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Issues for clinicians training international medical graduates

Andrew W Holt

To the Editor: The review of issues faced when training international medical graduates (IMGs) by Pilotto and colleagues is indeed timely.[1] Their systematic presentation of these issues resonates loudly with many of the daily challenges of hospital practice.

While their review referred to the shortfall of doctors, it failed to emphasise how critical this shortfall already is in some areas of hospital practice. As workloads escalate, IMGs increasingly underpin the provision of critical care clinical services. Among trainees in my department, the rise in the proportion of IMGs whose first language is not English has been dramatic, increasing from 22% of trainees in 2000 to 83% in 2007 (Box).

In my experience, these doctors arrive with high expectations of the system that will train them to be critical care specialists, and place enormous pressure on themselves to achieve this. IMGs with English as a second language require greater early supervision to orient them to differences in hospital systems and language. Later, they require more assistance in preparing for the Fellowship examinations than IMGs whose first language is English. Between 2000 and 2007, an increasing clinical workload has left less time and resources for their training, and currently the needs of these IMGs are often not being met. These doctors are crucial to the provision of clinical services in our hospital, and their needs should not be ignored. Anecdotally, we are already seeing IMGs previously desperate for any training position now "cherry picking" hospitals with better resourced training programs.

On average, compared with Australian medical graduates, IMGs with English as a second language spend longer in Fellowship training programs and are more likely to reattempt examinations; and the registration, training and examination fees for IMGs are considerable. The specialist medical colleges should already be in a position to fund initiatives for IMGs whose first language is not English. However, regrettably, as far as I am aware, they receive no specific help in undertaking the language-rich examination process for a Fellowship in critical care medicine.

When I reflect on my specialty training, the thought of having to pursue this in an unfamiliar language is overwhelming. Not surprisingly, IMGs constantly perform under the pressure of "not measuring up". Their appreciation of the help and training they receive is immense. However, I think one of my more important tasks as Supervisor of Training, particularly early in their training, is to remind IMGs of the great clinical work they perform day in, day out. The debt we owe them is also immense — who needs whom the most?

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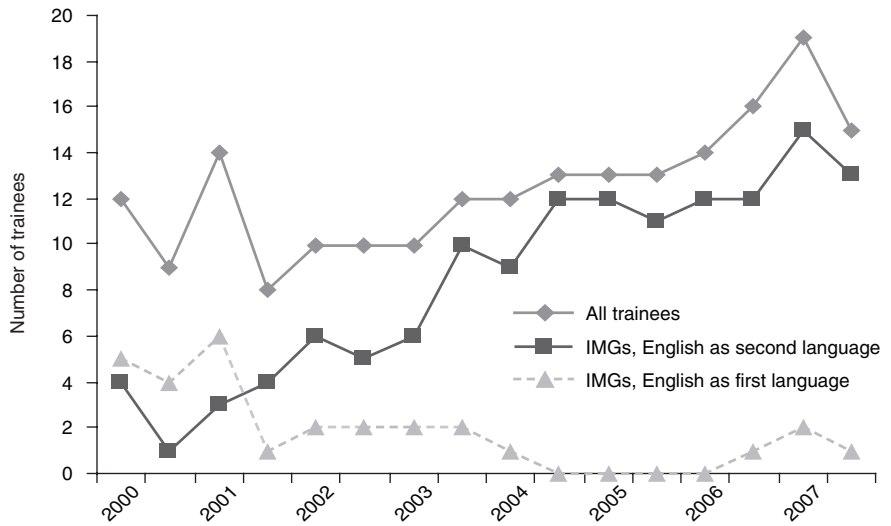
1 Pilotto LS, Duncan GF, Anderson-Wurf J. Issues for clinicians training international medical graduates: a systematic review. *Med J Aust* 2007; 187: 225-228. ❑

Number of critical care trainees at Flinders Medical Centre, Adelaide, South Australia, 2000–2007, by origin and English-speaking status



