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From the President...

Dear IMSANZ member,

I am honoured to assume the Presidency of IMSANZ at a time when there is increasing acknowledgement among College and Government circles that Australia and New Zealand are in critical need of more physicians who can practice general medicine. Two key factors have prompted a major rethink of how physicians should be trained and remunerated and how they can be afforded the opportunity to practice both general and sub-specialist medicine: the impending crisis of inadequate numbers of medical specialists in rural and regional areas, and the need for all physicians, regardless of specialty, to better manage the demands of an ageing population with multiple chronic diseases.

Getting to where we are now is in no small part due to the tireless efforts of the outgoing president, Les Bolitho. Les has been a strong advocate for general medicine in many different ways: procuring a co-ordinating role for IMSANZ in this year's College ASM in Hobart which attracted a record attendance; in ensuring that a strong contingent of senior IMSANZ members attended the Forum in General Medicine recently convened by the College; in representing IMSANZ on the Specialties Board, the Adult Medicine Division Committee, and Pathology working group; assisting the College executive in bidding for the International Congress of Internal Medicine meeting in 2010; in promoting the activities of the Rural Physicians Network in Victoria; in profiling IMSANZ as an international advisor in healthcare reform by undertaking consultancies to Laos and Nauru; and in leading the production of important publications which have given IMSANZ a public voice within both the fellowship and government. IMSANZ is in a stronger position politically and collegiately because of the work of Les Bolitho and we are fortunate that he remains willing to continue working in several of his previous positions.

Over the coming weeks, IMSANZ Council will debate a manifesto of policies that will provide the vision and agenda for action for the next two years, and we will communicate these to you within these pages.

My prime concerns as president are:

1) to hear, and act for, the people 'at the coalface', to ensure Councillors bring to the table innovative yet practical ideas that you, our members, want to see implemented;

2) to increase our membership to the one in three fellows who practice, at least partly, general medicine so that IMSANZ, alongside other special societies, can present itself as the representative voice of general medicine;

(continued on page 2)

As you turn the pages...

3) to do everything we can to attract more basic trainees into our specialty and lead them into satisfying career paths; and

4) to help recreate a charter in teaching and research for general physicians that we can call our own.

In achieving these objectives I welcome your thoughts, suggestions and support. Please feel free to contact me or any of the IMSANZ Councillors and committee representatives listed in subsequent pages.

Let IMSANZ be seen as the Society which welcomes original thinking and debate and is capable of making a significant contribution to the betterment of healthcare on both sides of the Tasman.

IAN SCOTT
President, IMSANZ

PAST PRESIDENT'S REPORT

Prediction

"Prediction is very difficult, especially when about the future."

Niels Bohr (1885 – 1962)

"If the future is difficult to predict, create your own direction."

Anon

Embrace the "Physician Within"

The General Medicine Forum in March 2003 provided an opportunity for the College and the Special Societies to examine the future role of physicians in general medicine. The recognition of the importance of embracing the "physician within" in all trainees and physicians and providing the opportunity to expand their skills in general medicine will be essential for the provision of a well trained and responsive physician workforce.

The Forum on General Medicine

The Forum on General Medicine is to was be held in Sydney on to Thursday 20 March 20, 2003. The RACP has acknowledged the continuing difficulties in recruitment and retention in General Internal Medicine in Australia and New Zealand.

The Purpose of the Forum: ***To provide an overview of the key issues confronting General Medicine in Australia and New Zealand, and to outline strategies that the RACP could implement, or recommend to other bodies, to address those issues.***

Considerable time and energy has was been expended to ensure this forum will resulted in tangible and long lasting benefits to trainees and physicians in general medicine.

I would like suggest this was actually the 'Inaugural Forum on the Future of General Internal Medicine' and there will be future meetings to discuss training and workforce issues in Australasia.

There were many objectives in holding the Forum - we were attempting to:

- Focus the College on the important role of GM in training and the future medical workforce
- The need to ensure an adequately trained workforce for the Australasian population
- In uence university medical graduate numbers
- In uence hospital administration - especially in NSW
- In uence the need to re-establish GM units in Sydney
- Learn from NZ experience
- Discuss length of training
- Consider dual training
- Review SAC guidelines
- Open discussion re SAC involvement in training - esp. joint GM and & specialty
- Open discussion on timing of examinations and duration of required training
- ? Shorten or lengthen training
- Modular training
- Documentation of experience
- Work - lifestyle - family issues
- Gender and non - gender issues
- AMC accreditation

... And I am sure there were a number of secondary issues on the line too!

Needless to say - there were many issues and opinions canvassed ... And many issues to explore in future meetings.

The final document will be important in the long-term determination of the renaissance of General Medicine.

General Internal Medicine

Defining the role of the Consultant Physician in General Internal Medicine (GIM) will present an interesting and formidable challenge in the immediate and foreseeable future. Over the past 25 years there has been significant and continuing pressure to diminish the role of GIM in tertiary teaching hospitals. This had reached the crisis situation of GIM Units almost being extinguished in central Sydney, but like all species facing extinction there is an encouraging renaissance and realisation this is not a tenable position. Our colleagues now are providing support for the re-establishment of training and receiving GIM units, but there is significant support required to consolidate these positions. There is much to be done by so few, for so many.[1]

The role of the consultant physician in General Internal Medicine encompasses the breadth and depth of medicine, and the application of the evidence based knowledge obtained to the practice of the Art and Science of Medicine. We are able to provide advice to our patients on diagnosis and management, advise them of appropriate investigations, and provide timely referrals to specialty physicians whilst interpreting and coordinating their results and management options.

The Hospitalist

There is a movement in the United States to promote The Hospitalist – a clinician specialist who manages a patient's acute hospital course and who specialises in hospital medicine, free of any compelling priorities of ambulatory care.[2] In the US the Hospitalist adherents are soon to be in comparable numbers to cardiologists.

The major "driver" for this trend in the US was initially related to funding. This may also have arisen from a relative oversupply of physicians and the high cost of indemnity insurance.

The Hospitalist is usually a specialist physician. About half are general physicians rather than single system specialists; the others are often specialists in intensive care. The US movement is establishing its own credentials as well as areas of research and teaching. The evidence for the impact of the hospitalist is so far unconvincing, although there is some evidence that patient length of stay is decreased when hospitalists manage care. The evidence for improved quality of care and patient satisfaction is equivocal.

This Hospitalist movement is encouraging from the position of the General Physician being appreciated and making resurgence. However, this introduces another level of dislocation in the management of patients. The disease process does not stop at the hospital doorway.

Workforce Issues in Australasia

Australia is in the impending crisis of limited medical workforce availability. This will directly affect the efforts of IMSANZ and medical units to increase the General Internal Medicine workforce. There are numerous issues, which will need to be encompassed in the process to attract, recruit and retain increasing numbers of trainees. The changing expectations of graduates emerge in medical school and are now being re ected in our trainees. These include safe (restricted) working hours, the desire for modular and transportable training, job-sharing, and feminisation of workforce (women graduates are now 55% of graduates- rising to 60% by 2010). Australia has had a limited number of medical graduates – (currently ~1250 per year), however there is significant opportunity to increase student intake with a reported 77% of applicants not been accepted into the medical course, although achieving appropriate entry requirements.

Ian Scott thanking Les Bolitho on behalf of IMSANZ members.

THE YEAR IN REVIEW 2002- 2003

March 2002

IMSANZ NZ Meeting Akaroa

Excellent program, wonderful venue and great company – what more needs to be stated!

April 2002

First World Rural Internal Medicine Specialists (RIMS) Conference, Shepparton, Victoria / April 25 & 26

This was a world first meeting for Rural Physicians. The networking continues to provide important connections.

RACP National Rural Summit
Shepparton, Victoria / April 26 & 27

This was an important and defining meeting with substantial changes in College policy and support for rural and remote health care physicians. Recommendation for RACP to hold Forum on General Medicine.

May 2002

IMSANZ ASM Brisbane

The Brisbane IMSANZ ASM and RACP ASM were a successful and excellent way to commence this year. Attendance at the IMSANZ Day was gratifying with over 90 members registering to attend the academic program and enjoy the dinner at River Canteen., on the Brisbane River. Our thanks to Roche Australia for their support. The IMSANZ Roche Award for the best Advanced Trainee paper, was presented to Anthony Brooks at the dinner. Congratulations to Ian Scott for his enthusiasm and skills in organising the IMSANZ Day

International Congress of Internal Medicine
Kyoto, Japan / May 26-30

In late May I joined he RACP delegation with President RACP Robin Mortimer and Geoff Metz to attend the ICIM 2002 meeting in Kyoto Japan. 3000 delegates from Japan and around the world, attended the ICIM.

The International Society of Internal Medicine was founded in 1948, and represents general physicians from 60 countries.

Australia was invited to nominate a member to the Executive Council of ISIM, and Prof Napier Thomson has accepted the appointment.

The RACP has submitted an expression of interest to hold the ICIM in 2010 in Australia. We are currently in the process of selecting a host city. We are making progress with the development of the bid for the ICIM, to be submitted at the next ICIM in Granada, Spain in September 2004.

The support of IMSANZ and RACP will be important in ensuring the success of the bid, and members are encouraged to attend the Congress if at all possible.

June 2002

June dissolved in a haze of travel in the French Provinces, only to return to reality and realise there were reports to be written and business decisions to be confirmed!

July 2002

RACP ASM SPC invitation for Hobart 2003

In July 2002 the RACP Annual Scientific Program Committee confirmed the offer for IMSANZ to develop and organise Days 2 & and 3 for the RACP ASM in Hobart on May 27 and 28, 2003. This has foreshadowed a change in direction for the ASM, and an attempt to ensure the meeting is more relevant for the practising physician, and aiming to encourage the resurgence of interest and support by all specialties for the ASM.

The IMSANZ Education Committee enthusiastically supported this expanded role for IMSANZ. There have been many challenges and changes, which have been encountered in the process. However, I am satisfied the ASM Program will present interesting topics and educational activities for all participants.

IMSANZ has been invited to organise the Scientific and Clinical program for the RACP ASM Canberra 2004 meeting. I would suggest IMSANZ aim to be involved with organising the ASM each year, including Wellington 2005. This association will provide invaluable experience for our involvement with the ICIM in 2010.

September / October / November / December

Committee meetings with the RACP AMDC (Adult Medicine Division Committee), Specialties Board, Medical Workforce Advisory Committee and Rural Taskforce ensured I was in Sydney at least two days per month. Additional state, national and Australasian teleconferences provided further lines of communication.

Involvement with the MSOAP (Medical Specialty Outreach Assistance Program), Australian Health Care Advisory Reference Group on Improving Rural Health, State based selection process for Advanced Training program in Rural Medicine and focus on the Wangaratta Private and Public hospital committees ensured there was little time for leisure pursuits.

Neil Graham and Michael Kennedy attended the ESIM Summer School in Alicante, Spain as guest tutors. Leonie Callaway (Australia) and Toni Staykova (New Zealand) attended as IMSANZ Advanced Trainee representatives from Australia and New Zealand. All reported an excellent and worthwhile experience with the development and reinforcement of the global community of Internal Medicine. We should continue this association and encourage our trainees and tutors to attend.

I am indebted to Cherie McCune, IMSANZ Secretariat, who has worked tirelessly since her reappointment in August 2003 to ensure the Society is in a sound financial position. Collation of members database, follow-up on outstanding subscriptions, negotiations with NZ IMSANZ, and collection of outstanding monies has been an immense undertaking. Unfortunately, the increasing costs of running a society with 410 current members has resulted in an increase in membership subscription, with the attendant changes to GST, accounting practices and reporting liabilities. A successful and active society needs to be on a firm financial background, which IMSANZ members can be assured is now in place.

The IMSANZ logo has been updated. This initially occurred in response to the request from a number of publications to receive approval from IMSANZ.

A new brochure entitled 'Imagine the possibilities: A Career in General Medicine' has been produced for distribution to medical students, trainees and administrators.

January / February 2003

The summer heat, drought conditions and bushfires all took their toll on our patients, property and stock. The College in Sydney was oblivious to many of these issues – apart from the occasional local bush fire or dust storms! Teleconferences, faxes, and the ubiquitous emails continued relentlessly.

Organisation for the Forum in General Medicine in March 2003, and the RACP ASM in May 2003 needed ongoing attention.

Invitations to Melbourne, Sydney, Brisbane and Cairns as Host City for the ICIM needed to be finalised.

March 2003

The Rural Physicians' Network meetings in Wagga, NSW and Daylesford, Victoria were held in March 2003, and provide excellent venues to discuss scientific and medico-political issues relating to physician practice in rural Australia.

The Inaugural Forum on the Future of General Medicine was held on Thursday March 20, 2003 in Sydney. There will need to be further meetings to consider training and workforce issues in General Medicine in Australasia.

The New Zealand IMSANZ meeting was in Napier, Hawkes Bay in March and presented an interesting and diverse range of topics for discussion and interaction, with an excellent social program. There needs to be increased interaction across the Tasman to maximize opportunities.

April 2003 included the AMDC meeting, an educational session with Winnie Wade from the RCP London on Medical Education, a Specialties Board meeting, and concluding preparation for the Hobart ASM.

We have received submissions from Melbourne, Sydney and Brisbane to be the host city for the ICIM in 2010. Evaluation and additional information will be obtained before a Host City is announced. We will then proceed with selection of a Professional Conference Organiser (PCO) to assist in the organization and running of the ICIM. The next step, after selection of a PCO, will be to liaise with the Host City Venue, the PCO, the Commonwealth and State Health and Tourism departments and to develop a comprehensive and cohesive presentation for the bid to be presented to the ICIM in Granada, Spain in September 2004. We will need all your support and enthusiasm - please consider attending the Congress in 2004.

Conclusion

I would like to convey my appreciation for the support, counsel and guidance received from all members of the IMSANZ Executive and Council, and advice and contact from members of IMSANZ, which has been considered in all decisions.

I have been honoured to have this opportunity to serve you in the capacity of President of this dynamic, robust and active society. I would like to thank you all for the privilege, and I have worked diligently to expand the spheres of in uence in all aspects of General Medicine – in metropolitan, rural and remote health.

The Internal Medicine Society of Australia and New Zealand has an important role to fulfill in the future of General Medicine in Australasia. We need to embrace the "Physician Within" all Fellows of the College and promote the renaissance of General Internal Medicine in all aspects of our daily practice, for the benefit of our patients and all who receive our care.

I would like to recommend to you Dr Ian Scott, incoming IMSANZ President who, I am sure, will provide exemplary leadership IMSANZ in the next two years.

LES BOLITHO

"THE BAY BITES BACK" - IMSANZ NZ Meeting, 27-29 March 2003

The year opening IMSANZ meeting held in the Hawkes Bay and co-ordinated by Rob Armstrong and the Hawkes Bay Hospital team has set an extremely high standard for the remainder of 2003.

Napier provides an outstanding venue with a beautiful facility for meetings of our size looking out across the water and with easy access to the facilities of the town.

The program included a number of invited speakers from the Hawkes Bay. An Intensive Care/Emergency perspective to oxygen therapy was provided by Dr Ross Freebairn, Intensive Care Specialist, in a presentation entitled "Can You Have Too Much Oxygen". Ross presented a small amount of data, which supported the delivery of high- ow oxygen in the treatment of hypoxia, which he argued strongly is of greater benefit to more people than restricting oxygen uniformly for fear of precipitating secondary hypercarbia. As usual this fails to address the small number of patients who present with predictable hypercarbia complicating oxygen therapy. There was an update presentation on the medical management of HIV/AIDs, which is becoming increasingly complicated and there is increasing recognition of the side effects of the therapeutic agents being used. There were two entertaining and informative symposiums, one on sleep, focusing primarily on sleep disordered breathing and a symposium on the medical aspects of fitness to drive, re ecting on the latest publication from the Land Transport Safety Authority, published May 2002.

There was once again a paucity of registrar presentations. Graeme Dickson took the Young Investigators prize of $500 plus a $2000 sponsorship to take his presentation to the RACP/IMSANZ Hobart Meeting, for a presentation on the "Impact of Late Referral on Patients receiving Renal Replacement Therapy", reporting data on these patients from the Waikato Renal Unit.

A substantial amount of discussion, primarily at the AGM, was based around the recently completed RACP Forum in General Medicine held in Sydney with representation by John Gommans, John Henley, and Phillippa Poole from IMSANZ New Zealand plus other New Zealand College representatives, amongst a larger Australian contingent. It is clear there are some overlap issues between Australia and New Zealand but there is a significant diversity of problems and the solutions will need to be at least partly generic via actions of the College, and also local, at least at a state wide level in Australia. There continues to be a strong interest from IMSANZ in the development and progression of this theme.

Once again, typical of a New Zealand IMSANZ meeting, the social program was outstanding, well attended and enjoyed by all to varying degrees of excess! The senior members of the party were to the fore, particularly in the extra-curricular late-night activities, with karaoke once again a popular pastime.

The conference dinner at the Mission Estate complemented fine food and fine wine in an outstandingly beautiful environment and provided a suitable completion to an otherwise busy and demanding academic day.

The final event of the academic program was an exercise in lateral thinking led by Rob Armstrong, which was enjoyed by most and demonstrated the literary strength of some and the weakness of others. The unnamed recipients of the prize for best score, scoring 11½ out of a maximum of 20, were sitting side by side.

Rob Armstrong and his team are to be congratulated for a fine meeting for both the social and academic programs.

A feature arising out of the AGM relevant to all IMSANZ members was a focus on program planning for IMSANZ meetings, both within New Zealand and Australia and potentially offshore in the Pacific Islands, and the IMSANZ executive will address this at their next meeting. We would certainly encourage more Australian members to travel to New Zealand for the meeting and perhaps a subsequent holiday break. As a New Zealand group, we need to work more aggressively to encourage registrar presentations at our meeting.

BRUCE KING
Secretary/Treasurer IMSANZ New Zealand
Nelson

THE STATE OF GENERAL INTERNAL MEDICINE

Views From The Front Line

It is with great pleasure that I assume the presidency of IMSANZ at a time when the RACP executive is having a major re-look at the status of general internal medicine (GIM) in Australasia in terms of workforce, training and research opportunities. As discussed elsewhere in this newsletter, a number of us from IMSANZ Council attended a full day General Medicine Forum (GMF) convened by the college to discuss the future of GIM with pre-circulation of background papers in which IMSANZ presented relevant statistics and proposals for reform. As part of our preparation, a survey was conducted of the current IMSANZ membership in ascertaining your needs and wishes, and I thank those who returned our questionnaire (n=220 of 420 sent; response rate=52%). I thank Cherie McCune for collating and entering the data into a spreadsheet.

