Undergraduate medical education

Dear Editor

As undergraduate medical education expands, more clinical placements are needed for medical students in all health care facilities, particularly outside of busy public teaching hospitals. However, there are suggestions that the teaching capacity of general practice may also be constrained. While a survey of rural Queensland indicated potential room for expansion – so long as logistic issues a such as transport, accommodation and additional clinical rooms could be solved[1] – there is no recent information available about the situation in the rest of Australia.

In late 2005, we conducted a survey on behalf of the Australian Medical Council to determine the teaching capacity of three Australian regions where expansion was mooted, covering outer metropolitan (western Sydney), provincial city (Ballarat) and rural (Northern Rivers of NSW) regions. A brief questionnaire was sent to all GPs in the three regions, seeking information on current teaching roles, expansion potential, and teaching incentives. Despite a low response rate of 15%, the results raise important questions for general practice.

Only 49% of responding practices accepted students for clinical placements, and the organisation of clinical placements was predominantly ad hoc. A minority had either placement coordinators or formal arrangements with medical schools. About half preferred students from a medical school with which they have a relationship, but about 70% accepted students from more than one medical school. Divisions of general practice appeared not to play a coordination role.

Practices were interested in the type of placement (eg. John Flynn or standard placements), possibly because of timing or funding issues, and 58% of respondents indicated that payment was important. Despite the potential competition from placements for interns and students of other health professions, almost all respondents hosted only medical students, so current competitive pressures are not strong but may increase should nonmedical student numbers increase or attract better funding.[2]

Should the picture emerging from this survey be more generally true, there may be need for much better coordination of student placements in general practice, which is now a significant provider of medical education. More robust organisation may improve the efficiency of student allocations, allow for stronger advocacy for teaching resources, and ensure more even quality of the students' learning experience across an increasingly diverse range of medical school curricula.

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Assessing somatic symptoms

Dear Editor

The article by Ellis et al[1] (*AFP* August) emphasises the importance of assessing somatic symptoms in the recognition of psychological distress and depression in our patients. Clark[2] confirms this, listing 15 somatic symptoms in a summary of the main grief phenomena. Somatic symptoms are also important presentations for cross cultural workers experiencing psychological distress during re-entry adjustment.[3] I am grateful to the authors of the article for challenging us to carefully evaluate somatic symptoms and this may also be extended to the diagnosis of grief in the general practice setting.[4]

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ADDRESS LETTERS TO

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The opinions expressed by correspondents in this column are in no way endorsed by either the Editors or The Royal Australian College of General Practitioners

BMI of Australian general practice patients

Dear Editor

We refer to the article by Valenti et al (*AFP* August) in which self report data from patients in the BEACH program indicated that 63.3% of males and 52.6% of females were overweight or obese.[1] Disturbing though these figures are, measured data from recent cross sectional surveys investigating the prevalence of chronic disease risk factors in rural populations in Victoria indicate significantly higher levels of overweight and obesity with 74.8% of males and 65.1% of females overweight or obese.[2] As reported elsewhere,[3] the use of self reported data continues to underestimate the true extent of this problem.

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Breastfeeding

Dear Editor

It was very disappointing to be confronted by an advertisement for infant formula in the midst of the 'mother and baby' articles in September's *AFP*. Not only does the advertisement appear to breach the International Code of Marketing of Breast Milk Substitutes, which the RACGP apparently supports, but I would have expected the college to avoid advertising infant formula altogether in accordance with its own Position Statement on Breastfeeding.

Kathy Garran
Darwin, NT

Reply

Two other letters – making similar points – were received on this topic. All three correspondents have been invited to submit a discussion piece on the GP's role in supporting mothers and babies with common breastfeeding difficulties. The advertisement referred to does not breach the appropriate guidelines. *Australian Family Physician* will continue to ensure that it is not involved in the marketing of infant formula in ways that interfere with breastfeeding; breast milk is best for babies.

Steve Trumble
Editor in Chief
Australian Family Physician

Is salmeterol safe in asthma?

Dear Editor

The use of evidence based answers in the case review by Spurling et al[1] (*AFP* August) was appreciated. I also agree with postscript results based on a meta analysis by Saltpeter et al[2] with regard to an increase in LABA asthma related hospitalisation and an increased risk of life threatening asthma and asthma related deaths.

There is data suggesting several polymorphisms at positions within the human ß2 adrenergic receptor gene. Asthmatic patients who were homozygous for the variant with an arginine at the 16 amino acid position of the ß2 receptor gene experienced decline in airflow and worsening asthma control when treated with a beta agonist.[3]

Another report suggests the use of a long acting beta agonist worsens asthma control by negative feedback mechanism ß2 adrenergic receptor, which is an adaptive response to stimulation of receptors. Continuous stimulation results in desensitisation followed by down regulation of receptors.[4]

Given the above data, it may be safer to consider increased doses of inhaled steroids in moderate persistent asthma in a stepwise manner. Despite this, if symptoms persist after confirming patient compliance, inhaled anticholinergics may be added.[5] Some patients with persisting symptoms may be tried with a LABA while constantly monitoring them for any adverse effects.

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