IMG = international medical graduate. ◆

Dangerous liaisons — syphilis and HIV in Victoria

David E Leslie, Nasra Higgins and Christopher K Fairley

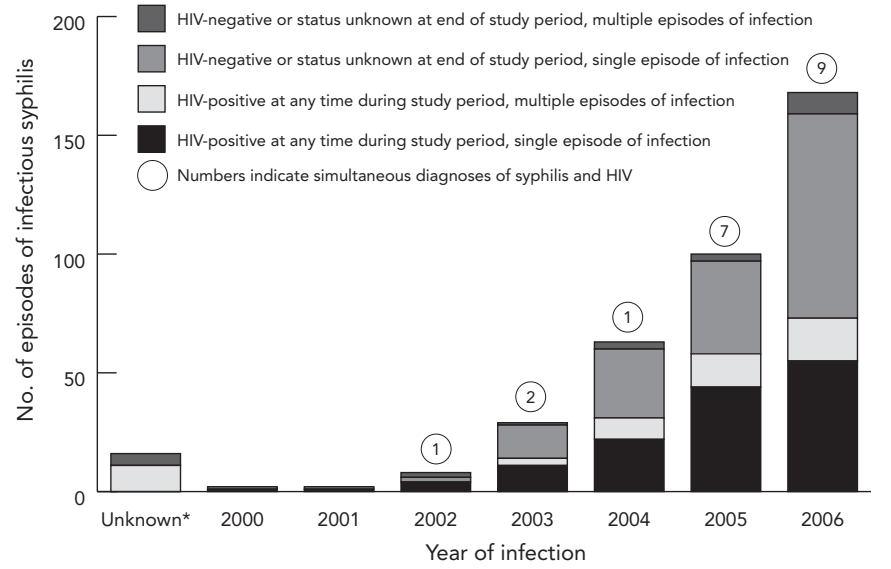
To the Editor: In Victoria from 2000 to 2006, infectious syphilis notifications (primary, secondary and early latent infections) increased about 25-fold from 0.2 cases per 100 000 population in 2000 to 4.7 cases per 100 000 population in 2006.[1] The number of new diagnoses of HIV has also increased since 2004.[1] After observing a few patients presenting with both syphilis and a concurrent new HIV diagnosis, we investigated the association of the two diseases using retrospective laboratory data. As the Victorian Infectious Diseases Reference Laboratory (VIDRL) incorporates the state HIV reference laboratory and also acts as the reference laboratory for syphilis serological testing, it was possible to identify the HIV status and/or time of HIV diagnosis of 85% of patients identified with infectious syphilis, based on syphilis serological findings and polymerase chain reaction testing as previously described.[2]

Three hundred and forty-seven male patients fulfilled the criteria for infectious syphilis in the period 1 January 2000 to 30 December 2006. This represents 68% of all patients with infectious syphilis notified to the Victorian Department of Human Services over the period. Within the group of 347 patients, there were 310 with a single episode of *Treponema pallidum* infection, of whom 44.5% were HIV-positive.

Thirty-seven patients were reinfected with syphilis, including 21 with their first episode recorded since 2000, and 11 with a serological pattern consistent with old treated syphilis recorded before reinfection during the study period. Of the 37 patients, 33 (of whom 23 were HIV-positive) had a second recorded episode and four (of whom three were HIV-positive) had a third recorded episode within the study period. Overall, 70.3% of patients with multiple episodes of syphilis were infected with HIV. Twenty patients presented with a concurrent diagnosis of infectious syphilis and previously un-diagnosed HIV infection. The trend over time is shown in the Box.

Several international studies have highlighted the disproportionate incidence of syphilis in patients infected with HIV in recent years. There is now good evidence that syphilis and HIV act synergistically with regard to both transmission and progression of both diseases.[3-5] The above data clearly demonstrate the strong association between

Episodes of infectious syphilis in Victoria by year of infection and HIV status



*Patients with evidence of prior syphilis infection at an unknown time. ◆

HIV infection and infectious syphilis in Victoria, and this trend continued in the first half of 2007. Given the more frequent syphilis reinfections observed in the HIV-infected group, it indicates persons with HIV form a potential reservoir for syphilis infection in this state. We would strongly recommend that any patient presenting with possible syphilis or HIV infection in Victoria or elsewhere in Australia should be tested for both diseases.