The following table provides the key results, which includes comparisons between physicians living in capital cities (metro)and those practising elsewhere (non-metro):

	All (n=220)	Metro (n=115)	Non-metro (n=105)
Age (mean)	51.7	52.8	50.7
Male/Female (%)	88%/12%	87%/13%	90%/10%
Physician category (%)			
Gen physician	29	34	26
*Gen physician c specialty interest**	56	47	65
*Subspecialist c general interest**	15	19	9
Practice type (%)			
Salaried F/T	19	12	25
*Salaried with right of private practice**	16	15	16
Private practice with public hospital appt	48	50	47
*Private practice only**	10	16	4
Other	7	7	6
Workload (mean/median hours)	51.3/54.5	51.0/55.0	51.8/52.0
Workload profile %			
Direct patient care	73	69	78
Practice management	12	12	11
Teaching	7	8	6
Research	4	5	3
Other	4	6	2
Professional development opportunities (%)			
RACP ASM attendance	38	34	44
Specialty Society ASM attendance	59	58	61
Hospital grand round attendance	79	79	80
Journal club attendance	54	50	57
Quality assurance meeting attendance	64	69	59
Mentoring (%)			
*Medical students**	76	84	68
*Basic physician trainee**	68	76	60
*Advanced physician trainee**	46	57	33
No mentoring	14	11	18

Research [current +/or past involvement] (%)			
Research methods course	44	50	39
Patient recruitment for clinical trial	89	64	86
Principal investigator	59	64	54
Desire for greater research involvement (%)	50	52	51
Preferred types of research (%)			
Clinical trials	54	57	51
Health service research	46	46	47
Clinical epidemiology/EBM	41	44	36
Clinical education	31	29	35
Other	8	7	8
Expected time of retirement (%)			
In next 12 mo	5	5	6
1-5 years	19	18	21
5-10 years	19	17	20

***P<0.05 for metro vs non-metro comparisons.**

So what are the take-home messages? Well, not surprisingly there are significantly more general physicians with a subspecialty interest in non-metro areas than in metro areas while the reverse is true of subspecialists with a general interest. More than half of all respondents are generalists with a subspecialty interest. Almost half of the total group is in private practice with a public hospital appointment while greater relative numbers of full-time public general physicians are to be found in non-metro areas. Clearly there are less opportunities for the latter to mentor students and trainees because of limited rotation of these folk to non-metro locations. A little more than a third attend the RACP ASM with a higher proportion attending subspecialty society meetings. Of interest, at least a third of respondents have been, or are currently, involved in research in some form or other and half wish to have greater research involvement. Finally, just under half of respondents will retire within the next 10 years which, given existing shortfalls in the general physician workforce and static rates of entry of advanced trainees into our discipline, raises concerns about adequacy of general medical specialist coverage, particularly in non-metro areas.

There is great need for IMSANZ and its members to do all we can to attract increased numbers of bright and enthusiastic trainees into general internal medicine. The eloquent and heart-felt presentations of a couple of our advanced trainees, Leonie Callaway and Sarah Lynn, at the GMF inspired me with their passion for our discipline. We also need to do what we can to support current fellows in practice, and create opportunities for professional development, teaching and research activity. When we asked respondents to state what single action by the college or IMSANZ would most improve their lot, some of the recurring themes were as follows:

- promote the status and value of general medicine within the college, governments, other professional groups, health and hospital administrators, and the public at large.
- lobby for better remuneration of general physician services and remove fee inequities between general physicians and procedural specialists.
- reinstall or expand general medical units in teaching hospitals in promoting the discipline, providing whole-of-patient care, and attracting more trainees into general medicine as a career.
- increase the exposure of trainees to non-tertiary practice by establishing more trainee rotations to regional hospitals.
- allow general advanced trainees to acquire procedural and other specialty skills by quarantined rotations through specialty terms.
- promote more dialogue and networking between IMSANZ and other generalist groups such as general practitioners, intensivists, emergency physicians and geriatricians.
- lobby for more support for general physician-mediated research and education in non-tertiary hospitals.
- support rural physicians by developing locum services, rural meetings, upskilling courses, and distance learning, and improving the clinical relevance of the RACP-ASM.

These are all worthwhile suggestions and you can be assured that I and the rest of IMSANZ council will work hard to realise these aspirations over the next 2 years. We look forward to your ongoing support.

IAN SCOTT
President, IMSANZ

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2003 – 2005

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CAREER CHOICES IN NEW ZEALAND

Medical Women

At the end of 2000, a comprehensive survey of female medical graduates the University of Auckland, was undertaken by a third year medical student as a summer studentship. This examined their life and career patterns, and investigated critical factors in career decision making. The purpose was to inform women, and those involved in the training and employment of medical women. There were 305 responses (a 73% response rate). The study confirmed workforce data that a smaller percentage of the female workforce is entering general practice (42% vs. 60% in 1986, $p < 0.001$) and a greater proportion entering clinical specialties, particularly anaesthetics, paediatrics, medicine, and surgery.

The study showed there were four distinct factors important in career choice - interest, exibility, women-friendliness and job security, although the first two of these were rated more highly. These factors were similar for all vocational groups, with the exception that women in obstetrics and gynaecology, and surgery did not rate exibility highly, and those in general practice did not rate interest as highly as exibility. The greatest job satisfaction (rated from 1 = minimal to 9 = maximal) was reported among those doing community medicine (7.6) and psychiatry (7.3). The lowest rates were found in adult medicine (5.9) and in emergency medicine and GP (6.2).

Thirty one (10.2%) of the women were either advanced trainees in adult medicine or medical specialists. 43% of these women reported they had decided on a career in adult medicine by the end of medical school. 42% had children (14% of those who were in their first 9 years post graduation, and 75% of those who were at least 10 years post graduation). The mean age at the birth of the first child was 31 years. Those women physicians 10 years or more post graduation worked an average of 41 hours per week (compared with the average for the whole study of 34.5 hours per week). Only 52% of women adult physicians said they would undertake the same career again.

The study size did not allow a further comparison between the medical specialties, and there were several limitations to the methodology- the main one being that it was retrospective, and subject to survivor bias! It does not capture data from the increasing numbers of women who have recently entered training schemes. Comparison of the results with a survey undertaken by Dr Gillian Durham in 1986, did show, however, a remarkable consistency in the factors important in career choice.

The results provide insights into the reality of medical women's lives in New Zealand. That female physicians had the lowest level of satisfaction of all vocational groups is concerning, and a challenge to the College, Special Societies and SACs, as well as health services. Barriers to participation of medical women in training and employment need to be systematically examined and removed. This is not only to allow women themselves to reach their full career potential, but for workforce and socioeconomic reasons. Initiatives that allow, and value, more exible training and work practices, particularly through the years of child raising, are necessary for women and the health workforce at large. These could include career maintenance options, more part time and job share posts in hospitals, modular and exible training, and facilitated re-entry to training programmes once children are older. As decisions on career are being made relatively early for some women, it seems important to expose students to positive undergraduate experiences and to provide information and support through medical school and in the early postgraduate years on how to balance career and other roles.

The study was sponsored by the Medical Council of New Zealand.

LAWRENCE J, POOLE P, DIENER S.
Critical factors in career decision making for women medical graduates. Medical Education 2003;36:1-9.

LAWRENCE J, POOLE P.
Career and life experiences of New Zealand women medical graduates. NZMed J 2001; 114: 537- 40.

Members of the SAC in General Medicine are:

- Dr Mark Morton
  Chairman
- Dr Michael Kennedy
  Coordinator for Advanced Training
- Dr Adrianne Anderson
- Dr Robin Beattie
- Dr Clive Hadfield
- Dr Diane Howard
- Dr E Ann Gillett
  Committee for Physician Training Representative

Purpose of the Forum:

To provide an overview of the key issues confronting General Medicine in Australia and New Zealand, and to outline strategies that the RACP could implement or recommend to other bodies; to address those issues.

Setting the Scene:
General Medicine in Australia and New Zealand

The College hosted the National Rural Summit in Shepparton in April 2002. This was held in conjunction with the First World Rural Internal Medicine Specialists – RIMS - Conference. One of the recommendations of the Rural Summit[1] was to hold a Forum in General Medicine to provide an overview of the key issues confronting General Medicine in Australia and New Zealand, and to outline strategies that the RACP could implement, or recommend to other bodies to address, those issues.

Definitions

I will refer to the following broad definitions during the presentation today and hope to avoid confusion with the terminology.

General Physicians/Consultants: a Consultant Physician in adult General Internal Medicine - this refers to the broad group of physicians who a breadth and depth of knowledge and experience which makes them ideally suited to providing high quality specialist services across a spectrum of health and illness, which is not limited by the boundaries of medical subspecialties.

Specialist Physicians/Consultants: a Consultant Physician in a medical specialty - this refers to those physicians who predominantly spend their time and expertise in one particular discipline or specialty of medicine.

There are varying mixtures of clinical practice and expertise. Hence we have: **General Physicians/Consultants with a Specialty Interest** and **Specialist Physicians/Consultants with a General Interest** – or responsibilities in General Medicine.

(Specialist physicians who do not confine their practice to referred patients are relatively small in number and have not been included in these categories.)

The term **Paediatricians** refers to the broad category of the RACP College members of the Division of Paediatric and Child Health– with similar emphasis on General Paediatricians and Specialist Paediatricians.

The definition of physicians is in accordance with the Australasian and English system, rather than the American reference to physicians of primary care and is more directly related to the American General (and Specialist) Internist.

Physic: The art and Practice of healing; the theory of diseases and their treatment.

Physician: one who practices the healing art, including medicine and surgery; a healer; one who cures moral, spiritual or political maladies.

Doctor: one skilled in, and therefore competent to teach, any branch of knowledge; an eminently learned man (or woman): a teacher, instructor; one who inculcates learning, opinions, or principles… a doctor of medicine refers to any medical practioner or physician, other than a surgeon.

"All are but parts of one stupendous whole, whose body is nature, and God the soul."

Alexander Pope, 1688-1744

"I grow old ever learning many things."

Solon, 640-558 B.C.

Introduction

General Physicians have a breadth and depth of knowledge and experience, which makes them ideally suited to provide high quality specialist services across a spectrum of health and illness, which is not limited by the boundaries of medical specialties.[2]

The reasons for the decline in general medicine are many and complex, and include matters relating to remuneration - the relatively undervalued art and science of consultation compared to interventional procedures, changes in technology and hospital practice lifestyle issues, and loss of academic departments of general medicine and general physician role models. The compartmentalisation of care by medical specialties has led to a restricted view of single organ conditions, with limited ability to appreciate the broader issues of concern to the patient and his/her wellbeing.

General Medicine has been the foundation of Physicianship since the days of ancient history. We are all aware of the doyens of medicine throughout the ages. Perhaps one of the most widely quoted is the Canadian physician Sir William Osler (1849-1939) who returned medical teaching to the patient's bedside and encouraged the role of the general physician in patient management.

We acknowledge all our teachers and mentors who have provided inspiration and guidance for personal careers in General Medicine.

Clinical Workforce Survey 2001

The coverage of the biannual RACP Workforce Survey was assessed against the complete Fellowship role of 8,215 names of Fellows ever admitted to the College up to June 2001. The report covers over 96% of Fellows practising adult internal medicine in Australia and New Zealand.

The Clinical Workforce Survey 2001[3] identified 4323 Fellows of the College clinically active in ŧinternal medicine in Australia and was comprised of 474 General Physicians in adult medicine, 2913 Specialist Consultants in adult medicine, 416 General Paediatricians, and 520 Specialist Paediatricians.

In New Zealand, there were 590 physicians in adult and paediatric medicine, with 89 General Physicians in adult medicine, 361 Specialist Consultants in adult medicine, 71 general paediatricians, and 69 specialist paediatricians (cf comparative table from Survey NZ).

There were 3,387 RACP fellows engaged in adult medicine in Australia of whom 474 were consultants in general medicine[4], with 336 (71%) nominating a particular specialty interest). In comparison, the specialist workforce comprised 2,352 Specialist Consultants, including 513 Specialist Consultants with responsibilities in general medicine.

In New Zealand, 89 General Consultant included 57(64%) who nominated a specialty interest. There were 77 Specialist Consultants with general responsibilities, and 284 Specialist Consultants without general responsibilities.

Adult Specialist Consultants in Australia included cardiologists 435 & 52 with general responsibilities, gastroenterologists 267 & 81, Neurologists 236 & 14, thoracic physicians 177 & 66, endocrine 160& 60, rheumatology 153 & 31, and nephrology 113 & 39. In total, of these 1541 specialist consultants, 313 (20%) had general responsibilities. All specialties include Fellows involved with combined responsibilities.

There are significant numbers of general physicians with specialty interest, and specialist physicians with general interests, identified in the adult medicine workforce. Our role is to ensure the stability and enhancement of this workforce to provide training and employment opportunities for the foreseeable future.

RACP Special Societies

When the Royal Australasian College of Physicians was founded in March 1938, every physician was expected to have knowledge and experience in all branches of internal medicine. For the next 35 years specialisation was not encouraged. However, the rapid and enormous expansion in knowledge demanded specialisation.[5]

The fawning of the Special Societies in Medicine, within the College, has occurred progressively since the 1950's - Neurology 1950, Paediatrics 1950, Cardiology 1952, Rheumatology 1956, Endocrinology 1957, Gastroenterology 1959, Thoracic 1960, Medical Research 1961, Haematology 1961, Nephrology 1965, Nuclear Medicine 1970, Geriatrics 1972, Clinical Oncology 1972, Diabetes 1973, Intensive Care 1975, Infectious Disease 1976, Transplant 1982, and several more Societies, Faculties and Chapters in more recent years. The progressive development of specialisation resulted in the fragmentation of medicine into the realms of the superspecialist who have become the hedonistic icons of medicine over the past 40-50 years.

Internal Medicine Society of Australia and New Zealand

The realisation of the impending 'extinction' of the General Physician resulted in the formation of Societies in General Medicine in Australia and New Zealand in the early 1990's. Continuing dialogue and cooperation between the executive members resulted in the formation of the Internal Medicine Society of Australia and New Zealand (IMSANZ) in 1997.[6,7]

The role of IMSANZ is to promote the pivotal role of the General Physician in Internal Medicine, provide a visible, vibrant and vocal society to promote General Medicine and the role of the General Physicians, provide advice for general physician trainees and assist in their training, and to support the RACP SAC in General Medicine.

A freestanding body, IMSANZ has endeavoured to forge close links with the Royal Australasian College of Physicians and work in harmony with the RACP.[8] This close liaison is perhaps re ected in the role of IMSANZ as co-ordinator of the RACP ASM Scientific Program in Hobart in May 2003.

The important issue we should focus on following this headlong rush for super- specialisation is the adage **'the whole person is greater than the sum of the parts'**. This encapsulates the role of the general physician in the world of modern medicine.

General physician numbers have declined – relatively and in absolute numbers over this time[9] (**Appendix 1**), whilst the numbers of specialist physicians has increased.[10] (**Appendix 2**)

The increasing numbers of physicians, however, does not meet the expected supply requirements to provide services to an ageing population in Australia and New Zealand.[11]

Workforce in General Medicine in Australia and New Zealand 2001 Dent O RACP 2001[12]

The College and IMSANZ acknowledge the expertise and assistance received from Owen Dent with his further analysis of the data on General Consultants obtained in the RACP Clinical Workforce Survey 2001. The workforce survey covers over 96% of Fellows practising adult medicine or paediatrics in Australia and New Zealand. (Appendix 2)

There were 3,387 RACP fellows engaged in adult medicine in Australia of whom 474 were General Consultants (GCs), 336 (71%) nominated a particular specialty interest. In comparison, the specialist workforce comprised 2,352 Specialist Consultants (SCs), including 513 Specialist Consultants with responsibilities in general medicine.

In New Zealand, 89 General Consultant included 57(64%) who nominated a specialty interest. There were 77 Specialist Consultants with general responsibilities, and 284 Specialist Consultants without general responsibilities.

Sex and Age Distribution

In Australia there are 61 adult General Consultants who are women (16%) compared to 469 Specialist Consultants (16%). Similar proportions were General Consultants with and without a specialty interest.

The age distribution of General Consultants is markedly older than that of Specialist Consultants – 45% of General Consultants were aged 55 or older as compared to 24% of Specialist Consultants (15% GCs vs 5% SC aged 65 or older).

Working Hours

In Australia, 87% of GCs worked more than 35 hours per week, 50% more than 50 hours, and 21% more than 60 hours. If a full-time GC were defined as one working 35 hours per week, the 474 Fellows work the "full time equivalent" of slightly over 700.

In New Zealand, 88% of the GCs work > 35 hours, 36% worked > 50 hours, and 9% worked > 60 hours. Similarly, the 89 GCs represent a FTE of 122.

Changes in GC workforce 1981-2001

The GC workforce declined irregularly from 633 in 1981 to 474 in 2001. The decline was greater for GCs without a specialty (48% fall) than for GCs with a specialty interest (10% fall). In the same period the SC workforce increased by 222% from 890 to 2865. This increase was greater among SC without general medicine responsibilities (261%) than among those with general responsibilities (123%).

The total number of physicians entering general medicine has declined more or less continuously over time whereas the number leaving has uctuated. Apparently practice as a GC has been more attractive to physicians already established in the workforce than to new young Fellows.

Ageing Population

The increasing age of the Australasian population – and world population – poses significant challenges to the provision of appropriate healthcare. The timely provision of ambulatory, preventative services will ensure the already over committed hospital based medical services can be contained - but only if there is continuing investment in adequate community based services. At present there is minimal focus on this extremely important aspect of care (Global Population figure) – females now have a life expectancy of 83 years and males 81 years in Australia. This ageing population will provide many challenges for the delivery of adequate, appropriate and timely health care for urban and rural Australians. General Physicians are ideally suited to provide continuity of care on a life long basis in patients who may have a multiplicity of complex, often interrelated, medical problems.

Global shortage of trained medical personnel

There is a global shortage of trained medical practitioners, including physicians. The General Medical Council in England has recently announced there is an impending crisis with the need for up to 10,000 physicians in the next 5-10 years to upgrade the UK National Health service and provide adequate succession planning for physician services[13]. The number of general physicians has been decreasing, but there is growing support for increased training opportunities in the NHS.[14] The USA currently has 26,000 overseas trained medical graduates filling domestic medical positions, not all physicians, and realises there is a major shortage of medical graduates in USA.

Authorities now acknowledge the problems associated with active recruitment of medical staff from developing countries, which depletes the less fortunate countries and is not to be condoned by developed countries.

Global issues, which need to be addressed locally in Australasia, include the requirement for an increase in medical school admissions, the planning for increased numbers of medical graduates, including the increasing numbers of women in the workforce - women are estimated to be >-60% of medical graduates by 2005 in Australia, and the necessary commitment of funding and resources for increased hospital based training positions on a continuing basis in many countries.

