics in Cardiology, Respiratory medicine, Endocrinology, Haematology, Immunology, Psychiatry, Rheumatology, Dermatology and Elderly Medicine. Meeting the various subspecialties in one place reminded me that Acute Medicine is actually part of General Medicine. There were also many sessions on policy and administrative issues of running acute medical units. It gave me some understanding about acute medical units and how they operate in UK. In the session "Developing your AMU" one of the speakers was from Australia, Dr Alasdair McDonald, President Elect of the Adult Division of the Royal Australasian College of Physicians and a past president of IMSANZ. He compared the Australian acute medical units with UK system and gave an overview of the Australian experience.

I found poster sessions very interesting. Most of them were about AMU organisation, design, audits and novel ideas about running AMU. I found two posters were from Australia, sharing the Australian experience. I was able to share problems (and find answers) with presenters including multidisciplinary team allied health professionals. This contributed to good discussion and debate on acute medicine. There were some parallel hands-on sessions on practical procedures like ultrasound guided central venous lines and pleural aspirations.

Overall the conference gave me good experience about acute medicine and I was also able to understand the UK model and why it is not exactly suitable for Australia. However I also realised how forming new AMU models in the context of local settings and staffing infrastructure will definitely help our overburdened emergency units and hospitals.

I wish to thank the IMSANZ committee and members for giving me this wonderful opportunity to enhance my medical experience which will prove very useful to my everyday clinical practice.

NADARAJAH MUGUNTHAN
Advanced Trainee Registrar
Gold Coast, Qld

A FRIENDLY REMINDER

Members are reminded that the Membership Fees were increased at the last Annual General Meeting to take effect from January. The last increase was in 2009.

Membership fees for 2011 - 2012 are:

Full Membership - AUD 250

Trainee, Pacific and Associate Membership - AUD 62

Above amounts will attract GST where applicable.

Members subscription invoices will be emailed early in January 2011.

FROM THE EDITORS

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

We are most grateful for contributions received from members.

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

We welcome contributions from physicians and advanced trainees.

Job vacancies and advertisements for locums can be published.

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

Tell us what you want!!

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

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

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

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

A/Prof Ian Scott
Director of Internal Medicine

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

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