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1 Sexually transmissible infections. *Victorian Infect Dis Bull* 2007; 10 (1): 16-22. http://www.health.vic.gov.au/__data/assets/pdf_file/0018/48222/vidbv10i1.pdf (accessed Mar 2008).
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A case of periportal fibrosis in a Sudanese refugee

James Daveson and Graeme Macdonald

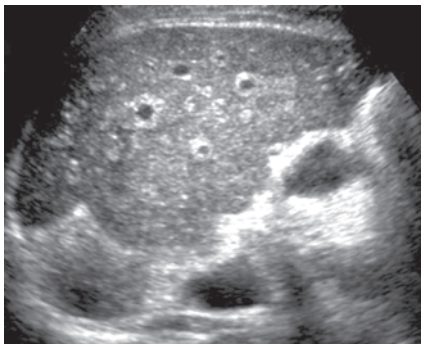
To the Editor: A 37-year-old male Sudanese refugee presented with lethargy, nausea, abdominal discomfort and bloating. He had chronic hepatitis B and a 2-year history of hazardous levels of alcohol consumption (90 g/day). On examination, there were no features of chronic liver disease.

His liver enzyme levels were elevated (alkaline phosphatase, 189 U/L [reference range (RR), 40–110 U/L], γ-glutamyltransferase, 456 U/L [RR, < 50 U/L], alanine aminotransferase, 51 U/L [RR, < 45 U/L], and aspartate aminotransferase, 53 U/L [RR, < 40 U/L]), but synthetic function was preserved and serum bilirubin level was normal. Hepatitis B virus DNA was 1.3×10^3 IU/mL, consistent with a low-level viraemia, while HBeAg and anti-HBeAb were both non-reactive. His platelet count was reduced (115×10^9/L [RR, 140–400×10^9/L]), suggesting portal hypertension. The remainder of his chronic liver disease screen was unremarkable. Endoscopy revealed four grade 1 oesophageal varices, mild portal hypertensive gastritis, and patchy erosive duodenitis.

The irregular liver and periportal fibrosis seen on ultrasound (Box 1) raised the possibility of cirrhosis. Subsequently, a biopsy of the liver showed preserved liver architecture, with periportal fibrosis and active schistosomiasis (Box 2). A diagnosis of *Schistosoma mansoni* infection was made, based on the histological appearance of the ova.

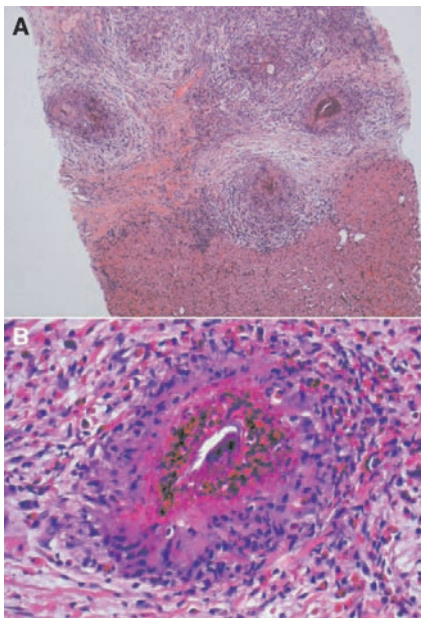
S. mansoni is the leading cause of chronic liver disease and portal hypertension in sub-Saharan Africa.[1,2] Adult worms reside in mesenteric vessels, but their migrating eggs

1 Liver ultrasound



Ultrasound shows an irregular liver with marked periportal fibrosis. There is no intra- or extrahepatic biliary tree dilatation. The portal vein flow is antegrade. No focal hepatic lesion is seen. ◆