Physician Shortages in Australia and New Zealand

In Australia the database for determining adequacy of physician services is virtually non-existent. The only documentation is where physicians practice, and there has been no systematic attempt to correlate demand for physician services with the demographic data. The estimate from a survey for the National Rural Summit in April 2002 is there are at least 200 unfilled positions for physicians in rural and remote Australia at present.[15] There has been no stocktake of physician services in urban, outer-urban or rural and remote Australia.[16] Hence, workforce planning urgently requires attention from the College and the Federal and State governments. Crisis management of physician services, as demonstrated in rural NSW is expensive, fragmented and provides sub-optimal, sporadic and discontinuous care. The rural population already receives suboptimal care, with higher mortality and morbidity in all benchmarked medical conditions.[17]

The Role of the General Physician

The role of the General Physician has undergone stages of evolution over the past decades. Originally venerated as the embodiment of the classical physician, but now subsumed by the rising spectre of specialisation, there are now 27 Societies, Faculties and Chapters within the College. These proponents of specialisation may have limited working knowledge of the whole person - our patients - and how they live, work and function in society.

There is more to the Art and Science of medicine than organ-oriented care – remember **the whole person is much greater than the sum of the parts!**

Rural Physicians

In addition to a complete and solid grounding in all aspects of internal medicine, the general physician understands the importance of developing rapport with patients and family and developing an understanding of the local idioms – a discussion of the nuances of stock markets in Melbourne, Sydney or Auckland may have a different meaning to a similar discussion in Wagga, Wanganui or Wangaratta!

Similarly, the physician in the ambulatory care setting develops valuable interaction with local practitioners and staff in a two way learning process where the objective is to progressively educate and induce changes in the local health care system and to provide best practice on all occasions within the context of permissible local circumstances. The provision of health care in rural and remote regions may be considered 'pioneering' at times

by our learned urban colleagues, but may be the best practise available in those particular clinical settings.

The role of the general physician is a combination of medical expert/clinical decision maker, communicator, collaborator, manager, health advocate, scholar and professional[18] – as well as mentor, confessor figure, family member and participant in local community activities.

The rural physician embodies the role of the 'decathlete of medicine'. He or she needs to be exible, alert to changing needs of our patients, often confronted by acute medical conditions with which we may not be familiar, and needing to assess and instigate management from first principles in order to stabilise our patients before establishing a definitive diagnosis and arranging treatment or transfer for advanced medical care. The rural physician – general or specialist – needs to receive additional training opportunities, and ongoing support from our urban colleagues. It is imperative to establish strong networks with referral hospitals and personnel, and to realise if we initiate a request for assistance this may be due to a number of factors. These include the need for investigation or intervention, and can include the need for affirmation and prioritisation of our management plan. Remember, if the condition is 'not a problem' in your specialist unit, it may be seldom encountered in community practice. Hence it is essential to develop mutual understanding and respect between physicians of all persuasions. It is also imperative to engender confidence in patients returning to rural or community ambulatory care – not only in their ability to survive and regain their health, but also in their referring physician. It is essential to continue to build the relationship between tertiary specialists and referring doctors – be they general practitioners or general physicians. The approach of fragmented specialist care leads to unnecessary patient anxiety and confusion and additional costs in the health care system.

The Roles of the General Physician in Tertiary and Teaching Hospital

The role of General physician in referral hospitals is to provide a depth and breadth in management and diagnosis of patients with complex, multi-organ and often difficult, inter-related management problems. The General Physician is ideally suited to provide coordinated care with multiple specialties, schedule and coordinate investigations and invasive procedures, and to liase with family and referring doctors and ensure the 'overall picture' is workable and united, rather than individual units providing con icting opinions and management plans.

The general physician is exible, adaptable, approachable, well versed in the nuances of medicine, with a working knowledge of multiple specialties and always amenable to the introduction of new techniques, treatments and information.

Apart from this he or she is able to provide a breadth and depth of clinical perspective, which is highly valued by our patients, colleagues and staff.

Continuing Professional Development for General Physicians

The general physician is saddled with a voracious appetite for continuing professional development, and works diligently to accumulate and integrate accurate evidence based medicine (EBM) and up-to-date knowledge, develop re ective learning portfolios and sequester an insane/inane number of MOPS points each year to demonstrate their proficiency in all aspects of internal medicine. The need for exible and personally tailored learning programs including online material, teleconferencing, audiovisual learning, print material and personal attendance at conference, updates, grand rounds and overseas meetings is only tempered by limitations on clinical services, and the largesse of our bank managers! Clinical and practice audit is a routine part of general physician responsibilities.

Evolving roles for general physicians

The role of the General physician is rapidly changing and continues to evolve[19].

In the US of America and Canada the role of the Hospitalist is currently gaining momentum[20]. They recently held their 5th Annual conference. The hospitalist is defined as an acute care general physician providing services in the acute hospital setting, but without ongoing community based services. This 'new' role for essentially a well-trained general physician has been created by increasing pressure within the North American health care system to provide coordinated, whole-person clinical care in a cost effective environment. Fragmentation into specialist care is costly, often intervention or investigation driven and results in suboptimal care due to the lack of coordination and rationalisation of health care resources.

General Medical Units in Australia

In Australia over the past 30 years, there has been significant pressure to downsize general medical units, or limit their ability to admit selective cases, deemed to be the realm of the specialist units. In Sydney the majority of tertiary hospital general medical units have been disbanded. This has had desired short-term results with 'empire' building of selected specialties. However this has resulted in disastrous consequences for long term planning, due to poor perception of the importance of the role of general physician in providing a valuable overview of patient management. The limited training opportunities for general physicians, and the limited opportunities for training rural physicians, will result in severe and significant shortages of rural based physician services in NSW for years to come.

The re-establishment of General Medicine units in Sydney hospitals is to be applauded. Further general medicine units will hopefully 'appear' in the foreseeable future. However, the physicians staffing these units will need to be carefully selected for their skills as general physicians, and if not adequately trained in general medicine, may need to attend upskilling and reskilling sessions to avoid preventable morbidity in these units.

There is a degree of urgency in introducing changes to the College training programs, re-establishing and enlarging general medicine units and ensuring there are adequately trained and experienced general physicians in hospitals and in ambulatory care. The ageing population ensures there will be increasing numbers of older patients with complex medical problems presenting diagnosis and management, often requiring peri-operative assessment, and ongoing hospital and community based care. This is not to deny the younger patient access to general physicians for assessment and advice on their medical condition, and to provide treatment options for chronic medical conditions in a lifelong basis. This form of trust between doctors and patients, although not unique to general medicine, can certainly be a rewarding feature of the doctor-patient relationship.

Another matter of significant urgency is the need to provide a viable, dynamic and highly skilled workforce. The age of the general physician is older than in their specialist colleagues, there are fewer female Fellows in general medicine, and although there is a relatively stable, but small number of Advanced Trainees in General Medicine there is significant attrition of ATs as they progress through training due to the persuasive seduction of specialty units with in our tertiary centres.[21]

In 1975 A Grant Kerr addressed the RACP ASM and comments: "The role of the consultant physician is largely exercised in prolonged interviews requiring full concentration… It is possible that a degree of masochism is an essential prerequisite for a successful private consultant in medicine, combined with the necessary physical properties of grey hair, gold embroidered spectacles and a rather anxious demeanour".[22] The greying of the general physicians is a sign of follicular fallout, and does not necessarily re ect neuronal fallout!

Conclusion

The renaissance of Consultant Physician in General Internal Medicine is slowly evolving in Australia, with indications the process has gained significant momentum in New Zealand – especially with newer Fellows training in dual certification – ie General Medicine plus a specialty. We need to examine the issues of training in dual specialties – can adequate experience be obtained in three years of advanced training, or should we expand this period to four years?

Should the College revisit the entire training program? Would we be better served by an entrance examination at the end of PGY3 – with commonality to all Colleges, then four years of advanced physician training, including two years in General Medicine, with an exit assessment or examination to ensure consistency and quality of the training experience for all Fellows. The issues of shorter working hours, reduced exposure to clinical medicine, modular training, discontinuous training due to family commitments, the increasing recognition of the needs of women - and men - in advanced training positions, and the issue of portability of training experience between Australasian and overseas institutions needs to be re-examined by medical educators from all the medical colleges.

We are following the trends in Europe and North America, and will be significantly disadvantaged if we falter in the move to regenerate, and support the role of general medicine units and general physicians.[23]

The specialist unit provides a haven for the pinnacle of knowledge in a specialty.[24] However, the General Physician is able to provide a panorama and unsurpassed vista, which enables a broad overview of life, fitness and health. The General Physician is able to provide much needed continuity of care, which can result in significant benefits with lifelong management, support and rapport for our patients.

LES BOLITHO

FOOTNOTES

1 *The Royal Australasian College of Physicians Report on the National Rural Summit April 27-28, 2002*

2 *IMSANZ – General Medicine in Australia and New Zealand: The Way Forward. December 2000*

3 *Dent O Clinical Workforce Survey 2001 RACP*

4 *Dent O Workforce in General Medicine in Australia and New Zealand RACP February 2003*

5 *Wiseman JC To Follow Knowledge RACP 1988*

6 *Scott IA, Greenberg PB General internal medicine in Australia and New Zealand – a renaissance MJA 1998; 168: 104-105*

7 *Cohen A, Greenberg P Graham N General Medicine in Australasia. Internal Medicine Journal 2002; 32: 495-497*

8 *Rules of the Internal Medicine Society of Australia and New Zealand Inc May 1999*

9 *Graphs from Peter Greenberg, 2001 from Dent O Clinical Workforce Survey 2001 RACP*

10 *Dent OF Workforce in General Medicine in Australia and New Zealand February 2003 RACP*

11 *Dent OF, Goulston KJ Trends in the specialist workforce in internal medicine in Australia, 1981- 1995" MJA 1999; 170:32-35*

12 *Dent OF Workforce in General Medicine in Australia and New Zealand February 2003 RACP*

13 *www.jchmt.org.uk - Higher Medical Training Curriculum for General (Internal) Medicine 1 January 2003*

14 *www.rcplondon.ac.uk - Workforce data*

15 *The Royal Australasian College of Physicians Report on the National Rural Summit April 27-28, 2002*

16 *Morey S Survey Australian rural physicians 2003 (unpublished)*

17 *Ansari K etal Reducing demand on hospital services in Victoria: opportunities for targeted intervention Health of Victorians 2001; 1,2:28-31*

18 *CanMEDS 2000 project. Skills for the new millennium: report of the societal needs working group. The Royal College of Physicians and Surgeons of Canada. 1996*

19 *Scott IA, Greenberg PB General Internal Medicine MJA2002; 176,16*

20 *Hillman K The Hospitalist; a US model ripe for importing MJA 2003; 178: 54-55*

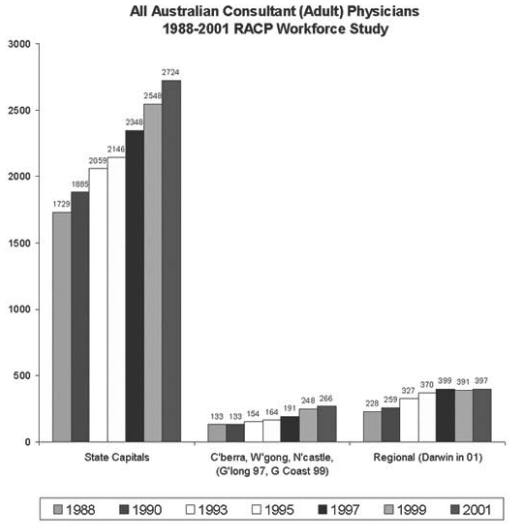
21 *SAC General Medicine RACP – personal communication*

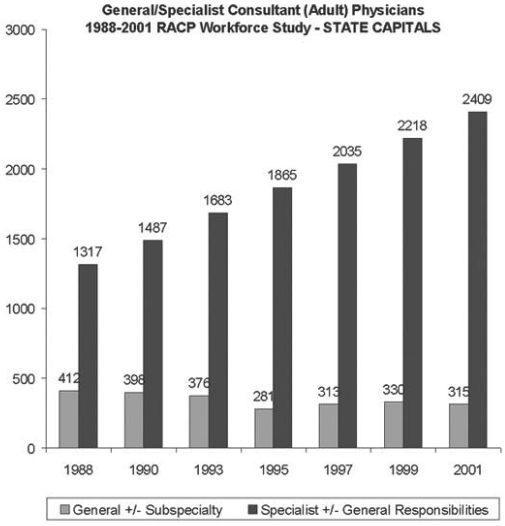
22 *Kerr Grant A Aust NZ J Med (1976), 6 pp 103-105*

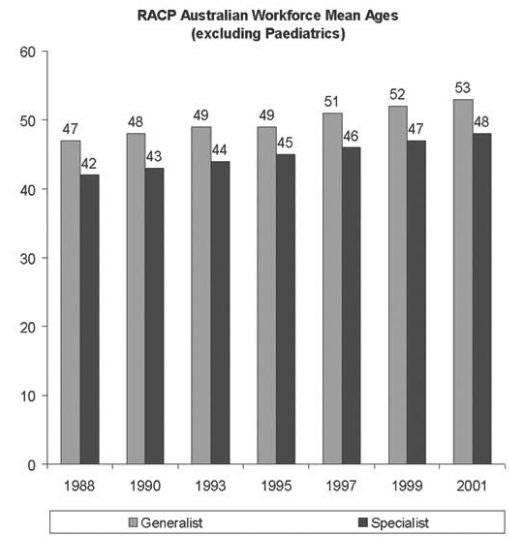
23 *Prediction is very difficult, especially about he future. Niels Bohr 1885-1962*

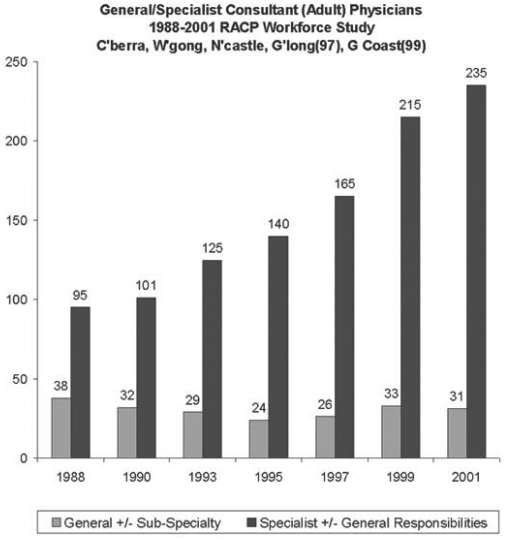
24 *An expert is a man who has made all the mistakes, which can be made, in a very narrow field. Niels Bohr 1885- 1962*

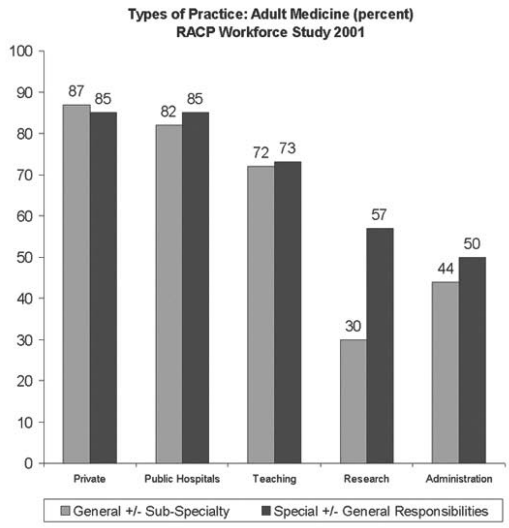
EXTRACT FROM RACP AUSTRALIAN CLINICAL WORKFORCE SURVEYS: 1988 - 2001

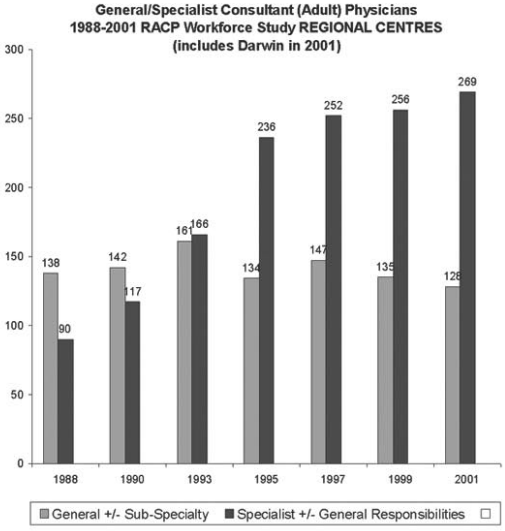












Ref: RACPWorkforce88-01

APPENDIX 2. Dent of Workforce in General Medicine in Australia & New Zealand, February 2003, RACP

FIGURE 1. Age Distribution

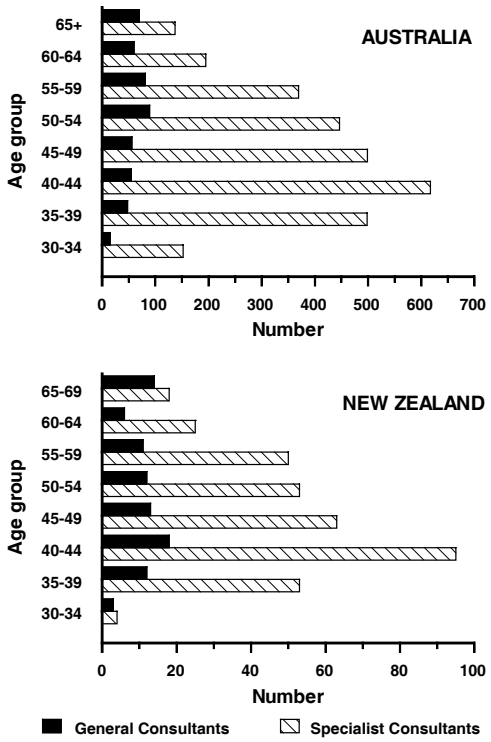


FIGURE 2. Age Distribution Of General Consultants

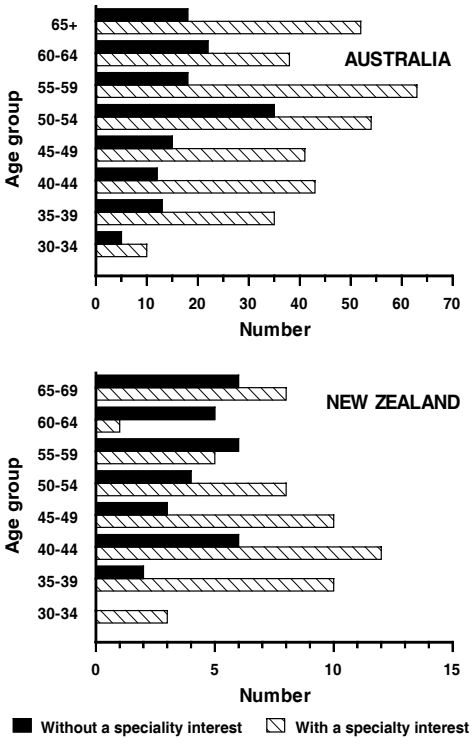


FIGURE 1. Age Distribution

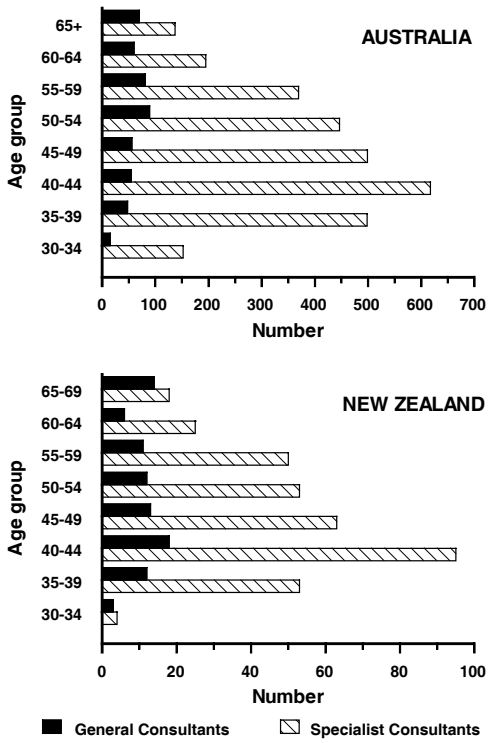


FIGURE 4. RACP Australian Workforce*

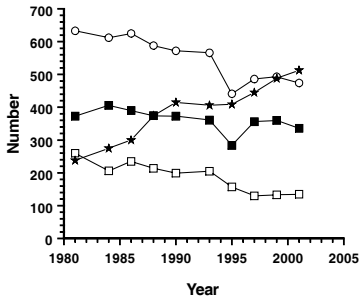
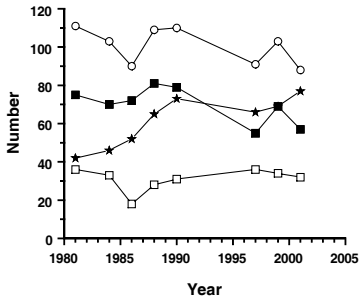


FIGURE 5. RACP New Zealand Workforce*



○ All General Consultants
□ General Consultants without speciality interest
■ General Consultants with specialty interest
★ Specialist Consultants with general responsibilities
* N.B. Specialist Consultants without general responsibilities omitted

The need to strengthen general internal medicine

The practice of consultant physicians in Australasia, as elsewhere in the world, is undergoing rapid change and is subject to considerable stress. External forces such as physician shortages (especially in rural and remote regions), growing demand for inpatient and outpatient services from an ageing population, increased complexity and acuity of inpatient care, rising public expectations, limited or contracting resources, and demands for better quality and safety in health care are factors for which the RACP must now develop co-ordinated and sustainable policies in regards to recruitment, training and accreditation of physician trainees.