2 Liver biopsy specimen



Preserved round to oval parasites with ova, some with a refractile exoskeleton and small lateral spine, can be seen. The viable forms suggest active infection. The surrounding inflammation contains numerous eosinophils, with fibrous expansion of the portal tracts. The adjacent liver revealed a preserved architecture with a normal METAVIR score of A0F0 (haematoxylin–eosin stain; low-power [A] and high-power [B] magnification). ◆

lodge in hepatic presinusoidal radicals, resulting in inflammation and granuloma formation. The inflammatory reaction eventually leads to occlusion of portal veins and secondary portal hypertension.[3] Hepatocellular function usually remains normal.[1]

Although the "gold standard" for diagnosis of *S. mansoni* infection is microscopic examination of faeces, this test may be negative (as it was in this case). Serological screening is recommended, but these assays cross-react with other helminthic infections and are unable to distinguish active infections from previous exposure.[1]

Praziquantel should be offered to previously untreated patients with positive serology results; after a single dose, 70%–100% of patients cease to excrete eggs.[1] In patients who have left *S. mansoni*-endemic areas, an oral dose of 60 mg/kg split in two and given several hours apart should ensure cure.[1]

Our patient was treated with praziquantel, with ongoing follow-up for hepatitis B and portal hypertension. In retrospect, the patient's history and the sonographic appearances were consistent with schistosomiasis. This clinical scenario is of increasing relevance, with a growing number of people from Africa now living in Australia.

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Overweight and obesity in Australia

John A Hawley and David W Dunstan

TO THE EDITOR: Australians are fatter than they have ever been before. The prevalence of overweight and obesity (body mass index $\geq 25.0\,kg/m^2$, or waist circumference >80 cm for women or >94 cm for men) in Australian adults is approaching 60% for both sexes and has more than doubled in the past 25 years.[1]

A prudent public health policy to fight the growing obesity epidemic would undoubtedly be to target strategies that avert this condition in the first place. So we were perplexed by the Australian Medical Association's recent proposal to the Victorian Government to fund five public hospitals to provide 3000 obesity-related operations (ie, bariatric surgery) over the next 3 years.[2] It appears the blueprint for the new millennium is to invest taxpayers' money in modern technologies in an attempt to arrest overt clinical disease states.

To attack the growing burden of obesity by investing in strategies that target secondary and tertiary treatment is an admission that we may win battles on a few fronts, but lose the war. We propose placing greater emphasis on implementing and enforcing primary prevention strategies to fight obesity. Primary defence mechanisms can decrease obesity prevalence by preventing the condition in the first place! Indeed, the health care industry is paradoxical in that its principal goal is to end health problems and human suffering, and by so doing put itself out of business.[3]

We need to attack the environmental roots of obesity, namely our sedentary lifestyles and caloric excess. Emphasis on secondary and tertiary prevention is too little, too late and will not reverse the growth of obesity — the funds to treat obese individuals are finite, while the number of Australians with the potential to become overweight or obese is not!

In a letter to President Roosevelt voicing concerns about the Manhattan Project (the project to develop the atomic bomb during World War II),[4] Niels Bohr wrote:

> A weapon of an unparalleled power is being created which will completely change all future conditions of warfare. Unless some agreement about the control of the use of the new active materials can be obtained in due time, any temporary advantage, however great, may be outweighed by a perpetual menace to human security.

Obesity-related disorders impact on daily living. While bariatric surgery may provide a "magic bullet" for a few individuals, the time has come to legislate for minimum health standards, and to provide support for people to effect lifestyle changes to meet these requirements. Otherwise, obesity will remain a permanent threat to Australian society.

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1 Cameron AJ, Welborn TA, Zimmet PZ, et al. Overweight and obesity in Australia: the 1999–2000 Australian Diabetes, Obesity and Lifestyle Study (AusDiab). *Med J Aust* 2003; 178: 427-432.

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Douglas G Travis

COMMENT: Obesity is a complex public policy issue. There are no easy solutions, and the medical profession needs to work with communities, governments, researchers, teachers, parents, industry and others to help all Australians achieve and maintain a healthy weight.

The Australian Medical Association (AMA) Victoria has six priority action areas to promote healthy weight:

- Ban food advertising to children;
- Simplify food labels;
- Promote physical activity every day;
- Improve clinical tools;
- Improve treatment options; and
- Evaluate and educate.

Bariatric surgery is one of the treatment options that needs to be further explored. Among many other items, AMA Victoria's state budget submission for the 2008–09 financial year[1] calls for a trial of 3000 bariatric surgical procedures to be performed in public hospitals, as part of a comprehensive approach to weight loss.

The evidence before AMA Victoria indicates that bariatric surgery is a safe and cost-effective treatment for a proportion of morbidly obese Victorians.[2-5] However, bariatric surgery is an extreme response that should only be explored in extreme circumstances. There are many morbidly obese people who find themselves in these extreme circumstances and may benefit from the surgery if other approaches have failed. Further, bariatric surgery is cost-effective, as the costs are lower than the ongoing costs of treating chronic conditions associated with obesity.

Bariatric surgery is not the only policy approach to obesity being pursued by AMA Victoria. We see it as a small part of the solution, although it has been a larger part of

recent media attention on the issue. I am pleased that the AMA has been able to highlight obesity as an important public policy issue, and I look forward to working with a range of partners to explore possible solutions.

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1 Australian Medical Association Victoria. Victorian state budget 2008–2009: AMA Victoria submission to the Treasurer, the Hon John Lenders MLC. http://www.amavic.com.au/icms_docs/20403_AMA_Victoria_submission_for_State_Budget.pdf (accessed Apr 2008).
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A food "lifeboat": food and nutrition considerations in the event of a pandemic or other catastrophe

Craig B Dalton, Michelle A Cretikos and David N Durrheim

To the Editor: The article by Haug and colleagues on household food stockpiling is a useful contribution to a neglected aspect of disaster planning.[1] However, rather than providing a guide to what foods should be stockpiled, it may be more valuable to encourage families to increase the amount and rotation of the non-perishables they currently purchase. The authors seek to promote a balanced nutritional diet, but encouraging a family to continue their usual purchasing patterns when stockpiling for a pandemic or other disaster is a simpler, more sustainable, and possibly more effective way to promote household food stockpiling. We must assume that the family currently survives, for better or worse, on their current food purchase pattern.

While the article states that supermarket stocks will become depleted within 2–4 weeks, it is likely that stocks would become significantly depleted at an individual store level within 2–3 days of the last truck delivery, particularly if panic stockpiling occurs. How long interruptions to the food supply chain last will depend on the nature of the disaster, but the Australian Government Department of Health and Ageing recommends that people have "enough fluids and food on hand to last you and your family a week."[2] It does not provide guidance on how much water is required per day.

This is an important issue, as mains water could be unavailable within hours to days of electricity supply outages, because electricity is required to pump water into elevated water reservoirs to maintain water pressure. People may be unaware of their daily fluid requirements and may run out of water and other potable fluids before they run out of food. The US Health and Human Services recommends a 2-week food and water stockpile ("one gallon of water per person per day"), which is roughly equivalent to four litres per person per day.[3] A random household survey in the Hunter Region of New South Wales after a storm-related disaster in June 2007 revealed that over 80% of households had enough non-perishable food for 3 days, but less than 40% had enough stored drinking water for 3 days (Hunter New England Health, unpublished data).

Community continuity planning should be based on an understanding of baseline household food and water reserves, and household capacity and willingness to stockpile across all social strata. Governments should actively promote household stockpiling and identify strategies to bridge the shortfall in households unable to stockpile.

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1 Haug A, Brand-Miller JC, Christophersen OA, et al. A food "life-boat": food and nutrition considerations in the event of a pandemic or other catastrophe. *Med J Aust* 2007; 187: 674-676.
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Jennie C Brand-Miller, Jennifer McArthur and Anna Haug

In reply: Dalton et al have raised several important points for discussion. They suggest that an adequate food "lifeboat" can be procured by simply encouraging a family to continue their usual purchasing patterns. Unfortunately, accumulating non-perishable items in this way would be a fast route to certain nutritional deficiency. It is the perishable items — fruit and vegetables, bread, meat and dairy products — that supply the bulk of micronutrients in modern food supplies. Within a few short months, an individual relying on usual pantry supplies could be suffering from acute deficiencies of vitamin C, and folate and other B vitamins. Babies conceived during this period would be at risk of neurological defects.