As lifespan lengthens and more elderly sick with multi-organ dysfunction present in increasing numbers to hospitals and ambulatory care services, patients and their advocates are becoming increasingly disillusioned with fragmented, uncoordinated care among different specialists, and instead are searching for a more holistic approach provided by a single physician who has skill in diagnosing and managing a broad spectrum of illness, who can prioritise patient needs and therapeutic goals, and who can refer patients as appropriate to the services of specialists.[1] Rigorous, risk-adjusted studies have shown that for many common conditions, general physicians are capable of providing care of equivalent quality to that of specialists,[2-4] and in some cases with improved cost-effectiveness.[3] The greatest strength of GIM is its role as an integrating, cognitive specialty. General physicians are ideally placed to define and provide an equitable standard of care within a constrained health care system, and to lobby for sensible amelioration of these constraints.[5]

Under the pressure of increasing caseloads, casemix-based funding and fixed bed stock, hospital stays now comprise episodes of rapid-fire evaluation and treatment, with early-as-possible discharge and further changes to management being conducted in outpatient clinics where patient numbers are growing exponentially as a result of the shift from inpatient to outpatient care. Opportunities for complete assessment and intervention in older patients at risk of adverse outcomes from sensory deficits, cognitive impairment, and other geriatric syndromes are compromised if the focus of care is limited to one organ disease or single specialty. Involvement of different specialists needs to occur concurrently not consecutively under the direction of a single physician who acts as the patient's care co-ordinator.

The present situation whereby specialists are required, or encouraged, by hospital managers in some parts of Australia to practice general medicine in the form of on-take rosters for acute general medical units, in the absence of training or certification in general medicine,[6] is a violation of quality and safety requirements and discriminates against the employment of properly qualified general physicians with implications for trade practice law. Similarly, the current pressure on specialists to subsume generalist responsibilities in both their inpatient and outpatient care of patients with multi-specialty problems in the name of efficiency[7] is untenable given their lack of training and upskilling in general medicine and the need for their time and expertise to be more directed at managing patients referred to them with serious, complicated, single-system disease.

There are several advantages to specialists in ensuring that GIM continues to have a strong presence in all hospitals, including tertiary hospitals. These comprise:

1. The ability, particularly in periods of peak demand, to transfer care of patients from specialty clinics and wards who have mild to moderate disease, are at low risk of complications, or are not intended to undergo specialty-related procedures;
2. Availability of a mechanism whereby patients who may need referral to specialists undergo initial evaluation and work-up by a general physician, rendering any subsequent specialist consultation more efficient and appropriate; and
3. Availability of physicians who can manage those clinical problems in patients being cared for by specialists which lie outside the latter's area of expertise.

The Internal Medicine Society of Australia and New Zealand has consistently advocated for the retention and augmentation of the role of consultant physicians in general internal medicine (GIM) in both hospital and outpatient practice.[8-10] Statistics profiling the current shortfall in numbers of general physicians, estimates of the numbers of general physician required in the future, and survey-assessed preferences and professional needs of general physicians currently in practice are outlined in other papers in this forum. The overall conclusions arising from this data are:

The numbers of practising general physicians are presently proportionately less than for any other specialty in internal medicine, and will continue to fall over time as the current general physician workforce, which is already older than that of specialists, retires over the next 5-10 years unless there are significant increases in the numbers of trainees who are certified in general medicine.

The numbers of physician trainees choosing general internal medicine for advanced training are declining relative to other specialties, the chief reasons being:

1. The lack of access of trainees to an integrated program of advanced training which includes multiple specialty training rotations;
2. The negative perception of general medicine conveyed to trainees from their specialty peers and senior colleagues; and
3. The impression that career opportunities (particularly hospital appointments and research positions) and professional development needs are more likely to be compromised if one chooses GIM as one's main specialty.

General physician trainees if wishing to practice in non-metropolitan sites are required to develop procedural skills

in a specialty, but opportunities to acquire these skills within specialty rotations are currently very limited as such rotations are reserved for advanced trainees in that specialty or require trainees, for purposes of certification, to perform a minimum number of procedures which is not attainable within the limited duration of the rotation.

Academic career opportunities for general physicians and general physician trainees are severely curtailed due to the absence of a research training infrastructure and limited number of research awards, grants and positions in sciences relevant to GIM such as health service research, outcomes management and evidence-based medicine.

Recommendations for change in advanced training in general medicine

With this background, the federal council of IMSANZ offers the following recommendations.

Dual certification in general medicine and other organ-system specialties. In order to protect the quality of acute general medicine being delivered in both urban and regional areas, and to increase the number of physicians with the requisite skills and knowledge to optimally manage problems involving different organ systems, irrespective of any one specialty interest, all physician trainees enrolling in advanced training as from July 2004 and who intend to practice as a physician with both general and specialty responsibilities should be required to obtain certification in both general internal medicine (as determined by the SAC in General Medicine) and the relevant specialty (as determined by the SAC for that specialty).

Dual certification in general medicine and geriatric medicine or other 'generalist' discipline. All trainees enrolling in advanced training in general medicine as from July 2004 and who intend practising as a general physician with no particular organ-system based specialty interest should be encouraged to:

1. Obtain certification in both general medicine and geriatric medicine; or
2. Undertake an elective year in applied clinical research in areas of practice relevant to general medicine (see below under 'General medicine and specialty rotations'), subject to ratification by the SAC in general medicine.

General medicine and specialty rotations. The advanced training program in general medicine for the purposes of dual certification should comprise:

1. A minimum 12 months rotation in general medical units of a teaching hospital which has received RACP accreditation for advanced training in general medicine; and
2. A further 12 months of specialty exposure comprising rotations of three to six months each in any of the following specialties (excluding that specialty in which the trainee seeks secondary certification): cardiology, respiratory medicine, endocrinology/diabetes, renal medicine, neurology, infectious diseases, vascular medicine, intensive care and emergency medicine. Depending on future practice intentions, rotations would also be permissible in public health, indigenous health, rural medicine, occupational health, tropical medicine, medical administration, addiction medicine, palliative care and medical education. The composition of the second year rotations may be decided on the basis of input from the SAC for the specialty which is to follow but will require ratification by the SAC in General Medicine.

Curriculum in general medicine. The advanced training program in general medicine should include formal training and assessment in the following disciplines:

1. Clinical epidemiology, critical appraisal and health informatics;
2. Cost-effectiveness and utilisation analysis; and
3. Quality improvement and systems analysis. The curriculum in each of these disciplines should comprise a modular course (of minimum four and maximum eight modules which include end-of-module self-tests) conducted over the two year program. Each discipline might be assessable by:

1. Successful completion of the modular course; and
2. Submission of a project report relevant to that discipline which may consist of a case report with detailed literature review (as a critically appraised topic), report of a specific audit or quality improvement project, or some other form of research report. All project reports should be expected to attain a high level of scientific rigor and be submitted for publication in a peer-reviewed journal.

Time spent in the second year specialty rotations may be assessable by means of skills log books, specific projects (such as audits, examples of involvement in health management/ resource allocation, or an educational task) or self-tests or other forms of external assessment developed in collaboration with specialty SACs that would enable trainees to receive some form of written certification of time spent in specialty rotations and skills acquired as a result.

Accreditation of the two year advanced training program in general medicine should only be granted if the SAC in General Medicine has received confirmation that the trainee has successfully completed all assessment requirements and has received all required project reports and deemed them to be satisfactory. The curriculum and assessment criteria should be developed by a working party comprising representatives from IMSANZ and the SAC in General Medicine.

Accreditation requirements for general medical units. General medicine units in teaching hospitals (including private hospitals) should only be accredited for the purposes of advanced training in general medicine if all of the following criteria are satisfied:

The general medical unit is supervised by a consultant general physician, or a general physician with specialty interest provided that at least 50% of clinical service time is spent undertaking general physician responsibilities.

The general medical unit has an average caseload of between 15 and 20 inpatients with minimum caseload of 12 patients, with one medical registrar and one resident/intern position.

The general medical unit participates in an acute on-take roster of at least one in five shifts (whether these be sessional, daily or weekly rosters) for admitting acute medical patients directly from emergency departments.

The general medical unit should have the ability to care for all acute patients presenting with any condition which does not require immediate admission to a specialised ward wherein care is mandatorily supervised by a specialist eg coronary care unit, dialysis unit, intensive care unit, high-dependency respiratory ward. (This qualification pertains to tertiary hospitals in which specialised units usually adopt 'closed' rather than 'open' policies to care delegation ie. the specialist administering the unit also assumes (together with his/her staff) exclusive responsibility for the direct care of patients within that unit).

The general medical unit provides an outpatient service comprising a minimum of 20 occasions of service per week, or the equivalent in ambulatory care experience (such as hospital in the home or outreach services to other health care institutions).

The general medical unit has access to those diagnostic and other ancillary clinical services deemed essential to the effective and safe practice of GIM on the part of IMSANZ and SAC in General Medicine.

The general medical unit is situated in a hospital that provides or guarantees reasonable access to those specialty services deemed essential to the effective and safe practice of GIM on the part of IMSANZ and SAC in General Medicine.

Access by general physician trainees to specialty procedural training. Advanced trainees seeking dual certification should have access to training programs in the required procedures for their specialty interest. For example, those pursuing a cardiology, respiratory or GE interest should be able to receive training and accreditation in echocardiography, bronchoscopy and GI endoscopy respectively. In the case of echocardiography and GI endoscopy IMSANZ provides a formal syllabus, and in the case of GI endoscopy, IMSANZ has a full representative on the conjoint committee for GI endoscopy.

New models of hospital care based on general medicine

In recent times, a number of new models of hospital care centred on a 'generalist' physician have been advocated both in Australasia and overseas.[11-14] In light of these developments, and in order for the above accreditation requirements to be met and the underlying environmental factors that have prompted this refocus on general medicine to be addressed, the members of IMSANZ council would propose the following models of care for consideration on the part of the college and its SACs, hospital Divisions of Medicine, and hospital executives.

General physicians as care co-ordinators or hospitalists in regards to acute medical admissions. General medical units should assume the role of care co-ordinators for all medical patients admitted acutely (ie non-electively) to hospital.[9,11] In simple terms, this means that while patients may initially require admission to specialised units supervised by specialists (such as CCU, ICU, etc) or require intervention from surgical specialists, the prime responsibility for co-ordinating and providing specialist medical care for patients with multiple medical problems or chronic illness rests with general physicians. Those acute presentations, which may mandate early consultation with specialists, are listed in Appendix 1. In such cases, care would be shared between general physician and specialist with prime responsibility for care being transferred back to general physicians once patients are rendered clinically stable and in no further need for immediate specialist intervention.

Acute medical assessment units supervised by general physicians within large hospitals. With the exception of those cases for whom immediate admission to specialised unit is mandated, all medical patients presenting acutely to hospitals of more than 200 beds would be admitted to an acute medical assessment ward supervised by general physicians.[13,14] This admission procedure would apply irrespective of whether or not such patients may have received inpatient or outpatient care from various subspecialties in the past.

General physicians as assigned consultants to acute surgical patients. General physicians might be routinely assigned to providing medical review and peri-operative care to all acutely admitted (ie non-elective) surgical patients who satisfy certain risk criteria (eg elderly age, more than one organ system disease, receiving more than 4 separate classes of medication, recent [<6 months] hospitalisation for acute medical condition). Early physician involvement in the management of such patients may assist in optimising patient outcomes, reducing length of stay, and decreasing costs, including those incurred by multiple referrals to different specialists.

General physician triage of new patient referrals to hospital outpatient clinics. As a consequence of collaboration between general physicians and specialists, criteria might be formulated which determine which patients of those referred to hospital clinics may benefit from first being evaluated at general medical clinics before being referred to already burdened specialty clinics. In a similar fashion, general practitioners considering referring patients to hospital for admission and wanting to access specialist opinion might be directed in the first instance to a call centre or triage desk supervised by general medical registrars or consultants who would decide whether patients required admission and to which unit, or whether patients could be safely assessed at a fast-track general medical clinics supervised by general physicians.

Alliance between general physicians and other 'generalist' disciplines. As a result of the more central role played by general physicians in the care of patients admitted to hospitals, there

would need to be closer collaboration with other key 'generalist' specialist groups involved in inpatient care, namely emergency medicine, intensive care and geriatric medicine. Dual certification of trainees in these disciplines, shared training programs, and more formal and regular communication between executives of IMSANZ and SAC in General Medicine and their counterparts in the other three disciplines need to be strongly promoted.

Implications of new models of care for physician training programs

As a consequence of these proposed changes to existent models of care, there would need to be changes in the physician training program in order that the appropriate number of appropriately trained general physician trainees are made available. Some of the changes that might be required are as follows:

Training pathways and mentoring schemes for general physician trainees. The increased number of advanced trainee positions in general medicine mandated by these new models of care should require creation of new general medicine trainee positions in regional and community hospitals as well as in tertiary hospitals. Given the necessity of specialty exposure in the second year of general medicine and immersion in the specialty of interest thereafter, a co-ordinated approach to training programs which involves close networking between tertiary and non-tertiary hospitals is vital to ensuring that a training pathway for each trainee is mapped out and adhered to over a 4 year period. Particular emphasis should be given to establishing as many training positions as possible in accredited non-tertiary metropolitan and provincial hospitals.

In addition, IMSANZ would propose that a mentoring scheme be established whereby trainees pursuing a career in general medicine be encouraged to seek out a senior mentor who can provide personal and professional support and ensure that the trainee's needs are being met as he/she tracks through the training pathway.

Increased number of specialty registrar positions reserved for general physician trainees. Specialty units would need to reserve a greater proportion of their advanced trainee positions for:

1. trainees seeking dual certification in general medicine and that specialty; and
2. advanced trainees seeking certification in regards to the 3-6 month specialty rotations mandated in the second year of general medicine training.

Changes in role of specialists viz-a-vie general physicians. Specialists may need to take on more of a consultative and educative role with respects to the care of patients with chronic illness and multiple system problems and less of a directly supervisory or 'hands-on' care role. In this way, more of a specialist's time could be redirected to managing patients with complicated or rapidly advancing single organ-system disease while delegating the care of patients with more stable or less progressive illness to general physicians whose skills in managing that disease would be maintained by the use of guidelines, protocols and other decision supports developed in collaboration between specialists and general physicians. Members of IMSANZ have been actively involved in CSSP projects and other activities where such collaboration has yielded improvements in care and better communication and co-ordination of care between general physicians and specialists.[15]

Intensification of upskilling and quality improvement programs. There should need to be more intense development and implementation of clinical practice guidelines, update courses and workshops, clinical decision support tools, quality improvement programs, and self-directed learning packages on the part of both IMSANZ and specialty societies in order to ensure that this upskilling of general physicians is achieved. Such a need has been strongly voiced in the respondents of a questionnaire survey of practising general physicians.[16]

Accreditation of general physicians acting as trainee supervisors. General physicians who would act as supervisors and consultants to advanced trainees in general medicine should be expected to maintain a high level of knowledge and skill in the management of a diverse array of common clinical conditions. This should be in addition to the guarantee that such physicians are active participants of the college MOPS program. IMSANZ and the SAC in General Medicine should implement strategies that aim to ensure that all general physicians in such positions commit themselves to an individualised program of professional development and peer review.

Development and implementation of an academic agenda in general medicine. In promoting the academic profile and knowledge base of GIM, general medical units and general physicians would need to design, implement and participate in a teaching and research agenda that is unique to GIM. The sciences of diagnosis, prognostication, clinical reasoning, clinical pharmacology, obstetric and perioperative medicine, utilisation and audit, quality improvement and cost-benefit analysis are areas where practitioners with generalist skills and outlook are capable of making significant contributions in applied clinical knowledge. In particular, Divisions of Medicine, university departments and research centres in the major teaching hospitals, and the college more generally, should actively enlist and support those general physicians capable of conducting programs in teaching and research in GIM.

Changes in basic physician trainee enrolment and training. Given that a prime aim of these proposals is to increase the numbers of general physicians working in regional Australasia, the college should consider implementing (or at least trialling) a preferential entry scheme into physician training for those from rural and provincial locales or those committed to practising in such areas. In addition, in order to prevent those with active interest in general medicine at enrolment from losing that interest during their first 2 or 3 postgraduate years, they should be accorded preference in the allocation of rotations to non-metropolitan hospitals during basic training.

Global view of changes in general medicine

The above proposals are not without precedent in other parts of the Western world. For example, in the UK, the Royal College of Physicians are revamping their advanced specialty training program to include more time in general medicine and for trainees to seek dual certification in general medicine and a specialty.[17] In 2000, a full chair in general medicine was established at the Harvard Medical School charged with the resurrection of the teaching and graduation of general internists.[18] In New Zealand, general physicians have constituted the cornerstone of the specialist medical workforce for the last 30 years with no apparent decline in professional standards or clinical outcomes compared to Australia.[19]

Convincing fellows and advanced trainees in both GIM and specialty medicine of the merits and feasibility of the above proposals will not be easy. Many political and logistical obstacles should need to be overcome. However, the need for change has been convincingly presented in other papers at this forum and the RACP is obliged as the bearer of standards in specialist medicine to provide a considered and workable response. IMSANZ stands ready to work with and support the college in its endeavours. The following quotation serves to provide inspiration: "It takes a lot of courage to release the familiar and seemingly secure, to embrace the new. But there is no real security in what is no longer meaningful. There is more security in the adventurous and exciting, for in movement there is life, and in change there is power."[20]

Appendix 1. Acute medical presentations, which may require early consultation between general physicians and specialists. *(This list focuses on common conditions and is not intended to be an exhaustive list)*

Neurology

Acute severe neuromyopathic weakness suggestive of acute neuropathic and/or myopathic process or cord compression syndrome that places the patient at risk of ventilatory failure or irreversible neurological damage (eg. suspected acute myasthenia gravis, Guillain-Barre syndrome, etc).

Gastroenterology

Haemodynamically compromised acute upper GI bleeding ie. BP <110/70 (although threshold could be higher in elderly patients), pulse rate >90, haemoglobin less than 11 grams/1 or more than 2 grams less than previous baseline, or patients with ongoing significant haematemesis/malena).

Acute hepatic failure: Hepatic synthetic dysfunction consisting of hepatic encephalopathy; gross jaundice (serum bilirubin >40 mmol/l), corrected prothrombin ratio >2, serum albumen <25grams per litre.

Respiratory

Respiratory arrest or near-arrest (most of these should first go to intensive care).

Acutely dyspnoeic patients (including asthmatics) who present cyanosed or have other clinical features or arterial blood gas results suggestive of acute respiratory failure, or any patient who has the potential for rapid deterioration on the basis of past history or lack of response to immediate intensive bronchodilator therapy.

Severe, life-threatening pneumonia as defined by the following clinical features: systemic hypotension, confusion or altered level of consciousness in non-elderly patients with no other underlying causes, extensive bilateral or multilobar involvement.

Large-volume (>200mls) haemoptysis.

Cardiology

Acute coronary syndrome in patients in whom early invasive intervention is being considered.

Cardiac arrest or cardiac arrhythmias, which are potentially life threatening or associated with major haemodynamic instability.

Endocrine

Diabetic patients with diabetic ketoacidosis.

Thyroid storm or severe hyperthyroidism with overt cardiac, psychiatric, ocular or neurological complications (e.g. cardiac failure, psychosis, marked proptosis and/or visual impairment).

Myxoedema coma or pre-coma

Newly diagnosed acromegaly or other pituitary tumours, Cushing's syndrome, Addison's syndrome, pheochromocytoma, diabetes insipidus who present with clinical features of decompensation or complication.

Renal

Acute progressive renal failure (serum creatinine $\geq$ 0.3mmol/l) in patients with previously normal or stable renal function and in whom pre-renal and post-renal causes have been excluded.

Acute nephrotic syndrome presumed secondary to primary renal disease in the absence of predisposing systemic illnesses.

Any patient with acute or acute-chronic renal failure that may require dialysis to treat uid overload, congestive heart failure, life-threatening hyperkalamia or accelerated/malignant hypertension.

Haematology

Undiagnosed significant pancypopenia (two or more of the following: haemoglobin <90; WCC <2.5; platelet <15).

Undiagnosed marked neutropenia (WCC <1.5).

Undiagnosed isolated marked thrombocy-topenia (platelets <5) associated with overt bleeding or high risk of serious spontaneous bleeding.

Acute leukaemias.

Prepared by Ian Scott in consultation with IMSANZ Council, 04/03/03

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Attributed to Alan Cohen.

GENERAL MEDICINE IN NEW ZEALAND - AN OVERVIEW

- The problems are not new, only more pressing in their demands to be solved.
- Although General Medicine is recognised as having a stronger voice in health delivery than some parts of Australia, performance is patchy.
- The strength of General Medicine varies in tertiary hospitals, secondary and provincial hospitals.
- Delivery of healthcare is altered by other spheres of in uence (particularly EM and subspecialty groups).
- There are encouraging signs of enhanced GM involvement, particularly in the major hospitals. The development of Admission/Assessment and planning units, run by inpatient services, is likely to promote such improvement.
- Increasing involvement of physicians in clinical governance, has improved performance and quality of care.

Positive Aspects Of General Medicine In New Zealand

- Remains a strong player in most large hospitals (including tertiary institutions).
- Strong performance in provincial hospitals.
- Enhanced collegiality (for physicians and trainees) because of formation and popularity of IMSANZ.
- Increasing popularity of General Medicine as a career option (see paper J Gommans).
- Recognised by the majority of Health Boards as an important contributor to service delivery (cost effective).
- Recognised by the University as the most crucial group to provide undergraduate teaching.
- Significant co-operation between General Medicine and subspecialty services (with some notable exceptions).
- Major resource for training and exam preparation of advanced trainees.

Negative Aspects Of General Medicine In New Zealand

- Heavy workload, with relatively poor remuneration and peer recognition.
- Constant 'picking away' at General Medicine territory by both EM and specialty groups.
- Differing hospital settings require different solutions – no generic solution for all.
- Increasing involvement of subspecialists with an 'interest' in GM rather than the other way round.
- Academic General Medicine units being led by subspecialists with varying expertise in GM, and vested interest in promotion of their own specialty.
- Increasing loss of continuity of care.
- Quality of life issues, with heavy weekend work commitments.

Enhancing General Medicine In New Zealand

- Promote role of 'Co-ordinators of Care' and enhance concept of 'shared care'.
- Increase numbers of acute care Physicians, preferably in Admission/Assessment and Planning Units.
- Impress on Management the quality and cost effective nature of General Medicine care.
- Work closely with EM physicians at the front door to achieve 'seamless' process of patient care.
- Work with specialists and refer early in appropriate situations.
- Look closely at remuneration to make sure GM is not disadvantaged.
- Develop innovative rosters for junior staff to provide more 'grunt at the front' (recognising difficulties in union demands).
- Continue to promote "Champions" in General Medicine, providing role models for younger doctors.
- Enhance private practice opportunities.
- Upgrade GM as a specialty in its own right.
- Stress importance of Ward based teams to limit "continuity of care" concerns.
- Allow "time off ward" with teaming to provide in-house cover.
- Development of enhanced Research Capacity, with improved clinical audit. (Improved IT will help in information gathering).

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TRAINING OPPORTUNITIES

What makes New Zealand a successful model?

General Internal Medicine (GM) has always been strong in NZ and the number of advanced trainees (ATs) choosing GM remains high (37% of all ATs in NZ) and is increasing. Many factors contribute to this including hospitals that are a "natural" size for GM resulting in strong departments in most hospitals, ample exposure to GM during basic training, access to hospital based outpatient clinic experience, the rapid uptake of dual and post FRACP training and good support for GM from the NZ committee of the RACP.

The population distribution is such that 15 of the 21 District Health Boards have base hospitals that are a natural size for departments of medicine to be largely staffed by general physicians (+/- a specialty interest). Most of the larger hospitals providing tertiary services with specialty units also have strong departments of GM. Because many NZ physicians need (and have) expertise in GM and do general medicine acute call there is a continuous demand for replacement physicians with GM expertise, hence excellent job prospects exist. A recent survey (1) of Australian ATs in Geriatric Medicine confirmed that 2/3 made their specialty choice prior to FRACP part 1 and factors strongly contributing to AT choice included exposure to the specialty at registrar level (73%) and specialist role models (61%). The widespread prevalence of GM in NZ ensures that our junior doctors have ample exposure to GM during basic training - 90% of current NZ trained ATs have at least 12 months exposure to GM during basic training and at least 6 months at registrar level. As most publicly funded outpatient clinics occur within public hospitals our trainees also have good access to outpatient clinic experience.

Dual training is a significant contributor to the dramatic growth in ATs under the SAC in GM (more than doubling between 1998 and 2003). This trainee driven initiative resulted from those recognising their need to be competent in GM as well as their subspecialty, in particular those wanting dual recognition of Geriatric and General Medicine training. In 1998 the SACs in GM and Geriatric Medicine established agreed rules for dual training and ATs voluntarily extended their training time to satisfy these. AT demand has resulted in expansion of dual training to include other SACs. In 2003 half (37/72) of the ATs in GM are undergoing dual training involving 8 other SACs. Post FRACP supervised training has also allowed ATs to complete or expand their GM training. The SAC in GM also adopts a exible approach and agrees to supervise "orphan trainees" – those not yet accepted into or doing runs not consistent with chosen specialty SAC training programmes or ATs who change their mind part way through specialty training. These ATs are encouraged to continue on with general or dual training.

Problems do exist. The perceived status of GM amongst other specialists, their trainees and specialty SACs discourages some ATs while the increasingly prescriptive training programmes of some SACs and pressure to do "pure" specialty training hinder dual training despite strong RACP (NZ committee) support. It is sometimes difficult to ensure that ATs in GM get equal access to specialty training posts and that this training is of the same quality and degree of supervision as specialty ATs. The major demand for general physicians is in the provinces but the vast majority of GM training occurs in tertiary centres. This, combined with significant migration of new physicians overseas results in some recruitment and retention problems.

In summary NZ does well at training in GM largely because GM is widespread and strong departments exist, job prospects are good and basic trainees are exposed to and subsequently choose GM for AT, increasingly with dual training. If strong departments of GM did not exist it is difficult to see how ATs could be exposed and attracted to, let alone trained in GM!

DR JOHN GOMMANS
Chairman, NZ SAC General Medicine

FOOTNOTE

[1] Hilmer S. et al. Why do Physician Trainees select Geriatric Medicine – ASGM, Darwin 2002

A TRAINEE'S PERSPECTIVE OF GENERAL INTERNAL MEDICINE

Why choose Internal Medicine?

Interim Trainees in General Medicine

As is well known, many trainees supervised by the Specialist Advisory Committee in General Medicine are not dedicated trainees in Internal Medicine. Some of the reasons trainees will choose to do an interim year of advanced training in general medicine include:

1. To have a year of accredited training while awaiting a training position in another subspecialty.
2. To have the year of their FRACP examination accredited as a year of advanced training.
3. To spend a year trying out a number of subspecialty areas to make a decision regarding the most suitable career path.

These trainees have definite needs that need to be considered by the college before making any changes to the current training structure.

Dedicated Trainees in Internal Medicine

I am aware of 18 current or recently graduated trainees in internal medicine. The reasons for choosing internal medicine training include:

1. To gain broad experience and procedural skills for rural and provincial practice.
2. To provide a base for developing special interests in perioperative medicine, obstetric medicine or medicine in disabled people.

3. To complement research interests in health systems, public health, or evidence based medicine.
4. To combine with subspecialty training.

Several trainees who initially felt that training in internal medicine was a reasonable option have decided that the best approach is to a keep a "foot in both camps" and pursue combined training in internal medicine and a subspecialty.

Other factors that in uence the decision to pursue training in internal medicine include:

1. An interest in the "breadth" of medicine.
2. Excellent general physician role models (this is certainly the case in Queensland).
3. A belief that general physicians have an important role in the provision of health care. Many trainees are concerned that the involvement of multiple subspecialists results in fragmented care, which can be overcome by the involvement of a well-trained generalist.
4. Abundant employment opportunities, both in the private and public sector.
5. Flexible training, which is particularly suited to those that have special interests, family commitments or other lifestyle requirements.

Challenges in Training in Internal Medicine

Many trainees who initially decide to pursue a career in Internal Medicine revisit this decision. Some simply "jump ship" and decide that the problems of training in internal medicine are insurmountable, and they will be better served by a well-defined subspecialty. Others "believe" that internal medicine is important, but to keep their sense of self worth intact, decide that they will be best served by combining both internal medicine and a subspecialty.

Some of the major challenges are as follows:

1. Trainees in internal medicine are usually offered rotations that have not been filled by subspecialty trainees, who are routinely given preference (even when the advanced trainee in internal medicine is a superior candidate).
2. Trainees in internal medicine have difficulties accessing high quality, well-supervised procedural training.
3. Trainees who have chosen internal medicine need a robust self-esteem and an unfaltering belief that what they have chosen is worthwhile. Subspecialists frequently denigrate the role of general medicine, and make trainees feel that training in general internal medicine is a waste of time. Advanced trainees in internal medicine require an enormous amount of mentoring and counseling regarding these issues, even in hospitals where internal medicine is well established.
4. There is a sense that training in internal medicine is for those who have failed to gain a more "prestigious" subspecialty position. In my experience, this is rarely the case, and many excellent trainees choose internal medicine, because they feel that the holistic care they can offer is a worthy pursuit. In addition, almost half the advanced trainees in internal medicine that I know are holders of first-class honours degrees. Despite this, many trainees find the perception that they are academically challenged or unable to gain a subspecialty training position very confronting.
5. Although many trainees choose internal medicine because it is exible, and caters to a wide variety of interests, some trainees find that the lack of a clearly defined training program is a barrier,
6. Usually subspecialty trainees are surrounded by an enthusiastic collegiate environment and have specific educational meetings to cater to their learning needs. In contrast, advanced trainees in internal medicine often lack a sense of "belonging" to a community of senior colleagues and do not have unique educational meetings to cater to the specific needs of a generalist.

Selection Processes in Internal Medicine

Undergoing a proper interview process to gain a training position in internal medicine is an important component of validating the career choice of the trainee.

Previously, at the Royal Brisbane Hospital, advanced trainees in internal medicine were welcomed with open arms, and there was no formal selection process. The problem with this approach was that it denied trainees the important experience of attending an interview. It also contributed to the sense that internal medicine would accept any trainee, regardless of their suitability.

There is ongoing debate regarding the role of centralized selection processes. One of the considerations in this debate that is important is the issue of "quarantined" subspecialty training positions for advanced trainees in internal medicine. Resolving this issue is a key component in improving the opportunities for trainees in general internal medicine.

What do Trainees in Internal Medicine Need?

1. A well defined set of training options, which provides both a clear training pathway, but is also exible enough to cater to the unique requirements of some trainees.
2. "Quarantined" access to procedural and subspecialty training.
3. A sense of "belonging" to a worthwhile community of likeminded colleagues.
4. A sense that general internal medicine is a worthy career choice.
5. Regular meetings that address the specific educational needs of advanced trainees in internal medicine.
6. Formal selection processes, recognizing that not all applicants will be suited to the "subspecialty" of internal medicine.

Should all trainees in Internal Medicine spend part of their advanced training in rural or provincial locations?

This is obviously a difficult issue. If trainees in internal medicine were the only advanced trainees who have a "compulsory" component of rural training, then I would predict that a substantial number of trainees would choose another specialty.

Trainees who harbour thoughts of rural and provincial practice should be pro-actively identified, and nurtured. They should be provided with first class training opportunities, and have significant efforts spent on tailoring the perfect training program. The Victorian Rural Physicians Network seems to have made excellent progress with this model. Forcing unwilling trainees to rural and provincial locations is unlikely to result in any long-term workforce solutions.

Parenting is a major issue for many trainees, who have already endured the difficulties of rural secondments during basic training and the complete life disruption associated with RACP examinations. Given that nearly 50% of trainees are women in their late 20's and early 30's, serious consideration needs to be given to the impact of decisions about the nature of advanced training on the issues of child bearing and raring. This is particularly important for general medicine, as many trainees choose general internal medicine because it seems to be a reasonable solution to achieving "work life balance".

Should training in Internal Medicine be increased to four years?

Given the reduction in working hours, and increasing medical knowledge, this may be a reasonable consideration. In addition, strengthening training in internal medicine may help to overcome some of the problems with the perception that this is an "easy option".

However, there is currently **NO** evidence regarding how long one should train to practice as an independent physician. Clearly there are many aws in prescribing a period of "time", but this has been a practical approach, given that the much more useful, but elusive problem of defining competence is a difficult issue.

Australian physicians already spend more time in training than virtually anywhere else in the world (with the exception of the United Kingdom). In the face of emerging workforce shortages, there would need to be very clear evidence of benefit to justify lengthening of the training program. I am not aware of any recently graduated trainees who clearly needed a longer period of training.

The college has enormous power over trainees, who are consumers of the "training and educational products" of the college. If training was lengthened, this would have implications regarding income, family planning, research and other pursuits. I strongly believe that if an "intervention" such as increasing the period of training is enforced by the college on its relatively powerless consumers (trainees), that there should be very good evidence that there is clear educational benefit. The problem that all educationalists grapple with is that some trainees will be competent after two years of training, whereas others might never be competent. We need to develop innovative training solutions to deal with this problem.

If training in internal medicine took longer than training in other subspecialties, this would make internal medicine much less attractive.

Should all trainees in Internal Medicine do dual training?

Many trainees are choosing this approach. The advantage of insisting on dual training is that this raises the profile of general medicine, and makes it clear that specialists in internal medicine are capable of subspecialty work.

One of the problems is that many tend to end up predominantly practicing in their area of subspecialty, and general internal medicine comes a distant second or is lost altogether.

There is plenty of demand for well-trained specialists in internal medicine. To gain employment, or work in the private sector, there is currently no need for additional subspecialty training.

Once again, proscriptive training requirementssuch as this may mean that even fewer trainees choose internal medicine. One of the challenges is to ensure that training meets the requirements of the individuals who want to practice internal medicine. One of the risks is that developing a well constructed, exible, attractive training program may fall prey to a variety of political agendas, which although important, do little to improve the attraction of general medicine.

DR LEONIE CALLAWAY
3rd Year Advanced Trainee in Internal Medicine
Obstetric Medicine Fellow
Mater and Princess Alexandra Hospitals, Brisbane

POTENTIAL OUTCOMES FROM GENERAL MEDICINE FORUM

The General Medicine Forum was held in Sydney on Thursday 20 March 2003 with the morning session covering current and future workforce issues, and training issues in the afternoon session.

Due to time constraints, the planned panel discussion on recommendations, priorities and implementation did not occur.

We have the opportunity to consolidate the issues presented and prioritise the recommendations, and encourage implementation of these recommendations

The RACP Specialties Board meeting on Friday 2 May will hold focus sessions on

- the outcomes from the General Medicine Forum, and
- the role and interaction between the College, the SACs and the Special Societies

Draft Document for Potential Outcomes from GMF

I would like to propose a framework for discussion and suggest outcomes and priorities should be considered along the following guidelines:

- Global Issues
- Australian Federal Government Issues
- New Zealand Government Issues
- Australian States and Territories Issues
- University and undergraduate training issues
- State Hospital training issues
- The RACP College issues
- Issues for SACs
- Issues for Special Societies
- Trainees – basic and advanced training issues
- Rural Training and Workforce

Introduction

Embrace the "Physician Within"

There are significant numbers of Fellows in the College who acknowledge their role in General Medicine – in the 2001 Clinical Workforce Survey:[1] 474 physicians indicated they were primarily involved with General Medicine or with a specialty interest. A further 519 indicated Specialist practice with general responsibilities. (Total Adult Physicians in Australia: 3387 – 474 General Consultants, 2913 Specialist Physicians – 519 with general responsibilities).