We agree that an important issue is the possibility of failure of the mains water. Indeed, many of the foods in our list require water for cooking (rice, pasta etc). Rainwater tanks and the ability to sterilise water by gas heating or chemical means may be lifesavers. We agree that governments should be actively promoting appropriate stockpiling in homes, places of employment and in areas of essential infrastructure.

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Misleading advertising of PI-based drug information?

Jim R Stockigt

To the Editor: Why are those who market officially sanctioned information about pharmaceutical products not constrained by the advertising standards imposed on those who sell these products? Medicines Australia, which formulates a code of conduct for the pharmaceutical industry, imposes penalties, both financial and withdrawal of offending material, against misleading advertising of pharmaceutical products[1,2] Why are similar standards not applied to advertising of information about these products?

There are well documented flaws in Australian drug information sources,[2,3] such as

MIMS (the Monthly Index of Medical Specialties), that are based on product information (PI) authorised by the Therapeutic Goods Administration (TGA). Some PI is decades out of date;[2] bottlenecks in updating TGA-approved PI are apparent.[4]

In this light, advertising of PI-based information in the bimonthly MIMS summaries seems anomalous. The April–May 2008 bimonthly print edition of MIMS claims to present "100% pure knowledge", and states that "you can count on MIMS being up-to-the-minute", and that "MIMS is essential knowledge that Australian health professionals can trust". Previous bimonthly MIMS summaries make similar assertions.

Until PI can be brought to an acceptable professional standard — a task that may be slow[4] — it would seem appropriate to rein in misleading claims about PI widely used by health workers. Medicines Australia, or the National Prescribing Service, a government-funded body committed to "quality use of medicines", could lead this initiative.

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Elizabeth A Donohoo

In reply: MIMS is held — and has long been held — in high regard in the Australian health care market. The vast majority of MIMS subscribers recognise that the quality information provided by MIMS is essential in their daily encounters with their patients.

However, the product information (PI) produced in MIMS publications is only part of the information provided to health care professionals through various MIMS publications.

Furthermore, it must be stated clearly that MIMS is not responsible for producing the PI-based drug information. This responsibility remains with the manufacturer, and the PI is subsequently approved by the Therapeutic Goods Administration (TGA).

MIMS collates information from various sources, both locally and overseas, and publishes it in an easy-to-use, well structured and familiar format for its customers. MIMS has long been committed to providing such "essential knowledge that Australian health professionals can trust" since the introduction of the first MIMS publication 45 years ago.

However, MIMS does acknowledge that there is an issue with some PI not being reviewed more regularly, and is committed to working closely with any appropriate organisation to address deficiencies in the current process. Nevertheless, it would seem inappropriate to say that PI for all drugs is not a quality information source. PI for the vast majority of drugs published in MIMS is as current as possible, given the constraints of publishing, the updating process by pharmaceutical companies and the delays in approvals through the TGA.

The study reported and referenced by Stockigt focused on old, generic-based medicines.[1] While there is an issue with manufacturers keeping these current, this is clearly a responsibility of the TGA and the manufacturer, not MIMS. PI for newer products is an important quality information source for the prescribers of medicines; if it were not, then the TGA would not permit manufacturers to make PI available in the first place.

With respect to Stockigt's concerns about the accuracy of MIMS advertising, we stand by our assertion that it is MIMS policy to provide the most up-to-date medicines information available, capably delivered by the MIMS professional editorial team.

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1 Stockigt JR. Barriers in the quest for quality drug information: salutary lessons from TGA-approved sources for thyroid-related medications. *Med J Aust* 2007; 186: 76-79. ❑

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