This would suggest nearly one in three physicians have experience in General Medicine. If we can enhance this broad spectrum of experience and embrace the "Physician Within" we will be able to acknowledge the depth and breadth of experience in general medicine of physicians within Australia and NZ.

It is important to stress the "physician within" concept i.e. that all physicians are, to greater or lesser extent, general physicians, both in training and in practice. Taking such a stance may reduce the division between generalists and specialists. "General" medical services can be suitably delivered by a variety of physicians, with appropriate training and experience.

In conjunction with the above, there might be an increased emphasis on specific strategies to address:

- Training etc in acute care medicine (along the lines of the RCP document on this topic which I think is excellent). This not only might address the issue of who looks after the patients who present at the "front door" but may assist in "clawing back" some of the ground previously lost to ED doctors;
- Specific training for physicians in rural or isolated practice. The NZ model of training jointly in General Medicine and a subspeciality might best address this;
- 'Physicians need to come together to design systems of care to maximise long-term health of patients'.[2]

Global Issues

There is a global shortage of trained medical personnel – doctors, nurses and allied health professionals. The ageing world population will exacerbate this trend. Countries can no longer expect to fulfil their quotas for clinicians and health care workers from overseas countries.

The UK has acknowledged the need for an additional 15,000 doctors in the next five years. New medical schools have been established in an attempt to increase numbers of medical graduates. However, there will be a minimum of 15-17 years from the commencement of medical school until commencement of practice as a Consultant Physician. There are 26,000 overseas trained doctors (OTDs) occupying medical posts in the USA, indicating a significant shortfall in self-management potential.

Australia has 2,600 OTDs, although this figure significantly underestimates the number of doctors, including urban and rural physicians required currently in Australia. The Internal Medicine Society of Australia and New Zealand survey[3] estimates a shortage of at least 170 general physicians presently.

Recommendation:

- Increase undergraduate and postgraduate training opportunities within Australia and New Zealand in an attempt to ensure self-sufficiency in medical, nursing and allied health fields.

Australian Federal Government

There is an urgent need to enter ongoing dialogue with the Department of Health and Ageing to reinforce the role of the Consultant Physician in General Medicine in the Australian Health care system.

The College should engage the department in constructive dialogue in all areas of mutual interest including:

- Recognise that efficiencies and economies result from Physicians with general medicine training (a subtle but, important difference) providing 'whole patient' health care
- Promote efficient use of health care resources and maintain highest standards of care
- Achieve meaningful population health goals
- Recognise health consumers role in determination of appropriate care delivery mechanisms
- Rationalise acute care services – see general comments
- Facilitate technological developments
- Achieve economies of scale
- Recognise community demands for locally accessible, whole patient health care services
- Recognise Physicians with general medicine training are key participants in all aspects of health care including clinical epidemiology and critical appraisal, ethics, clinical informatics, health technology assessment, clinical audit and health service research

- Aim to~~i~~ enhance and provide physical infrastructure and human resources for the practice of internal medicine in non-metropolitan localities

Recommendations:

- The Royal Australasian College of Physicians should engage the Department of Health and Ageing in meaningful, ongoing discussions on the role of physicians in general medicine in the delivery of high quality health care in urban and rural Australia, and aim to enhance the training and workforce opportunities on each occasion.
- There is a need to address the specific issues of training, recruitment and retention in areas of Acute Care Medicine and Rural/Regional Medicine.

New Zealand Government

The role of the Physician with general training in New Zealand medicine has been appreciated and enhanced with training and employment opportunities. However, there is a relative paucity of trained physicians in New Zealand and the Government should be encouraged to increase training and workforce opportunities.

In the Clinical Workforce Survey 2001 there were 450 adult physicians – including 89 general physicians for a NZ population of ~4.3 million Maori and non-Maori inhabitants (vis Victoria, Australia ~ 4 million inhabitants with 1065 physicians – 52 in rural Victoria serving ~1.3million population, with a subsequent relative maldistribution of workforce.) There may well be a similar maldistribution of workforce and significant 'unmet needs' for inhabitants in regional and rural New Zealand.

There are increasing numbers of Advanced Trainees entering dual training programs in New Zealand – ie General Medicine and a Specialty, thus graduating with Dual Certification. This trend is to be encouraged, but does prolong the training program – addressing this issue could be one of the specific roles of the College. The Advanced Trainee program needs to be reassessed and consideration given to combining AT programs, or extending all programs to take into consideration shorter working hours, and part-time or interrupted training programs.

Recommendations:

- Assessment of New Zealand urban, regional and rural health workforce requirements for optimum healthcare delivery.
- Recognition of the physician with general medicine training as being able to provide efficient and economic 'whole patient' health care.
- Increase training and workforce opportunities for Physicians in general medicine.

Australian States and Territories Governments

The States and Territories Governments have delineated responsibilities in providing health care to the Australian population in urban and rural Australia. The Australian Health Care Agreements are negotiated each five years and provide the basis for funding health care services, including training and workplace opportunities. The New AHCAs are due to be enacted in the May 2003 budget.

If there are increased medical graduates in the foreseeable future, then there will need to be additional funding for postgraduate training posts. The recognition of the need to provide adequate infrastructure, personnel and equipment, with funded maintenance and replacement programs will require negotiation with the States and Territories.

The provision of health services to non- urban areas requires specific consideration and negotiation.[4]

The seamless delivery of health care with minimisation of artificial boundaries – eg cross border issues needs to be pursued by all stakeholders.

Increased service delivery to regional, rural and remote communities needs to be actively promoted. The Rural Physician can be a General Physician or a Specialist Physician with general responsibilities and has a major role in the provision of health care services to people in their local environments.

If people require transport to treatment centres, specific arrangements need to be developed to ensure adequate access to appropriate and timely health care services.

Recommendations:

- The College, and State Committee representatives to work closely with State and Territory Health Authorities to determine appropriate health care delivery in urban, regional, rural and remote locations.
- Promote the development and establishment of suitable general medical services to stress the "general physician within " concept (acknowledging that there are a number of models of a suitable service in tertiary teaching centres), to ensure appropriate, cost effective 'whole of patient' care.
- Ensure general medical units are available for postgraduate training to provide adequate numbers of physicians for the workforce in urban and rural settings.
- Work closely with Authorities to maximise cost-effective care delivery for all patients in hospital and ambulatory care settings.

University and undergraduate training issues

There is the capacity within the current University medical schools to increase intake and provide additional training places. If the entry level is redefined and interview and assessment processes continued there is the potential to increase undergraduate and postgraduate places. Currently 77% of applicants to the medical course are not accepted, even though they have achieved the minimum entry score suggested by the Universities.[5]

There will be a need for additional funding for infrastructure and educational personnel to provide the teaching, tutoring, mentoring and guidance required by the course. There will be requirement

for support for existing and development of new training positions in urban and rural hospitals and ambulatory care settings with equipment, computers and IT, and infrastructure support. Physicians with general training provide excellent teaching and clinical guidance, as they are able to provide a broad perspective on the whole of patient care.

Recommendations:

- Increase medical school intake to increase medical graduates and workforce, realising the significant delay of 15-17 years from medical school intake until admission to Fellowship and commencement of Consultant Physician practice.
- Universities, clinical schools and teaching hospitals- urban tertiary and secondary and rural hospitals and ambulatory care settings cooperate in developing long-term viable plans to increase capacity to teach and supervise increased number of medical, nursing and allied health students- including provision and update of adequate teaching resources.
- Expand or re-establish academic general medical units in universities and teaching hospitals.
- Maintain, expand or re-establish General Medical Units in metropolitan teaching hospitals.
- Expand General Medical units in non- metropolitan hospitals and rural health services.

State Hospital Issues

All hospitals can be considered as teaching hospitals – the level of supervision, quality of experience and value of the attachment will vary between hospitals and locations. Similarly, the duration of the attachment, and the ability to work with minimal supervision in the ambulatory care setting all need to be assessed.

General medical units are able to provide a depth and breadth of experience in managing patients with a wide range of complex medical problems and expansion and upgrade of these units is to be encouraged.

Recommendations:

- Develop General Medical units, which are the primary receiving units who accept, assess and supervise management of all patients admitted to hospital.
- Determine protocols and pathways to ensure all patients receive optimum and appropriate specialist medical care.
- Ensure early and appropriate referral to Specialty medical units, as clinically indicated.
- Develop and integrate perioperative care programs by GMUs.
- Develop training programs and rotations for general medicine advanced trainees.
- Training, service appointments and workforce planning should consider life, work and exibility issues and safe-working hours and on-call conditions.
- Maintain, expand or re-establish General Medical Units in metropolitan teaching hospitals.
- Promote the development and establishment of General Medicine Units in all tertiary centres for teaching, training, service and management of patients admitted with acute medical conditions.
- Expand General Medical units in non-metropolitan hospitals and rural health services.
- Liaise closely with Emergency Medicine units to optimise teaching and service provision.
- Encourage close liaison between Intensive care units, high dependency units, and critical care units.
- Determine which hospital level services are delivered more efficiently and cost effectively by general medicine physicians.
- Develop audit systems to identify where Generalist core is more cost efficient than specialist care. However, physicians must come together to design systems of care to maximise long-term care of patients.
- Increase cooperation between all medial specialties, 'silo'/ 'empire building' mentality and reappraise patient oriented management priorities.
- Align clinical and organisational goals.

Issues for the Royal Australasian College of Physicians

The College is the key educational and certifying body in Australasia with a coordinating role in training, continuing professional development and workforce issues for physicians of all Specialties, including General Internal Medicine.

The College has viewed this pivotal position as essentially a passive, integrative role, rather than directive role. However, with the changing roles envisaged, as expressed for the impending AMC Accreditation in 2004, the College will have a potentially more directive and supervisory role. Currently this position is devolved to the Special Advisory Committees and the supervisors of training.

The College will need to establish a lead role in establishing training and workforce requirements for Australia and New Zealand.

Recommendations:

- The College promote and support development of general medical training in all teaching hospitals – urban and rural locations.
- Training to be a priority to ensure adequate workforce physicians to provide clinical services for urban, rural and remote communities.
- *Facilitate integration of training between SACs and Specialty units.*
- *Ensure adequate training positions for GIM trainees.*

- The College should encourage training in general medicine plus a specialty.
- General medicine training be closely allied with geriatric training.
- Encourage Hospitals to establish and maintain General Medical Units.
- Acute general medicine becomes a recognized area of training and practice.
- Establish discussions with interested parties in Acute Care Medicine - integrate training with Colleges of Emergency Medicine, Intensive Care and Cardiology and develop dialogue with Aged Care Medicine to establish acute care guidelines for elderly patients.
- Council, AMDC and Specialties Board to initiate and facilitate ongoing discussions to ensure general medicine training for basic trainees.
- Promote development of training programs in all States and territories, and New Zealand, to ensure all advanced trainees have opportunity to experience general medicine, in addition to specialty practice, and develop "the physician within"[5].
- Actively explore processes to promote retention of current physicians and to extend functional working lifespan for senior Fellows.
- Develop new career pathways to promote changing clinical practice models with increasing seniority.
- Provide retraining and upskilling opportunities for physicians contemplating change from specialty interests to practice in general medicine.

Issues for SACs

The Special Advisory Committees hold a strong position in the hierarchy of the College training program, determining requirements for training and advising on those who have completed their prescribed course work and achieved Fellowship. The SACs see themselves as the last bastions of Puritanism, protecting their domains, and ensuring the ATs in their SAC receive the best training possible, to the exclusion of those in GIM unless they are profane to be 'committed' specialists.

The College needs to provide "guidance" for their SACs with respect to the elective year, the duration of training for joint general medicine/specialty training etc

Recommendations:

- Engagement of the SACs in discussion, and promote enhanced horizontal integration of training opportunities and goals.
- Open training programs to enable joint training in General Medicine and Specialty Medicine.
- Encourage provision of training opportunities in Specialty units for those pursuing General Medicine or Rural Medicine careers.
- Training positions in specialty units be "ear-marked" for trainees outside that discipline eg for general medicine or another speciality.
- Ensure physicians promote the role and function of General Medicine at all levels of training.

Issues for Special Societies

The role of the Special Societies is to support and promote the specific interests of their members - both physician and non-physician members. It is essential for all members to respect other disciplines and specialties.

Recommendations:

- Whilst promoting excellence in specific interest areas Special Societies should encourage members to expand clinical horizons and develop competency in other areas of medicine – general or additional specialty.
- Promote recognition of importance of General Medicine, as a specialty field.
- Promote the development and establishment of General Medicine Units in all tertiary centres for teaching, training, service and management of patients admitted with acute medical conditions.

Trainees – basic and advanced training issues

Trainees, whilst developing skills and contacts in their chosen specialty, need to develop appreciation of the broader skills base needed by all specialities including General Medicine.

Recommendations:

- Develop Advanced Trainees committee to encourage interaction between trainees and College, SACs and Special Societies.
- Encourage BTs and ATs to consider career in General Medicine – see above.
- Encourage trainees in GIM to develop individual clinical career pathways.
- Develop training opportunities in conjunction with trainees, to re ect interests and career goals.
- Consult trainees, develop strategies to encourage career pathways in GIM, and provide mentors and career forums to discuss training progress and aspirations.
- Recognise hospital based training programs consist of a service component and opportunities for exposure to supervised training in disease management and procedural skills development.
- Regional and state based selection for training will develop three year rotational programs providing career pathways for trainees, providing certainty and planning for the training period, with the aim of the trainee entering practice in the fields of interest, in the region where majority of training conducted, especially rural medicine trainees.

- Work closely with BT's and AT's to ensure achievement of training career goals, satisfaction with selection of specialty training units and opportunities for development of skills in General Medicine.

Rural Training and Workforce

There are specific needs and skills to be acquired for trainees to confidently enter independent practice in rural, regional and remote Australia. These skills include ability to develop independent practice, with extensive network of distance-based consultation and contact with colleagues. The requirements for development of the multiple facets of physicianship enunciated in CanMEDS 2000 is essential in Rural based practice including medical expert/clinical decision maker, communicator, collaborator, manager, health advocate, scholar and professional

Recommendations:

- Develop and promote rural based training opportunities.
- Develop and promote consortia/liaison between tertiary centres, secondary metropolitan centres, and rural regional centres.
- Recognise General Medicine training provides an excellent basis for Rural Medicine practice, however Rural Medicine encompasses all Specialties and disciplines in medicine.
- Training opportunities should be promoted and enhanced for rural medicine trainees.
- Procedural medicine training needs specific opportunities for general and rural medicine trainees.
- The increased clinical workload, and experience, in rural training posts requires attention and discussion with trainees.
- Promote and support Departments of Rural Health and Rural Clinical Schools to ensure interest and commitment of training opportunities.
- Promote clinical and research opportunities in rural medicine.
- Encourage conjoint training opportunities for General and Rural Medicine trainees.
- Encourage joint training in acute medicine, interventional medicine, critical care medicine and develop expertise in multiple areas of acute and convalescent medicine.

DR LESLIE E BOLITHO
April 16, 2003

ENDNOTES

[1] Dent O Clinical Workforce Survey 2001 RACP
[2] Cram P, Ettinger WH Jnr.Physician Exec 1998 Jan-Feb; 24(1): 40-45
[3] General Medicine in Australia and New Zealand: the way forward 2000 RACP
[4] See Improving Rural Health AHCA www.health.gov.au/haf/ahca.htm....
[5] ABC Radio News 15/04/03

IMSANZ (NZ) UPDATE

At the Napier meeting, Phillippa Poole (Auckland) took over the NZ vice president role, following a sterling stint from Bruce King (Nelson). Fortunately for us all, Bruce has agreed to stay on as an IMSANZ councillor, for a further year. At the council meeting in Hobart, Briar Peat (Middlemore) was elected to the third New Zealand Councillor position. Graeme Dickson (Waikato) has agreed to take on the NZ Advanced Trainee position on the IMSANZ Council for the next year. We welcome the two new Councillors and will value their inputs into the key areas of focus this year. The IMSANZ president is now Ian Scott (Brisbane).

It was very sad to farewell Neil Graham (Tauranga) off the IMSANZ Council. For those of you new to IMSANZ, Neil was one of the founders of IMSANZ in 1997 and became the first New Zealand President in 1999. Neil has agreed to act as an elder statesman for us and I'm sure will keep us on track if we stray from core principles! Thanks to Neil for being such an enthusiast and mentor to many of us over the years. We look forward to your future input.

Heartening to see at the RACP meeting in Hobart in May was the taking seriously of three key issues for IMSANZ. The issues are interrelated and are:

* the importance of general medicine for Australia & New Zealand
* the rural specialist workforce
* training (both for basic and advanced trainees)

The time allotted allowed further in-depth discussion and a building on the momentum already obtained at the General Medicine Forum in March. Les Bolitho (immediate past president) has effectively brought these issues onto the agenda at various levels in the complex College committee structure, and will continue to do so. However, he can't do it alone and we all need to contribute and support the initiatives.

One of the key tasks this year will be to define the curriculum both in general medicine, and for those who are dual training. In New Zealand, we are very fortunate to have a close working relationship between IMSANZ and the SAC (General Medicine) and some exibility developing between some of the SACs. However, the impending AMC accreditation process in 2004 is acting as a driver for the College to demonstrate a more transparent and quality education process. This necessitates a close examination of the roles of all the bodies involved in the governance and delivery of physician training, as well as the training itself.

There is always incoming information for comment and input. I will send this out to you as it comes to hand. In the meantime if you wish to contact me (or other Council members) about any IMSANZ matters, email me at p.poole@auckland.ac.nz, or call 09 373 7599 ext 86440 or 86747 (sec).

See you at the joint RACP/IMSANZ meeting at Rotorua in early September, or at the March 2004 meeting in Nelson. Get those controversies ready, or risk being nabbed with ten days to go!

PHILLIPPA POOLE

FORTHCOMING MEETINGS

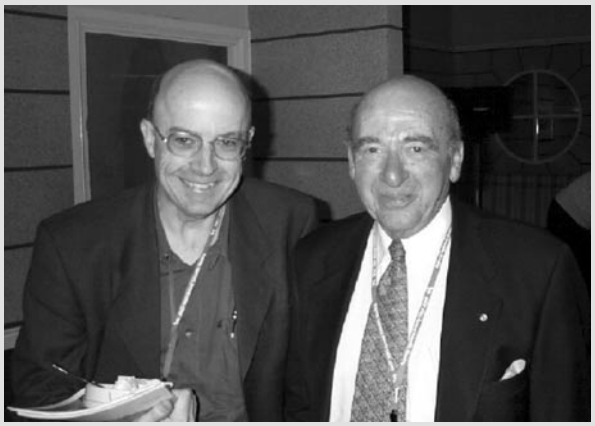
2003 - 2004

2003	**September 3-6**	**RACP New Zealand Annual Scientific Meeting, Rotorua** *In conjunction with IMSANZ, NZ Rheumatology Association and the Faculty of Rehabilitation Medicine* Topics to be discussed include: • In ammatory Mechanisms in Atherosclerosis • Vasculitis Update • TNF alpha Blockade- Clinical Applications • Practical management issues in osteoporosis. • Steroid induced Osteoporosis - Detection, Prevention, Management • Pathogenetic mechanisms in Giant Cell Arteritis & Polymyalgia Rheumatica • Controversies in Medicine Contact: Paul Reeve Phone: 07 843 8444 Email: Paul.Reeve@xtra.co.nz
	October 21-25	**Medicine & Pregnancy 2003, Esplanade Hotel, Fremantle, WA.** *Inaugural meeting of the International Society of Obstetric Medicine combined with ASSHP, ADPS, OMGA and Foundation Meeting of the Australasian Maternal Fetal Medicine Colloquium.* Contact: sneylon@racp.edu.au *or* www.racp.edu.au/asshp/map2003
	November 22	**Eleventh National Symposium on Hepatitis B and C** **St Vincent's Hospital, Melbourne** *International Speaker – Prof Christian Brechot.* Contact: Ms Eleanor Belot Phone: 03 9288 3580 Fax: 03 9288 3590 Email: belote@svhm.org.au
2004	**March 1-12**	**Cardiac Intervention and Wilderness Medicine on board 'The Peregrine Mariner' in Antarctica** Information: www.peregrineadventures.com
	May 17-19	**RACP Annual Scientific Meeting, Canberra**
	June 2-5	**ASMs of the Canadian Society of Internal Medicine and the Association of Internal Medicine Specialists of Quebec, Hilton, Quebec City, QC** Information: Canadian Society of Internal Medicine 774 Echo Drive, Ottawa, ON K1S 5N8 Phone: 613-730-6244 Fax: 613-730-1116 Email: csim@rcpsc.edu Website: http://csim.medical.org
	September 26 - October 1	**International Congress of Internal Medicine (ICIM)** **Granada, Spain**

Life Members

At the Annual General Meeting in Hobart on 26 May 2003 the first two life members of IMSANZ were honoured.

They are Prof Alex Cohen of Perth and Dr Peter Greenberg of Melbourne, both of whom were instrumental in the establishment of ASCPIGM (Australian Society of Consultant Physicians in General Medicine) which in 1997 became IMSANZ. The Council voted unanimously that their vision and hard work be recognised by the granting of life membership of the Society.



Prof Alex Cohen (right) with Simon Dimmitt.

Dr Peter Greenberg.

RACP Meeting Report - Hobart, 2003

This was my first trip to Tasmania, and I absolutely loved it! By taking the ferry from Melbourne to Devonport, and then driving through to Hobart I had the opportunity for a little exploring, as well as avoiding any other 'hijacking' attempts by people with sharp wooden objects on planes!

It was great being aware of such an IMSANZ presence at an Australasian College Meeting, and I think Les and his team did really well with their involvement in the programme. Sometimes I wonder if Australians forget that it is an Australasian not an Australian College, but think that I am thankful that I practice in the New Zealand system rather than the Australian one, where I can happily ignore the private system and be thankful that a public position can fund my lifestyle.

One of the things that I love about medicine is that there is always something different to focus on and learn about.

I have only relatively recently moved from the situation of no longer being overwhelmed by the responsibility of being "in charge" of the team on the ward round (really just focusing on patient care, and my own CPD) to being able to address one of the other roles of being a professional; that of a teacher.

It is a happy coincidence that the College has introduced, with the same theme as the Skills for the New Millennium (SNM) in New Zealand, a skills day as the first day of the meeting in Hobart.

I look at the "bright young things" working as registrars and house surgeons in our hospital, and recognise that our current system focuses much more on the science than art of practicing medicine. I feel hugely lucky to have worked with wonderful clinicians over the years, and really want to be able to share with my junior staff some of things they taught me. For me this is moving from a personal re ective practice, to a re ective practice for the whole team.

Hopefully my team will benefit from the changes in the way I am able to give feedback (the art of supervision intro to supervisors workshop) and planning of my teaching sessions (teaching on the run, and clinical teaching workshop).

Everyone needs regular reminders of the links between (lack of) communication and complaints and litigation. I was sorry not to get to the sessions regarding allocation of resources. As always the young investigator session was outstanding. It is wonderful that the level of research amongst trainees is so high. What is disappointing was that the session ran concurrently with the IMSANZ AGM... does it say something about our views on politics and business being more important than research?? I regret that I "lost" the other trainee presentation session in the programme.

The symposia run by the special societies were all worth attending as interesting updates and catch-up sessions. All cardiologists should have to work as generalists too... They should be reminded that for the majority of our patients, the heart is just the pump for transporting the drugs around the body!

I enjoyed the skills sessions, and thought that it worked well in combination with the ASM, but probably get more out of the smaller workshops at our SNM meetings - this year running at Huka Village, Taupo, 7th and 8th November.

After the break away, I am almost feeling ready to hit the ground running again!

KIRSTEN HOLST

Palmerston North, New Zealand

IMSANZ/ROCHE ADVANCED TRAINEE ABSTRACTS...

Five advanced trainees presented abstracts in Hobart to a packed audience (standing room only!) **Leonie Callaway** of Brisbane won the prize for the best presentation with Graeme Dickson of Hamilton, New Zealand the runner up. Our *congratulations* to them and all other trainees who presented.

Award winner Leonie Callaway with College President Robin Mortimer at the Adult Medicine Dinner.

CONGRATULATIONS!!

Thank you and congratulations to all members of the IMSANZ Council and Education Committee and all IMSANZ members who combined to ensure the RACP ASM Hobart 2003 was "the most successful ever" – according to an RACP Executive Member. We are awaiting the official assessment!

IMSANZ NEW ZEALAND VICE-PRESIDENT'S REPORT

I have had the pleasure of acting as NZ vice-president of IMSANZ for the past two years, during which time I think we have achieved a greater stability in the trans Tasman relationship and consolidated on the previous extensive work of Neil Graham and others during the early years of IMSANZ.

I am equally pleased to hand over the vice-president role to Phillippa Poole, who has agreed to take on this post as part of succession planning.

I report the activities of the New Zealand group for the past twelve months.

IMSANZ New Zealand

We receive a constant stream of information via the College, the Health and Disability Commission and the Ministry of Health on activities for comment, which I will report separately. The more generic Society issues have included communication with the Council for Medical Colleges regarding issues of internal medicine, particularly issues related to potential credentialling processes. This has been received and added to the Council of Medical Colleges discussion.

We have looked to consolidate the De Zoysa Trust Young Investigator's Award and awarded that last year to Dr Seshasayee Narasimhan. This will be awarded at the joint IMSANZ/RACP meeting at the end of each year to supplement the generous Glaxo sponsorship for the meeting earlier in the year.

We have been invited to send a representative to the New Zealand Medical Association Specialist Forum and Sisira Jayathissa has attended the past two meetings. It was agreed, in discussion with myself, that initial attendance be undertaken with a view to considering the question as to our ongoing long-term involvement. Sisira's opinion is that representation is appropriate and he has agreed to continue in this role. The meetings are held in Wellington and a Wellington representative has some attraction for this reason.

I attended the annual meeting of the New Zealand Specialties Board, which within the College has some alignment to the previously mentioned Medical Association Specialist Forum. This group is a College initiative of long-standing, to open channels of communication between specialist societies and the College. The chairmanship has recently been taken up by Dr Mark Lane and is another forum, in which I think representation should be maintained. Historically, this has been undertaken by the New Zealand vice-president, however in discussion with Phillipa, I would be happy to continue this as an IMSANZ representative.

We received documents from the College on recommendations towards improving the provision of physician services in small centers and rural New Zealand and we had several members on this working group.

A personal observation on the outcomes would be that there is insufficient detail in the recommendations to be of value to physicians working in rural environment, to use as part of any argument to support improvements in their situation. This, I suspect, was an opportunity missed but may well have been constrained by a College requirement.

The Paediatric Society of New Zealand has been active at a general and political front and produced a draft position statement to which we replied, generally supporting their development of Paediatric Services and also supporting the development of appropriate systems to meet the needs of young adults in a transition between paediatric and adult services. We did, however, mention that these transition pathways need to be developed in local environments and not be based entirely on a tertiary-care model.

Once again, through the College, the Health and Disability Commissioner requested a list of nominations, of people who would be prepared to assist the HDC. The reply was, as previously discussed directly with HDC, that we felt it would be appropriate for requests to come through the IMSANZ NZ executive, with a short list of nominations from the entire group, presented. This has previously not met the HDC requirements. However, the lack of response to this suggestion suggests that it may have been accepted.

Ministry of Health

We received and made responses to:

Review of Human Tissue Legislation and Regulatory Framework

The response was a limited expression of interest and since that time, in July 2002, we have had no further communication.

New Zealand Medicines and Medical Devices Safety Authority

We generally supported the establishment of a New Zealand register of medical devices and encouraged the move towards alignment in definitions and approach between New Zealand and Australia, and ultimately within a more global harmonization, perhaps initially focusing on the Pacific Rim.

Health Practitioners Competency Assurance Bill

We made a submission to the Health Select Committee in writing only, focusing on concerns within the Bill including definitions and scopes of practice, quality assurance clauses and representation on various proposed committees. We also discussed concerns that there was no specific recognition of the additional costs of these activities.

Proposals to amend aspects of New Zealand's Medicines Law

This was a large document structured into a number of regions to which I made reply on areas which semed relevant to internal medicine. Issues raised included some legislative change, which seemed sensible, however there were issues related to widening of prescribing to allied health professionals including dentists, nurses and others. I expressed some concerns about the issues of prescribing in this setting and suggested a possibility was combined prescribing in conjunction with an appropriate medical practitioner. Electronic prescribing was considered for inclusion in the legislation but the lack of attention to issues of data security for outpatient prescribing, was raised. Much of the document was based around the NHI number as an important identifier and issues related to patient identification were included in our reply.

Operational Standard for Health and Disability Ethics Committees

We were not specifically asked to comment on this document and the Ministry of Health responded to my complaint that this was not circulated widely for discussion in draft format, suggesting that, as it was placed on the Ministry's website, it was available to all!

New Zealand responses can be provided at your request.

Training

We have had ongoing involvement with the SAC General Medicine and recent activities include the nomination of David Nicholls, Manakau DHB, and Sisira Jayathissa, Hutt Hospital, to the SAC, as the SAC group increased its numbers by one and replaced Peter Black, who had been a long-standing committee member and Chairman, who had retired.

Current membership includes myself, John Gommans (Chairman), Denise Aitken (IMSANZ), along with other IMSANZ figures representing other College bodies.

We will be looking for a replacement for myself in twelve month's time.

Forum on General Medicine – Adult Medicine Division RCAP 20 March 2003

We look forward to feedback from the participants in the General Medical Forum.

Meetings

- 2003 IMSANZ RACP Hobart 26-28 May (*early bird registration closes soon)*
- 2003 Rotorua IMSANZ/Rheumatology/RACP 3-6 September - coordinator Paul Reeves
- 2004 Christchurch IMSANZ Thoracic Society RACP Dates uncertain - in October? Local coordinator?

Newsletter

Tom Thompson continues to have an active role in the editorial committee and I encourage all members to consider submissions for publication through the newsletter. This is a useful document and IMSANZ activity but requires the support of all members for contributions.

Finances

I would like to thank Kingsley Logan who has acted as treasurer for a great number of years, including through the transition between the New Zealand Society and the combined Australian New Zealand grouping.

As part of finalising some financial arrangements for the IMSANZ Group, I have taken over the role of treasurer and would be happy to continue in this role with the meeting support.

Financial issues include the presence and/or necessity for a New Zealand account, which under current arrangements has been agreed to be maintained at $NZ5000 by annual top-up if required from the IMSANZ base account. This continues to be questioned and discussions as to its value and/or alternative options would be of use whilst Cherie McCune and Les Bolitho are available to contribute.

We currently await a return on the fiscal outcome of the Dunedin meeting 2002.

The monies, which remained in the New Zealand account after full and final reimbursement to the IMSANZ base account have been separated into an 'Internal Medicine Foundation' account and include the money donated by the De Zoysa family to support the registrar prize. It is suggested that the Internal Medicine Foundation is an organisation representing the New Zealand group of IMSANZ and that it endeavours to provide support for advanced trainees in general internal medicine in New Zealand.

DR BRUCE KING
NZ Vice President, IMSANZ
Nelson

NORTHEAST HEALTH WANGARATTA

Wangaratta, Victoria

Consultant Physician, Consultant Paediatrician

- **Two positions**
- **Fee for service, assured hospital income**
- **Co-operative private practices, low overheads**
- **Possible joint academic appointments**

Northeast Health Wangaratta includes the busy 116-bed acute Wangaratta District Base Hospital (WDBH), which has an annual inpatient throughput of more than 12,000 and over 17,000 emergency medicine attendances. Servicing a population catchment of 90,000 from Wangaratta and the surrounding towns, it is the major regional health service and specialist referral centre in north east Victoria. It has a large complement of specialist medical staff and is well equipped with modern radiology, pathology and nuclear medicine departments. A 40-bed private hospital with HDU facilities is located nearby.

The Hospital's General Medicine Department has two accredited Registrars and two Interns from the Royal Melbourne Hospital. It has a 15-bed Paediatric Ward and six-bed, Level 2 Special Care Nursery. The region has about 800 deliveries a year, with about 500 at WDBH.

Candidates with an interest in undergraduate medical student teaching or broader academic activities may be considered for a part-time appointment with The University of Melbourne's Rural Clinical School (RCS), which is based in Shepparton and has a node at WDBH. Students from the RCS are additional to those rotated from Melbourne teaching hospitals.

The current three Physicians and two Paediatricians are keen to attract an additional Physician and an additional Paediatrician. On call duties are shared within each group. Each group practises from its own rooms, sharing facilities and expenses. The Physicians also provide services from the Wangaratta Cardiology and Respiratory Service.

You should have a medical qualification registrable with the Medical Practitioners Board of Victoria, Fellowship of the Royal Australasian College of Physicians (or a comparable postgraduate clinical qualification which is recognised by the RACP and allows you to be certified by the Health Insurance Commission as a Consultant Physician or Consultant Paediatrician) and appropriate specialist experience.

Wangaratta is just over two hours freeway drive from Melbourne. It is at the hub of a region which includes Victoria's high country and ski fields; and is flush with wineries and gourmet food production, and home to the Wangaratta Jazz Festival. As well as having sophisticated amenities and facilities, Wangaratta is unrivalled for those with a love of outdoor activities such as canoeing, kayaking, bush walking, mountain and road biking, cross country and down hill skiing, and gliding, hang gliding and paragliding.

We would be delighted to hear from anyone with a longing for a fabulous rural lifestyle and stimulating specialist practice as a Physician or Paediatrician. Please contact Les McBride in the first instance at:

Mail: Level 35, 101 Collins Street, Melbourne, Vic 3000
Phone: (03) 9663 0944
Fax: (03) 9663 9388
E-mail: lmcbride@ihug.com.au

Cleveland McBride
Executive Search and Selection

M50507

GENERAL PHYSICIAN (VMO)

~ Two Positions ~

Caloundra Private Hospital, Sunshine Coast, Qld

Sunnybank Private Hospital, Brisbane, Qld

The General Physician will provide private outpatient consulting services onsite together with management of general medical admissions and will be responsible for managing the entire episode of care including initial referral, management of inpatient care, liaison with GPs regarding inpatient and ongoing care, and follow-up.

The Hospitals can support you through providing consulting suites, comprehensive practice management andbusiness development support to assist in developing a broad referral base.

To learn more about these exciting opportunities, please contact Wayne Bruce -

Email: wayneb@trakrecruit.com | Phone: 02 9232 8148 | Mobile: 0407 245 799

Feel Like A Change?

General Physician in established rural VMO practice in NSW coastal belt would be interested in a six month job swap with colleague in similar practice elsewhere in Australia, to commence July or December 2004.

Please send expressions of interest, in confidence, to IMSANZ Secretariat, 145 Macquarie Street, Sydney 2000

GENERAL PHYSICIAN

Peri-operative physician is required for full-time position at Sydney Adventist Hospital, a large high-acuity private hospital in Wahroonga to manage pre- and post-operative medical problems in a wide range of surgical patients. The will be the right to private practice with fee-paying patients.

This is a “ready made’” practice with immediate full-time consultation load and a large and reliable referral base of surgeons. There is a vision to expand to extra physician in the future.

The Hospital will provide assistance with consultation rooms on-site for an initial period. There is a new SAN Clinic Specialist Centre under construction with sophisticated diagnostic facilities available and a large range of supportive medical specialists.

FOR FURTHER DETAILS PLEASE CONTACT

Dr Chris Swan, Director of Medical Services, Sydney Adventist Hospital, Wahroonga

Phone: 61 2 9487 9401 | Fax: 61 2 9487 9425 | Mobile: 0410 698277 | Email: chrissw@sah.org.au

EUROPEAN SCHOOL OF INTERNAL MEDICINE (ESIM)

ALICANTE, SPAIN
25-31 October 2003

IMSANZ is calling for expressions of interest from Advanced Trainees in general internal medicine, who are members of IMSANZ, to attend the European School of Internal Medicine (ESIM) in Alicante, Spain from 25 to 31 October 2003. IMSANZ and sponsors will support each trainee – one from Australia and one from New Zealand – with a return economy airfare and ESIM course registration and accommodation costs up to a total of $4000.

This year the program will be on 'New Challenges in Internal Medicine' and includes such topics as:

- HIV vaccines
- How can we manage orphan diseases?
- Quality index in taking care of patients
- Hormonal therapy replacement; how and for whom?
- How to avoid biases in research studies
- Validity index of diagnostic tests
- Early diagnosis and better treatment of dementia
- How can we manage disseminated cancer disease?
- Current status for organ transplants
- Judicious use of immune response in medicine (immuno-supressors and immuno-modulators in internal medicine)
- Difficulties in getting a paper published
- The use of invasive techniques in Cardiology

If you would like 'first hand' information please contact last year's attendees:

Leonie Callaway in Brisbane on 07 3840 8111 or 07 3351 7441
or email to Leonie_Callaway@health.qld.gov.au

Toni Staykova in Auckland on 09 535 3244, mobile 025 866 397
or email to toni_staykova@yahoo.co.nz

For further information, a full list of the preliminary program topics and an application form please contact the IMSANZ Secretariat on 02 8247 6206 or imsanz@racp.edu.au. **Applications close on Friday 18 July 2003**. The selected delegates, chosen by IMSANZ Council, will be advised within three weeks of the closing date.

Enquiries can also be directed to Dr Ian Scott, IMSANZ President, at ian_scott@health.qld.gov.au

EUROPEAN SCHOOL OF INTERNAL MEDICINE

Alicante, 2002 - Leonie Callaway

First Impressions

Alicante is located on the Mediterranean Coast. The surrounding landscape is reminiscent of the Nullabor Plains (hot, dry, minimal hardy vegetation). It is a fascinating place to wander around, with interesting old buildings, a palm lined boulevard, and some amazing shops. The beach is scattered with fabulous blue and white umbrellas, which gives a very "mediterranean" feel to the foreshore.

The delegates of ESIM concluded that respiratory medicine would continue to be a growth industry in Spain. Cigarette smoking is allowed in public buildings. The airport terminals were filled with a haze of smoke, resulting in an unpleasant yellowing of the paintwork. The hotel where we stayed, predominantly used by retired Spanish Doctors was af icted with a similar problem. One of the American delegates was invited to attend the hospital with Prof Jaime Merino. He was surprised to find nurses smoking in the intensive care unit!!

The People

The opportunity to meet with internal medicine trainees from 18 other countries was clearly a highlight of this trip. We discovered that we had much in common. Bed shortages, challenging patients and budgetary pressures seem to af ict most countries! Most trainees were in the very early stages of their training, so Toni Staykova and I were very much the "elders" of the group!!

The Academic Program

Speakers were invited from 14 different countries. The focus was on evidence based diagnosis and management of medical emergencies.

Novel approaches that I had not encountered before included:

- the use of ultrasonography to assess central venous pressure at the bedside, to assist in the uid management of the elderly
- the use of baclofen in the management of acute alcohol withdrawal (a multicentre randomized controlled trial is in progress)

Other sessions provided a sound overview of topics such as bacterial meningitis, bleeding complications following antithrombotic therapy, drug overdose, and fever in the HIV patient.

In addition, there were clinical case presentations from each of the trainees in attendance. This was a fascinating review of interesting and rare clinical cases. Three important points that I discovered were:

1. Clembuterol overdose is increasingly common in Europe. This is a drug used in raising cattle, and ingestion of cow liver can result in a severe beta agonist overdose.
2. Severe calcium channel blocker toxicity can be treated by insulin infusion (as per the New England Journal of Medicine protocol).
3. Faecal calprotectin may be a useful marker of mucosal damage in Crohn's disease, and may be able to more adequately assess disease activity.

Medical Professionalism Project

There were several working group sessions exploring this recent initiative of the American Board of Internal Medicine (ABIM 2002, Annals of Internal Medicine, 136; 3: 243-246). Delegates were given scenarios, and discussed the application of the principles of the Medical Professionalism Project. This project is an important step towards defining the principles underlying professional, ethical medical practice.

Safety and Quality in Health Care

Terry Wardle, from the UK has recently completed an interesting review of patients who died in hospital. He discovered serious inadequacies in documentation, investigation, promptness of consultant review, diagnostic accuracy, assessment of resuscitation status and adherence to resuscitation guidelines. The Royal College of Physicians is supporting further research and a confidential inquiry into these matters. There is ongoing consideration regarding how to improve this situation.

Training in General Internal Medicine – A global perspective

The discussion on training in internal medicine was absolutely fascinating. Training in Australia is very similar to the UK system. The USA has a significantly shorter period of training and very different mechanisms for in training assessment and examination. They have just introduced compulsory recertification examinations every ten years. Therefore, they seem to have given a lot of thought to the core knowledge that is required for a physician to be competent (as opposed to having an in depth knowledge of the latest immunology and genetics). Within Europe, there are widely disparate training schemes, with no standardized assessment of competence. There are initiatives within the European Union to formalize training and assessment in internal medicine.

In the USA, internists function as primary care doctors for adults. They have two to three years less training than subspecialists. In the UK, most general medicine is performed by "Acute Medicine Specialists" or by sub-specialists who continue to practice general medicine. Throughout most of Europe, the concept of broadly trained specialists in internal medicine is not well developed. However, increasingly the need for specialists who can manage chronically unwell patients with multi-system disorders is being recognized.

Emerging Workforce Shortages

It is interesting to note that much of Europe, the UK and Australia have significant shortages of medical staff. Estonia, Greece and Spain are producing more doctors than required to meet their needs. These countries export doctors to other parts of Europe. The European Union is working towards a policy of safe working hours for doctors, which is going to have a major impact on the numbers of doctors required. The UK, in particular, is grappling with the problems of trying to introduce "night shifts" into their rostering to comply with EU directives. This is going to result in massive workforce shortages.

The Social Program

On Sunday night we went to the "Welcome Ceremony" at Santa Barbara Castle, high above Alicante, watching the sunset, while eating tapas and being serenaded in authentic Spanish style! On Monday night, we were treated to a display of Andalucian singing and dancing. On Tuesday night, we went to "Darsena", a lovely restaurant overlooking the Marina in Alicante. We feasted on tapas and the "ubiquitous" paella, accompanied by good quality Spanish wines. On Wednesday afternoon, after three days of intense academic activity, we travelled to "Terra Mitica" in Benidorm, to revitalize ourselves with rollercoasters, ume rides and the other delights that a theme park has to offer. On Thursday night, the grand finale of the social program was the "Gala Dinner". The Scottish Contingent provided much entertainment by insisting that everyone learn Scottish Dancing – ask me to show you the pictures of Dr Michael Kennedy – Scottish Dancing Superstar!!

The Case of the "Lost Baggage"

While I was in Madrid Airport, just prior to embarking on the final leg of my journey to Alicante, I wondered how they ever managed to get bags from one aircraft to the next, given how busy and chaotic the whole place was. There were several rows of parked aircraft. We had to catch a bus between the airport terminal and the aircraft, because the terminal is just too small. Well, I didn't need to wonder for very long. Unfortunately, a couple of hours later, I found myself in a line with hundreds of other Iberian customers at the lost luggage counter. One of the Scottish delegates at the conference told me he had own with Iberian twice, and on both occasions his luggage was delayed for several days!

Several conference delegates had their luggage delayed, but I was the only person still "luggageless" by the end of the week!

Compulsory Retail Therapy in Spain

I am a great believer in retail therapy. However, the key elements to effective retail therapy are that:

1. You don't actually need anything – it is just fine to wander around shops for hours and not buy a single thing.
2. You can communicate with the shop assistants (Where is the shoe department? Please bring me the next size. I'd like to try the black rather than the red!)
3. You know where all your favourite shops are.
4. You know what size you are (Italian 3A? European 42? US 10?)

So shopping in Alicante for essential items, not being able to speak any Spanish, not knowing what size I was, and not knowing where to go looking all made for a very stressful "retail" experience. I would like to thank Jaime Merino for his assistance liasing with Iberian Airlines, and for pointing me in the direction of a wonderful department store – "El Corte Inglese". I would also like to thank Toni Staykova for lending me the fabulous shiny orange shirt for the gala dinner.

Practical tips for IMSANZ Newsletter Readers

To date, my luggage has never been located. It took more than six weeks for the airlines and insurance company to settle my claim. Given that general physicians have a holistic approach to life and have broad ranging interests, I offer IMSANZ newsletter readers the following practical advice:

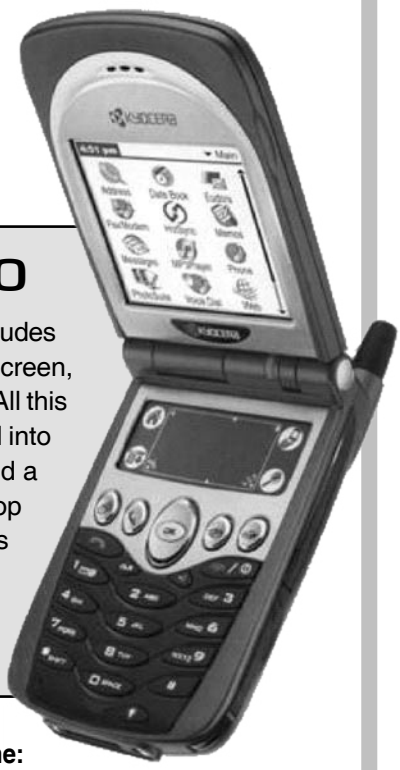
1. Only ever carry hand luggage – you really can exist for more than a week with only two sets of clothes – wearing evening attire to a gala dinner is unnecessary.
2. Read the fine print on your insurance policy!
3. Buy your airline ticket on a credit card where you are the primary card holder –that way you have insurance cover from your credit card as well – you are not covered if you are the secondary card holder travelling without the primary cardholder.
4. BEWARE - Madrid Airport has a lost baggage section with hundreds of bags.

Acknowledgements

I would like to thank IMSANZ and Roche Pharmaceuticals for their generous sponsorship. Lyn Abery and Cherie McCune, IMSANZ secretariat staff, were very helpful with the organizational aspects of the trip. Dr Michael Ward, Director of Medicine at the Royal Brisbane Hospital was very supportive in assisting me to gain special leave to attend this conference. The logistics of attending an international meeting are increased when one is the mother of a fifteen month old! So, finally, and not by any means least, I would like to thank my husband Murray and my mother, Olive Harris, for looking after Emily while I was away.

KYOCERA 7135
- A NEW TOY OR A GREAT TOOL FOR A BUSY PHYSICIAN?

ANDREW BOWERS, Dunedin



SUMMARY: 9/10

This latest revision from Kyocera updates the tool into an extremely useful machine! It includes all the power of a latest generation CDMA cell-phone, pager, Palm PC PDA with colour screen, Web browser, Fax-modem for your laptop, email client, web browser and MP3 player! All this comes with the power of mobile jetstream speed. All of these are beautifully integrated into a device that is smaller than my old Palm 105 PDA. If you are used to carrying around a cell-phone, a pager and a PDA then this is the device for you. If you carry around a laptop just so that you can check your email in the Koru lounge, or want to listen to MP3's during the long transits, then this warrants some serious consideration. Combine this with all the free medical Palm OS software available and it is a real winner, which has quickly become indispensable for me on a busy medical ward.

Telecom NZ recently asked me to review the Kyocera 7135. Kyocera call it a Smartphone, but I am not really sure that name does it justice. This is an all-in-one device that is a leading player in the tide of integrated multimedia personal devices. And I say about time too. For years we have been lugging around separate devices for phoning, being paged, organising appointments...and the list just keeps going on and on. At around NZ$1300 this device will replace 4 other devices that together could cost over $1900. Kyocera state a talk time of 3 1/2 hours and standby time of 160 hours. "Synch"ing it to the PC (via USB or Serial or IR or wireless Internet! connections) drains the battery quickly, but the cradle charges at the same time. The cradle also has space in the back to charge a second battery, so that unlike most PDA's with inbuilt batteries you are not left without its use while the battery recharges. This is a huge benefit for those always on the move around the wards.

This phone has some real "WOW!" value.

Everyone that I have shown it to wants one. Right from when I flipped it open and heard a Star Trek Tricorder sound I was sold. This was apparently only the second one in New Zealand and it is soon to be released in Australia, so I expect that shock value will last for a while. At 186 grams and the size of a pack of cards it is comfortable in the trouser pocket, not noticeable attached to the belt and a bit too heavy to go in the shirt pocket. It is built to be strong and really has a high quality feel about it.

MP3 Player:

It has a good MP3 player. Songs are stored in the (optional) Secure Digital card. Of course it is possible (and necessary on a ight) to turn off the phone and leave all the PDA and MP3 features working. Play quality is good with the headphones.

Pager:

This works with Telecom's paging service and most hospital services.

Notification pops up on the LCD screen shown, followed by a reminder envelope icon. All voice mail, text messages and page numbers are kept in the "messages" inbox. An LCD screen at the top lights up when a page is received. You can set it to vibrate or ring, with a customised MP3 fragment available for phone messages and reminders. I use a clip from Monty Python, which surely beats the usual paging tone.

Cell Phone:

This latest generation device is tri-band, CDMA digital PCS, CDMA digital cellular and analogue. (Phew, try to say that one without looking like a geek) What this all means in real-speak is that you can use it an increasingly large number of countries. Perhaps still less than the competing GSM network. But you get a much better sound clarity and super-fast Internet features that only come with these latest phones. This tri-band technology means easy roaming between NZ, Hong Kong, Australia, and the USA and Canada without having to worry about switching phones or hiring them at your destination. There are still holes in Europe, but I gather England is online now.

I recently tried this out in Australia and was nicely surprised to see that it not only worked very well, but it updated the time on the PDA automatically and adjusted for daylight savings time differences between Queensland and New South Wales on the PDA.

Some have said that the 025 or GSM networks gives better coverage in the cities, but this hasn't been my experience. I have not experienced any black spots yet and it has worked in some pretty tight gullies too. This is significantly better than my experience with a GSM phone here in New Zealand.

Other phones cannot use the great speed of the CDMA 1x network internet connection. This phone can be used as a PC modem connecting

KYOCERA 7135 *review continued from page 41...*

- A NEW TOY OR A GREAT TOOL FOR A BUSY PHYSICIAN?

your laptop at up to 153Kb/s which is faster than I get with my "broadband" connection at home. Or I can connect directly to my inbox without the need for a PC. Watch those data charges though! These have to come down before I will be doing too much surfing by phone.

The speaker sound has more depth to it than most phones, so I can hear a call easily in a busy corridor or street pavement.

PDA Features:

I have estimated that I used to miss about 1 in 10 meetings at work simply because I forgot they were on or got distracted by clinical work. Who knows how many other important things were delayed for the same reason. Since I have had this I haven't missed any meetings because I am reminded immediately, not when I get back to my PC. It may have saved my life too when it reminded me of my wedding anniversary (My wife forgot!). Paper notebooks don't open themselves up and remind me when needed either.

But is this enough to justify buying one? How many times have you been asked for an appointment on the telephone when you are nowhere near your desk or don't have a pen nearby to jot it down on a piece of paper that you lose? Priceless.

There is a huge amount of medical Palm software out there, and this is seriously useful to have at my finger tips on the rounds, and perhaps even better than having internet access on a ward round.

Here are some very useful links to Palm OS medical software sites:

www.epocrates.com

This is a great free drug database that you can use to look up that small print drug interaction or adverse reaction with ease. It is updated with every sync too

www.sanfordguide.com

This is a reasonably cheap anti-microbial database with treatment recommendations and probably represents a gold standard

www.hopkins.abxguide.org

This antimicrobial database is free and well written. Hasn't updated on SARS yet though. It updates with every sync also.

http://pbrain.hypermart.net/medrules.html

This is a free EBM tool featuring clinical prediction from medical literature

www.medcalc.be

Wow! Med-Calc is a free collection of about 30 different calculators for such things as Creatinine Clearance, A-a gradient, BMI, CHD risk, you name it and it is probably here! There would be few days that I don't use this.

www.ddhsoftware.com

This is a free database viewer that you will need to access the free medical databases that are available at this site

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There are hundreds more free or cheap programmes for medical staff available at ***www.palm.com***

The competition is increasingly using Pocket PC by Microsoft. The few advantages that Pocket PC may offer seem to be lost by hugely greater power consumption. When I recently tried one I found that it ran down in a matter of just a few hours making it unusable for my days, and I had to leave it in the cradle to recharge. Palm also has a far greater amount of software available and medical users should still consider Palm OS to be the standard as around 80% of medical people have chosen Palm over other OSs.

Kyocera have done a very good job of integrating the features of phone and PDA, and this represents a major upgrade to their last effort.

Is it a toy or a tool? You decide. But what is wrong with mixing work and pleasure anyway! Write in and keep this medical use of Palm devices discussion going.

Outlined below are recent publications of relevance to general internal medicine. Please send along additional publications and/or comments.

Internists worried as concern about general medicine's future spreads

Sullivan P. Canad Med Assoc J 2003;168:1032. Subspecialties, with a narrower focus, are more attractive to Canadian trainees than generalist programmes.

Generalists and gerontology. Bolitho LE. Med J Aust 2003;178:96. Les Bolitho comments on the editorial "Generalists and gerontology" (Med J Aust 2002;177:281) and outlines the role of IMSANZ and the RACP in addressing the key issues confronting general internal medicine

The future of primary care. Sox HC. Ann Intern Med 2003;138:230-231. Harold Sox, who has been a very active member of the USA Society of General Internal Medicine, wrote this editorial for an issue of Annals of Internal Medicine which reviewed primary care in the USA. In contrast to Australia, primary care is provided by practitioners in general internal medicine and by subspecialty practitioners, as well as by practitioners in family medicine. Many of his comments on the USA situation also apply to the antipodes.

The care of the acute medical inpatient – whose job is it? Raju M. Canadian Society of Internal Medicine Winter Newsletter 2003;4-5 (http: //www.csim.medical.org). The impact of the evolution of the "Hospitalist" is discussed.

The hospitalist: a US model ripe for importing? Hillman K. Med J Aust 2003;178:54-55. Hillman calls on an evaluation of the possible development of a hospitalist system within Australia, within a setting of changing roles of acute hospitals and the types of patients likely to be managed within them.

Training on the internal medicine teaching wards. Flegel KM and Palepu A. Canad Med Assoc J 2003;168:997-998. This commentary discusses the adequacy of current Canadian internal medicine teaching wards to provide appropriate experiences for medical student and early postgraduate training.

Clinicians, educators, and investigators in general internal medicine – Bridging the gaps. Mukamal KJ, Smetana GW & Delbanco T. J Gen Intern Med 2002;17:565-571. Specific strategies for collaboration between divergent streams of clinician educators, investigators, and administrative leaders within medical schools are proposed.

The role of the medical consultant. Cohn SL. Med Clin N Am 2003;87:1-6. This is a well-reference review of the concepts of preoperative medical evaluations. Issues addressed include "determining the question", "answering the question", "improving compliance" and "co-management and benefits of medical consultation".

The following papers address the continuing issue of differences between generalists and specialists in terms of knowledge and outcomes:

Differences between generalist and specialists: knowledge, realism, or primum no nocere? Turner BJ and Laine C. J Gen Intern Med 2001;16: 422-424 (editorial).

Specialty of ambulatory care physicians and mortality among elderly patients after myocardial infarction. Ayanian JZ, Landrum MB, Guadagnoli E and Gaccione P. N Eng J Med 2002;347:1678-1686.

Specialty care for heart failure: Does it improve outcomes? Massie BM and Ansari MN. American Heart J 2003;145:209-213.

In uence of physician specialty on adoption and relinquishment of calcium channel blockers and other treatments for myocardial infarction. Majumdar SR, Inui TS, Gurwitz JH, Gillman MW, McLaughlin TJ and Soumerai SB. J Gen Intern Med 2001;16:351-359.

Relation of physician specialty and HIV/AIDS experience to choice of guideline-recommended antiretroviral therapy. Stone VE, Mansourati FF, Poses RM and Mayer KH. J Gen Intern Med 2001;16:360-368.

Physician specialization and antiretroviral therapy for HIV. Landon et al J Gen Intern Med 2003; 18:233-241.

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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 will now be published twice a year in June 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 Cherie McCune, IMSANZ secretary.

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

Submissions should be sent to either:

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Should you wish to mail a diskette please do so in 3.5" format.

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